

than the convulsive sprees of the neurotic inebriate. In the latter, the intervening seasons of total abstinence prevent the establishment of habitual disability in the nervous powers; while in the habitual drunkard, nervous disabilities, latencies and inhibitions become perpetual, insurmountable, in a word, *constitutional*.

The chronic inebriate furnishes a ready and sure illustration of the foregoing facts and doctrines. He is debased and defective in every department of his nature. Physically, mentally, morally he is wounded, maimed, crippled, deformed, in equal degrees. Yet his moral deficiencies are the most obtrusive, because they lie most upon the surface. A gentleman of my acquaintance has been a steady drinker of ardent spirits for nearly thirty years. His moral nature is latent, if, indeed, he has any. He is not vicious or malignant, but he is an incessant and shameless, because motiveless, liar. With great coolness he will invent stories totally without foundation and on the most trifling subjects,—all the attendant circumstances and details being of the utmost exactness. And so he cackles on, and will continue so to do till the end of life.

Now this seems very foolish indeed, and likewise very inoffensive. But this man is, in truth, on the verge of insanity. Not only is he morally bankrupt, but his intellect is both sterile and disordered. Amongst the great army of the unrecognized insane there are none more common, or more really dangerous, than the chronic and steady drinkers of ardent spirits. These men in early life acquired the usual habits, both of thought and action, that belong to the average citizen. Automatically, with the guide and hints of the examples of others in their midst, they manage, without much effort, to keep in the ordinary grooves of daily life. If such a man is a farmer, by force of habit he farms as others do; and in a judicial inquiry, should that fact be established, it very likely determines nothing. If he is an artisan, or physician, or lawyer, he may, by automatism and example, pursue his avocation with reasonable success. But let some supreme crisis intervene, so as suddenly to throw him upon his own unaided powers; let instant rage or, what is more consonant with his nerve defect, jealousy, come over his mind and disposition, he will then be thrown out of the grooves of automatic life and, acting upon his own true nature, he will herald to the world his real condition. Then desperation, murder, suicide, true representatives of his actual mental state, will burst unexpectedly upon the scene. To the great body of chronic inebriates this crucial test of insanity is never applied; they live without recognition, and die with their dreadful infirmity unknown and unsuspected.

There is another large field of inquiry related to the jurisprudence of inebriety. It is that one opened by the property of alcohol which promotes

proliferation of the interstitial tissue. This field includes the whole organism, for the connective tissue goes everywhere. Dr. Sieveking asserts that "there is scarcely a degenerative condition of the body that may not result from the habitual use of ardent spirits."³ Dr. Maudsley speaks of that "more dangerous form of habitual indulgence in small quantities of wine and spirits throughout the day by which some active men of business endeavor to spur their overtaken energies."⁴ Alcoholic structural affections of the stomach, liver, kidneys and brain are familiar to all. They are invariably associated with physical changes in the connective tissue of the organism; and they originate from the persistent, the unremitting, the *habitual* influence of alcohol upon the bodily structure.

And this completes the tale of the essential departments of human nature—mind, soul, body. Each and every one is grievously and permanently disabled; and indeed wrecked, in the chronic inebriate.

THE EARLY REMOVAL OF ABDOMINAL CYSTIC TUMORS.

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BY C. R. REED, M.D.,
OF MIDDLEPORT, OHIO.

By the term "cystic tumor" in this paper will be included tumors having their origin or growing from the uterus or its appendages, the bulk of the tumor chiefly fluid and contained in a cyst or sack; uni or multilocular, of the ovary, the parovarium, the broad ligament, or the Fallopian tube. It was formerly the teaching and practice of ovariologists that the removal of cystic tumors of the abdominal cavity should be delayed until they had produced emaciation, or the fat in the abdominal walls had been absorbed; the general health began to suffer; the vital organs become injured to irritation, and the long-continued pressure of the peritoneum had rendered it tolerant of irritation and less disposed to inflammation than when the tumor was removed at an earlier stage.

But the teaching of modern abdominal surgery is to remove the cystic tumor as soon as the diagnosis is clear, while the general health is unimpaired and the tumor is simple in character, has formed no adhesions to surrounding tissues and its contents have not undergone degeneration. While the tumor is yet small and free from complications, its contents thin and flow readily through the canula, but little time will be needed for its removal, and it is now the generally received opinion that the time consumed in the operation is in a direct ratio with its success. The

³ Life Assurance, p. 59 (1878).

⁴ Pathology of Mind, chap. ix, p. 434 (Appleton, 1880).

long continuance of the anæsthesia and exposure of the abdominal organs to the atmosphere render the shock more severe and of longer continuance, thereby largely increasing the death list of the operation. Under modern aseptic surgery shock is one of the chief causes of death in abdominal section, and whatever tends to lessen its severity or shorten its duration increases the ratio of recoveries. That cases recover after operation which had existed five, ten, or even twenty years are but exceptions to the rule.

American authors differ widely on this question of early or late operation for the removal of abdominal cystic tumors, while European authorities advocate the early removal. Goodell "Lessons in Gynecology," p. 362, says: "The operation should not be performed when the cyst has first been discovered, but when it has grown so large as to distend the belly, and when the woman has become thin and her health has begun to fail. . . . The abdominal wall having become thinner, the incision will be proportionally shorter and shallower; that the patient being now less full-blooded both hæmorrhage and inflammation will be less likely to occur, and that the pressure and rubbing to which the peritoneum has been for some time subjected will make it less vulnerable, and therefore less likely to take on inflammatory action."¹ If this theory be true, the operation in the well nourished should be preceded by a full venesection.

Emmet, in his "Principles and Practice of Gynecology," p. 711, referring to the doctrine of delay, as taught by Goodell and others, says: "But, on the other hand, the patient was deprived of all chances of recovery when the removal was delayed until the vital powers became so much depressed that she could not recover from the shock of the operation. With greater experience in the method employed it has already been demonstrated, as we shall see hereafter, that all the advantages are now greatly in favor of an early operation, before adhesions have been formed."

Sir Spencer Wells, in his late work on "Abdominal Tumors," in speaking of palliation by tapping, says: "But this advice as to tapping, and especially as to renewed tapping, as a means of cure must be restricted absolutely, as I have before stated, to cases in which the cyst is single and the contents clear and non-albuminous. In all cases of multilocular or dermoid tumors, where the abdominal distension is sufficient to injure the general health or cause local suffering, there must be no faltering, no suggestion of alternatives or delay. Justice to the patient demands a positive recommendation of excision, and generally it should be accompanied by a warning against the danger of delay. Every one who takes upon himself the responsibility of such counsel should

have a clear idea of the base on which it rests. And it may be traced out summarily in this form. The health has already deteriorated, and though the tumor itself be neither malignant, inflamed, or suppurating, nor the seat of hæmorrhage, yet its mere presence is the cause of the patient's decline. To let things go from bad to worse without doing anything, especially as that worse is a certainty, would be acting against the very first principles of medical science. The presence of this morbid growth in the body may give rise to other diseases. The contents too, whatever they may have been at first, alter in their character and become less and less benign, and by too long waiting sympathetic morbid action may be set up in the corresponding organ and thus make the ablation of both imperative. Time, too, gives the opportunity for adhesions to form, for rupture or destructive peritonitis to occur. It is possible to operate too early as well as too late, to place a person's life in peril by operation before it is endangered by disease, just as it is possible, on the other hand, to delay operation until the powers of life are so exhausted that recovery after a severe operation is impossible. He further says that ordinary medical treatment by drastic purgatives and hydrogogues often do harm, and rarely good, and any specific medical treatment by iodine or bromine, or mercury, or gold, or, arsenic, or lime or potash, used with the hope of checking the growth of such tumors, is useless, and he further says: "I have become more and more disposed to advise the removal of an ovarian tumor as soon as its nature and connections can be clearly ascertained and it is beginning physically or mentally to do harm, since the risk of the operation under such circumstances is certainly less, and the possible evils of delay are eluded."

Sir James Y. Simpson, in speaking of the treatment of abdominal tumors, says: "He had no belief whatever that iodine, or mercury, or muriate of lime, or aqua potassa, or diuretics, or deobstruents, or aught else, was capable of absorbing and removing the complicated structure and contents of a multilocular cystic tumor of the ovary."

Matthews Duncan says: "We know of no one example of the cure otherwise than by the operation of Ephraim McDowell, of an ovarian dropsy, properly so called. Not one, however many may be found described, or whoever may be the describer. Cures by one or moreappings, cures by medicines, cures by spontaneous rupture, cures by advancing pregnancy have been, if not most egregious mistakes, almost certainly cures of parovarian cysts, whose history, as already known, quite accords with and explains such erroneous allegations."

Mr. Lawson Tait, in his late work on "Pathology and Treatment of Diseases of the Ovaries," pages 252 and 253, says: "The treatment of ova-

¹ Dr. Goodell, in the 2d edition of his work, corrects his statement as quoted above.

rian tumors by therapeutics need not be discussed, further than to say that it is limited to the administration of tonics to sustain the functions of the patient, or to correct some errant condition which might diminish the chances of success for the surgical treatment of the case. For the cure of an ovarian cystoma there is nothing known to have the slightest influence, save an operation for its removal, and those patients who unfortunately are led to believe that some drug or other, or some fanciful form of treatment will relieve them from the necessity of an operative ordeal, are only induced to waste time which is valuable and to run risks which may be avoided. Of tapping I have said as much as I think necessary, but here I may repeat what everyone knows now, that it never cures a tumor and that it only brings about complications. It is my firm belief that if ovarian and parovarian tumors were never tapped, but were removed early in their history, we should only have a casual mortality from the operation of ovariectomy. Tapping, therefore, in my practice has become only a palliation for tumors I could not remove.

Many other plans have been devised for the radical cure of ovarian tumors, but they are all now abandoned in favor of ovariectomy; and such methods of treatment as the injections of iodine, or the establishment of fistulous tracks, can only be justified under very exceptional circumstances. Before the re-introduction of the intra-peritoneal method (of treating the pedicle) by Dr. Keith, we used to delay the removal of an ovarian tumor as long as the patient could get about comfortably, and this was justified by the fact that with the clamp we got only about 75 per cent. of recoveries. But now that we can get 95, and when we might get 99 per cent. of recoveries, if there were no delayed or tapped cases, my rule is to remove an ovarian tumor as soon as it is discovered, and this will soon come to be the received practice. The earlier the operation is performed the more certain the patient is to recover, for the less likely are there to be any complications." Tait further says: "However advanced a case may be I never refuse to operate, for I have seen some of the most unpromising cases recover without interruptions."

I have quoted at some length from Sir Spencer Wells, Lawson Tait, and others, as their statements are corroborated by the following cases, with others that might be detailed, coming under our observation.

Case 1.—Mrs. S., aged 36, mother of several children, first noticed an enlargement or tumor of left ovarian region about January 1st, 1875. The tumor was of slow growth the first three or four months, then grew rapidly, when the pressure becoming great and refusing an operation for removal she was tapped June 23d, 1875, about seven months after the tumor was first noticed. The relief was entire for three months when the cyst

rapidly refilled. On October 7th she was again tapped, under protest, with relief for six weeks. The cyst then rapidly refilled, and tapping was again done November 29th, with but partial relief. The fluid removed the first two tapplings was thin and albuminous, now became thick, flocculent and purulent. She was now rapidly failing in nutrition and strength, and suffering severe pain in abdomen. On December 13th, fifteen days after last tapping, the fluid was again removed by trocar with much obstruction in flowing through the canula. It now became evident that each tapping prostrated her more, nausea and vomiting becoming frequent and the end rapidly approaching, and as we refused to tap her again, she and her friends consented to removal of the tumor, and about the 20th of December she was seen by Dr. Dunlap, of Springfield, Ohio. Dr. D. tapped her with a large aspirator, hoping that by again emptying the cyst she would recuperate sufficiently to undergo the operation of removal. She continued much the same, and on January 6th, 1876, the tumor was removed by Dr. D., Mrs. S. dying from shock one hour after the operation.

The tumor was a unilocular cyst without complications or adhesions and easily removed. We believe that had Mrs. S., and friends, consented to an early operation, while health and strength were good, she would have survived the operation, and that she was the victim of delay. The temporary relief usually following a first tapping deceives the patient and friends and leads them to believe that its occasional repetition will indefinitely prolong life. Of this deception she and her friends should be warned.

Case 2.—Miss S., aged 16, commenced menstrual life at 13, one year after which she observed an enlargement of the lower abdomen. This growth we are told slowly increased the first year, the general health suffering but little. The second year rapid development and failing in health and strength, though able to walk about. The tumor now so large as to displace the abdominal organs and greatly increase the circumference of the chest. Menstruation, heretofore irregular, now ceased. Her treatment was wholly medicinal, and no doubt an injury rather than a benefit to her. A consultation now resulted in a diagnosis of ovarian cyst, and its removal recommended and positively declined. She persistently refused an operation for relief, and rapidly became more emaciated and anæmic, nausea and vomiting and loss of appetite now became prominent symptoms. When we saw her first, November 2d, 1887, and diagnosed a large cystoma which was rapidly destroying life, and the end was near. We objected to any further medication and told her her only hope was in the removal of the growth which we did on the 5th of November. She bore the ether badly, vomited frequently during its administration, and also during the operation, which neces-

sarily prolonged it. The abdominal walls were free from fat and very thin, which made the tumor readily accessible, which was found to consist of three large cysts and several smaller ones, the walls of each thick and tough, and contents of each unlike. The large cyst in front and below was filled with thin fluid and readily emptied; the second with colloid contents and slowly flowed through the canula; the third had adhesions to the abdominal wall posteriorly, and contents so thick and dense that they would not flow through the tube and the wall had to be punctured with the scalpel and the semi-solid contents scooped out with the hand. The adhesions were broken up with the hand, the emptied cyst walls were brought through the incision. The tumor was found to grow from the left broad ligament, with a long, broad pedicle, which was tied with the Staffordshire knot.

The difficulty in evacuating the two latter cysts made the operation a long one. There was no hæmorrhage requiring ligature, the condition was one of anæmia. The abdominal organs were forced, by pressure, from their normal positions and did not occupy that place when the tumor was removed. The uterus and ovaries were small and healthy and were not disturbed. At the close of the operation the radial pulse was barely perceptible. The shock was great. After the anæsthesia passed off there were indications that she might rally, but she died two hours after the operation.

There is nothing unique or unusual about the above cases; they are given in detail as we think they teach a lesson. The life of the young girl was a sacrifice to her fear and dread of an operative ordeal. They teach us the utter inefficiency of a cure by medication; that the removal of the cystic tumor is her only hope and safety; that tapping is but temporary relief, a false hope, and complicates removal as a means of cure. The woman who has an abdominal cystic tumor should be told by the physician that its early removal while it is small and free from complications is almost free from danger, and warned of the danger of delay. Then will cystotomy be shorn of its terrors and the per cent. of recoveries in this country nearer approach that of Great Britain and Continental operators. Other cases have been seen by us that have been tapped again and again, and died. Others have passed away without even this temporary relief, and successful cases coming under our observation, operated on early, are not detailed here as they would be void of interest and extend this paper beyond its intended limits.

May, 1888.

THE BERLIN SEWAGE FARMS now yield a profit of two per cent. on the capital invested—a very favorable result, considering all things.

RETINITIS HÆMORRHAGICA FOLLOWED BY GLAUCOMA.

BY KENT K. WHEELOCK, M.D.,

PROFESSOR OF OPHTHALMOLOGY AND OTOTOLOGY IN THE
FT. WAYNE COLLEGE OF MEDICINE.

March 19, 1888, Mrs. Esther Smith, æt. 71 years, widow, consulted me on account of an eye trouble. She stated that her vision had been somewhat obscured in her left eye for a few days, and that at the time of her visit she was quite unable to distinguish objects on account of everything being clothed in a deep purple color. Upon examination I found R.E.V. = $\frac{2}{8}$: + 1D. V. = $\frac{2}{8}$. L. E. V. = perception of form.

Ophthalmoscopic examination showed a large number of circular red spots in all parts of the fundus, macula especially presenting the appearance as seen in embolism of central artery of retina, except the hæmorrhage was not defined, but shaded off into other hæmorrhages. Tension normal. Patient well preserved, and gave no evidence of heart changes or vascular degenerations which I could detect. Fundus and vitreous hazy in certain strata. I prescribed sol. muriate of pilocarpine one-fourth per cent., teaspoonful to be taken every hour till sweating was induced. This was followed by amelioration of the distressing chromatic changes and by improvement of the vision, so that fingers could be counted in the temporal field. Pot. iodide was then ordered, with ungt. hydrargyri, lanoline as a base, rubbed over brow and temple. No especial change occurred subjectively beyond the gradual fading out of the purple color which before surrounded all objects. Objectively the hæmorrhagic spots faded and brightened with the usual persistency.

Finally, about the middle of May, tension began to increase slightly and a pinkish red blush stole over the sclerotic and circumcorneal area. Eserine was promptly applied, but acted badly. I advised operative procedure, but the patient was timid and could not consent.

On June 20, after an unusually bad night and intense circumorbital pain, the patient consented to an operation. Having grave doubts as to the success of any operative interference save enucleation, which the patient would not consent to except as a last resort, and fearing the possible extrusion of the ciliary body, vitreous, etc., if an iridectomy were done, by reason of sudden relief of the corneal counter-pressure, I elected to do a sclerotomy. As long as there was a fistulous opening in the line of the incision, which was not completed above, a small bridge being left for support, pain was not experienced. When this fistula closed the trouble returned with increased force, and the pain was less bearable by reason of the patient being reduced in nervous force. Seven days after the sclerotomy it was evident that another operation must follow. Seeing no evidence