

VAGINAL HYSTERECTOMY FOR PYO-SALPINX AND FOR UTERINE MYOMATA.¹

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It is not at all strange that one skilled and experienced in vaginal hysterectomy should welcome the application of this operation to other affections than the single one of cancer of the uterus, to which it was formerly limited. The important question for consideration is the choice of operation in cases of small fibroids, pus-tubes and pelvic abscesses. Those advocating vaginal hysterectomy in these cases present at least one very strong argument in favor of the abdominal rather than the vaginal operation; that is, that much greater skill is required for a vaginal than an abdominal hysterectomy.

Now, when it becomes a question of choice between the two operations, in fibroids, pus-tubes, pelvic abscess, cancer of the body of the uterus, and sometimes cancer at the os, if the abdominal operation be the simpler and the easier one to do, this is one good reason for giving it the preference. Then if it be attended with as little immediate and remote danger as the more difficult vaginal hysterectomy and be followed by as prompt and complete recovery in as large a percentage of cases, we certainly have no reason left for substituting for it the vaginal operation.

We are much more liable to certain accidents in removal of the uterus by the vaginal than the abdominal route, namely, injury of the bladder, ligation of the ureters, hemorrhage from defective ligation of uterine or ovarian arteries. When clamps must be used, in place of ligatures, there are the accidents that attend their use.

In abdominal hysterectomy the ligation of the upper portion of the broad ligaments, including the ovarian arteries, is a perfectly simple matter. Then the bladder is easily and safely separated from the uterus. Next the uterine arteries are readily found, just below the internal os, and there secured without the least danger of including the ureters. Then with bladder and ureters well pushed out of the way, we dissect and remove the uterine neck with perfect safety, or leave it *in situ*, as in Baer's operation.

I recall these steps of the operation to emphasize Dr. E. W. Cushing's statement that it is a much easier operation to do than vaginal hysterectomy, and to show that it is free from the two great dangers of the latter operation — injury of the ureters and hemorrhage.

As to the after-results of the two operations, in my own experience patients after abdominal hysterectomy for fibroids, unruptured pus-tubes, or cancer in the os or body of the uterus, have recovered with less disturbance and as rapidly as after the vaginal. Especially when clamps are used we often get abdominal distension and reversed peristalsis — in short, a localized sepsis that delays recovery.

The tissue caught in the blades of clamps must slough and come away — a process often occupying two or three weeks. Rarely after complete abdominal hysterectomy a hernia occurs, and frequently after the vaginal operation there is prolapse of the bladder. This complication I have seen in several instances; it is much more troublesome and incurable than hernia.

It is true that the shock from the abdominal operation is greater than from the vaginal. This shock,

even if the Trendelenburg posture is used, is only temporary. It is very rarely fatal, and only in those patients septic from pelvic abscesses, or in those who have lost a great amount of blood from fibroids or cancer. These patients would die of shock as readily, and more readily, I think, in ordinary hands, if operated by the vaginal route.

In one direction I am a good deal inclined in favor of vaginal hysterectomy, and that is in cases of extensive abscesses in the pelvis. I do not mean pus-tubes the size of the thumb or wrist, where the pus is contained within them, but when the pus is more or less diffuse in the pelvis.

Barring acute intestinal obstruction and appendicitis, they are the most fatal abdominal operations we have. I have not done the vaginal operation in these cases, but it seems to me that here would be a very great advantage for vaginal hysterectomy in its more extended application.

EXOPTHALMIC GOITRE TREATED WITH ANIMAL EXTRACTS, AND ESPECIALLY EXTRACT OF THYMUS.

BY ROBERT T. EDDES, M.D.

It is undoubtedly well in trying to reach therapeutic conclusions in regard to new remedies to wait until cases have accumulated in sufficient number to be used for statistical analysis. This is especially true where there are great variations in the severity and course of different cases and different epidemics, and when considerable numbers are likely to come under the observation of a single individual.

When, however, a chronic disease is not very common, never occurs in epidemics and its usual course under other methods of treatment is already pretty well known, the report of a single case with reference to a new and little-used remedy may, without impropriety, be ventured upon as a contribution to more extensive statistics.

With this apology I present the following case of exophthalmic goitre treated with certain animal extracts:

Miss X., age thirty-four, whose father died of apoplexy and mother of phthisis, had, several years ago, a goitre described in one account as "exophthalmic," which is said to have been cured by electricity in two weeks. Recently, after much domestic and personal care and worry, she lost sleep, became nervous and hysterical, and developed neuralgias in her neck, chest and arm. She is said to have had pleurisy, but this I consider somewhat doubtful. When she entered the Adams Nervine Asylum in October she presented a typical case of exophthalmic goitre. The eyeballs were prominent; there was a tumor in the neck, not large, to be sure, but perfectly evident; the pulse was rapid and irregular, and she was in a condition of great nervous restlessness, both bodily and mental. There was possibly a very slight systolic murmur along the left edge of the sternum and a very loud one over the right lobe of the thyroid, but with this exception and the violent throbbing of the carotids there were no other physical signs. The weight was 112½ pounds, the blood color 71, and the urine generally a little below the average, with urea less than 20 grammes per diem.

About a month after her entrance she was put upon capsules of dried thyroid, which were continued nearly

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another month without perceptible influence upon her condition or the secretions, urea and uric acid being quantitatively examined.

Early in February she was put to bed, and given bromide of potassium in considerable doses.

In May and June she received hypodermic injections of nuclein prepared from spleen, and later an extract of spleen prepared for me by Parke, Davis & Co. There was no favorable result perceived from these, but a good deal of local pain and increased nervousness therefrom. On the whole, however, during this time she gained flesh and lost in restlessness; but the pulse was never recorded below 104, and the carotids were still throbbing with great violence.

On July 15th she began to take capsules of dried aqueo-glycerine extract of the thymus gland, using most of the time three, containing each one and one-half grains, per diem.

On August 5th, she was feeling much better but there was no very obvious change in the symptoms; and on September 7th she was discharged, "relieved," still taking the capsules.

She was seen on November 18th. She had stopped the thymusine about four weeks after leaving the asylum (because her supply gave out), and until a week or two ago had felt better. Had tried to go to work, but could not. Now her general appearance is less nervous and manner less excitable. Pulse 108, irregular. Considerable throbbing of carotids, but perhaps less than formerly. Less swelling of thyroid. Feels less restless, and considers herself much better. She was provided with capsules to take twice a day, and report when they were gone.

On December 6th, the pulse was 92 — the first time I had ever found it at that figure, although it was taken while she was sitting up and after reaching my office, presumably by walking, while previous observations had often been when in bed. She said she was better, and considered the swelling of the thyroid less. She considered herself competent for not too laborious employment. Later I heard of her as engaged in a shop during the active Christmas season.

The number of cases of exophthalmic goitre so far reported as having been treated by thymus is by no means so large as might have been expected in these days of the popularity of animal extracts in therapeutics. It has, however, been used, and with good results, in simple goitre.¹

David Owen² made an interesting and successful experiment with this agent, and certainly without any prejudice in its favor, for he thought he was treating a patient with exophthalmic goitre by thyroid feeding until he discovered that, by a mistake of the butcher, she had been having thymus.

R. D. Cunningham³ treated three cases with good results, the first two with raw or slightly broiled thymus, and the third with thymus tabloids, twelve to fifteen five-gramme tabloids per diem.

Miculicz⁴ treated eleven cases of goitre, of which only one, however, was exophthalmic, with doses of ten to fifteen grammes of thymus, increased to twenty-five, three times a week. In ordinary goitre his results were confirmatory of those of Bruns, but in the exophthalmic the good results as to nervousness, palpitation, dyspnea and attacks of threatened suffoca-

tion were obtained without any marked diminution in the size of the thyroid tumor.

All three of these writers close their papers with interesting discussions of the physiological questions raised, and to that of Cunningham is appended quite an extensive bibliography.

My thanks are due to Messrs. Parke, Davis & Co., not only for calling my attention, during the course of a correspondence relative to spleen extract, to this preparation with which they kindly supplied me, but also for the references to the recent literature of the subject.

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MICROCOCCLUS BRISOU.

A CONTRIBUTION TO THE STUDY OF DIPHTHERIA.

BY A. GASTON ROETH, M.D., BOSTON.

THIS organism, first recognized by Roux and Yersin,¹ has heretofore never been described, nor have its biological characters ever been studied. Its presence has simply been noted as being constant in benign forms of diphtheria and pseudo-diphtheria, beginning with the case of the child Brisou.

The following are its characteristics:

M. BRISOU.

OCCURRENCE. — In membranes and on congested parts of throat.

GENERAL CHARACTERS. — Small, spherical coccus 0.6 μ in diameter, single and in irregular groups, non-motile, odorless, chromogenic. Rapid growth. Non-pathogenic for mice or guinea-pigs. Stains well with the ordinary stains and with Gram's method. Grows best at 37° C. and on serum. Aërobie grows at 37.5° and at 20° C.

COLOR. — Gray.

GELATIN is liquefied. Stick culture: Nail-like growth and liquefies rapidly. Plate: Colonies raised, small, with well-defined zone, with granular yellowish contents.

AGAR. — Streak culture: Broad towards lower edge, with irregular borders. Grows very luxuriantly on glycerine agar. Wurtz: Litmus not reddened.

POTATO. — Dirty grayish growth, and with irregular margins, spreading towards lower edges and raised above surface.

MILK. — Not coagulated.

SMITH SOLUTION. — Gas produced.

NITRATES. — Not reduced to nitrites.

BOUILLON. — Turbid, rapid, cloudy growth, on shaking a white precipitate forms at bottom of test-tube.

Although associated with both the Klebs-Löffler and with the bacillus of pseudo-diphtheria, it remains a fact that its presence invariably denotes a favorable termination of the case; therefore, to my mind, it seems that its isolation and recognition is certainly of great importance to the diagnostician, and consequently this micrococcus should find a place in the literature of diphtheria.

What its rôle may be in this disease, whether it inhibits the virulence of the Klebs-Löffler as it is said the bacillus coli does in the presence of the Eberth bacillus, or what other functions it may or may not possess, is not the purport of this communication; these points no doubt will be made clear in the future.

The above brief description is purely for the purpose of presenting to the profession another factor in the study and particularly in the prognosis of this disease.

CHOLERA in Egypt is confined to a few villages in the delta, and is apparently dying out.

¹ Vide Annales de l'Institut Pasteur, 1891, p. 660.

¹ Bruns: Deutsch. med. Woch., 1894, No. 41.

² British Medical Journal, vol. 1, 1895, p. 361.

³ New York Record, June 15, 1896.

⁴ Berlauer. klin. Woch., 1895, p. 342.