residence, where he had drunk twice of ale. He lived in a thickly settled portion of the town, was well known, and because of his kindly manners was a general favorite.

The next morning, two men, while rowing in a boat on a pond about a quarter of a mile from where McCarthy lived, and about the same distance from the saloon, saw, perhaps twenty feet from the shore, the gray head of a man apparently floating just beneath the surface of the water. The body was taken to the shore, identified as that of McCarthy's, and I was called to view it.

The posture of the body was that of semi-sitting, and it was properly clothed. The head, face and neck were covered with cuts and bruises. The most striking features were the loss of the right ear, a large denuded surface on the right side of the neck which exposed the opened external jugular vein, and the absence of all blood from the clothing.

An autopsy was made that afternoon and the following facts were ascertained: The body was that of a man well nourished, rigor-mortis was present, and cadaveric hypostasis was marked on the face and the upper part of the chest. The palms and the hands were blanched and wrinkled, and crepitation was noticed by pressure applied to the right side of the chest down as far as the nipple. As was stated, the neck and face on the right side were the seat of many injuries. Beginning with the nose, on the right side there was a cut one inch long, the tip of the nose was denuded of skin and a V-shaped cut extended through the cartilage separating it from the bone. Just below the right eye was a scratch three-fourths of an inch long. There was a bruise on the cheek one inch in diameter; three other smaller bruises on the cheek, from which the skin was partially denuded. The right ear was separated from the side of the head leaving a jagged irregular edge, the auditory canal being filled with clotted blood; below the ear and in front was a denuded surface two and one-half by one and one-half inches wide, the lower border irregular in outline; in this wound the opened external jugular vein was seen. Behind and slightly above the right ear was a scalp wound one and one-half inches in diameter; below and behind this was a cut two inches long that did not go through the scalp; leading into this from above was a cut one inch long and from below a cut an inch and a half long. Above and three inches behind the right ear was a cut three inches long extending through the scalp, and in this region were several other cuts and scratches from two to three inches long.

Passing to the internal examination of the body, the lungs, deeply pigmented, were prominent and did not collapse after the sternum was removed; both were firmly attached to the thoracic walls, the pleural cavities being nearly obliterated. On applying sufficient force to remove the lungs much water tinged with blood escaped into the thoracic cavity. A ligature was applied so as to include the trachea and the large blood-vessels, and the lungs and heart were found to float in water. Pressure applied to the cut surface of the lungs caused the escape of a watery fluid, in fact, the lungs seemed to be saturated with water. The heart, opened under water, showed the escape of bubbles of air or gas; the left side of the heart was nearly empty, while the right side was filled with soft clots.

The abdominal organs were normal; the stomach

contained about four fluid-ounces of light-brownish colored fluid.

On removing the scalp, areas of discoloration were noticed beneath the external wounds. The brain was normal and the skull was not fractured.

The wounds found on the face and neck and described as cuts and bruises were peculiar in appearance. The cuts, with one or two exceptions, would perhaps more properly be described as deep scratches. The denuded surface on the neck was deeper at its upper portion, gradually growing more shallow until at its lower border the line was irregularly notched.

A second visit to the pond in which the body was found and a more careful examination of the premises, revealed agencies that could possibly have caused some of the injuries noted. Along the shore of the pond, about fifty feet from where the body was found, was a short section of barbed-wire fence several lengths of which were submerged. Although there was no current in the pond, it is perhaps possible that the face of the body came in contact with the barbed wire causing the injuries. This may have been the case, although one would suppose that if the body had been in contact with the fence a sufficient length of time to cause the injuries, the clothing would have become attached to it. The bottom of the pond is composed of soft mud, there being no stumps of trees or large stones anywhere in the vicinity. The other injuries might have been due to the body being struck by a row-boat, although it seems hardly credible that an ear could be severed from the body in such a manner.

An inquest was held but no decision has been made by the judge. The medical evidence was to the effect that the cause of death was drowning, and that the wounds were probably received after death in some manner unknown.

WHAT SHALL WE DO WITH TENDER AND PAINFUL STUMPS AFTER LAPAROTOMY?

BY BYRON ROBINSON, CHICAGO.

WHAT shall we do with painful and tender stumps after laparotomy, has no doubt puzzled many gynecologists. In one of my series of one hundred laparotomies, three patients bitterly complained of tenderness, pain, and a dragging, sickening sensation on active exercise. Careful vaginal examination soon convinced me that it was in the left stump of the broad ligament. The painful stump had periods of exacerbation. It would remain relatively quiet for some time, and the patient would only complain of it as a tender spot, or a little increased ache toward night after the day's exercise. But the sense of a tender locality in the pelvis would not entirely disappear. Only by slow, careful and gentle manipulation can one locate the stump in times of quietude. At the times of exacerbation the tissue around the stump, or especially a large part of the pelvis, will be so tender that one cannot localize any distinct point. There may be occasionally slight edema and thickening, but general local tenderness and pain is the general symptom. One patient complained of burning in the whole lower abdomen and pelvis. In this special series of one hundred cases the neurotic stumps appeared all (three) on the left side. This may be owing to the clinical observation that the left appendage is affected seven times out of ten. Again, the blood-vessels and nerves

are more in quantity on the left side. The veins do not return with the same facility as they do on the right. The nature of the cases may be better understood by a short presentation of them.

CASE I was single, twenty-eight, slight build, one hundred pounds, old hip-joint trouble. She was delicate in appearance, and in a neurotic, sensitive condition. She had had salpingitis and ovaritis for about two years. The left appendage was found thickened and tender, especially more than the right. In laparotomy I removed both appendages, tied the tubes with twisted silk (No. 12), and closed the abdomen without drain. She recovered well. Some three months later I was called for rectal trouble, or rather pain in the pelvis with mucal discharges from the rectum. She had severe spells of pain in the pelvis. At first I could not locate any tender point or stump by the most careful examination, though she was slightly tender on the left side. I called Dr. Fergusson, who excluded the hip-joint from any guilt in the trouble. I then called Dr. Bacon to pronounce whether any rectal disease existed, but he said the rectum was guilty of nothing. After the joint and rectal specialists had found nothing in their fields, I kept up periodic examination; and some six months after the operation the trouble could be quite distinctly located in the left stump of the broad ligament. The irritation on the stump is reflected on the rectal nerves, and to the patient the disease appears to be in the rectum. She is unable to work, and has an exacerbation of the pelvic pain every three to six weeks, at which time considerable mucal discharge arises from the rectum. All wounds are perfectly healed.

CASE II from this series of one hundred sections, occurred in a married woman of thirty-two. She had no doubt been infected by her husband seven years before at marriage. She was neurotic, pale and irritable. She had dysmenorrhea, and was generally run down. In laparotomy I allowed Dr. Sessions, the interne at the Woman's Hospital, to tie the ligature around the appendages after I had enucleated them from a bed of severe inflammatory adhesions. No. 12 silk was used. Six weeks after the operation she developed pain on the left side and since, that is for eight months, she has been a severe sufferer. In fact, she says now she suffers more than before the operation. The tenderness in the left side is easily localized, and to move it causes agony, especially at times of exacerbation, for she has times of relatively ease and quiet. Her wound healed perfectly with no drain-tube.

CASE III was in a married woman of thirty-six, who had been ill for some two years. In laparotomy both appendages were removed, tied off with No. 12 silk, and the abdomen closed with no drain. She developed emphysema in the right side, the size of a saucer, just above the ilium. She had also pleuritis on the right side. Recovery was slow and she complained of much pain for a month on the side. Three months after, she visited my office, when I found that the left stump had a tender spot on it. She gained flesh, but the pain in the left stump is very severe on slight pressure. Her wounds healed perfectly. On digital examination previous to the operation the left appendage was the more diseased.

In this series of one hundred sections three distinct cases arose of painful and tender stumps. They were all on the left side. In all, the left appendage was

more diseased than the right. The silk used was No. 12, braided and well boiled. They were all of a neurotic disposition, debilitated by long-continued disease. The diseased, painful and tender stump began to be localized in the earliest case six weeks after the operation. The cases are now continuing six to ten months old. No drain-tube was used, and the wounds all healed perfectly. It is likely that one or all will require a second operation.

The question now arises, How can we avoid a painful and tender stump after section? I have tried kangaroo tendon in the abdomen, but not long enough to secure pronounced views on the matter. It is not yet fully understood what produces a neuroma on the end of a ligated stump. It does not appear to be merely infected wounds. It does appear to occur in neurotic, debilitated patients.

In my clinic come patients from other gynecologists, who suffer from painful and tender stumps. Such patients are neurotic, but they may have been made neurotic by continued pain and irritation in the stumps.

It would no doubt be better, if it were possible, to isolate the arteries and ligate them alone.

The occurrence of a painful and tender stump in a neurotic patient is a severe blow to surgery, as such patients give unlimited scathing criticism to operations. It makes them everlasting foes to surgery.

Our suture materials and our methods of application may yet be changed for the better.

Medical Progress.

RECENT PROGRESS IN GYNECOLOGY.

BY F. H. DAVENPORT, M.D.,

Instructor in Gynecology, Harvard Medical School.

TREATMENT OF THE STUMP AFTER MYOTOMY.

MANGIAGALLI¹ in a paper read before the International Congress at Rome discusses the various methods of operating, and comes to the following conclusions:

(1) The influence of the treatment of the stump on the mortality in cases of hysterectomy has been exaggerated.

(2) Other general and local conditions deserve much more attention; as the intra-ligamentous development of the tumors, which gives a bad prognosis.

(3) In order to be able to estimate the results of all methods of myotomy, it is necessary to divide fibromata into (a) intraligamentous, (b) subserous, submucous and interstitial. The second class gives with either an extra- or intra-peritoneal treatment of the stump a mortality of about five per cent., which can with difficulty be improved by total extirpation (abdominal or abdomino-vaginal).

(4) The intraperitoneal treatment of the stump must with few exceptions displace the extraperitoneal, since it gives the same mortality with less danger.

(5) The Zweifel method is to be preferred on account of its simplicity, and the possibility of rapid performance. Mangiagalli covers the elastic ligature with the dissected peritoneal flaps, without removing it as Zweifel does.

(6) The intraligamentous fibroids show at present a

¹ *Cent. für Gyn.*, No. 16, 1894.