

GYNECOLOGY.

UNDER THE CHARGE OF
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ETIOLOGY AND PATHOLOGY OF FIBRO-MYOMA.

ENGSTRÖM (*Med. Anzeiger zur Centralblatt für Gyn.*, Aug. 1890) calls attention to the fact that heredity seems to play some part in the etiology of fibrous growths of the uterus (as shown by an analysis of the histories of several families in which he had observed that two or more sisters suffered from them), as had been previously pointed out by Winckel, Carl Braun, and Gusserow—a fact which seemed to prove Cohnheim's theory of their embryonal development.

BOISLEUX (*Ibid.*) examined ten specimens of fibroid uteri removed *in toto* by Martin, with special reference to the detection of microorganisms in the cervical endometrium. Sections were made through that portion of the cervix which usually forms the stump after supra-vaginal amputation. In four cases he found micrococci which produced rich cultures on gelatine plates, and caused death in mice and guinea-pigs which were inoculated with them.

THE TREATMENT OF OVARIAN CYSTS BY FARADISM.

NOEGGERATH (*Ibid.*) reports six cases which were treated in this way from six to eight weeks, the tumor diminishing visibly in every instance and even disappearing entirely after a longer interval had elapsed. Proliferous multilocular cysts of moderate size are best suited for this treatment. The negative pole of the secondary current is introduced into the vagina (a sponge electrode being used), while the positive pole is attached to a large sponge electrode, which is placed on the abdomen. A current is used which is barely felt by the patient. Three *séances*, of half an hour each, are held weekly.

VUILLET'S METHOD OF DILATING THE UTERUS.

VUILLET (*Ibid.*) claims the following advantages for his method: Dilatation may be carried so far that the interior of the uterus may be inspected, and it may be maintained as long as desired. Perfect drainage is secured, the endometrium is rendered directly accessible to local treatment, and morbid growths are more readily removed through the dilated cervix, while intra-uterine hæmorrhage is most effectively treated by tamponing the cavity after previous dilatation.

EXTIRPATION OF THE BLADDER IN THE FEMALE.

PAWLIK (*Ibid.*) reports the following interesting case: The patient applied to his clinic on account of persistent hæmaturia. By catheterizing both ureters hæmorrhage from the kidney was excluded. Digital exploration of the bladder revealed the presence of a polypus the size of an almond, which

was removed *per vaginam* through an incision, its base being thoroughly cauterized. The patient was discharged cured. A year later she returned, extremely anæmic, stating that after enjoying good health for eight months the hæmaturia returned and had never ceased. Through the endoscope a diffuse papillomatous growth was seen, portions of which were removed for microscopical examination and proved to be malignant. The writer determined to extirpate the entire bladder, after turning the ureters into the vagina, in order to form a new bladder from the latter and the remains of the urethra. The preliminary operation was performed by inserting metallic catheters into both ureters (the patient being in the knee-elbow posture), incising the vagina opposite to the terminal extremity of each ureter, dissecting out the duct, and then ligating and dividing it two-fifths of an inch from its opening into the bladder. The cut end of each ureter was then stitched into the corresponding vaginal wound after removing the catheter; after healing had occurred there were thus formed two uretero-vaginal fistulæ. Three weeks later the radical operation was performed. An incision was made as for suprapubic lithotomy, the peritoneum was dissected from the bladder, and the latter was separated from its attachments as low down as the urethral opening, the organ having been previously distended with an iodoform emulsion in order to render it more prominent. At this stage the bladder was emptied and the cavity already made was packed with iodoform gauze on account of the oozing. The anterior vaginal wall was now incised just above the most prominent part of the urethro-vaginal septum, the bladder was drawn down through the wound and was cut away at the vesical orifice of the urethra. Here the patient collapsed, but was revived by the subcutaneous injection of ten ounces of warm salt solution, and the operation proceeded. The anterior vaginal wall was sutured to the anterior border of the urethral wound, the posterior border being united to a freshened surface at the entrance of the vagina in such a way as to produce a kolpokleisis. Before the sutures were tied elastic catheters were introduced into the urethra and carried into the ureters. The abdominal wound was closed, except at its lower end, through which were carried the ends of the gauze for drainage. The patient made a good recovery, but a fistula remained which communicated with the cavity that had formerly been occupied by the bladder, which did *not* heal for eight months. A second unsuccessful attempt at kolpokleisis was made ten months after the primary operation. This was repeated a month later, the anterior and posterior walls being united transversely; a minute fistula remained behind the urethra, through which urine escaped only when the patient was in an erect posture. She was able to retain control of her artificial bladder until twelve ounces of urine had accumulated, when she could empty it by contracting the perineal muscles. The woman made a perfect recovery and was able to undertake a journey from Prague to Berlin and to spend several days in sight-seeing.

[This remarkable case is certainly a triumph of plastic gynecological surgery, before which others sink into insignificance. The practical application of Professor Pawlik's long and patient experiments in catheterization of the ureters proves that this manœuvre is something more than a scientific pastime. The boldness of the conception and the untiring patience of the operator awaken our highest admiration.—ED.]