

speculum introduced under cover, and the examination made complete with it in position, the best gynecologist will fail to correctly diagnose three-fourths of the abnormalities needing attention. The diagnosis first, and inspection of the os afterwards. It is to be hoped that the younger members of the profession will not become factors in engrafting on the profession such abominable terms as "female weakness," which had its origin in an attempt to cover up ignorance. The time for these things to be winked at has gone by, and the man with imperfect preparation for great responsibility in gynecologic practice should receive encouragement only in the line of preparation for good work, rather than professional sanction for mutilation and murder of human beings. The man who takes money for medical treatment that he knows will be useless is no less a confidence man than the one that the law of our land would seize.

I call to mind a goodly number of cases of irritable bladder, cystitis, or nephritis so-called, permanently relieved by removal of an urethral carbuncle, repair of lacerated perineum, removal of hemorrhoids, repair of lacerated cervix, or amputation of some one or all as the case seemed to require.

Formerly I did these operations singly, or but two at a time, but for past three or more years have been doing them all at one sitting, if need be, and the patient's condition justified it. The causative factors must all be removed in any case if we expect satisfactory results. Amputation of the cervix, curettage, etc., will not cure a case of subinvolution due to causes that still continue active. The most that it could be expected to do would be to bring temporary relief, and thus gynecologic surgery is brought into disrepute. If we carefully reach and eliminate all the causative factors in each case, whether it be by surgery or medicines, we will be successful. If not, our results will rate us in the community unpleasantly close in importance to the average charlatan. Flexions have caused me more trouble than all other cases. Gradual dilatation with the Tait dilator has given me more satisfaction and my patients more relief than all other plans that I have tried. Though my patients are satisfied with it, I am not. They must, like the male urethral stricture case, have another *séance* once in one, two or more months. I have not done the Alexander operation in retroflexed cases on account of theoretical objections, but am inclined to think more favorably of it than formerly. From the operations that I have seen done extraperitoneally on the round ligaments, I am sure that the man who undertakes this operation should have the most accurate anatomic knowledge possible. No one should do an ablation of the appendages who can not palpate the normal ovaries and detect marked enlargement of the tubes. Ventral fixation bids fair to become quite popular in the near future, as it can now be done without an incision into the abdominal cavity.

From experience and observation, I am satisfied that intelligent surgery will permanently relieve or cure three-fourths of our gynecologic cases. I believe that obstetricians, midwives and the general ignorance of the community are responsible for one-half of the misery and ill health of our women.

All women should be examined in two weeks after delivery, and all lacerations of the cervix should be repaired before the woman is allowed to be on her

feet, especially if the tears be laterally placed. All lacerations will be repaired by nature if located anteriorly or posteriorly, and I am satisfied that if the woman did not assume the erect posture for four weeks, those that are placed laterally would also unite. The difficulty is in the woman's assuming the erect posture, and as the utero-vesical and rectal ligaments, so-called, furnish the uterus with its principal support, as soon as the woman is on her feet the anterior and posterior lips are forcibly separated and union is prevented, and finally we see the condition remaining one of permanent eversion. With care in our obstetric and gynecologic practice the life-long invalidism and justly dreaded maternity may soon become things of the past. Then the term "female weakness," and the occupation of the iodine gynecologist will be gone forever.

SOME UNCOMMON OR SINGULAR CASES.

Read before the Pennsylvania State Medical Society, May, 1894.

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Dysmenorrhea, Catalepsy, Hysteria.—In 1867 a female, single, age 18 years, of nervous temperament, came under my observation and treatment for a period of three years. There were dysmenorrhea with scanty and irregular discharge, tenderness over spine, hyperesthesia over surface of body, and great tenderness over the region of her genital organs. There developed during the early part of this period, many strange and unusual symptoms and she exhibited many remarkable freaks. One day she would have a jumping toothache, the next day she would be hysterically insane, almost uncontrollable, the following day she would be in a profound catalepsy, the day after she would be a songster and the following day she might be rational. Another day she would suffer colicky pains in the abdomen, followed by all sorts of contortions of the body. These conditions would repeat themselves, period after period, in various forms. In the evening of her catalepsy day while lying in bed quietly, she would suddenly spring from the bed, surrounded by the bed-clothing, and alight head foremost on the floor. On another evening following her song day, she would stand before a looking glass in the dim light from a smoldering fire in a grate and arrange her toilet, sing a song, or read a chapter out of the Bible. At other times she would run around on the furniture of her room, or dance on the "piano." One evening she endeavored to drive me from the room with a poker. Sometimes, in the evening, when sitting in a chair after the well day she would become paralyzed and have to be carried to bed. These varied conditions continued without interruption for about two years, when she commenced to convalesce. The last symptom or condition which manifested itself was invariably lighted up when a young man visited her. On the occasion of his visit she would become paralyzed or powerless to remove herself from the chair on which she was sitting, and would so remain until after the young man had left, after which she would be carried to bed. During the night she would recover the use of her limbs. This female afterwards married the then young man and now is the mother of three intelligent, healthy children, and is enjoying reasonably good health herself. I have no doubt if a similar case now, should fall into the hands of a laparotomist there would be an operation performed.

Dysmenorrhea.—In 1888 Mrs. J., age 21, used ice cold water as an injection immediately after having had intercourse with her husband and a short time before her expected period. In a short time thereafter a group of very painful and distressing symptoms presented themselves which were difficult to control. Among these were dysmenorrhea, tenderness on pressure over the abdomen, colicky pains in abdomen, borborygmus, functional derangement of the heart, insomnia, irritable temper, and loss of appetite. After a time, under my observation and treatment, she became dissatisfied and wanted to be relieved quickly; she consulted a laparotomist who advised laparotomy with a view to removing the left ovary. After considering the matter for some time she returned to me for further treatment. She is now enjoying good health and has had one miscarriage.

Stenosis of Cervix, Supposed Phthisis.—In 1869 M. C., a female, single, age 21, had been treated by a celebrated physician for two years for what he diagnosed as phthisis pulmonalis, and had made a very unfavorable prognosis. At this time I was called in to treat her. She presented the following symptoms: Emaciation, cough, expectoration, amenorrhea, tenderness over abdomen and over spine, anorexia, constipation, periodically colicky pains in the abdomen and inability to walk. This condition had continued with varied symptoms for a period of two years. I made a thorough and careful examination and, after weighing and examining all the conditions presented, I considered that this group of symptoms might have been caused by a stenosed cervix. Upon this conclusion I acted; dilated the cervix completely with a sponge tent and thereafter my patient soon recovered; she is now the mother of two children and weighs 160 pounds.

Prolapse of Uterus in Parturition.—Early one morning in the fall of 1872, I was called to see a case, a German woman in labor with her fifth child; she was attended by a midwife who undoubtedly to hasten labor had been giving the woman ergot. I found the head of the child outside of the mother with a portion of the womb covering head of child. The os was only partially dilated, not enough to allow the head to pass through. The part of the womb covering head of child outside the mother was thin and dry. The mother was still having light parturition pains. I quieted the mother with sulphate of morphia and anointed the parts of the uterus outside of the mother with lard. In about an hour the child was born. The uterus assumed its normal position and the woman recovered.

Fracture of Olecranon.—In 1882 J. S., a boy aged 15 years came under my care at the Pittsburgh Infirmary with ankylosed right elbow joint, from an injury received while working on a farm. The fore-arm was in a straight line with the arm. I put him under the influence of chloroform and in breaking up the adhesions of the ankylosed joint I fractured the olecranon. I put the arm in a rectangular splint and kept it there for three weeks. At the end of this period on becoming alarmed because some cases of smallpox had been received into the hospital, he surreptitiously made his escape. About three years ago I saw him for the first time since his escape from the hospital, and he told me he had quite a useful arm.

Retained Pessary.—Mrs. T. J. A., age 30, was confined with her third child, Feb. 16, 1885. The breech of the child presented, and after a tedious labor the child was born. One year afterward I was called to see patient with inflammation and great tenderness of the vagina. The hasty and imperfect per vaginam examination I was compelled to make led me to think that the hard ring-like condition at the upper part of the vagina which presented itself on this examination might have been produced by an inversion of uterus after the last labor, causing thereby the constricted parts of that organ to slough away. After having been annoyed with the case for a week and no improvement noted, I chloroformed my patient and extracted a hard, irregular round pessary. The pessary had been the cause of all the irritation and distress, and had been surreptitiously placed there by a midwife during a vaginal examination. The woman recovered soon afterward, but has since died of phthisis pulmonalis.

Obstruction of the Bowels, Intussusception.—W. K., age 32 years, a large fleshy man, a saloon keeper and beer drinker, was attacked June 6, 1890, with cramps and nausea at the stomach; did not know exactly when his bowels had been moved. On Sunday, June 8, 1890, was called and found him in the above condition though more intensified. I prescribed calomel and opium in 1 grain doses each, in powder every three hours, followed by warm water enema. I continued with this treatment till Monday when the pains had become very much more severe. He was in a kneeling posture with his belly resting on the side of the bed to gain relief. The hot water enema was continued. For the calomel and opium, I substituted a pill of a quarter of a grain each of extract of belladonna and sulphate of morphia to be given every hour. In the afternoon Dr. A. M. Pollock, of Pittsburgh, was called in as counsel in the case. He suggested that the warm water injections and morphia and belladonna pills be continued as before, and in addition thereto he recommended one-half grain of sulphate of morphia hypodermatically, administered every six hours or until the pains might be controlled by the morphia and belladonna pills. This treatment was kept up uninterruptedly night and day till June 12, when there was some indication of fecal odor in the warm water enema passed from the bowels. The treatment

was continued. On June 13 there was a thin fecal passage from the bowels with the warm water enema, and the hard and inflated bowels had subsided. He was considerably narcotized. At this time the morphia and belladonna pills and the hypodermatic injections of morphia were withdrawn. Strong coffee and Rochelle salts with hot enema were ordered to be given every three hours. On the afternoon of June 13 the bowels were well evacuated, pains subsided and the patient is in a fair way to recover. On the evening of June 13 he was attacked with delirium tremens which continued during June 13, June 14 and June 15. On that afternoon he slept three hours and also all of Sunday night. June 16, he was about the house and was well.

Some points in this case should not pass unnoticed. The amount of morphia and belladonna taken into the system in the four days was thirty-two and twenty-four grains respectively. The fact of his having delirium tremens would have precluded laparotomy.

Here we have the history of a case of obstruction of the bowels for just one week at least, and at no time during this obstruction did there arise a condition in the case which demanded an operation. If there had been a time during this obstruction in which the operation might have been demanded, it would have been early in the disease about Monday June 9, and that demand would have been only arbitrary. The point I wish to make is that there is no period in a case of obstruction of the bowels where an operation is called for until inflammation has set in, that we can prognosticate certainly that a case may not recover without an operation. Suppose this case had been operated on Monday, the third day of the obstruction, what would have been the result? Why certainly death! For no case of a recently opened belly could have survived such a strain as the belly of this man was subjected to during the time of his wild unmanageable delirium Friday night, Saturday and Saturday night, and Sunday forenoon, June 13, 14 and 15, so that in this case, at least, it may be said conversely to what I have heard a member in this Society state, that the laparotomist arrived just twenty-four hours too late to save life. The laparotomist, if one had been employed in this case, would have arrived just four days too soon in order to save the patient's life.

Abscess of the Liver.—In May, 1877, J. S., a farmer age 30, was admitted into the Pittsburgh Infirmary suffering with what had been diagnosed phthisis pulmonalis by his medical attendant. He was very much emaciated, had cough, fever, expectoration, night sweats and anorexia. After he had been in the hospital a short time there was an abscess in the liver discovered to be forming and finally its contents, three pints of pus, were evacuated and the patient afterward rapidly convalesced.

Laryngeal Diphtheria.—M. R., a male aged two years and eleven months, was taken with slight cold, as the parents thought, on Sept. 5, 1892. The slight cold or cough got worse and worse, when on September 18 a doctor was called in, who told the parents that an operation was the only thing that would be likely to save the patient. The parents therefore looked with anxiety on the case and expected every moment that death would relieve the suffering of their child.

On September 19, 11 A.M., I saw the child, who was very restless, with extreme dyspnea; abdominal breathing, aphonia, beads of sweat standing out on the face, anxious countenance, ringing hard cough, injected eyes, patient reaching out from mother's arms to go to father, and from father back to mother again. No diphtheritic deposit could be seen in pharynx. I ordered 3 grains of calomel to be given every hour and inhalations from slaking lime every three hours and whisky *ad libitum*.

September 21. Patient whispers; cough croupy, breathing abdominal, bowels moved about five times since last visit. Countenance anxious, eyes injected. Has coughed up some membrane, pulse irritable and quick. Calomel and whisky

continued, together with inhalations from slaking lime. Membrane extends from larynx along trachea and bronchii.

September 23, 10 A.M. Patient rested better previous night. Had five stools. Breathing still difficult; patient restless. Slaking lime inhalations, calomel and whisky continued, together with lime water spray to throat.

September 25, 10 A.M. Breathing more freely, not so restless. Voice at intervals natural. Had seven stools since last visit and has expectorated membrane about twenty times, each of which added to the relief of the patient. The patient has taken a pint of whisky since I first saw him. Treatment continued.

September 27, 10 A.M. Took three-quarters of a pint of whisky and has had seven stools since last visit. Patient slept all last night. Has no difficulty in breathing. Voice aphonic. Ate well this morning for the first time since illness. Bronchii, trachea and larynx clear. Treatment continued.

September 29, 10 A.M. Has been speaking in higher nearly natural tones since Tuesday afternoon, coughs some and expectorates a little mucus. Breathing freely and natural. Bronchii, trachea and larynx still clear, sleeps and eats well. Has had ten stools and has taken three-quarters of a pint of whisky since last visit. Treatment, calomel and whisky every three hours.

October 1, 10 A.M. Appetite good. Has had six stools since last visit and took a quarter of a pint of whisky; sleeps well; voice a little husky; whisky and calomel ordered to be given every four hours.

October 3. Patient has had five stools and took one quarter of a pint of whisky since last visit. Patient has about recovered, except there is still a huskiness in the voice due to a relaxed condition of the vocal chords. Dropped calomel and whisky and put patient on the following prescription:

R. Tinc. ferri chlor gtt xxx ij
Potassii chlorates gr. x ij—(12).
Syrupi toluanus.
Syrupi simplex āā 3ij.
Aquæ 3iss.

M. Sig. A teaspoonful three times a day.

October 7. The patient has entirely recovered.

During this child's sickness he took 876 grains of calomel and about a quart of whisky. I assert that calomel, in large and frequent doses, given a child suffering with laryngeal diphtheria prevents further exudation of membrane which will finally become detached and expectorated, and hence in the majority of cases thus treated if seen in the early part of the disease there is no necessity for intubation or tracheotomy.

The above makes a record of three cases of laryngeal diphtheria that have recovered under my care with the calomel and whisky treatment.

Renal Colic, Morphia, Convulsion.—I. K., age 32, well built and weight 160 pounds; suffering with orchitis, was attacked with renal colic on the evening of Feb. 14, 1894. At 8 P.M. he took an ordinary dose of morphia to relieve pain which afterward became more intense so that at 9:40 P.M. I gave him a hypodermatic injection of one-quarter of a grain of morphia with one one-hundred-and-fiftieth of a grain of sulphate of atropia. For two minutes after the injection he felt nausea at the stomach when he was seized with a convulsion and remained in this convulsion three minutes, after which he returned to consciousness and said he felt better.

DISLOCATION AND DOUBLE FRACTURE OF THE UPPER THIRD OF THE HUMERUS.

Read before the Cincinnati Academy of Medicine, June 4, 1894.

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For the surgical history of this unfortunate state of affairs I can not do better than to refer those who wish to inform themselves upon the subject, to Dr. McBurney's paper and report of a case of this kind published in the *Annals of Surgery*, April, 1894. This is the most complete and concise article that I have read. It is more especially interesting as he

offers the means of a plan of reducing the disarticulation which he himself was the first to devise and execute. This was done July 1, 1893, and has been the means of revolutionizing the treatment of this class of cases when the condition of the patient will permit. That no surgeon thus far reported has met with more than five cases shows that the accident is exceedingly rare. The cause is obscure, the statements of the injured being very unreliable.

It seems probable that in the larger number of instances the dislocation is produced by the usual mechanism—that is through violent sudden abduction of the arm; as in a fall upon the hand or elbow, and the head of the bone having become fixed in its new situation that fracture takes place through continued abduction, combined perhaps with force rotation, the edge of the glenoid cavity or of the acromion acting as a fulcrum.

The complication has also been produced a good many times by the surgeon in his efforts to reduce a simple dislocation. The dislocation has been usually subcoracoid, occasionally subglenoid and very rarely subspinous. Unless there is very much swelling there should not be much difficulty in making a diagnosis, as the head of the bone can be felt and crepitus defined.

The treatment formerly practiced was either immediate reduction or reduction by using the arm as a lever after the bones have become firmly united.

Thirty-six of the eighty cases reported were reduced, while forty-four were failures and as six of the eighty died as the result of traction, rotation, etc., it will be seen that any attempt at reduction by any means other than open arthrotomy is exceedingly dangerous.

The fracture in the 117 cases reported was in 69 at the surgical neck; in 27 at the anatomic neck; at the "neck" in 11; both anatomic and surgical neck were fractured in 6 cases; 1 case was comminuted, and the 'upper part' of the humerus was fractured in 3, "thus showing the line of fracture to be varied."

The very unsatisfactory results from former treatment, together with a mortality from manipulation alone being almost as high as that of hip joint, amputations should convince the surgeon and practitioner in general that other means should be adopted.

PLANS OF TREATMENT.

1. Immediate reduction by direct pressure upon the head.
2. Manipulation after union of fracture.
3. Arthrotomy and reduction of the head.
4. Resection of head of humerus.

Immediate reduction by direct pressure upon the head should be attempted but without extension upon the arm, even though it is known that the periosteum has not become detached. If the fragment is short, reduction may be accomplished but perseverance should not be indulged in.

2. Manipulation after union of fracture being so dangerous and unsatisfactory must, I believe, be relegated. Arteries, nerves and veins may be injured to an irreparable degree, beside the loss of a life may be the result. The present mortality being something like 15 per cent.

Resection of the head of the humerus should be made in old standing cases of dislocation causing pain and the loss of the use of the arm; in cases where reduction can not be accomplished by any