

what I learned in the blacksmith shop and in general practice. The best ideas I get to-day to help me in gynecology are such as I secured in taking private lessons in diseases of the chest, and such as I obtain from general practitioners in consultation, rather than from the medical journals filled up with authorities from the youngsters who are attempting to become specialists, like some of these Democratic Senators, "a tariff for revenue only."

DR. McLAREN—In regard to the excellent paper we heard from Dr. Newman, I can most heartily and most thoroughly agree with every position he has taken. It seems to me that the division between obstetrics and gynecology, as seen in America, is wrong to a great extent, and that we would do better work if our clinic hospitals were conducted like those of the German clinics, where the professor of obstetrics is the professor of gynecology.

A man should not expect to become a specialist at the very hour of his graduation. If he expects to be a specialist in gynecology, after his three or four years course he should have service in a hospital devoted to this class of practice, because no matter how thoroughly learned we are in the theory we must learn it practically. Let a man read and write and work to a great extent on his specialty, but let him do all the general work that he possibly can.

DR. GIBBONS, Idaho—I do not belong to this Section, but there is one thing I would like to say to the specialists. I have charge of an insane asylum, and I have been connected with the treatment of the insane for a number of years. I want to say to the specialists that if you can find a way by which you can unsex the men, you will not have to unsex the women so much. (Applause).

I have observed that my patients in the insane asylum without any special treatment for the uterine organs usually get well. In the insane asylums you will find very little uterine trouble.

MRS. BROWNELL—I do not agree with Dr. Newman's pessimistic views in regard to the women of the present day. I was in Chicago last year and I noticed everywhere the business energy and life of the women of that city, and with what rapidity they moved about.

The older ones will remember that forty or fifty years ago cloth shoes were worn by the women; look at the common sense shoes they wear to-day. I think the ladies of to-day have advanced 20 per cent. within the last ten years in regard to health, and I expect to see the advance continue.

DR. HENRY PARKER NEWMAN—The subject of my paper would be favorable for prolonged discussion I am sure, but owing to the lateness of the hour I think it is best to adjourn. Some one, however, evidently misunderstood the purport of it, by crediting me with attacking the health and development of woman. I do not do so. On the other hand, as a gynecologist and a specialist I hope, and we all hope, to see womankind raised to a higher standard; that is our aim and that is our purpose.

The only idea I had in presenting this paper was to sound the alarm of some of the mischief that is being done, or will be done, if gynecology degenerates into simply surgical procedures. It is a field which covers so much and means so much, that it is certainly pitiful to read some of the gynecologic literature, and even to attend some of the special societies, in which the subject of gynecology seems to have become circumscribed and belittled until we hear nothing but surgery, plastic operations, and matters of like importance from beginning to end.

The Gynecologic Sequela of Grippe.—Ballentyne in the *Edinburgh Medical Journal* has observed among the sequela of grippe a tendency to produce metrorrhagia, menorrhagia, and hemocele. In newborn children the author has noticed the great mildness of the disease as compared with its effects in adults.

A CASE OF DIDELPHIC UTERUS WITH LATERAL HEMATOCOLPOS, HEMATOMETRA AND HEMATOSALPINX, WITH SOME REMARKS ON THE TREATMENT OF THESE CONDITIONS.

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The uterus didelphys is undoubtedly one of the rarest malformations met by the gynecologist. Until recently it was thought to exist only in connection with deformity of other organs of such serious nature as to interfere with the life of the fetus; at present, however, there are on record a number of well authenticated cases in adults; in a cursory examination of the recent literature I have been able to find ten or eleven, a few of them with lateral retention of menstrual blood in vagina, uterus and tube, as in my own case.

By uterus didelphys we understand two well formed and entirely separated uteri, with no partition wall, which have either no connection with each other at all, or at least a very loose one, but with only one cornu and, therefore only one tube and ovary accompanying each organ; in other words, two complete uteri unicornes. In connection with this anomaly we may have a double vagina, one for each uterus, or there may be only one single vagina or a complete vagina with an incomplete one, as in the case to be described.

The history of the case is briefly as follows:

On January 13 of this year (1894) I saw, in consultation with my friend, Dr. Jos. N. Hoffmann, Miss Olga M., age 18, who had been confined to bed for several days with severe pains in the pelvis, especially marked on the right side. The temperature was but slightly increased and the pulse a little accelerated. The pains were constant but she had paroxysmal exacerbations which were described as cramps of an expulsive character. In addition, there was frequent and painful micturition. Abdominal palpation disclosed a tumor located in the pelvis and reaching about three or four inches above the symphysis pubis and extending over to the right inguinal region, and also to the left to a point midway between linea alba and left anterior superior spinous process of the ileum. This tumor on the right and in the median line was smooth, elastic, but not fluctuating; along its left upper surface a projection was noticeable which at the time was compared to a thumb, but was of larger size. A digital examination revealed normal external, vaginal parts; about two inches from vestibule the finger encountered a round, fluctuating mass almost entirely blocking the vagina. To the left of it the finger was able to pass the tumor along a very narrow, slender canal, but no cervix could be reached. This mass was continuous with the mass felt above the pelvic brim, where it became broader and wider, filling up almost the whole pelvic cavity. On the right side it reached to the ileum; on the left, however, a small space was left between the iliac bone and the tumor. The latter was distinctly fluctuating in its lower segment, but felt harder and firmer, although elastic, in its suprapubic portion. The projection attached to the left side above described, was a firm body of the shape of a normal uterus, recognized as such, carried up out of the pelvis by the growth. The tumor was tender but not extremely sensitive though the examination proved very painful.

On further questioning it was learned that the patient began to menstruate at 15, periods recurring regularly every three and a half weeks, till the winter of 1893, when they came every two weeks for awhile; since then, every three and a half weeks again; duration, two to four days, quantity normal until recently, but much increased of late; always accompanied since first appearance with paroxysmal pains chiefly in right side and back before, during and after menstruation; has been especially marked during last year. They were principally of a bearing-down character; also

pain on walking and sitting. This pain was so severe that she was scarcely able to attend to her work and at times she was compelled to go to her bed for several days. Bowels regular until last six months, during which time they were only moved after medicine. The only diseases had were diphtheria twice and measles. Occupation, domestic since 12 years of age. She was well developed, of healthy rather robust appearance, weighing about one hundred and twenty-five pounds and of more than medium height. As it was impossible to arrive at a satisfactory diagnosis and the case seemed to demand prompt surgical interference, exploratory laparotomy was advised, to which she readily consented. It was performed at Mercy Hospital, Jan. 20, 1894. The tumor was not adherent, presented a dark purple appearance, something like a myoma, was tense, elastic, but non-fluctuating. Attached to its left upper portion was the uterus forming a projection which was recognized before; it was of normal size and appearance, though unicornis with one normal ovary and tube. The surface of the tumor was smooth and convex, with a slight roundish, dome-like projection in the center. The true nature of the tumor was only ascertained when the tube on the right side was found greatly distended and of a purplish color; right ovary normal.

There was no doubt that we had to deal with a double uterus, the right one enormously distended with retained menstrual blood. With a scalpel the tumor was punctured a little to the right of the median line and over a quart of tarry-looking tenacious fluid escaped, which was at once followed by contraction of the uterus. The Fallopian tube was removed; it measured six inches in length and four and a half inches in circumference at the fimbriated end where it was largest; the latter was sealed and all traces of a fimbriae had disappeared. A long dressing forceps was introduced through the uterine incision and pushed down to the lower end of the sac where a counter-opening was made. Through this a long strip of iodoform gauze was drawn up to the uterine wound, but not through it, the forceps removed and the incision in the uterus closed with silk sutures. The right uterus was now of about twice the size of the left, the distance of the fundus of one from that of the other measured about three inches, the bodies were distinctly separate, there being a triangular space of at least two inches deep between the two organs. Some of the menstrual blood had escaped into the peritoneal cavity which was therefore washed out with distilled water and the abdominal wound closed without drainage. The patient reacted well and made an uninterrupted recovery. A week later she was again placed on the operating table, the strip of gauze packed into the menstrual sac removed and replaced by another. On this occasion we found that the lower end of the tumor was formed by an incomplete vagina, the vaginal canal in its upper half was double, the left vagina being complete, the right terminating in a closed sac.

February 9, she was again placed under the influence of an anesthetic, the vaginal sac freely incised and washed out, the septum between the two vaginae completely excised and its edges sutured together with catgut. Measurements showed the distance from the right cervix to the lower part of the blind vagina to be two and a quarter inches, and from this to the vulva two inches. The right cervix was fully an inch higher in the pelvis than the left one and larger in size; the right uterine cavity measured four inches in depth, the left one three inches.

She was anesthetized again March 7, a few days before her discharge from the hospital, in order to make another careful examination and to take accurate measurements. The vagina had now only one compartment from vulva to both cervixes; a slight linear cicatrix in the right vaginal wall and between the two cervixes uteri indicates the former location of the septum. The speculum exposes both cervixes very plainly to view; they are now almost at the same level, though the right one is still about a quarter of an inch higher and a little posterior to the left one; the right one is a little less accessible than the left and the slightly projecting remainder of the septum between both uterine necks conceals a portion of the right cervix. Bi-manual examination finds both uteri distinctly separate in an oblique position with their fundi pointing towards the anterior superior spinous processes of both sides. The internal surfaces of both uteri meet at an acute angle about an inch above the external os where they are connected; the connection being, however, quite a loose one, allowing distinct separate motion of each organ. The bridge connecting the two uteri is about one-third of an inch thick. When a sound is introduced into each uterine cavity at the same time they cross each other in the vagina at an angle of about 45

degrees. Both cervixes present a normal appearance and are of normal size, perhaps a little larger than usually found in a virgin; there is a scanty purulent discharge from the right os uteri.

Last examination made May 22 during menstruation, to ascertain whether the menstrual flow came simultaneously from both uteri. There was a characteristic bloody discharge from the right os uteri, but only some glairy mucus from the left.

The patient has been in good health since the operation; she has menstruated every two and a half weeks, lasting from three to five days with very little pain.

The case is interesting, not only from an anatomic and embryonal point of view, but also from a clinical one, inasmuch as it opens the question of diagnosis and especially the treatment in all cases of gynatresia with retained menstrual blood. It would be beyond the scope and intention of this paper to treat of all these points thoroughly; it is simply my purpose to refer to them briefly, hoping that the discussion will augment and complete what I can only barely allude to.

Embryology gives us a ready explanation of this very interesting and rare anomaly. As we know, the tubes, uterus and vagina are formed entirely by Müller's ducts. These may be divided into three parts; the first and upper part is destined to become the Fallopian tubes, the middle part the uterus and the lower third the vagina. They are formed parallel with those of the Wolffian body, and are in their upper extremity far apart, but in their downward course toward the uro-genital sinus they approach each other, coming close together in the lower third. After the eighth week this portion begins to fuse, the fusion always commencing at the lowest extremity and extending upwards until the lower and middle third have become firmly united, completing the vaginal and uterine canal at about the fifth month; but the upper third always remains apart. If for some reason this union at this early period of embryonal life is interrupted at any portion along the course of Müller's ducts, each duct may develop separately and independently, resulting in the formation of double organs. If fusion of the lower third of the ducts has already begun before the inhibitory influence has been brought into play, that portion will continue to grow as a single organ, while those parts whose union has been prevented will develop separately and independently as double organs. In the case reported, no doubt some such impediment to the fusion of Müller's ducts arose in the early part of the third month of fetal life, after a portion of the lower third had already become fused, which latter continued to develop into a normal vagina, while those sections of the ducts which remained separate formed double organs, a partial double vagina and two separate uteri.

The diagnosis of this malformation should not be very difficult when both vaginae are patent and both cervixes accessible to touch or vision, or where there is only one vagina containing two distinct and visible uterine necks. More difficult or impossible is the diagnosis in such cases as mine, where menstruation is going on regularly from one uterus, while the other imperforate genital canal is the seat of a complete retention of menstrual blood with hematocolpos, hematometra and hematosalpinx. In such cases including all forms of gynatresia with double genital canals, a positive diagnosis will usually only be made after an exploratory puncture or laparotomy.

The treatment is naturally limited to those cases

of genital malformation accompanied by gynatresia with menstrual retention. It is essentially the same whether the retention is due to a simple imperforate hymen or a vaginal atresia with single or double canal. The indication in all these cases is to establish an outlet for the pent-up menstrual fluid. Where the retention is confined to the utero-vaginal canal this is accomplished easily, and, with ordinary precautions with comparatively little risk to the patient. But when complicated with tubes distended with blood, a hematosalpinx—and I believe this is the usual result of long continued menstrual retention—a great element of danger is added which requires our most careful attention. The tension caused by the retained blood has usually produced such a marked atrophy of the tubal walls, reducing them to a mere thin membrane, as shown by a number of autopsies that the slightest pressure is sufficient to cause rupture. In addition to the imminent danger of rupture there is that of septic infection, which not infrequently has led to a fatal termination. Fuld (*Archiv für Gynakologie*, Band 34), has collected sixty-five cases of gynatresia with hematosalpinx, of which forty-eight were fatal. He divides them into two groups: Those with a single and those with double utero-vaginal canal. In the first group, containing twenty-seven operated cases, fourteen recovered; of the second, consisting of twelve cases only, three were cured; in only four cases was laparotomy performed, all of which got well. This collection of cases can not fail to impress us with the great mortality attending this condition, and it is therefore not surprising that such great authorities as Dupuytren and Cazeaux discouraged operations for hematometra, which were nearly always followed by a prompt and certain death, preferring to leave them to nature, though the final result seems to have been equally unfavorable. With the aid of antisepsis and our greatly improved operative technique, much of the fear formerly entertained in dealing with these cases has disappeared, but it can not be denied that even at present they are not devoid of considerable danger. It is often very difficult to guard against sepsis, and the possibility of rupture of a distended tube should not be overlooked.

To prevent these two most frequent accidents it is necessary to provide for very slow but thorough drainage of the closed utero-vaginal canal. This can be best accomplished by a very small incision into the obturating membrane, and inserting a small rubber or what is better, a glass drainage tube, the projecting end of it to be well covered with iodoform gauze. Injections for the purpose of aiding the outflow of the thick tarry fluid had best be avoided. When the vagina has become completely emptied, a careful examination should be made to ascertain the condition of the uterus and tubes. If after thoroughly draining the utero-vaginal canal the tubes have failed to empty themselves into the uterine cavity, laparotomy becomes indicated and the more promptly it is performed the better it will be for the patient. In cases of complete absence of the vagina with hematometra, an attempt should be made to reach the sac through the natural channel, the closed uterus incised, and drainage provided for by inserting a small glass drainage tube.

In the cases where the uterus can not be made accessible in this way without injuring the neighboring organs, especially bladder and rectum it would

be better, in my opinion, to do a laparotomy, puncture the distended uterus, wash it out thoroughly and closing it by sutures, at the same time removing the adnexa. This would be preferable, in my judgment, to an incision either through rectum or bladder, as is usually recommended, or to a parasacral or a pararectal incision, as suggested by Pozzi.

MESSAGE IN GYNECOLOGY.

Read in the Section on Obstetrics and Diseases of Women, at the Forty-fifth Annual Meeting of the American Medical Association, held at San Francisco, June 5-8, 1894.

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No branch of medicine has made such rapid advance in a comparatively short space of time as gynecology. Though ovariectomy had been performed successfully for more than seventy years, it was not until the publication of Marion-Sims' work on "Uterine Surgery," some thirty years ago, that diseases of women forced a recognition from the medical world as a separate branch of medicine. From that time on, gynecology has, as it were, leaped full-grown into existence. New operations and methods of operations were successfully tried, improvement followed upon improvement, and operative gynecology became a source of admiration to the profession as well as to those whose lives have been relieved by the surgeon's knife, of manifold burdens.

But while there is so much light, there is much darkness. How many ovaries, how many wombs have been sacrificed, how many women have been made sterile, to satisfy this *furor operativum*. While one mutilating operation was thus succeeding another, very little thought until of late years, was given to the manner of preserving the generative organs by more conservative treatment, and of bringing about restoration without intervention of surgical procedures. The indisputable merit of having given to the medical profession a therapeutic agent to successfully combat many uterine and ovarian disorders belongs to Thure Brandt, of Stockholm. Since his publications on "Massage in Gynecology," the foremost gynecologists have tried this method of treatment, have expressed themselves as fully coinciding in all that is claimed for it, and have pronounced it valuable as rendering unnecessary, in very many cases, operative interference. The object of uterine massage is to bring about a healthier state of the circulation and to impart *tonus* to the various structures of the genital tract. It is indicated in all disorders due to chronic inflammation, as well as in such diseases as cause uterine displacements, produced by relaxation of the ligaments, or by pelvic exudations, with or without adhesions.

Before describing the technique of massage, I will mention some of the general directions to be observed. The patient should be placed in the usual position on her back with legs well drawn up, as is customary in gynecologic examination. Antisepsis should be observed as in gynecology or obstetrical work. As massage in the beginning of the treatment is somewhat painful to most patients, it should be given gently, and the force should be gradually increased; it will thus be borne even by sensitive women, especially if the physician encourages them. To reduce the pain caused by the hand (particularly in nulliparæ) on the abdominal parietes, it is well to