

delivery. He appends a table of thirteen cases by different operators, showing a maternal mortality of $69\frac{2}{3}$ per cent., and foetal mortality of 100 per cent.

EXTIRPATION OF THE UTERUS FOR RETAINED PLACENTA WITH SEPSIS.

ROOSENBURG (*Nederlandsch Tidschrift voor Geneeskunde*, 21, 1889) reports the case of a patient who miscarried at six months, the placenta being retained. Septic infection followed, and, failing to remove the placenta, Roosenburg extirpated the uterus through the vagina as a last resort. In two hours after operation the patient's temperature fell from 105° to 99° F. and remained; the pulse steadily improved; recovery was complete in fifteen days. The placenta was tightly adherent to the uterus, and the uterine wall was in beginning gangrene.

CURETTING THE UTERUS IN PUERPERAL INFECTION.

PORAK (*Journal de Médecine de Paris*, No. 38, 1889) has collected 326 cases of abortion, in which fever occurred in 10 per cent. and death in $\frac{1}{10}$ per cent. Delivery was artificial in 25 cases, 16 of which had no complications. Treatment of these cases was prophylactic asepsis in the great majority. In a few cases in which intrauterine douches were unsuccessful the curette and douche were employed, but generally to no advantage. Porak believes that the curette, if used at all, should be used promptly, and that it is generally inferior to the simple douche; occasionally it gives brilliant results.

GYNECOLOGY.

UNDER THE CHARGE OF

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FIXATION OF THE RETROFLEXED UTERUS AFTER REPLACEMENT, ACCORDING TO SCHÜCKING'S METHOD.

THIEM (*Centralblatt für Gynäkologie*, October 19, 1889) describes the operation as he is accustomed to practise it, with a slight modification of the original technique. He first introduces a catheter into the bladder and pushes it to the left, where it is held by an assistant. Schücking's needle is then introduced into the uterus and is passed through the anterior fornix, is threaded, and is withdrawn, the ligature being tied in the vagina and left *in situ* for a few days. A Thomas's pessary should be introduced at once to support the uterus. The operation is not suitable for cases of prolapsus. Schücking's and the writer's recent cases (thirty-six) have all been successful. In one instance two years have elapsed since the operation, and the uterus still remains

in good position. One patient has had a normal labor without a recurrence of the displacement.

THE INDICATIONS FOR DILATATION OF THE CERVIX UTERI.

STOCKER (*Frauenarzt*, October, 1889) concludes a paper on this subject with the following deductions: 1. The cervical canal should be dilated in women who have passed the menopause, and have hemorrhage which is clearly of intra-uterine origin; 2. In younger women in whom no sufficient cause for the hemorrhage can be discovered in the adnexa; 3. Whenever the curette is used; 4. In all forms of chronic endometritis requiring thorough treatment.

The writer prefers Vulliet's method of dilating the uterus, by using tampons of iodoform gauze.

VENTRAL FIXATION OF THE PROLAPSED UTERUS.

MÜLLER (*Centralblatt für Gynäkologie*, October 26, 1889) has performed this operation in twelve or fifteen marked cases of prolapsus with unsatisfactory results. In most cases there was sooner or later recurrence of the displacement, usually due to stretching of the adhesions to the anterior abdominal wall. In a few instances the wall itself was drawn down, forming a cup-shaped depression.

PLASTIC OPERATIONS FOR THE CURE OF PROLAPSUS UTERI.

FEHLING (*Centralblatt für Gynäkologie*, October 26, 1889) does not approve of performing anterior colporrhaphy simply as an adjunct to other operations on the cervix and vagina. He thinks that a better result is obtained by doing the operations at different times, keeping the patient in bed for four or five weeks if necessary; this allows the uterine supports time to recover their tone and thus insures retention of the organ in its normal position. In performing anterior colporrhaphy he denudes two oval surfaces on the anterior vaginal wall, half an inch apart, the long axes of which converge toward the cervix; these are brought in contact with wire or silk sutures. Colpo-perineorrhaphy is performed at a second sitting. The writer reported sixteen cases, all of which were successful.

NORMAL AND ABNORMAL CHANGES OF POSITION IN OVARIAN TUMORS.

FREUND (*Centralblatt für Gynäkologie*, October 26, 1889) says that while an ovarian tumor is small it lies normally behind the uterus, elevating that organ slightly and pushing it somewhat toward the opposite side of the pelvis. The pedicle lies on the anterior aspect of the tumor, and is not twisted. In the second stage of its growth the cyst rises into the abdominal cavity and moves forward until it lies in contact with the anterior abdominal wall. The uterus is pushed backward, but is not retroflexed, and the bladder is compressed from above; the pedicle now lies behind the tumor, and is somewhat twisted.

Deviations from this normal course are noted in the following cases: 1. Intra-ligamentous cysts, or those which are rendered immovable by deep intra-pelvic adhesions; 2. Fixation of the uterus by adhesions; 3. Double ovarian tumors, which mutually prevent change of position; 4. Firm nod

unyielding abdominal walls, which do not relax as the tumor presses against them.

STATISTICS OF TOTAL EXTIRPATION OF THE UTERUS AT THE DRESDEN CLINIC.

MÜNCHMEYER (*Frauenarzt*, October, 1889) stated at the recent meeting of the German Gynecological Society that between 1883 and May, 1889, there were 110 cases of hysterectomy, 80 being for cancer. Of the latter, four patients succumbed to the operation, while of the remainder 62 were still living, only three of whom had a recurrence.

Freund, in commenting upon this report, stated that in 1878, he had removed a cancerous uterus from a patient who was still perfectly well, and Olshausen said that he had one who had no recurrence twelve years after amputation of the cervix uteri for epithelioma.

THE HIGH-TENSION FARADIC CURRENT IN GYNECOLOGY.

Bröse (*Centralblatt für Gynäkologie*, October 19, 1889) recommends this agent highly for the relief of pain due to oöphoritis and perioöphoritis. The anode should be introduced into the vagina, while the cathode is a large plate placed on the abdomen. Bröse uses a bipolar electrode. The *stance* should be prolonged until the sensitiveness of the ovary is noticeably diminished. From four to thirty-five applications may be required. The effect of this treatment is permanent. The writer reports twenty-five cases of oöphoritis and perioöphoritis, twenty-one patients being cured, and two improved. The faradic current is useful in cases of subinvolution and dysmenorrhœa, but has no effect on pelvic exudates, though it relieves the accompanying pain.

PERINEOTOMY; A NEW METHOD OF REMOVING SUBPERITONEAL GROWTHS.

SÄNGER (*Archiv für Gynäkologie*, Bd. xxxv. Heft 3) had a case of dermoid cyst situated in the *cavum subperitoneale*, which he reached and removed from below in the following manner: A vertical section was made in the perineum, extending from a point an inch behind the right labium majus to the right of the anus; the attachment of the levator ani was divided, after opening up the ischio-rectal fossa, and lastly the pelvic fascia, allowing direct access to the subperitoneal space, from which the growth was readily shelled out. The wound was plugged with iodoform gauze and healed rapidly. The writer perfected the operation by experiments on the cadaver, and found that he could easily reach the pelvic cavity through a vertical incision three inches in length beginning just behind either labium and extending downward midway between the anus and the tuber ischii, the levator ani being first divided; subperitoneal tumors, hæmatomata, or exudates could be reached in this way without difficulty.

This operation should be distinguished from that proposed by Zuckerkandl (see *THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES* for December, 1889) for the extirpation of the cancerous uterus. Säger performed the latter on six cadavers and found it so difficult that he did not think that it would ever become popular. Hegar had proposed opening

Douglas's pouch through an incision extending from the tuber ischii to the tip of the coccyx.

Hegar, in discussing the paper, called attention to the difference between perineotomy, excision of the sacrum, and the parasacral incision of Wölfler. He had successfully excised the sacrum in order to reach Douglas's pouch and remove diseased tones and to open pelvic abscesses. The wound healed well and there was perfect drainage.

THE TREATMENT OF PELVIC ABSCESS.

WIEDOW (*Archiv für Gynäkologie*, Bd. xxxv. Heft 3) says that it is easier to detect fluctuation in extra- than in intra-peritoneal abscesses. Explorative puncture is dangerous; it is safer to rely on the general symptoms of suppuration. If an abscess lies just beneath the skin, it should be opened thoroughly and drained, while if it is deep within the pelvis, a counter-opening should also be made. To reach deep-seated abscesses it may be necessary to resect the sacrum, to open up the ischio-rectal fossa, divide the levator ani muscle and to split the pelvic fascia (Hegar's method), or to follow the plan suggested by Zuckerkandl. If the peritoneum is healthy and can be pushed upward, it may be advisable to reach the abscess by an incision parallel with Poupart's ligament. It is useless to try to close abscesses with fistulous tracts, except by attacking the focus directly and draining the abscess in some other direction.

THE FLAP-SPLITTING OPERATION ON THE PERINEUM.

SÄNGER (*Archiv für Gynäkologie*, Bd. xxxv. Heft 3) reported, at the last meeting of the German Gynecological Society, the results of his experience with Tait's operation for the repair of lacerated perineum. He has operated in seventy-one cases, ten times for complete laceration. Anterior colporrhaphy was also performed in twenty-four cases, and posterior colporrhaphy in ten, both operations being done in sixteen. The lacerated cervix was frequently closed at the same sitting. In no case did the perineum fail to unite, though perineo- and recto-vaginal fistulae were noted in four instances. The parts were restored to their normal condition without loss of tissue. The writer rejects catgut entirely as a suture, and has had better results with silver wire than with silkworm gut.

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