

were short and irregular in length. Within the vitreous body of the right eye there was an opaque floating body (Fig. 4) which had one end attached to the posterior lobe of the lens capsule; the other end was whipping about like a sail in the wind, and looked not unlike a cysticercus. The father said that his daughter's eyes always had the present appearance, as though "they were all sight," as he expressed it, until she was about 4 years old, when the narrow band (Fig. 1) began to appear, but this band had not widened any for several years. Previous to the third year of age the eyes were totally black, as is shown in the small photograph (Fig. 6), taken when she was but 3 years old.

In looking up the subject in the literature, I find that only a few lines are devoted to this peculiarity. Some authors merely mention the fact that we occasionally have irideremia; some do not even mention it. Very few attempt to give the etiology or account



in any way for the strange phenomenon. One suggests that it may be due to inflammation of the uveal tract during fetal life. I have visited almost all of the large eye clinics of Europe and New York, and I have besides treated, in my private and clinical practice, about 15,000 patients, and this is the first case it has been my fortune to meet. In this case the irideremia is not entirely complete, there being, as I have stated, a narrow rim of iris encircling the ciliary region. Many of the authors state that irideremia is bilateral, whereas in coloboma of the iris it is frequently unilateral, and when the latter anomaly is confined to one eye, it is usually in the left. Coloboma is almost always associated with microphthalmus or macrophthalmus. There is frequently nystagmus associated with irideremia, but in the case under consideration there is no involuntary oscillation of the globe. Stenopaic disc is advised as treatment, but this did not improve vision in the least in my patient. I prescribed only spheric glasses, as cylin-

ders did not help. I regret that the patient does not live in the city, that I might have an opportunity of seeing her often and making further observations, more especially concerning the action of the ciliary body and the *modus operandi* of the power of accommodation. Evidently the ciliary muscle as well as the ciliary processes was defective. The field of vision in this case was nearly normal, as Fig. 6 indicates.

RETENTION CYST OF GALL-BLADDER.

APPENDICAL ADHESION CAUSING INTESTINAL OBSTRUCTION; FIBROMYOMECTOMY COMPLICATED BY PREGNANCY.

BY J. HENRY BARBAT, M.D.

SAN FRANCISCO, CAL.

Mrs. P., aged 29 years, previous health good except for chronic constipation, had first attack of pain three months previous to operation; the pain being in the region of the gall-bladder and lasting for three or four hours. The second attack occurred a month later and was so severe that I was called in to relieve her. The pain was continuous in character with occasional exacerbations, which caused her to cry out. The bowels were constipated and the patient had been vomiting; there was icterus, but no mass could be felt in the abdomen. A diagnosis of gall-stones was made and the patient advised to have an operation. She preferred to wait, and as the pain subsided somewhat, thought an operation unnecessary.

A month later I was called in and found exactly the same condition of affairs with the exception that the gall-bladder could be felt somewhat to the right of the normal position. Her temperature was 103 F., pulse 110. She consented to an operation and was removed to the hospital. The abdomen being opened at the right border of the rectus muscle, the gall-bladder was found distended, thickened, inflamed and adherent to the surrounding structures and covered with patches of lymph. An endeavor was made to bring out the duodenum, in order to make a cholecystenterostomy, but after liberating the adhesions it was found that the inflammatory thickening had rendered the walls of the gut so thick and brittle that it was impracticable to attempt anastomosis.

Careful palpation of the gall-bladder and cystic duct failed to reveal any calculus. An aspirator needle was inserted into the gall-bladder and a clear thick fluid removed, which proved to be mucus, showing that the cystic duct was completely occluded. The only thing to do was to drain the viscus, so a second small incision was made about an inch to the right of the first and the gall-bladder stitched to the peritoneum from the inside. This proved a very satisfactory method, as there was plenty of room to work through the large incision, and it would have been impracticable to have worked through the smaller one from the outside. The reason for making the second incision was that the gall-bladder lay about one and a half inches more to the right than normal, and owing to its thickened and inflamed condition it was not advisable to make sufficient traction to draw it to the first incision. The gall-bladder was opened on the third day, about four ounces of mucus evacuated, and a drainage-tube inserted. Every other day for three weeks following, the wound was dressed and from one to twenty stones removed, ranging in size from a pin-head to a pea. In all, 143 stones were removed; the

wound was kept open for one week after the last stone was taken out, and then allowed to close.

For the first ten days no bile came through the wound, showing the cystic duct to be obstructed either by a stone or thickening of its wall; after this period the bile began to flow in increasing quantities until about a pint a day was passed; the wound closed completely four days after the drainage-tube was removed, and the patient has been free from pain ever since.

SLIGHT APPENDICAL ADHESION CAUSING OBSTRUCTION OF BOWEL.

Master P., aged 10 years, previous health poor, had been under a physician's care for seven weeks before I saw him, on account of some obscure bowel trouble which appeared to get worse. The attending physician, believing the appendix to be at the bottom of the trouble, asked me to see the case in consultation. The child had been having paroxysmal pains all over the abdomen, which had become so severe that he would scream and writhe in agony about every hour. He was constipated and required large doses of purgative to obtain an evacuation of the bowels. He was vomiting and having occasional hiccough, and had lost his appetite. Examination revealed a marked degree of emaciation, with a distended abdomen. The abdominal wall was so thin that the loops of intestine could be distinctly seen, and during a paroxysm the intense vermicular action was plainly evident. The colon was not distended, so a diagnosis of partial obstruction of the small intestine was made and an immediate operation advised. The abdomen was opened in the median line and the loop of obstructed bowel sought for; a thick tense band was felt passing from about the level of the umbilicus to the right inguinal region, which proved to be the appendix.

The tip was found adherent to a loop of ileum and was freed without difficulty; the organ being congested and thickened, was removed. The obstructed bowel was found just above the point where the appendix was adherent, and the whole mass brought out of the abdomen. I attempted to loosen the adhesions which caused the obstruction, but found the bowel so brittle that it was considered dangerous to continue, so I made a lateral anastomosis about three inches below the obstruction, by means of a medium-sized Murphy button. The button was passed on the twelfth day. The relief was immediate and the boy began to call for food on the third day. His appetite was ravenous and he gained fifteen pounds in three weeks. I was sorry that I had to leave the obstructed bowel in the abdomen, but the little patient was so weak and took the anesthetic so badly that we thought him dead several times during the operation, and as the mesentery was very much thickened and the mesenteric glands in the neighborhood of the obstruction much enlarged, it would have required more time to remove the loop and make an end-to-end anastomosis than would be safe under the circumstances. An examination of the loop showed that the appendix had become adherent to the bowel and held it in such a position that a sharp bend was produced; at first this did not cause much disturbance, but after inflammatory thickening began the obstruction became progressively worse until at the time of operation it was almost complete. One of the enlarged mesenteric glands was removed and examined microscopically, but showed nothing but inflammatory disturbance, thus eliminating a tubercular origin.

FIBROMYOMECTOMY COMPLICATED BY PREGNANCY.

Mrs. G., aged 39 years, IIpara, youngest child 4 years old, previous health good, two years ago noticed some discomfort and pain in the lower part of the abdomen. In March, 1898, she felt a lump on her right side, in the inguinal region, for which she consulted physicians who advised its removal. Her menstruation had been regular up to July, 1898, when it ceased until October, then appeared for a few days and stopped entirely. Her abdomen had been growing steadily larger until, when I first saw her in January, 1899, she appeared as large as a woman at term.

There was considerable pain during the two months previous, which had been steadily increasing until she was willing to undergo any operation for relief. She had noticed no signs of pregnancy. Examination showed an irregularly enlarged abdomen, evidently containing one or more large fibrocystic tumors and a few small ones. No sharp dividing line could be felt between the masses, so it was concluded that they were all part of the uterus.

A possibility of pregnancy was discussed, as the os was blue and patulous, but the patient could not believe herself in that condition and, even if she were, the pain and progressive emaciation were sufficient incentive to remove the diseased parts as soon as possible.

She was operated on at the Waldeck Hospital, on Jan. 26, 1899. Before opening the abdomen it was deemed advisable to curette the uterus as it would probably have to be removed. At the first stroke of the curette, fluid began to pour out and continued until about a gallon had come away. As it was evident that the fluid was amniotic, the curettement was dispensed with and the abdomen opened near the median line. A large mass presented, which was delivered and removed by applying clamps to the broad ligaments and cutting above them. The vessels were picked up separately and ligated, and the cut surfaces whipped over with fine catgut.

The cervix was left. The patient made an uninterrupted recovery except that the pulse was slightly accelerated, keeping above 85 for two weeks, and probably due to the removal of both ovaries. I regretted that I had not implanted a piece of one of the removed ovaries in order to prevent sudden menopause and its accompanying nervous phenomena. The specimen was composed of a large fibroid which occupied the whole anterior and lateral walls of the uterus. There was a smaller fibroid on the fundus, and a fetus six months old, which occupied the posterior portion of the uterus. The anterior wall of the uterine cavity was formed by the large fibroid and was soft and friable; the remaining walls were very much thinned and softened.

Cases of this character impose grave responsibilities on the operator, more so if it is possible to make a diagnosis of pregnancy before operating; if we can determine definitely the age of the fetus we are justified, if the case is not too urgent, in waiting until the completion of the seventh month, and removing the fetus before beginning the removal of the fibroid uterus. In the case before us there was nothing to indicate the existence of pregnancy, except the cessation of the menses, and as the patient had practically stopped since July, 1898, we would expect her to have felt life before the time of her first visit; but even if a positive diagnosis of pregnancy had been made it would not have been a contraindication to immediate

operation, as the patient was in a very miserable condition, and in the light of subsequent developments it would have been dangerous to have allowed her to go to term, as there would have been danger of rupture of the uterus if the labor pains were at all severe. As to whether the tumor would have prevented the descent of the fetus if the case had gone to labor, it is difficult to say, as the fibroid might have been pushed up out of the pelvis by the subsequent growth of the child and left the birth canal free; but it would have been at the expense of the cervical canal, which would have been thinned to a dangerous extent.

SOME PATHOLOGIC CONDITIONS OF THE OVARIES THAT CAUSE GREAT PAIN.

BY GEORGE HALLEY, M.D.

KANSAS CITY, MO.

No physician who has been engaged long in the practice of medicine has not had complaints coming to him from his female patients, of excessive pains in the lower portion of the abdomen. The pain is not always confined to the pelvic portion of the abdominal cavity; but often extends both above and below it. The pain radiating upward from the pelvis, follows a line about two inches inside the crest of the ilium, radiating upward and backward, often losing itself beneath the floating ribs. Downward, it is found most often in the front of the thigh. Occasionally it is found on the outside of the thigh, and rarely in the back part of it. Sometimes it is confined entirely to the lower portion of the iliac fossa and upper two inches of the thigh. The pain is usually of a dull, aching, persistent character; increased markedly by physical exertion of any kind, and very seriously aggravated by movements of the pelvic contents or pressure on them, no matter how slight. Often the pain is a real hyperesthesia, the slightest touch exciting manifestations of pain as much or more than a deep pressure. It is occasionally found to be much worse as the menstrual period approaches; gradually improving after the flow has ceased, and reaching its maximum of improvement at the middle of the time intervening between the periods. At other times the pain appears to be persistent and is of about equal intensity throughout the menstrual period, diminishing, or becoming entirely absent during the period of flow, to return again with a full or increased intensity, three or four days after the cessation of the flow.

The physical symptoms attendant on, and coincident with this painful condition, are usually constipated bowels, painful or difficult micturition, great nervousness with prostration, often amounting almost to a mania. Sleeplessness is often a marked symptom, practically disqualifying the sufferer for any of the ordinary duties of life. The pathologic condition that is most often found is perhaps cystic degeneration of the ovarian substance. But this condition is not always present, and in a goodly number of cases that I have met with in my recent investigation of this question, there has not been so much of a cystic degeneration as of a varicose condition of the pampiniform plexus. This, I am satisfied from observation, is a very frequent cause of the painfulness complained of when there is no, or very slight, disease of the ovarian structure. I have again and again found the veins composing the plexus as large as a

lead pencil, and in some cases, tortuous, with the walls enormously thickened. One lady, on whom I operated recently, had no cystic degeneration of the ovarian tissue, but some of the vessels of the plexus were as large as the internal jugular vein, and the walls of these vessels were abnormally thick in proportion to their size. In these cases the train of morbid symptoms are, to some extent, characteristic of the pathologic conditions found, and enable the observer to determine, with considerable degree of accuracy, the character of the disease he is about to encounter.

Thus the cystic ovary is excessively painful to the touch, either through the vagina or rectum, while in varices of the plexus, the ovary is not so painful, or not painful at all. The pain is continuous throughout the intermenstrual periods, but little difference being observed at any time.

The pain is usually much worse as the menstrual period approaches, and remains severest in cystitic ovaries during the time of flow. Not so, however, with those in whom a varicose condition of the venous plexus exists. They usually suffer most during the intermenstrual periods, their period of rest being after the flow has been fully established. Such patients usually express themselves as being able to do more work and feel better while they are menstruating, than at other times. The pain is often so severe that the patient has to remain in bed, the flow generally giving relief after the first day of menstruating.

Examination of the organ, after the abdomen has been opened, will show it to be much in the same condition as the testicle of a man suffering from varicocele. Indeed, it may with perfect justice be said to be a varicocele of the ovary. These women, too, usually differ in the amount of blood lost at each menstrual period, from those suffering from cystic disease of the ovary. The flow is usually much longer, and the blood lost during the period very much greater. The flow, too, is frequently found recurring with greater frequency, the periods not uncommonly recurring two or three times in a month. In cystic disease of the ovary, the periods, as a rule, are not regular. They are almost invariably much farther apart, five, six, seven or eight weeks, or often three, five, or six months elapsing between menstrual periods.

This is not a constant condition by any means, but sufficient to be remarked. The writer has many times found those suffering the most, perfectly regular in the period of recurrence, as well as in the amount of blood lost. Occasionally a varicose condition of the vessels and a cystic degeneration of the ovarian structure are found together; then the symptoms will be mixed.

As to treatment, much has been written of late on the benefit of hot douches in pelvic pains and inflammations, and while no one can be more willing to give credit to its usefulness and curativeness than myself, I have found that when used freely and hot (as it always should be to get the best results) in those suffering with either cystic disease of the ovaries, or varices of the plexus, it greatly aggravates the symptoms, rendering life a burden to the sufferer. The indication, when the disease has been diagnosed, is to either entirely remove the ovary and tube with the upper portion of the broad ligament, or to ligate both ends of the vein of this plexus with some good strong material, and cut out, or ligate and cut out,