

Clinical Department.**A CASE OF EMANSIO MENSIIUM, OR ABSOLUTE AMENORRHEA, IN A MARRIED WOMAN TWENTY-SIX YEARS OLD.¹**

BY W. L. BURRAGE, M.D.

THE following case seems to be of sufficient importance from its rarity to warrant being reported:

Mrs. E. H., Irish American, twenty-six years of age and married four years, consulted me for the first time April 2, 1897. She had never menstruated, and had had no menstrual molimen whatever.

She had lost her mother and one brother by phthisis; her father had rheumatism, and another brother had had rheumatic fever three times. Of three sisters, one (older than the patient) had four children, and of the two younger, one (aged twenty-two) had painful catamenia and weak spells, and the other had no uterine symptoms. The patient had varioloid when a baby, and scarlet fever at eighteen years of age. As a girl she had been healthy and of average strength. When seven years old she fell from the second story of a building to the cellar; but from the account of her sisters, received no more serious injuries than a shaking up and bruising. For five or six years Mrs. H. had suffered from periodical headaches coming on about a month apart, but with no definite regularity; and for the last year the headaches had been much more frequent, many times as often as once a week.

The pain was in the top of the head and coursed downward into the ears; and an attack would last, at first, three days every month, and for the last year a day or two nearly every week. The headaches were accompanied by nausea and great tenderness of the scalp, and were generally worse in the middle of the day and in warm weather. She had suffered off and on for four years with pains in the ankles, back and elbows. At times she walked lame because of the pain and swelling of the ankles. Had never had rheumatic fever. Digestion fairly good. Bowels regular. No periodic abdominal pains. No hemorrhages from the mucous surfaces of the body. Hot flashes of moderate severity had annoyed her of late, also sweating of the palms of the hands and axillæ and an evanescent eruption appearing on the arms and legs—papular reddened areas, circular in shape, about two centimetres in diameter and disappearing on pressure. No cough. No vesical symptoms. Coitus normal. Slight white vaginal discharge. No loss of weight. Urine, strongly acid, slightly high in color, 1.027, no albumin.

Physical examination showed a well-developed, fairly nourished woman of average height and weight; black hair and blue eyes and a rather muddy complexion. The hips were well proportioned; the breasts small, with diminutive nipples. Pubic hair and vulva normal in every respect. Vagina normal. Uterus small, symmetrical, retroverted and retroflexed in the back of the pelvis, conforming in anteflexion to the curve of the sacrum, along which it lay and to which it was fixed by firm posterior adhesions. Behind the cervix on the left could be felt a knuckle of the left Fallopian tube, about the size of a slate pencil in diameter, thickened and slightly tender; and on the right side it was possible to make out only a small mass of indefinite outline that was sensitive on deep

pressure. The anterior lip of the cervix was somewhat flattened. The external os was patulous, and a probe entered the canal of the uterus a distance of 4.7 centimetres, and after traction on the cervix and using slight force, the point of the probe went by a tight constriction a farther distance of one centimetre, making the total uterine depth 5.7 centimetres, or two and a quarter inches.

The examination would show, then, evidences of an old inflammatory process about the tubes and ovaries, resulting presumably in atrophy of the ovaries, chronic inflammation of the tubes and stenosis of the uterine canal, besides anchoring the uterus in a pathological position in the pelvis.

It would seem that the initial inflammatory process must have taken place early in the patient's life in order so to crush the ovaries out of existence as to do away with menstruation altogether. Whether the varioloid, or the fall that she received, or tuberculosis, should stand in a causative relation to this process, we find it difficult to decide. It is certainly a very common occurrence to meet with an almost exactly similar uterine condition due to inflammation of the adnexa following septic abortion and labor where amenorrhea is not an attendant symptom.

The stenosis in the uterine canal being so near the fundus would point to an atrophied uterine body. It seems to me that this case is in a quite distinct class from those instances of amenorrhea from non-development or anomalous development of the uterus or vagina, for in the latter there is apt to be one or more attempts at menstruation, and an infantile uterus, small vagina, hypertrophy of the clitoris or other abnormality pointing to a primary lack of development.

VENTRO-FIXATION, WITH A REPORT OF TWO OPERATIONS ON THE SAME CASE.¹

BY GEO. W. KAAH, M.D.,

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THE patient, forty-eight years of age, was seen by me in consultation with Dr. Paine, of Brockton, February 28, 1896. Her previous history and symptoms are not essential for the purposes of this paper. Her uterus was found retroverted, adherent and sensitive.

The operation was March 10, 1896. After curetting, and repairing the lacerated cervix, I opened the abdomen, broke up the adhesions and brought the fundus forward. That there might afterward be some mobility of the uterus, I passed a suture of about No. 5 braided silk through the base of each round ligament. These two sutures were carried through the peritoneum and fascia on the corresponding sides of the incision and there fastened. I closed the abdomen with the full assurance that even should one ligature give way from any cause, the other would keep the uterus forward. Convalescence was uneventful, and the patient returned home relieved of the pressure symptoms caused by the retroverted uterus.

I saw her again in May, two and a half months after the operation, and found the uterus in good position.

In October of the same year she suffered severely from an attack of dysentery, which was epidemic in

¹ Read before the Obstetrical Society of Boston, May 18, 1897.¹ Read, by invitation, before the Obstetrical Society of Boston, May 18, 1897.

Brockton at that time and the pressure symptoms returned in full force.

I saw her in the early part of this year and greatly to my chagrin found the uterus retroverted. I tried packing the vagina to bring the uterus forward again in the hope that a support could be worn, but I was not successful. The only course was to open the abdomen again, and this I did on March 18, 1897, almost exactly a year after the first operation, the incision being made a very little one side of the old one. On passing my fingers into the abdomen I felt a small cord attached to the abdominal peritoneum close to the line of incision, and extending through the coils of intestines down into the pelvis. Traction upon this cord brought the fundus into view, and showed its attachment to be at the base of the round ligament where the suture had been originally placed. A second cord was found on the other side. The left cord, about half a centimetre in diameter, was ten centimetres long; the right cord, not quite so thick, was eighteen centimetres long. The uterus could be lifted from its retroverted position by either of these cords. The silk sutures could not be found and apparently were absorbed.

This second time I fastened the uterus forward by a single suture of No. 10 braided silk passed first through the fascia and peritoneum of one side of the incision, then through the fundus of the uterus at the level of the round ligaments, taking in a half to three-quarters of an inch and carrying it about an eighth of an inch deep and then through the peritoneum and fascia of the opposite side. I have done a number of cases this way and have not had uterine bleeding of any amount. The stitch when tied brings the fundus to the abdominal wall and the edges of the incision together, and is a buried suture. I have had stitch sinuses in some cases but the uterus has remained in place after the stitch came away. I have tried twisted Chinese silk in my last case thinking it might be better sterilized than the heavy braided silk. I have had no stitch abscess from it.

The first ventro-fixation was by Koeberle in 1869, although Dr. Hunter mentions that about 1867-68 Dr. Sims suggested keeping the uterus forward after it had been replaced, by passing a silver wire through the abdominal wall and into the fundus. This idea was never carried out by him.

Koeberle removed two normal ovaries and fastened the stumps in the abdominal incision.

Tait, in February, 1880, reports two cases where, while closing the abdominal wound, he passed a stitch through the fundus of the uterus and fastened it to the abdominal wall.

Olshausen, one of the pioneers in this operation, made a report in September, 1886, at the Berlin Medical Congress. He wished it distinctly understood that he recommended limiting the operation to those patients whose age or condition makes pregnancy improbable. Only in rare unconquerable cases of adherent retroflexion and prolapsus does he believe the operation justifiable.

His method (Garrigues) is to carry a suture through the round ligament near the edge of the uterus, and the anterior layer of the broad ligament, then through the parietal peritoneum and part of the rectus muscle. Two more sutures are inserted below the first. Three similar sutures are placed on the other side, making six sutures in all.

Leopold fastens the uterus by three sutures through the fundus and abdominal wall and removes the sutures at the end of twelve to fifteen days.

Czerny passes two catgut sutures through fundus and peritoneum muscle and fascia but not integument.

Kelly, to whose writings upon this subject I am much indebted, reaches over the broad ligaments with his sutures and lifts the uterus by three sutures passed through the ovarian ligaments of each side, and through the abdominal parietal peritoneum. He says adhesions form at once but then soon stretch by the simple weight of the uterus, so that within two weeks the corpus uteri sinks to the level of the anterior vaginal wall.

Dorland, from a study of 179 cases of pregnancy following ventro-fixation, says in effect: "The object of the operation is to restore the uterus to its normal position and yet not fix it so firmly as to interfere with gestation and parturition."

In this Dorland goes beyond Olshausen, one of the originators of the operation, who limited its use to cases where pregnancy was improbable.

Dorland further says:

"If properly performed, hysteropexy should not result in a firm adhesion between the anterior uterine wall and the abdominal parietes, but in the formation of a partially elastic band which maintains the anterior position of the uterus, but does not destroy its mobility. To prevent this objectionable firm fixation some employ absorbable sutures and others remove the sutures within two weeks after operation. With fixation properly performed the uterus during gestation will gradually detach itself from the abdominal wall or the adhesions will stretch, and as the uterus undergoes involution it is restored to its original condition before the onset of the disease that rendered the fixation obligatory."

Dr. Penrose mentions having had an opportunity of examining the ligaments resulting from ventro-fixation in four cases. There were no adhesions present; there was a pliable ribbon from one and a half to three inches in length, about one-twelfth or one-eighth of an inch in thickness. In one case the ribbon broke as the uterus was drawn up through the abdominal incision, showing how yielding and fragile the structure is. He continues: "If all operators would endeavor merely to make a single, almost thread-like band, extending from the anterior abdominal wall to the top of the fundus uteri, little, if any, trouble would result from subsequent conception."

Peterson mentions finding these bands in a case where he performed a second celiotomy for intestinal obstruction from another cause.

In all the cases I have seen reported, the uterus has been found, when the abdomen was opened later, connected to the anterior abdominal wall by a band or bands of tissue, varying in length, up to those found in my case, and it is reasonable to suppose that a majority of cases of ventro-fixation have such bands, particularly those cases where the uterus is not firmly fixed. I have been taught and always considered that any band thus extending across the abdomen is a constant source of danger to the individual—the more bands the more danger. That these bands are not all so friable as that of Dr. Penrose is evident from the right one in my case having been stretched to eighteen centimetres, probably by intestinal force, while the left one was but ten centimetres, and yet each band in itself was

strong enough for me to draw the uterus out of Douglas's fossa to the opening in the abdomen. The case further shows that while a thread-like band may not complicate a future pregnancy, it does not always hold the uterus forward.

Dr. Grant's microscopic examination shows the bands to consist of "muscle fibres surrounded by connective tissue and numerous blood-vessels." These bands then would tend to grow firmer with age and so more dangerous. That no cases have been reported of intestinal obstruction due to this cause is no evidence that it has not occurred, nor does it warrant us by operation to add that element of danger to the patient.

In the view of ventro-fixation, as exemplified by this case, it seems to me to follow, that any method which holds the uterus forward by stitches on each side is faulty, in that it results in two bands at least, and that any method that allows of the formation of even a single band is undesirable. The class of cases in which ventro-fixation is indicated is in complicated retro-deviations; here *pregnancy* is always a doubtful matter; it should not be made a test for a successful operation, nor should it be made of paramount importance. Ventro-fixation is done to relieve the patient of symptoms depending upon malposition of the uterus; and this it does do decidedly. If it is found that succeeding pregnancies as a rule have an unfavorable course the rational procedure would seem to be, to always remove the ovaries in a ventro-fixation; and thus bring it in fact to Olshausen's limitation.

Medical Progress.

REPORT ON DERMATOLOGY.

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AIROL IN DERMATOLOGICAL PRACTICE.

As substitutes for iodoform, iodol, sozoidol, aristol, nosophen and dermatol have been introduced, and while all are in varying degree effective, none can compare with iodoform. Dermatol possesses marked astringent powers, but its antiseptic action is insufficient. To obviate this disadvantage iodine was added, and the preparation called aïrol obtained. It is a fine, greenish powder, insoluble in water. Haegler showed that its poisonous action is much less than that of iodoform. It was tried by Löblowitz¹ at Pick's clinic in Prague in a variety of skin affections, and the conclusion reached that healing was accomplished at least as quickly by its use as by iodoform or other antiseptic powders, although the difference was not marked. An especial advantage was the quickness with which it cleaned up suppurating surfaces; in other words, its antiseptic properties are marked. In most instances the ulcers treated presented a clean appearance by the third day. The astringent action was also marked, the secretion usually became less after the preparation had been used for twenty-four hours, and constantly diminished during the following days. This was seen by the color of the powder applied. Aïrol, when brought into contact with warm fluids, is changed into a yellowish-red powder by the breaking up of a part of its iodine. Hence as the amount of secretion diminishes a larger and larger part of the powder applied remains uncolored. Its power of

stimulating granulations in syphilitic ulcers is not great, and a disadvantage was found in a somewhat irritating effect on the mucous membranes in certain places. It was thought, however, that this only occurred when the epithelium had been macerated by a previous process and thus made more susceptible. The writer concludes that aïrol is an antiseptic that is usually quite sufficient; if a more energetic antiseptic action is desired, recourse must be had to iodoform; as an astringent, aïrol holds a high place; it has no odor and is very cheap.

THE BACTERIOLOGY OF SEBORRHEA AND ALOPECIA.

Sabouraud, whose late work on the tinea and on alopecia areata has received so much attention, endeavored to prove that seborrhea taken in its strict etymological sense, as a hypersecretion of the sebaceous glands, is caused by a specific pathogenic microbe.²

The oily seborrhea of the non-hairy parts offers two symptoms, an over-production of normal sebum, and an increase in the normal diameter of the sebaceous outlets which may be seen with the naked eye. On the hairy parts, particularly upon the scalp, a third symptom is added, namely, a diffuse falling of the hair, at first paroxysmal and which finally becomes persistent. Upon the scalp secondary infections may be grafted on a seborrhea, causing desquamative conditions, as pityriasis capitis, while on the face the different forms of acne may appear. The micro-bacillus of oily seborrhea is obtained by staining preparations of sebum by Gram's method, and consists of a small organism much like a coccus, easily stained by all aniline coloring matters. This bacillus is found in the upper third of the follicle, and its colonies are encysted in a mass of horny matter and sebum. This "cocoon" of cornified cells and sebum, containing in its centre the colonies of micro-bacilli, is the cylindrical plug that is expressed from the seborrheic skin. If these "cocones" increase greatly in size, a comedo is the result, which by a secondary infection may be converted into an acne pustule.

The formation of the seborrheic cocoon in the outlet of the hair follicle causes a progressive hypertrophy of the sebaceous gland. There is an invasion of leucocytes about the papilla of the hair, which gradually atrophies and dies. That this is due to a toxin from the bacillus may only be conjectured. Sabouraud energetically opposes the present classification which separates acne from the seborrheas from which it is derived. Unna and Hodara's acne bacillus, and the bacillus described by the former in oily seborrhea of the scalp, he considers identical with his micro-bacillus of seborrhea. Considerable difficulty was found in cultivating the bacillus of seborrhea; and as inoculation experiments proved failures, Sabouraud is forced to admit that he has not been able to clearly prove that it is the cause of seborrhea.

With regard to alopecia areata Sabouraud had previously studied its histology, which he now finds to be precisely similar to that of seborrhea. A differential diagnosis cannot be made by the microscope; and the bacillus which he had previously regarded as probably the cause of alopecia areata is the micro-bacillus of seborrhea. But his courage does not fail, and he reaches the rather startling conclusion that the etiology of alopecia areata and seborrhea is the same,

¹ Löblowitz: Archiv. f. Derm. u. Syph., 1897.

² La seborrhée grasse et la pelade, Annales de l'Institut Pasteur, February, 1897.