

flammation. There are evidences from the character of the alvine discharges that ulceration had taken place previous to the severe attack of colic and constipation in December, 1867. At that time it was the occurrence, perhaps, of ulceration, which loosened the impacted contents of the colon, and caused a spontaneous evacuation. A degree of contraction followed the healing of this ulcer, and henceforth the narrowed portion of the intestine became a centre of irritation, being rubbed against by the fecal masses in their passage downward, and more ready to ulcerate from the fact that ulceration had occurred before. The second attack, a little more than a year after the first, aggravated this condition; and finally the contraction became so great that periods of complete obstruction were both preceded and followed by diarrhoea. It is true the diarrhoea was often lenteric in character, and this circumstance, together with that of the formation of flakes of half-dried mucus and pus, almost like false membrane, may explain the later attacks. The hepatic disease, by maintaining portal congestion, and deranging primary digestion, contributed its share, not an insignificant one, to the final result.

A few words may not be out of place here in regard to the diagnosis of "spasmodic stricture," which was made in this case with so much unanimity by the great majority of physicians who had anything to do with its treatment. In the lower part of the rectum, where a positive diagnosis is possible, spasmodic stricture is known to occur and to be a cause of obstinate constipation. The finger or the bougie introduced will detect the narrowed portion of the intestine, and whatever fecal masses may succeed in passing the stricture will be small in diameter, and perhaps ribbon-shaped. When the spasm relaxes a free evacuation of the bowels occurs, and the intestine is found on examination to be of its normal calibre. In such a case it is probable that the stricture is produced and kept up by hard faeces pressing downwards on an irritable portion of the bowel, just as, not unfrequently, the finger in passing upwards causes spasmodic contraction and renders a complete examination impossible. Some permanent strictures appear as though they had arisen from the long continuance of spasmodic stricture. I am unable to see why this condition of things might not obtain higher up in the rectum, or even in the colon, although less probable there owing to the relative thinness of the muscular coat in these situations. The theory of spasmodic

stricture would offer a rational explanation of nearly all the symptoms in the case reported. There are two facts, however, which in my opinion exclude it, viz.:—1, The uniformly small diameter of the solid fecal masses, even in the intervals of obstruction. 2, The failure of the warm bath, sulphuric ether, &c., to produce an evacuation.

DR. PASSAVANT'S OPERATION FOR BREAKING UP POSTERIOR SYNECHIAE.*

Translated by B. JOY JEFFRIES, A.M., M.D.

"It is with great pleasure that I comply with your request to send you some details of an operation I have now practised more than a year, for breaking up posterior synechia. I will omit speaking of the endeavors hitherto employed to accomplish this, and only claim that they warrant our seeking some other method. I also omit the indications for operative interference in these cases, and would say in general that I have practised my operation where there were several synechia, and even broad ones, as well as where there were but single points, and up to this time with perfect success.

"This little operation consists in simply making a puncture at the edge of the cornea, passing in the iris forceps, grasping the iris, and by gently drawing breaking away its attachment at the pupillary edge. The forceps are then withdrawn without bringing the iris into the corneal wound. I employed this operation for the first time last year, on an eye with cataract, where there was a posterior synechia, intending to excise by iridectomy the portion of the iris grasped by the forceps should it inflame. There did not seem to me to be any other fear from the operation, provided the iris did not get fastened in the wound. Freeing posterior synechia by iridectomy had long ago taught us that there was no danger for the anterior capsule from these being broken up. The little corneal wound

* This is translated from a letter of Dr. S. Passavant to Prof. Gracq, which the latter published in the "Archiv für Ophthalmologie," 1869. In explanation of the operation I would say, that these synechia or attachments from inflammation, of the iris to the lens capsule or cornea, are the fruitful source of repeated attacks of iritis, and their removal has been attempted in various ways. The danger to the capsule and lens has, however, till now almost prevented ophthalmic surgeons from interfering, in the methods heretofore proposed and carried out. This little operation, so modestly set forth by Dr. Passavant, has proved eminently practical and successful, as we can attest, and we trust this notice will serve to attach his name to it. We regard it as next to iridectomy in importance, which it will of course naturally supplant in many cases.

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was still less to be feared. The result of this first operation was so satisfactory, without a trace of reaction, that I soon employed it on eyes without cataract. How little injurious it is to the eye, is seen from the fact that in more than fifty such operations I have not had a single bad sequela, and in some cases where there were several attachments, I repeated the operation on the same eye within a few days, once or twice within two days.

"I always made the puncture with the lance knife at the anterior junction of cornea and sclerotic, so that the internal aperture of the little wound should be far enough from the periphery of the iris to avoid its prolapsing, and yet sufficiently peripheric to allow me to easily grasp the iris. The puncture was made on the same side as the synechia, and large enough to allow an iris forceps to open readily. When the forceps enters, the aqueous humor flows off. Grasping the iris, gently drawing, letting go and carefully withdrawing the forceps, and we finish this slight operation. When there were two synechiæ close together, and the first pull did not free them both, I have again grasped the iris to free the second. I would, however, rarely recommend this procedure, but rather advise content with the freeing of a single synechia at a time, putting off to another day any lying beyond. This seems to me safer than a lengthened delay of the forceps in the anterior chamber, with the aqueous wholly or in part flown off.

"The iris getting pinched into the wound is the worst danger to be feared from this little operation. I have fortunately so far avoided it. If the iris, in spite of our best care, gets into the wound, it would be advisable to replace it most carefully, using a delicate spatula, or some such appropriate instrument. To avoid the iris sticking to the points of the forceps after we have opened them, and thereby being drawn into the corneal cut, I would recommend blunt-pointed forceps, without the sharp teeth closing together. I have used an old, very blunt pair of toothed forceps. The following will show that this apprehension is not simply theoretical. I learned from one of my colleagues, to whom I recommended this operation, that he employed it five times in freeing five attachments of the pupil in the case of a young man; a few days intervening between the several operations. In the right eye there were two, in the left three synechiæ. In the left eye the operations passed off well, leaving a perfectly movable pupil. In the right

eye the pupil became movable, but at one puncture the iris became attached to the corneal wound, producing a peripheric anterior synechia, which healed with slight inflammatory reaction.

"The freeing of a single, or even of several, fine attachments of the pupillary edge to the lens capsule, is so readily done by the method described, that any verification by details of cases seems superfluous. I may be allowed, however, to describe a single case, of those now in hand as an example, since it is one where several broad attachments were broken up.

"A girl 19 years old has had for a long time posterior synechiæ in both eyes. In the right eye there were two fine attachments at the upper part of the pupil, and a third broader one below. In the left eye there were four synechiæ; three of these were small, the fourth, on the inner side, a broad one. Repeated application of atropine could not break these attachments. There was also slight choroiditis. These cuts represent the pupils under atropine, the drawing being four times enlarged.

Right.



Left.



"All these attachments were broken up with intervening periods of from three to eight or ten days, during which the patient went home and followed her home occupations. The first operation was done April 14th, 1868, and the freeing of the last attachment June 15th, 1868. The pupils are now round and perfectly movable. The magnifying glass shows spots of black pigment left on the anterior capsule, where the synechiæ were broken. It should be stated that notwithstanding the freeing of all the attachments, the choroiditis continued, calling for local bleeding up to October; not, however, as I can see from other cases, in consequence of the operative interference, but in spite of it. The future must say whether the perfect freeing of the attachments has removed or only lessened the tendency to new synechiæ. As yet I have seen no return. This is the most desired result.

"It scarcely requires to be said in conclusion that the eye must be well fixed during this operation, and kept closed afterwards till the corneal wound heals. We have other methods of breaking anterior synechiæ; I will, however, state that I have employed this, to free several such attachments near the pupillary edge.

"I shall be pleased if this little operation, whose success I have so often already witnessed, meets with your approbation."

Selected Papers.

INVERSION OF THE UTERUS.

FROM an elaborate paper on this subject by Dr. Gaillard Thomas, in the *American Journal of Obstetrics*, we make the following extracts:—

The second method of taxis consists, not in manipulating the "constricted orifice in which the operator engages his fingers," so as to "dilate in advance the muscular fibres which oppose reduction," as Aran and Becquerel express it; but in dimpling or indenting the fundus itself, so as to make of the indented or invaginated portion a species of wedge, which is forced into the cervical constriction. In recent cases of inversion occurring, as the vast majority of these cases do, after labor, 350 out of 400 reported by Crosse having done so, the centre of the fundus may be indented and carried up through the cervical canal; and even in chronic cases such an invagination is much more practicable than one would theoretically suppose. As a general rule, however, my impression is that the manipulations practised on the fundus act, not in this way, but in overcoming cervical resistance, and thus accomplishing in a more indirect and imperfect way what the French method, styled the method of Viardel by Becquerel, does by engagement of the fingers within, and direct expansion of, the cervical constriction.

Dr. Emil Noeggerath, of this city, has offered a modification of the second plan, which I have resorted to with success on two occasions which will be hereafter reported, and which I regard as one of the most valuable suggestions which has been made of late years with reference to the subject. His method consists in compressing the uterine body, opposite to each horn, so as to indent one of these, and thus offer to the cervical canal a wedge, which passes up and is followed rapidly by the other horn and the whole body.

My experience in the reduction of three of my cases has been this:—the first result of manipulation has been to overcome the resistance of the cervix, so that the whole of this part turned over and enfolded the body, further progress being stopped by resistance at the os internum; then one

horn has gradually become indented, and thus the second part of the process of replacement has been effected. * * * *

Among certain comments on a case published in 1857 by Dr. Worster, of New York, where Dr. Thomas was engaged in consultation, the latter remarks as follows:

At the moment of reduction in this case, the fibres of the cervix having yielded as far as those of the os internum, which still offered a resisting stricture, I was pressing the thumb upon one horn and the index-finger upon the other, after Noeggerath's method. While doing this, I was conversing with the gentlemen who were with me, when, suddenly, my thumb sunk into an indentation. Supposing this to be due to penetration of the uterine tissue, I was about to withdraw my hand and report the accident to Dr. Worster, when, to my surprise, I found upon slight increase of pressure that the indentation increased. I now perceived that the horn had receded, and in a minute or two more the whole uterus rose into its place.

One point upon which Dr. Worster does not, in his essay, lay that stress which I think it deserves, is this:—at the commencement of the attempt I proposed making counter-pressure, not by the fingers, but by a conical plug of boxwood, with a handle a foot long, which I carried for the purpose. This plug was not introduced through the vagina, but was used thus:—the hand in the vagina lifted the cervix against the abdominal walls, so that the cervical ring could be felt through them, and the plug was then pressed into the ring by pushing before it the abdominal walls. During Dr. Worster's efforts I held this plug forcibly in the cervical ring, and during my efforts he did the same for me. It may have had no influence in dilating the constricted cervical canal, but it is worthy of attention as a rational attempt to accomplish that result. To my mind, and to that of Dr. Little, it appeared that its effect was evidently good. * * * *

CASE IV.—On the same night upon which I received Dr. Bishop's note requesting a consultation in the case just narrated, I received a letter from Mr. B., of Louisville, Kentucky, detailing the following facts:—

He stated that his wife, aged 23 years, a native of Indiana, had enjoyed good health until twenty-one months before that date. At that time she bore a child, and since then she had been an invalid.

Subsequent to this, menorrhagia of most profuse character had occurred at each