

the physical signs in the lungs are about the same as nearly a year ago, when marked dullness extended over the entire right lung; one having "cracked pot" percussion note just below the right clavicle. Medium râles were scattered throughout the right and also in the top of the left lung in each case.

Contractile processes are always chronic, but when (compensatory?) emphysematous changes occur in the opposite lung I think the chronicity will probably be even more pronounced.

SOME OF THE CASES WHICH HAVE BEEN REPORTED.

- 1868, Greenhow: Tr. of the Path. Soc. of London, vol. xix, pp. 159-161. One case.
 1880, Brackenridge: Lancet, London, vol. i, pp. 80-117. One case.
 1888, Kukharski: Kavkazsk. Med. Obsh., Tiflis, vol. xxv, pp. 511-523. One case.
 1893, Bard: Lyon Medicale. One case.
 1894, Van Ryn: Journ. de Méd. de Bruxelles. One case.
 1896, Fernet: Bull. et Mém. de la Soc. Méd. des Hôpitaux. One case.
 1897, Moutard-Martin: Bull. et Mém. de la Soc. Méd. des Hôpitaux, Jan. and April. One case.
 1897, Petit: Bull. et Mém. de la Soc. Méd. des Hôpitaux, July. One case.
 1897, Cochez: Gazette des Hôpitaux. One case.
 1898, Hall: Med. Fortnightly, St. Louis, vol. xiii, No. 4, p. 95. Two cases.
 1898, Oki: Tokio Iji-Shin Shi, pp. 126-128. One case.
 1899, Garnier: Presse Medicale, July 12. One case.
 1899, Lepine (Lyon): Soc. Méd. des Hôpitaux, May 26. One case.
 1900, Barbier: Bull. et Mém. de la Soc. Méd. des Hôpitaux, vol. xvii, pp. 187-191. One case.
 1900, André: Lyon Méd., vol. xcv, p. 417. One case.
 1901, Lannelongue: Compt. Rendu de l'Acad. de Sc., vol. cxxxii, p. 225. Two cases.

Clinical Department.

A CASE OF INVERTED UTERUS.*

BY C. H. HARE, M.D., BOSTON,

Gynecologist to Boston Dispensary and to Woman's Charity Club Hospital and to Out-Patients at Carney Hospital and at St. Elizabeth's Hospital.

Called upon to operate for an inverted uterus for the first time it was easy to reread, for methods, the paper of Peterson, of Ann Arbor, read before this society March 17, 1903, in which the methods of different operators are described, and the results of these methods, as reported in literature, are brought up to that date; but it was not so easy to select the one correct method, for it seemed a case of many modifications of the two routes, and no one method showing sufficient trial to stamp it as the best beyond dispute. The problem was one in mechanics as to how best to overcome a contracted and unyielding cervix. There must be an increase in the diameter or an incision of this tightening.

Peterson found 15 cases reported operated by the Thomas method or the abdominal celiotomy method, and its modifications, by pulling on the tubes and round ligaments and by intra-abdominal incision of the ring. There were 7 failures. Of these 7 failures, 4 had an hysterectomy or amputation done; 1 died, and in 2 details were not stated. By all vaginal methods, 26 cases were reported, with 3 failures and no deaths. With 88% successful by vagina, and 53% by Thomas method, which latter per cent was reduced to 33% when we deduct the cases

where incision was added to his method, it was my choice to operate by the vagina.

It seemed fair argument to recognize the fact that the ring could not always be dilated after abdominal celiotomy and dilating by vagina had not found favor; that by the upper route bruising and tearing of the soft parts was common and sometimes fatal in the most skilled hands; that the majority of cases were weak from hemorrhage, hence worse subjects for shock and sepsis, especially if, as has happened, the inverting pressure used after dilating should puncture a hole from the vagina into the peritoneal cavity; abdominal suspension hardly seemed imperative while vaginal suspension could be done if one was unwilling to risk a retroversion. If a favorable case is at hand, and no one knows whether or not it will be before trial, an incision of the cervical constricting fibres is all sufficient, as has been proven in several cases, and made the operator think the operation for inverted uterus was an easy and simple operation. This was the writer's delusion after his own case, but the error was at once corrected on looking up the literature of this operation. Slightly greater danger of rupture of the uterus in case of subsequent pregnancy after colpohysterotomy had little weight. Statistics argued strongly for a partial extending in case of need to complete anterior or posterior colpohysterotomy. With Piccoli's operation of complete posterior colpohysterotomy or incision from external os to fundus, showing 11 successes and 1 failure, and Spinelli's operation of complete anterior colpohysterotomy showing 6 successes and no failures, the writer decided to do the complete posterior incision in case the slighter methods failed, preferring to take the risks of a retroversion with or without adhesion, rather than the risks of injuring the bladder or ureters by the anterior incision.

Mrs. 4,419, age forty, married twenty years; seven children, two miscarriages. She was first seen by me fourteen days after her last child had been born. The previous child was four years old. Menstruation had always been every twenty-eight days, flowing six days and using about twelve napkins. No dysmenorrhea. She had never had any pelvic trouble. She was attended by a man of very large obstetrical training, to whom I am indebted for the history. She had some labor pains for about forty-eight hours which were moderately hard the last twelve hours. She delivered herself and the placenta followed at once, without trouble. There was profuse hemorrhage. Convalescence was normal and she sat up on the day of my first visit. The lochia was the same as after her other childbeds. There had been no pain. General weakness was her only complaint to me. Examination showed an old tear of the perineum and a mass filling the vagina, but no fundus could be felt by the hand on the abdomen. Moderate flowing followed the examination. Preferring to wait for operation, she was put to bed for general building up. She was operated Feb. 24, 1905, or twenty days after the birth. The urine was then acid, specific gravity 1032. No albumen, but sugar was present, unless there was some error in the test, for it was never found again after two days' later test. The hemoglobin was 50%. The openings of the Fallopian tubes were not seen. It

* Read before the Obstetrical Society of Boston, Oct. 24, 1905.

seemed so easy to think that taxis would replace, that it was tried without the slightest evidence of success. This dilated the uninverted portion of the cervix, but in no way touched the tight collar or constricting inner ring. The posterior lip of the cervix was then incised and the cut continued upwards for about one and a half inches, when a "give" was felt which made me try to reinvert and to my surprise the fundus went back with ease. Another surprise was to find that no opening had been made into the peritoneal cavity. The incision was closed with catgut and the uterus then was found in good position.

Looking back for an explanation of the ease of this operation the writer believes that taxis produced the great and essential, though unplanned for condition, which made possible the easy replacement. The squeezing incident to taxis made a large fundus small and squeezed out fluids which converted a solid, firm fundus into one of a pliable, leathery consistency. The patient made a good convalescence without temperature or pulse, but because of poor general condition and many vigorous children at home, she did not leave the hospital until the seventeenth day after operation, when the hemoglobin was 70%; the uterus in perfect position and with perfect mobility.

There is little argument in one case, but from theory and statistics the writer believes that operation for inversion of the uterus should be considered easy until proven difficult. If conditions are favorable a short incision by vagina permits replacement, but this failing, we only have to extend the same incision, after the loss of a few minutes, to a point where reinversion seems assured.

The patient was seen to-day (Oct. 24). She is an overworked woman in poor general condition, having lost weight from 172 down to 147 lbs. in two years. The first three menstruations after operation were profuse, but scanty since, flowing five days with one napkin daily. No dysmenorrhea; no leucorrhea. The uterus is in good position and freely movable. The cervix shows no evidence of operation, but looks like the ordinary, slightly torn cervix. She has no pelvic complaint and, in fact, has not seen any doctor since she left the hospital until she called her doctor for pleurisy two weeks ago.

A CASE OF EXTRA-UTERINE PREGNANCY.*

BY JOHN B. SWIFT, M.D., BOSTON.

THE interest, centering in the diagnosis of this case, seems to make it worthy of reporting.

The patient is a married woman, thirty-two years old. She has had four children; no miscarriages. She has always been well. I have attended her in her last three confinements. The labors have been easy, and the convalescence always normal. After her first confinement she had a retroversion of the uterus which was corrected by Alexander's operation, and the uterus has remained in good position ever since.

Her catamenial history is normal, the intermenstrual period being twenty-three to twenty-five days, and the flow lasting seldom more than two days. The youngest child is twenty-six months old.

Regular menstruation took place on Aug. 27, 1905, but, four days after the flow had ceased, there was a dark brown gritty discharge for several days. On Sept. 19, being the time for her catamenia, she was seized, while at breakfast, with a sudden sharp, very severe pain in the lower abdomen, beginning on the

right side. She felt faint, but did not lose consciousness. The pain was continuous, the abdomen became swollen and very tender, and there was a slight flow from the vagina, "just a stain."

The physician, who was called in, controlled the pain by a subcutaneous injection of morphia. Among other things a tubal pregnancy was suggested as the cause of the attack, and she was kept under careful observation. He has assured me that, at no time while she was under his care, was there any shock, aside from the faintness, or evidence of hemorrhage. The temperature was always normal, and the pulse about 80. She remained in bed about a week, during which time there were two slight attacks of pain, one on Sept. 21, the other on Sept. 23, neither of which required morphia.

She came to my office on Oct. 3 because she did not feel well, but could give no definite symptoms. She did not think pregnancy could be possible.

On palpation the abdomen was soft and yielding. There was some tenderness on deep pressure on the left side. No flatness or dullness on percussion.

By vagina the uterus was of its usual size and position, and I detected nothing wrong anywhere in the pelvis.

I advised her to remain in bed for another week and then to come to see me again, thinking, that, if she had had a tubal pregnancy which had ruptured, absorption would go on, but, if the sac was still growing, something might be felt later. She came at the appointed time having had no further trouble, but saying she felt much better.

On vaginal examination *something* could be felt to the left and behind the uterus, but I could make out nothing definite.

She was advised to come in to one of the private hospitals for an examination under ether, and operation, if any thing was found to warrant it. She objected to the hospital, saying her house in town was all ready for her to move into, so it was decided that she was to come home in two days. The night before she was to move they telephoned that she had a severe pain in her stomach, not like the former pain. I talked with the physician in attendance, who said this attack was nothing like extra-uterine, but rather like acute indigestion. It was suggested that a nurse be sent to them to assist in moving her to town. The next morning the nurse telephoned me that she did not think the patient should be moved that day, and asked that I go to see her. I found her rather nervous over the delay of moving. The nurse told me the attack of the preceding evening seemed to be due to indigestion, as the patient was relieved after vomiting undigested food. There had been no more abdominal symptoms. She came to town Friday, Oct. 13, and when I saw her, the next morning, she greeted me with the remark that she could not be pregnant as her regular menstruation had come on, and she felt well in every way. The nurse had found a small shred on one of the napkins which Dr. Whitney reported to be blood clot. On Oct. 16 she passed a clot resembling somewhat a cast of the uterus. Dr. Whitney reported on this: "Masses of clotted blood, among which were mingled large, single, nucleated cells similar in every way to those of a decidua. I could not find, however, any villi, or other evidence of intra-uterine pregnancy."

The original idea of an ether examination, with operation if found necessary, was decided on. On Oct. 19, under ether, there was found to be a mass, as large as my fist, behind and to the left of the uterus. The uterus was curetted, and then the abdomen was opened in the median line. On cutting the peritoneum

* Read before the Obstetrical Society of Boston, Oct. 24, 1905.