

remove to an infectious disease hospital; 2, isolate; 3, teach.

1. A hospital for infectious diseases only, and maintained by the corporation would be the ideal method of prevention of pertussis, but alas! 'tis only a dream; 2, isolation would be more tangible, but would be unsatisfactorily enforced for several reasons. Serious objections were proposed against quarantining smallpox at first, but no one questions that wisdom now. To card the house for whooping cough (and measles) the same as we do for diphtheria and scarlet fever, would be doing little enough towards quarantining. It is uniquely strange that children who have whooping cough or measles, the two most highly contagious diseases, (with very few exceptions), which kill nearly three-fourths as many as the two most dreaded maladies common to children, are permitted to go at liberty on the streets and elsewhere. It is a shame for intelligent Ohio!

About the only objection to house-carding for whooping cough, are the difficulties of making an early differential diagnosis; also, the irregularity of the course of the disease; also, the contagiousness of pertussis patients which is as long as the patient coughs, but not the same degree as in the paroxysmal stage. Because we can not prevent all the children from this contagium is no reason why we should not attempt to prevent as many as we can. We will then be doing more than we are now doing, and in time will receive our merited reward.

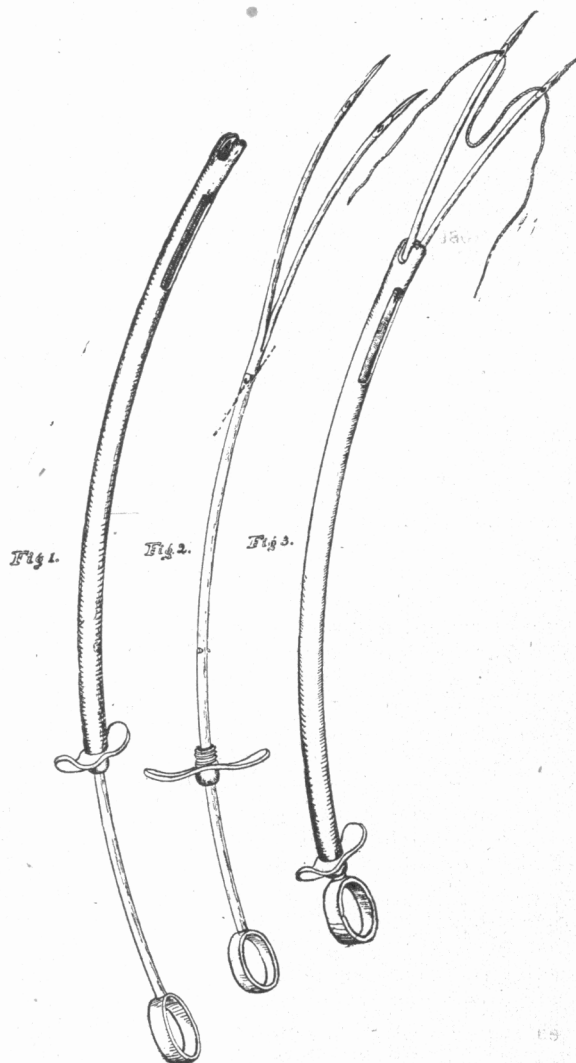
3. Teaching the laity the destruction secondarily caused from whooping cough is our duty much neglected. We should be the people's protectors and be active against everything that would jeopardize their health or life. To have them call our attention to any point of danger or benefit of health, is a served notice of our slothfulness. And this notice has been served on me not a few times during the epidemic of whooping cough just now abated. The laity can be taught to obey restrictions on one disease as well as another; and whooping cough will be no more difficult to restrict than tuberculosis which we hope will soon be under some kind of restrictions. There are people who send their children to school in any condition, for almost the sole purpose of getting rid of them for that time, caring nothing for the danger of their carrying the infection to others. Such parents or guardians should be fined or in some other way punished by the health officer. Again, there are children who for fear of being kept away from school will use deceit in the early part of the disease, thereby exposing others. It would then be necessary for each school teacher to be qualified to act on the prodromic and early diagnostic symptoms of contagious diseases, and prohibit entrance to the school yard until the receipt of a physician's certificate or a personal visit by the teacher at the home.

GASTRO-HYSTERORRHAPHY WITHOUT OPENING THE ABDOMINAL CAVITY.

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Our negative results in treatment of prolapsus uteri and retro-misplacements by pessaries and supporters have proven conclusively that we can never gain our point in supporting the prolapsed uterus from below, and that we must find some means to uplift same from above, and in this way substitute the office of the re-

laxed round and broad ligaments. For this purpose we have constructed the following instrument, consisting of a hollow tube like a big uterine sound; within this there is a piston-like rod with a handle at the outside and two needles threaded to one thread at the end inside. Now our idea is the following one: Place the patient in Trendelenburg's position, insert this instrument called uterine ventro-fixator into the uterus and after correcting misplacement of same, bring the fundus as high up as possible in direct contact with abdominal wall; then push the rod up until the needles protrude through the skin, unthread needles and draw the piston back, thus removing the needles and withdraw the instrument.



Pull the thread up as high and tight as feasible, then tie a strong knot after having made a little incision through the skin of the abdominal wall to embed the stitch, in this way fixing the uterus to the abdominal wall. The place is then dusted with iodoform and sealed with collodium.

As far as we can see, the first question, which would arise would be the following one: Is there danger of sepsis? We say not, if properly managed.

The vagina should be first well cleansed and packed with antiseptic gauze until rendered aseptic. Then on the day of the operation the uterus should be curetted and washed out with a strong antiseptic solution and then after perfect boiling of the instru-

ment, needles and thread, we think this danger would be eliminated.

The next question would be, shall we get adhesions by holding the uterus in contact with the abdominal wall in this way? We think we should, because by pulling the uterus up against the abdominal wall, these stitch holes must naturally give a little, perhaps they will even tear some; this will set up some local inflammatory action which will result in adhesions, which "report of cases" will prove, if the uterus is brought in *firm* contact with the abdominal wall. We may either leave this stitch in there permanently or may remove it after two to three weeks.

The only contra-indication for this operation, as far as we can see, would be adhesions of the intestines to the fundus uteri or portions of the abdominal wall, or firm adhesions of ovaries and tubes to the back, or presence of pus about the uterus and appendages. The interference with a large bladder can be easily avoided by keeping a sound in it during the operation.

Whoever has operated or seen the operation, will be convinced that the danger of wounding the intestines is almost eliminated because the uterus can be so plainly felt through the abdominal wall and manipulated in such a manner that all intervening tissues can positively be excluded.

Case 1.—Miss M. D., age 19. Retroversion with strong adhesions, after severe fall four years ago; since that time frequent painful urination, backache and difficult menstruation. I made the first operation at Bethany Hospital, Kansas City, Kan., April 21, under assistance of Drs. J. D. Griffith and S. I. Harrison, and R. A. Roberts, of Kansas City. Uninterrupted recovery; highest temperature recorded was 99.4. Patient had no pain nor inconvenience whatever and was discharged after three weeks' stay, (two weeks in bed) in the Hospital, with her uterus firmly adherent to abdominal wall hardly within the reach of the finger in vagina.

Case 2.—Mrs. F. O., age 37. Three children, youngest 5 years old; after last confinement, prolapsus uteri with pertaining complaints; operated April 22; highest temperature 99.7; very little pain; remained in bed thirteen days; discharged after three weeks; uterus in proper place. Uterine supporter was fitted to be worn about one or two months.

Case 3.—Mrs. R. T., age 26. After tedious labor case and forceps delivery, patient complained of backache, headache, and frequent painful urination. Examination showed retroflexio uteri. Operation April 24; temperature remained normal; slight pains over region of stitch. Contrary to my custom I did not embed the stitch in abdominal tissue but severed it the seventh day, in order to test adhesions which proved strong enough to make the uterus adhere to the abdominal wall. Uterine supporter was fitted and patient was discharged seventeen days after operation completely cured.

Case 4.—Mrs. A. K., age 43. Prolapsus uteri of nine years' standing. Operated April 25; clipped stitch May 2; found uterus strongly adherent and fitted uterine supporter. Discharged May 19 completely relieved.

Case 5.—Miss F. L., age 18 years. Kicked by horse in the abdomen about one year ago; since that time dysmenorrhea, headache, backache, fatigue feeling, etc. Diagnosis, retroflexio uteri. Operated April 26. No elevation of temperature; had a circumscribed peritonitis around the stitch as large two silver dollars. Made uninterrupted recovery and was discharged two weeks after the operation.

Case 6.—Mrs. A. B., age 25. Gave birth to twins, forceps delivery, two years ago. Diagnosis, retroflexio uteri. Was unable to do her own housework because of backache, headache, and constant desire to urinate. Operated April 29; highest temperature 99; very little pain. Did not embed stitch but cut it twelve days after operation; uterus remained in place. Uterine supporter fitted and patient was discharged twenty days after operation completely relieved.

Case 7.—Mrs. L. M., age 36. After fall from a wagon two years ago had adhesive retroversio uteri; difficult menstruation with constant backache and headache. Operated May

1; no rise of temperature; was discharged relieved, within two weeks after operation.

Case 8.—Mrs. J. K., age 26. Had three children. According to her own report had miscarriage two years ago; after that puerperal fever. Examination shows retroverted uterus almost immovable. Operation May 4; greatest difficulty in destroying adhesions. Rise of temperature second day to 102.2; third 101; the following day 100.3, but found in changing the vaginal tampon that uterus had dropped back as I expected.

There were three more cases operated upon which gave complete satisfaction though they are still under treatment, therefore reports later.

THE SURGICAL TREATMENT OF GRANULAR CONJUNCTIVITIS.

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The important feature in all forms of treatment of granulations of the eye-lids, whether surgical or otherwise, is to remove pathologic elements and prevent further invasion of the same with their destructive consequences, with the least possible harm to the conjunctiva and lids. Without proper treatment we know that granulations will in many cases ruin eyes, and in others cause serious lesions, either by inducing ulcerative processes or, in the more favorable cases, by producing cicatricial contractions and deformities of the lids. In fact, a large percentage of cases as they come for treatment, have already suffered in some way or other in the mobility or form of the eye-lids. These complications by the additional irritation they induce, further aggravate the unpleasant symptoms and not infrequently produce spasmodic contractions of the muscles of the lids, forming a serious obstacle to the successful treatment of the case. Therefore, often one of the first considerations in the surgical treatment is to remove such complications by the proper operation. A canthotomy in cases where this is indicated, through the powerful contractions of the orbicularis muscles, will give us the most valuable aid as a preliminary step to further treatment.

Other abnormal conditions as to mobility or shape of the eye-lids can frequently be corrected with great advantage before proceeding far in the treatment proper of the case before us.

The surgical treatment to be of any advantage in the cure of granulated eye-lids must be of a conservative nature and must seek, as far as possible, to *protect* rather than *destroy* invaded elements of the conjunctiva and deeper tissues. We must therefore place as foremost of all surgical measures, the expression rather than excision of the pathologic elements in all cases where this can be done. By this means we may not succeed completely in removing all the granulations, but we will succeed in suitable cases if the operation is thoroughly done, as it ought to be, to remove most of them and at the same time so stimulate absorption and physiologic tissue changes as to lead to a rapid cure of the condition, whether supplemented by further local applications or not. It is not to be forgotten that the ordinary remedies are applied, not with the idea of directly destroying the granulations but for the purpose of inducing that state of local hyperemia which most favors absorption, so that if we can directly, by expression remove these deposits, we gain valuable