

arose as to whether operative interference should be attempted, and Dr. Cheever and Dr. Prince kindly acted as consultants in the matter. It was finally decided that, under the circumstances, excision of the head of the bone would relieve the pressure upon the nerves, and that possibly, to a certain extent, their functions might be restored. With the patient's consent, therefore, I excised the head of the humerus on October 17th, through an incision in the anterior margin of the deltoid. The muscles in this operation were the supraspinatus, teres minor, and subscapularis. The long tendon of the biceps was dislocated from its groove, but not divided. The wound healed rapidly by first intention, and the patient was very soon able to use his arm to a far greater degree and with a much greater range of motion than was possible before the operation. He was very much pleased with the result of the operation. The condition of the nerves, also, improved considerably, but I am told by the neurologist that six months or a year will have to elapse after the operation before any very marked improvement can be noticed. Even if no further improvement actually does take place in the condition of the nerves, I should feel satisfied with the result of the operation, in that the patient has thereby secured a much greater range of motion and a corresponding increase in the usefulness of his arm. It may be interesting to note that the head of the bone was very much atrophied, and that, on being removed, it could be easily crushed in the bone forceps, showing pretty conclusively that had an attempt been made to reduce the dislocation by manipulation, a fracture would probably have taken place at the neck of the bone, and thus a new complication would have been added, and no good whatever accomplished.

In view of the good result thus far obtained in this case, I think I should be in favor of excising the head of the bone in any case of old-standing irreducible dislocation of the humerus, where the function of the arm has been seriously interfered with as in this case.

#### ADENOID VEGETATIONS.

BY FRANK M. SHERMAN, M.D., WEST NEWTON, MASS.

THE method of removing adenoid vegetations from the vault of the pharynx as practised in the clinic of Prof. B. Fraenkel in Berlin, appears to the writer so much better than any other that he has seen that he feels sure a description of it will be appreciated by those, not already familiar with it, who are interested in this subject.

The chief feature of the method is to have the patient so lightly anesthetized that although consciousness is lost, *reflex action is not abolished*, and blood or mucus is therefore voluntarily expelled. The patient, if a child, is held in the arms of an assistant in the upright sitting position, the operator sitting in front of the patient. The anesthetic is administered to the primary stage of anesthesia; the mouth is opened, and the tongue depressed with a rather long and slender tongue depressor—no gag is used—and with the Gottstein curette the growths are rapidly removed. Usually the larger portion of the separated growths is brought out with the instrument, and then the patient, on account of the most decided irritation of the fauces, begins to expel the blood, mucus and portions of the

growths which have been cut off. The finger is now passed into the naso-pharynx; if there still remain more vegetations, the curette is again used. It is often better to use the curette of Hartmann for the removal of these last remnants and tags of tissue. The operation done in this way—during the short duration of the primary anesthesia—must be done very quickly; the average time required is not far from one minute, although one frequently does it in less time.

The obvious advantages of the method are its safety and the speed with which it can be done. After the necessary practice it can be done very thoroughly. The anesthetic used very satisfactorily in Fraenkel's clinic is bromide of ethyl. The writer has used ether in all his cases, and likes it better than the ethyl. Patients who are not excessively nervous, nor too young to control can be treated without general anesthesia. The benefit from the removal of these lymphoid masses from the naso-pharynx is so great, so quickly seen, and so permanent, that there are few surgical procedures so satisfactory to the patient and the doctor. The opinion has been expressed, however, that notwithstanding the appreciation on the part of specialists and by very many general practitioners, of the exceedingly large number of children who suffer from the trouble, there still remain a great many cases which are not recognized and thus are debarred from the benefit of operative treatment. Mouth-breathing, earaches, "winter colds," nasal intonation, are symptoms that call for investigation, and simple palpation of the naso-pharynx will settle the question of the existence of adenoids.

#### A CASE OF ABDOMINAL PREGNANCY.

BY GEORGE W. KAAN, M.D.,

Surgeon to Out-Patients, Free Hospital for Women, Boston.

THIS case occurred in Brockton, Mass., in the practice of Dr. E. L. Frost, through whose kindness I was permitted to see it; and by his request I make this brief report.

The patient, a strong, well-nourished woman of thirty-six years, had one child and a history of a miscarriage some eighteen months before the present pregnancy, followed by recurrent pelvic pain.

Dr. Frost was called May 1, 1895, the patient complaining of pain in the right groin. The last menstrual flow was about April 1st, and this was considered one of her usual attacks. She apparently recovered from it, as she had from previous attacks.

One month later Dr. Frost was called for another attack of pain in the right side, much more severe than the previous one; but there was no collapse and nothing to indicate a ruptured tubal pregnancy, beyond a distinct tumor at the right side of the uterus, about the size of an orange, which could be felt from the outside. This gradually disappeared and the patient recovered slowly. At about this time she began to have morning vomiting.

There is nothing further to note until December 6, 1895, when Dr. Frost was called at noon and found the patient in labor. Examination of the abdomen showed a tumor of about full term with a sulcus across the lower third, and the part below the sulcus would harden as the pains came on. The fetal parts could be detected through the abdominal walls more distinctly

than usual. The fetal heart could be distinguished. Vaginal examination showed the head well down in Douglas's fossa; the cervix pressed close to the pubes, and the finger passed readily into the cavity of the uterus.

The diagnosis of abdominal pregnancy was made; and Dr. A. E. Paine, of Brockton, called in consultation, confirmed it. Knowing I was in Brockton that afternoon, Dr. Frost sent for me. A consideration of the best interests of the mother and child induced us to relinquish any idea of operating in Brockton and an attempt was made to obtain her admission to the Boston Lying-in Hospital. Through some misunderstanding there this could not be done, and she was taken to the Massachusetts General Hospital, where she arrived at about seven o'clock p. m. in fairly good condition and the fetal heart still beating.

The celiotomy was performed next day, and the child found dead. The report from there reads:

"Median incision from umbilicus to within three inches of pubes into peritoneal cavity, when tumor presented covered with peritoneum. Sac opened and gush of blood came, the knife entering the placenta. Hand plunged through placenta and child brought out; cord tied, cut, and sac packed with gauze. Placenta clamped with large forceps, intestines having been previously walled off. Across summit of tumor was adherent large intestine. Walling off removed. Sac packed with gauze. Upper part of incision sewed up with silkworm gut. Sterile dressing, swathe."

The mother did not recover. The autopsy showed:

"Sac in median line, evidently in left broad ligament, entirely covered by peritoneum. Uterus pushed downward, forward and to right. Across top of mass ran sigmoid flexure. In sac was placenta and about half a pint of post-mortem clot. Uterus enlarged, walls thickened. Tumor surface covered with soft, decidua membrane. Os patulous. Mass which lay above and posterior to uterus presented large cavity lined with smooth, soft membrane, in which lay portion of umbilical cord connected with placenta."

## Medical Progress.

### REPORT ON PROGRESS IN GYNECOLOGY.

BY EDWARD REYNOLDS, M.D.

(Concluded from No. 17, p. 418.)

#### DOUBLE UTERUS AND VAGINA WITH ADHESION OF ONE SIDE.

Baer also reports in the same journal the case of a girl of fourteen who had menstruated for eleven months before he saw her. At the second or third period she began to suffer intense pain with each recurrence, and soon after she detected a swelling in the right iliac region and a small protrusion at the vaginal orifice. The history was that of retained menstruation, except that there had been a regular monthly flow. On physical examination the right iliac region was found distended by a tense, globular, fluctuating mass as large as a cocoanut. On the upper border of this mass, an elongated, firm body, somewhat the shape of the uterus, could be distinctly outlined. The right side of the vaginal orifice was occupied by a mass the size of an egg, covered by vaginal mucous

membrane, purplish in color. By the side of this mass the finger entered what appeared to be a normal vagina, except that it was flattened by pressure on the right side by a dense fluctuating elongated mass which was continuous with the vulvar tumor. A small cervix was to be felt in the upper end of the vagina. A sound passed into the os entered the small, firm body already spoken of as borne on the side of the iliac tumor. A diagnosis of double uterus and vagina, with atresia of one vagina was made. Incision of the vaginal septum resulted in the escape of about a pint of the usual fluid. A pin-hole os was then discovered, and a free incision of the cervix resulted in the escape of a quart more of the same fluid. The uterine septum was then divided to the fundus, and the patient made a good recovery.

#### SEPTIC PYEMIA ORIGINATING FROM A PYOSALPINX.

Dürk<sup>13</sup> reports the case of a girl of nineteen who was admitted to the hospital for acute rheumatism of the right shoulder. After the failure of the usual remedies, pus was evacuated from the joint by an incision, but the patient died a few days later with the symptoms of general pyemia. A careful autopsy showed that the infection had originated in a pyosalpinx of the left tube. The urethra contained pus which under the microscope showed numerous intracellular gonococci. Cultures taken from the pus of the abscess in the shoulder-joint, from the left common iliac vein, and the pyosalpinx, all developed staphylococcus pyogenes aureus.

#### BACTERIOLOGICAL INVESTIGATION OF THE DISINFECTION OF THE HANDS.

Reinicke<sup>14</sup> has made careful bacteriological tests of various methods of disinfection of the hands, under the direction of Zweifel. The methods used were scrubbing the hands for five minutes with a brush, hot sterilized water and green soap, after which they were scrubbed with a one- to two-per-cent. corrosive-sublimate solution, five-per-cent. carbolic-acid solution, a one-per-cent. lysol, and a three-per-cent. trikresol solution. No one of these methods resulted in complete sterility; but complete sterility was obtained by hot sterilized water and soap, and then three minutes of scrubbing in either ordinary or absolute alcohol. Five minutes scrubbing in ninety-per-cent. alcohol without previous preparation yielded a rapid and comparatively complete sterility of the hands.

#### IMPORTANCE OF EARLY RECOGNITION OF CANCER OF THE UTERUS.

Kessler<sup>15</sup> presents a statistical report of cases of cancer of the uterus with a special reference to the amount of effort which their family physician had exerted in the diagnosis of their cases. He finds that in the majority of his cases the symptoms had been well marked for at least a year, and that in fifty per cent of these no vaginal examination had been made by the general practitioner. He emphasizes the long established principle that a vaginal examination should never be omitted in the case of a woman of middle or advanced age with atypical hemorrhages, and insists upon the importance of disseminating an impression of this necessity throughout the mass of the profession.

<sup>13</sup> Mùch. med. Woch., 1894, No. 37.

<sup>14</sup> Centralblatt für Gynäkologie, 1894, No. 47.

<sup>15</sup> St. Petersburg med. Woch., 1895, No. 37.