

was not so confident as others in its efficacy. The majority of cases of puerperal infection tended to recovery.

A CASE OF ATROPHIC PELVIS FOLLOWING INFANTILE MYELITIS; AND
A CASE OF ATROPHIC PELVIS FOLLOWING PARALYSIS OF ONE EXTREMITY.

BLANC (*Archives de Tocologie*, No. 9, 1889) reports for comparison the two cases enumerated above. The pelvis in the former was comparatively large, and maintained in the main a circular contour. The latter pelvis had one normal half, while the other was greatly lessened in its antero-posterior measurement, resembling an obliquely contracted pelvis. Blanc concludes that there exists an atrophic pelvis, as in infantile paralysis, and also an atrophic pelvis caused by paralysis of a lower extremity; the first comparatively simple in contour and causation; the latter resulting from complex forces occasioned by paralysis of a limb and resulting derangement in the mechanism of pelvic development.

GYNECOLOGY.

UNDER THE CHARGE OF

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THE CONDITION OF THE CORPOREAL ENDOMETRIUM IN CARCINOMA OF THE CERVIX.

ABEL and LANDON (*Archiv für Gynäkologie*, Bd. xxxv. Heft 2), after making numerous careful microscopical studies, arrive at the conclusion that in cases of cancer of the cervix the corporeal endometrium nearly always undergoes marked changes, which are of a malignant, as well as of an inflammatory, character. The histological structure of the diseased endometrium is often identical with that of round-celled sarcoma, which is to be regarded as the initial stage of cancer metastasis. The practical lesson to be derived from this is that, since in a given case of cancer of the cervix uteri the surgeon is entirely ignorant of the true condition of the corporeal endometrium, he ought not to be satisfied with high amputation, but should remove the entire organ.

[There is another question to be taken into consideration in deciding as to the relative merits of high amputation and complete extirpation in cases of cancer of the portio vaginalis, which is of more importance than the doubtful condition of the corporeal endometrium, and that is the state of the perimetritic tissue. Deductions based upon microscopical observations alone can hardly outweigh the well-established clinical fact that recurrence of the disease after high amputation occurs in the majority of the cases at the edges of the former wound, and not within the body of the uterus—it extends from

below upward. It should not be forgotten that competent observers have failed to find the changes above described.—Ed.]

VENTRO-FIXATION OF THE UTERUS.

F. SPAETH (*Deutsche med. Wochenschrift*, September 12, 1889) discusses this subject at length, reporting fifteen cases in which the operation was performed successfully by Prochownick. He thinks that it is indicated in about seven per cent. of the cases of retro-displacement, i. e., in women with retroflexed and adherent uteri, who still menstruate. Temporary vesical irritation was noted in several cases, but no more than after ordinary laparotomies. The results of ventro-fixation cannot properly be estimated until years have elapsed. Even after a few weeks there may be some tendency to backward displacement, but the most important point is that the patient's symptoms are relieved.

A NEW METHOD OF PERFORMING VAGINAL HYSTERECTOMY.

ZUCKERKANDL (*Wiener med. Press*, 1889, No. 7) suggests the following method of reaching the internal pelvic viscera through an opening in the perineum: The patient being in the knee-chest position, a transverse incision is made in the perineum, at the outer extremities of which lateral incisions are made, as in the flap-operation (______). The fibres of the external sphincter which extend to the commissure are divided, and the lower portion of the vagina is separated from the rectum, the attachments of the levator ani being divided on each side. The rectum is drawn backward, and the wound is opened up as high as Douglas's pouch, the posterior fold of peritoneum then being incised. Through this opening the fundus uteri is grasped, and the organ is retroverted. The broad ligaments are tied in sections, the bladder is dissected off, and finally the vaginal attachments are separated. The stumps of the broad ligaments may be returned to the cavity, the peritoneal wound being closed by sutures, or they may be stitched into the vaginal wound.

The writer claims that by this method the whole of the broad ligaments may be inspected before the ligatures are applied, and that the ureters may be seen and avoided, while the posterior vaginal wall is uninjured.

[We can hardly conceive what advantage is to be gained by complicating this operation through the addition of an extensive wound in the perineum. Any one who has tried to separate the bladder from the uterus from the peritoneal side, will appreciate the difficulties of the procedure, and the impracticable nature of the entire operation.—Ed.]

THE TREATMENT OF MALIGNANT TUMORS OF THE OVARY.

FREUND's paper on this subject (*Zeitschrift für Geburtshilfe u. Gynäkologie*, Band xvii., Heft 1) is based upon his experience in seventeen cases in which the malignant neoplasm was localized in the ovaries, and eight in which the peritoneum was also affected. He lays considerable stress upon the presence of hydrothorax as evidence of malignancy of the tumor; this was noted in ten cases, in only one of which it could be ascribed to actual metastatic disease of the pleura. This hydrothorax is no counter-indication to laparotomy; in

fact, the fluid rapidly disappears after the operation. This effusion accompanies papillomata of the ovaries, as well as carcinomata and sarcomata.

In three cases the umbilicus was the seat of cancer, thus rendering the diagnosis easy. Secondary growths on the adjacent peritoneum are not true metastases, but represent rather a sort of implantation of the original neoplasm; this distinction is of great importance clinically, since secondary tumors around the uterus do not contra-indicate operative interference—an opinion directly opposed to that expressed by Schröder. This applies to all varieties of malignant neoplasms of the ovaries.

With regard to the propriety of operating in these cases, the writer insists upon the similar course of malignant disease of the pelvic organs and that of the breast or extremities; the patient may live for years, so long as the functions of the important viscera are not disturbed. Even when the latter are affected, the surgeon may prolong life by removing ascitic and pleuritic effusions, breaking up intestinal adhesions, etc. Laparotomy is preferable to puncture in the treatment of cancerous ascites, as in that due to tuberculosis, because not only can the fluid not be entirely withdrawn by the aspirator, but there is more danger of hemorrhage and collapse. If fluid remains in the cavity, it irritates the peritoneum, and thus leads to fresh effusion. No one should attempt to remove these malignant growths who is not competent to treat all the formidable complications which arise in abdominal surgery, including resection of the intestine. The after-treatment of these cases requires unusual care. There is no more reason to fear septic peritonitis than there is after a simple ovariectomy.

The writer's results were very favorable, since he lost only one patient from pulmonary embolism.

THE DIAGNOSIS AND TREATMENT OF PAROVARIAN CYSTS.

WYKOWSKA (*Centralblatt für Gynäkologie*, October 12, 1889), from an analysis of seventeen cases, finds that there are wide differences in the anatomical structure and contents of these cysts; in only two cases did the fluid contain ciliated epithelia. In one-half of the cases circumscribed peritonitis was present. He recommends puncture *per vaginam* in preference to removal by laparotomy, but acknowledges that the diagnosis is often doubtful.

[We have quoted this article only to express disapproval of the palliative treatment advised, which is opposed to that which is generally accepted.—Ed.]

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