TECHNIQUE OF NEW METHOD OF ABDOMINAL HYSTERECTOMY.

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The dangers attending the abdominal removal of the myomatous uterus are shock, hemorrhage, functional injury to important organs near the uterus, and infection. The operation that I am about to describe to you has in view, as far as can be done by an improvement of technique, the removal of these sources of danger.

As you all know, in abdominal operations the exposure of the organs to unnecessary handling and the loss of heat they sustain are most potent agents in the production of shock; hence in the removal of myofibroma of the uterus, the abdominal cavity should be exposed for as short a time as possible. It is therefore the particular aim of this operation to secure access to the myomatous uterus in as short a time as possible and with as little exposure of the abdominal organs; hence, after opening the abdomen in the median line in the usual manner, tying off the broad ligaments on both sides by two sutures, the uterus is brought well forward into the wound and then on a level with the section through the broad ligaments, the peritoneum is divided from one side to the other, and the flap is reflected and sewed to the parietal peritoneum, when the opposite side of the uterus is dealt with in a similar manner. In making such a peritoneal cuff it is absolutely necessary to cut only through the peritoneum, and not through the large subperitoneal vessels in order to prevent hemorrhage. In making the cuff, the dissecting forceps is an exceedingly useful instrument; the process of deperitonization can be carried on readily by the use of the hand or a blunt instrument. As soon as the cuff has been sewed to the lower angle of the wound, the balance of the abdominal incision is closed; we then have the uterus with the tumor or tumors outside of the peritoneum.

I call this an extra-peritoneal operation. Rendering the uterus extra-peritoneal is a matter, in the majority of cases, of only a few minutes, when the balance of the operation can be performed at leisure. The later steps of the operation are not attended by immediate causes which expose the patient to the risks of shock. Having closed the balance of the wound, the uterus is then amputated at the desired point. Usually in cases of single or multiple myofibroma, the cervix is intact. If the cervix is affected the entire uterus can be removed. For the purpose of preventing hemorrhage during the amputation of the uterus, I then proceed to ligate the uterine arteries on each side, which is done by applying an indirect ligature. It is unnecessary to take time in isolating the uterine arteries; we can ligate and tie them very accurately with needle armed with medium-sized silk ligature. The amputation is then made by making an incision obliquely so as to make a cone of the stump of the uterus and a corresponding depression of the parts left behind. Very little hemorrhage attends this part of the operation, provided the arteries have been tied on both sides; at any rate, no additional ligatures are ever required.

After the uterus has been removed, I then excise the mucous membrane of the uterine canal and close

the wound with a row of absorbable sutures, chromicized catgut. For the purpose of arresting parenchymatous oozing the cut surfaces are then closely united by two additional rows of buried sutures; there is no need of elastic constriction, and nothing to induce subsequent necrosis of tissue. We leave the wound in a condition compatible for healing with primary union. If hemorrhage occurs at any time, the amputated cervix remains accessible for twenty-four or forty-eight hours. You perceive that so far the object we have in view is to expose the peritoneal cavity and its contents as short a time as possible, to control hemorrhage systematically and to prevent functional injury to organs near the uterus—the bladder, ureters and intestines. The organ is simply removed sub-peritoneally, leaving behind a peritoneal cuff. If the operator is sufficiently careful to resort to the necessary antiseptic precautions, the only source of infection during the operation will be the hands, the instruments, the sponge. There is no possibility of post-operative infection of the peritoneal cavity. The wound is usually two or three inches in length; its floor is packed with iodoform gauze, and two secondary sutures are at once inserted. Twenty-four or forty-eight hours later the gauze is removed. Usually a little parenchymatous oozing takes place, sufficient to saturate the inner part of the dressings. The wound is then closed. There is at no time any tension upon the stump. If infection should occur after the operation, it is limited to the wound outside of the peritoneal cavity.

Some of you may raise an objection to leaving so much of the abdominal incision unsutured immediately after the operation and may entertain the unfounded idea that ventral hernia will follow; but if you remember what you observe almost daily, that an aseptic granulating wound, when coaptated by suturing, heals as readily and as promptly as a recent wound, you will see that there can be no objection to the temporary packing of the lower angle of the wound until the time has elapsed that we no longer need to fear the two greatest dangers of laparo-hysterectomy—hemorrhage and infection.

Now, in bringing this new operative procedure to the attention of the profession the crucial test must be furnished by its results. Of thirty-three or thirty-five laparo-hysterectomies in unselected cases, not only every one of the patients recovered, but I have failed to observe in a single instance any untoward results. I believe, therefore, the Section will excuse me in pressing the merits of this method in dealing with such a formidable condition as myofibroma of the uterus; and, at any rate, I ask for this operative procedure a fair trial at your hands.

Insecticide for Tree-pests.—The year 1895 has been marked in some parts of the United States with an unusual prevalence of insects destructive to trees. The *Pharmaceutical Era* offers the following combination, which physicians may be glad to use now or put away for use next spring:

Corrosive sublimate	gm. 32.
Soft soap	litres 4,100.
Alcohol or wood spirit	cc. 500.
Water, q. s.	

Dissolve the corrosive sublimate in the alcohol or spirit and stir it into the soft soap, add water enough to make a stiff paint and apply to the base of tree with a brush. This is the best remedy against the borers of the apple and also for the woolly louse.