PART IV.

MEDICAL MISCELLANY.

Reports, Transactions, and Scientific Intelligence.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

President—EDWARD H. BENNETT, M.D., F.R.C.S.I.
General Secretary—JOHN B. STORY, M.B., F.R.C.S.I.

SECTION OF OBSTETRICS.

President—F. W. KIDD, M.D.
Sectional Secretary—JOHN H. GLENN, M.D.

Friday, January 7, 1898.

The PRESIDENT in the Chair.

Specimens.

DR. ALFRED J. SMITH showed a large fibro-myoma with uterus and appendages removed by cœliotomy on December 14th, 1897, from an unmarried woman, aged thirty-six. The patient noticed for the past seven or eight years a lump in her abdomen, which increased in size during menstruation; it caused little or no inconvenience up to two years ago when it suddenly got much larger and became painful to the touch. Menstruation ceased eighteen months ago.

Examination before Operation.—A large, solid mass the size of a seven months pregnant uterus filled the central portion of the abdominal cavity; it was movable upwards and could touch ribs on right side; it did not sink into the pelvis, as there was a clear margin about two fingers' width above the pelvis, which was quite clear on percussion.

Bimanual under Ether.—Cervix pointed downwards and forwards. Fundus, small posterior. Left ovary enlarged in front; right low down. Sound passed 5 c.m. Traction on cervix with volsella demonstrated no connection with tumour.

Diagnosis.—From facts stated above the tumour did not appear to be uterine. Every possible variety of tumour was suggested as a probable solution of the difficulty.

Abdominal Section.—Extensive incision was made; tumour was easily drawn out of abdomen, and in making tension on it to determine the pedicle, Dr. Smith was astonished to find ovaries and tubes coming out along with it. The pedicle was twisted loosely, it was quite translucent when untwisted, and contained no solid portion. A chain suture was introduced and tumour removed. On examining pelvis a solid mass occupying the position of the uterus was felt.

Specimen consists of a large fibro-myoma growing from the fundus of the uterus. The uterus consists of the fundus and supravaginal portion of cervix, with hypertrophied and elongated tubes and ovaries attached. An amputation had taken place sometime previously through the junction of the supravaginal portion of the cervix and the portio media. There was no accumulation of fluid in the uterine cavity, or any peritoneal adhesions. The case is interesting as demonstrating the difficulties of diagnosticating abdominal tumours, and to explain how the amputation took place. The twisting of the pedicle was certainly not sufficient. Recovery uneventful.

Dr. Smith also exhibited a large fibro-myoma of the uterus removed by cœliotomy. Recovery.

Dr. R. D. Purefoy.—(*a*) Myomatous uterus removed by cœliotomy; (*b*) Sub-peritoneal myoma removed by cœliotomy.

The Action of the Vaginal Plug in Accidental Hæmorrhage.

Dr. Hastings Tweedy read a paper on the action of the vaginal tampon in accidental hæmorrhage. He contended that when this was properly applied it directly compressed the uterine arteries, acting on them as does a tourniquet. A well-fitting plug should, in the first instance, fix the cervix by completely surrounding it with pledgets of moist cotton wool packed as tightly as possible, and should then fill the vagina to its utmost capacity, direct compression thereby being exercised on the uterine arteries. The obstruction to the circulation thus brought about causes moreover an accumulation of carbonic acid gas in the uterine muscles, which is a well-known and powerful stimulant to uterine contractions. He adduced arguments in favour of these theories founded on (1) observations made on the pregnant cadaver; (2) the analogy of Doyen's hysterectomy, where a steady down drag exerted on the cervix causes this operation to be bloodless; and (3) results

obtained in practice—where, as in one instance, hæmorrhage was arrested in spite of a large intravenous saline injection, and in a time too short to permit of any other explanation as to the plug's action.

Dr. Winifred Dickson said that accidental hæmorrhage had always seemed to her to be the very worst complication in midwifery. Why did he (Dr. Tweedy) think it better not to use the speculum? She thought that the plug ought to be sterilised. Did he plug with balls of cotton wool, and did he attach strings to them in order to facilitate their removal?

Dr. Macan thought that accidental hæmorrhage was amongst the most difficult of the accidents of parturition to treat. He could recall several cases where Dr. Tweedy's treatment might have been of service, if it was as serviceable as he (Dr. Tweedy) hoped it to be, but he (Dr. Macan) wanted proof of the statement that the uterine arteries are stopped by the process of plugging. As far as internal accidental hæmorrhage goes, before total detachment of the placenta, his method stopped the uterine arteries, and his treatment in these cases was most favourable. Plugging might be carried out as long as the membranes were perfect, but, after their rupture, there was no means of increasing the intra-uterine tension. So far, he (Dr. Macan) preferred to introduce a Barnes's bag in preference to plugging the vagina; also, in placenta prævia, where the bleeding surfaces were quite close, he preferred to use a Barnes's bag. He did not understand how Dr. Tweedy's method could twist the arteries very much, nor how the accumulation of carbonic dioxide could take place.

Dr. Alfred J. Smith said that he did not understand how a vaginal plug would so act as to compress the uterine arteries. Dr. Tweedy wanted them, he thought, to believe that his method was different from the method adopted in hospitals. To his mind the great difficulty in dealing with such cases was not in cases where labour had started at all, but in cases of concealed hæmorrhage, where the patient was collapsed and almost pulseless, with no labour pains, cervix quite hard, and where there was a pathological condition of the uterine muscular fibres. He thought that the best treatment in grave cases would be to ligature the uterine arteries direct, and the uterus could be then removed. Death from accidental hæmorrhage generally occurred after delivery, up to two hours after parturition.

Dr. Doyle considered that unless an artery was atheromatous very little pressure would stop it.

Dr. R. D. Purefoy said that the practice in the Rotunda

Hospital in such cases was to plug, and that accumulating evidence was distinctly in favour of continuing the practice. He thought that such subsidiary means as the use of a firm binder should not be forgotten, and also the stimulation of the uterine contractions by the careful manipulations of both hands.

Dr. Knott also spoke,

Dr. Tweedy, replying, said in answer to Dr. Dickson that he always used sterilised cotton wool. A much greater quantity of wool could be pressed into the vagina without a speculum. He did not employ strings, as by so doing he did not see how so tight a plug could be made with strings as without, and there was no difficulty in removing the pieces of cotton wool. Dr. Macan had said that he (Dr. Tweedy) had not adduced any evidence to show that the circulation was impeded. He (Dr. Tweedy) said that in one of the cases which he had been able to study he was easily able to bend the whole broad ligament by pressing in the lateral fornices and pulling down the cervix, and was able to tighten the lower portion of the broad ligament against the upper portion. A branch of the uterine artery ran to the cervix before the uterine artery entered the uterus, and if the cervix were pulled upon, and a plug placed outside the branch, the uterine artery must receive a sharp bend at the plug.

The Section then adjourned.

Friday, February 11, 1898.

The President in the Chair.

Exhibits.

Dr. Alfred Smith exhibited a pregnant uterus, showing fœtus *in situ*, with large fibromyoma, removed by Porro's operation.

Dr. Kidd exhibited a papillomatous ovarian cystoma, removed by abdominal section.

Dr. Jellett exhibited a subserous myoma uteri, removed by myomectomy.

Vaginal Colpotomy; its Advantages and Limitations.

Dr. T. Henry Wilson read a paper on this subject, and confined his remarks to the treatment of pelvic tumours and adhesions, discussed the advantages of both anterior and posterior colpotomy, and, contrasting them, claimed that both are valuable, but each individual case must be judged on its merits.

Having described the method of anterior colpotomy, he pointed out the facility with which the adnexa may be drawn down and examined, adhesions of the ovaries separated, and tubes and ovaries removed, or, if found healthy, replaced. Small subperitoneal myomata, if pedunculated, may be ligated, or if sessile, incised, removed, and the peritoneum closed over. Small ovarian and parovarian cystomata may likewise be easily treated, or if too large the contents may first be evacuated, the pedicle tied, and the cyst removed.

He expressed his disapproval of the operation of vaginal fixation for retroversion, except in cases past the child-bearing period, or for the control of hæmorrhage impossible by other means. He then dwelt specially on the treatment of pyosalpinx by this method, and laid stress upon the usual site of rupture of the pus sac when separating adhesions—namely, the posterior surface, which is the most unfavourable situation in operating by cœliotomy, but favourable when by vaginal colpotomy. He strongly advocated removal of the uterus in severe cases of pyosalpinx with dense adhesions of long standing.

Having described the operation of posterior colpotomy, he discussed the question of pelvic hæmatocele and pelvic abscess, pointing out the great advantage this method presented for efficient drainage. Densely adherent ovaries deeply situated in Douglas' pouch he regarded as suitable for the posterior operation, but he deprecated treatment of ruptured tubal pregnancy by the vaginal method. Two difficulties in colpotomy were emphasised—viz., rendering the vagina aseptic and reaching the peritoneum. He also drew attention to the ever-present danger of wounding the ureters. He compared the separation of adhesions by Schultze's method and vaginal colpotomy with the danger of concealed hæmorrhage in the former, and expressed his preference for the latter method as being more under control.

He insisted strongly that no one should undertake vaginal colpotomy who was not prepared to open the abdomen if found necessary, as there was always present the danger of uncontrollable hæmorrhage, and the possibility of being unable to complete the operation from below. He then mentioned certain cases not suited to this operation, as large dermoid tumours, deformity of the pelvis, rendering the operation very difficult; large ovarian tumours, and advanced ectopic gestation. He claimed as advantages the absence of risk of ventral hernia, less shock, absence of the distressing thirst so common after even exploratory abdominal incision, and more speedy convalescence. In summing

up he thought the question to ask oneself was—Can this be done by the vagina?

The PRESIDENT said that in some cases it is absolutely impossible to diagnosticate whether one is dealing with a single or a double salpingitis. As regards the removal of small subserous fibromata when the uterus is taken down, he said it was his experience to meet with a lot of these which never did the patient the slightest harm. It has been claimed that intestinal adhesions can be dealt with easily by colpotomy, and that the intestines never come into view; but there were a good many cases of intestinal adhesions when, if one were unfortunate enough in bringing them down so as to injure the intestines or the vermiform appendix, such cases would likely have to be finished by the abdominal method.

DR. A. J. SMITH did not think it the correct operation for ruptured tubal pregnancy, as a large blood-clot sometimes extended up to above the umbilicus, and he thought that this clot could not be as efficiently removed as by the abdominal method. He thought that for prolapsed ovaries and catarrhal tubes it was a matter of slight difference whether the abdomen was opened from below or above.

DR. HENRY JELLETT thought that enough importance was not given to vaginal cœliotomy as a means of diagnosis pure and simple. In certain cases of dysmenorrhœa, where it is ovarian, he thought it was justifiable to examine the ovaries if any sign of pathological condition could be obtained by a bimanual examination.

DR. SMYLY—When posterior or anterior colpotomy should be performed depended upon the circumstances of the case, whether the uterus was ante-verted or retro-verted, and where the pathological condition was situate. He did not approve of Dührssen's method of anterior colpotomy, but of Mackenrodt's. As regards vaginal fixation he did not altogether agree with Dr. Wilson; he did not think it a good method for ruptured tubal pregnancy on account of the difficulty in knowing when all the clots were cleared away. He had performed the operation for ovarian tumour for pyosalpinx in several cases, and for ruptured tubal pregnancy. With regard to pyosalpinx he said that the uterus is really infected before the tubes, and unless the uterus is removed the disease is not cured.

DR. R. D. PUREFOY thought that vaginal colpotomy was very suitable for small movable tumours, whatever their origin. He was of opinion that it was not as good as laparotomy for most cases of pyosalpinx and tubal pregnancy. Sometimes the operation was

very troublesome. He was quite unable to accept the proposition that in every case of pyosalpinx the uterus should be removed.

Dr. Winifred Dickson thought it a great advantage not to have an abdominal incision.

Dr. Wilson, in reply to the President, said that he was far from saying that every time a fibroma or myoma was diagnosticated a colpotomy should be done. It was not always the size of a myoma which caused the symptoms. The vermiform appendix is often seen in operations by the vagina, and may be taken out and put back without danger. Adhesions of the intestines to the uterus, ovaries, and tubes could be easily separated. He (Dr. Wilson) thought Dührssen's method very bad, and Mackenrodt's nearly as bad. If the fundus was not brought through the peritoneum most probably the operation would be a total failure and the fundus would subsequently retrovert. He did not think with Dr. Smyly that an abdominal section should be done to separate adhesions preparatory to removal of double pyosalpinx by the vagina. He believed that it was in separating the tubes from their adhesions that they burst. With reference to prolapse operations he thought that perhaps extirpation was the best method in elderly women. For younger women he thought that an anterior and posterior colporrhaphy and a properly fitting pessary was best.

The Section then adjourned.

ECZEMA FROM TOOTH-WASHES.

Professor Neisser, of Breslau, recently reported two cases of obstinate facial and labial eczema in children, with which, after months, he had been able to accomplish nothing by all manner of treatment. In both cases the eczema disappeared, practically without treatment, on the discontinuance of a patent mouth-wash called Odol, which is very popular in Germany. In two other cases the use of tooth-washes containing small portions of the essential oils of peppermint and cloves seemed to give rise to corresponding intractable eczema. As Odol contains small quantities of these oils for flavouring purposes, he considers that this is probably the irritant element, and warns the profession against allowing the use of such flavoured tooth-washes in practice.—*The Philadelphia Medical Journal*, March 12, 1898.