

this subject. Out of twenty-four cases investigated by him, ten were genuine and eight were simulators; the other six had genuine symptoms but they exaggerated considerably and feigned additional symptoms. Three of the cases of simulation are given at length, where local hysteria, general traumatic hysteria, and general traumatic neurosis were feigned, and the patients had successfully simulated against the examination of several physicians. Only three of the ten genuine cases had contraction of the field of vision. Rumpf's sign, of quickening of the pulse on pressure on painful spots, was not looked for, as Rumpf had not then made it known. Hoffman claims that there is no method generally available for detecting simulation, but he holds that, with so great a percentage of simulation in his cases, doubt must be thrown on the rarity of simulation claimed by Oppenheim and Strümpell. Exaggeration is certainly not uncommon, and is often due to the fact that the patient's statements as to his illness are not believed. These neuroses are of varying sorts, and are seen more commonly after slight injuries than after severe physical concussions. The courts afford an admirable school for teaching the symptoms and for increasing the number of claimants.

CHOREA.

Meyer<sup>17</sup> has analyzed the cases in the Berlin Charité. Six-tenths of one per cent. of all children treated in five years had chorea — 121 cases, of whom nine per cent. had rheumatism, thirteen per cent. heart-disease, and two per cent. the two combined. Chorea, he holds, is a symptom, like convulsions, due to various causes. It may be a disease in itself, a neurosis due to psychical causes; it may arise from organic brain disease; or a disease, due perhaps, to a rheumatic virus, which has for its symptoms, rheumatism, heart-disease and chorea.

Clinical Department.

GYNECOLOGICAL CASES AT THE CARNEY HOSPITAL.

SERVICE OF DR. F. W. JOHNSON.

CELIOTOMY: REMOVAL OF OVARIES AND TUBES.

H. C., single, twenty-one years of age, entered the hospital, surgical side, January 19, 1890. Through the kindness of Dr. M. F. Gavin, I got from the records the following history. She was delivered at the Boston Lying-in Hospital two months before she entered the Carney. Child and patient well until four days before entering when left breast become sensitive. Physical examination by Dr. Gavin showed swelling, redness and fluctuation of upper and outer segment of left breast. Abscess opened and drainage-tube inserted.

January 24th. Right breast having undergone abscess formation, it was incised and drainage-tube inserted. The chart shows the pyæmic state of the patient.

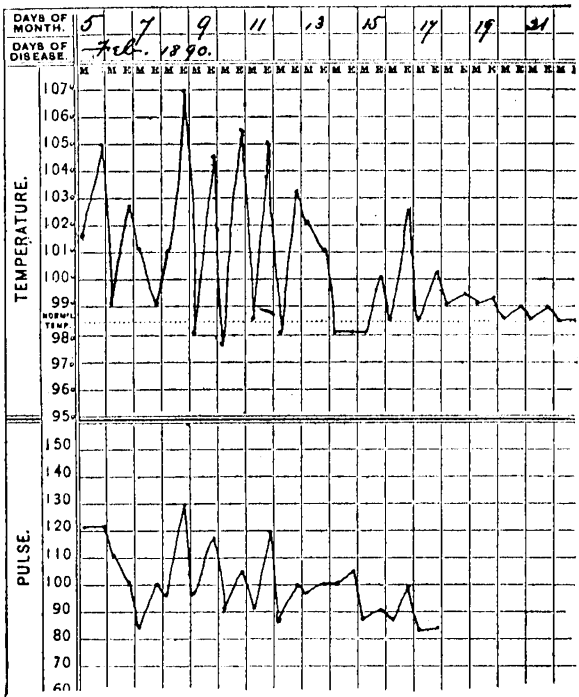
February 18th. Erythema on both sides of the face and on both arms.

March 22d. Transferred to Gynecological Department for treatment of salpingitis. On examination April 1st the uterus was found drawn over to the right side of the pelvis, and held there by adhesions. Tubes

<sup>17</sup> Berliner klinische Wochenschrift, July 14, 1890.

and ovaries were prolapsed down into the posterior cul-de-sac where there was great sensitiveness. Constant occipital and frontal headache deprived her of sleep. Dizziness, dyspepsia, backache and almost constant pain in lower part of abdomen. The above rendered her almost bed-ridden. For two months hot-water vaginal douches were daily used with the application of tincture of iodine twice a week to the posterior cul-de-sac. The only gain was removal of post-uterine sensitiveness. Here was a poor servant girl with no friends in this country, and obliged to depend on her own resources to keep her out of the poor-house. Considering her miserable condition it was evident that she soon would be added to that long list of paupers, and become dependent on the State.

With this in mind Drs. Gavin and Elliot saw her with me, and agreed that removal of ovaries and tubes offered her a good chance of getting back her health and strength.



Two days after the consultation celiotomy was done by me. Dr. Conant assisted. Dr. Gavin was present. An incision three inches long was made through the skin, the opening through the peritoneum being just large enough to admit the index and middle fingers. Tubes and ovaries were found fastened by adhesions. These were quickly freed and without clamp, after Tait's method, ligatures were placed and both ovaries with as much of the tubes as was possible, were removed.

Report by Dr. W. F. Whitney, on both ovaries and parts of the Fallopian tubes. The latter and the ligament connecting them with the ovaries presented nothing abnormal. The ovaries were slightly increased in size. The surface in general, smooth with an increased transparency as from the presence of fluid in the interior. Section showed the presence of numerous smooth-walled cysts of size varying from a pin's head to a large pea. Most of these were filled with a clear watery fluid, while some of the larger ones contained a firm, dark red coagulum. Microscopic exam-

ination showed a few Graafian follicles, and the cyst walls showed evidence of fatty degenerated cells similar in shape and color to those of the *corpora lutea*. The fibrous tissue seemed increased especially on the outer surface. Diagnosis: retention cysts and chronic fibrous thickening.

Dr. Whitney wrote as follows: "As you will see from the description of the specimens received this afternoon, the ovaries were extensively disorganized by the presence of retention cysts and fibrous thickening. Whether they were incapable of further function is doubtful as evidence of Graafian follicles were still found. The association of these retention cysts with painful menstruation certainly seems more frequent than mere accident would seem to warrant."

Convalescence was without a drawback.

Within ten days the old abdominal pains had ceased and have never returned. The dyspepsia got well and the constipation cured itself. But it was two months before the head symptoms disappeared. She is now doing kitchen work, sleeping well, eating well, and feeling well. Certainly a very gratifying result.

#### CELIOTOMY: MULTICULAR CYSTO-ADENOMA.

H. S., single, twenty-two years of age, entered the hospital July 26th. She was sent to me from the western part of the State. She was a pale, thin, sickly-looking subject. For five months she had noticed that her abdomen was increasing in size. General health as good as it had been for years. On examination it was found that the uterus was right laterally retroverted. The abdomen contained a smooth non-fluctuating but elastic tumor extending above the umbilicus.

July 30th. Celiotomy was done, Dr. Conant assisting. A cyst without adhesions was found growing from the left side. It contained one gallon of fluid which escaped readily through Tait's trocar. The pedicle was crushed by a Dawson clamp, tied with the Staffordshire knot, and the emptied cyst cut off. The right ovary was removed. Convalescence was without a drawback.

*Report by Dr. W. F. Whitney.*—I. A large relatively thick-walled smooth cyst, with evidence on the inside of trabeculae showing the existence of previous secondary cysts. The wall was fibrous in structure with small cavities lined with cylindrical epithelium. Diagnosis: multilocular cysto-adenoma. II. The other ovary was enlarged. Its fibrous tissue stroma increased and there were two or three retention cysts. Evidences of *corpora lutea* were present in deep orange-colored spots. Beyond the fibrous thickening there is no evidence of disease.

In the following eight cases the Alexander-Adams operation was done. In six of the cases there was backward displacement with adhesions. In one case the left ovary was prolapsed into the posterior cul-de-sac and fastened there by adhesions so that no pessary could be worn to correct the existing retroflexion, and in one case there was right lateral displacement.

Lateral displacements, retroversions and retroflexions with adhesions, are among the most difficult cases we are called upon to treat.

At times packing in the Sims's position persistently carried out, will overcome adhesions between ovary and tube, or ovaries and tubes, and peritoneum covering uterus, broad ligaments, or rectum: then the uterus can be replaced and kept in position by a pessary.

Still there are other cases where the adhesions will not yield to packing. In my experience these cases give a history of septic peritonitis following an abortion or severe vaginitis. This class has tried the patience of most everybody.

The old way, and the method that has been so much in use for years, is to gradually, by means of a uterine sound, replace the uterus, attempts being made every few days until the obstacles are overcome. It has been found in no small proportion of these cases that this use of the sound as a lever, was followed by a lighting up of the old trouble with the formation of new adhesions, and it was weeks or months before the pelvic organs were in a condition to be again subjected to the same treatment. This method has also been employed while the patient was under ether, the adhesions being broken up through the vagina and rectum by the fingers instead of by the sound. Peritonitis to any extent does not follow this procedure, but unless a pessary is put in to keep what has been gained, new adhesions will form holding the uterus out of place and perhaps more firmly than before, and unfortunately very few will tolerate a pessary immediately after the breaking-up of adhesions.

Another method is to do celiotomy, break up all adhesions, and do ventral fixation of the uterus. This operation I have done in various ways with excellent results. In one case only did the uterus return to its former position, and this took place three months after the operation.

The great objection to this procedure is that it necessitates opening the peritoneal cavity. For nearly a year I have been treating in the following manner cases of backward displacement with adhesions, and cases of backward displacement where there were no adhesions, but where a pessary could not be worn owing to the contraction of some old effusion in the broad ligament, usually the left.

Under ether the uterus is replaced, all adhesions being gently but *thoroughly* overcome by manipulations with the finger through the rectum, and it is surprising how readily this can be done. Then, while the uterus is held in position by an Emmet's repositor, the cervix being pushed well back into the posterior cul-de-sac, an Alexander-Adams operation is done. The uterus is thus held upwards, non-flexed, and forwards while the raw surfaces are gluing to the peritoneum.

I have done the operation many times and as yet no uterus has retroverted and in no case has peritonitis been set up. If time shows the results to be as good as at present, it seems to me that it will be the proper operation for such cases after packing, faithfully tried, has failed to overcome the adhesions.

Dr. J. W. Elliot kindly did for me the first Alexander-Adams that I ever saw. Some months afterwards Dr. F. B. Harrington did another for me. At this time through the kindness of Dr. W. M. Conant, I had the opportunity of seeing several dissections for the round ligaments at the Harvard Medical School. I was surprised to see how far forward the fundus uteri was tipped when the ligaments were drawn out and the anterior surface of the broad ligaments was brought against the internal rings. So securely and evenly are the rings closed it occurred to me that the Alexander-Adams operation might be done for the radical cure of hernia. But what surprised me more than anything else was the way in which the prolapsed ovaries and tubes were drawn up into their proper place. I have

had satisfactory proof on this point in the living subject.

I was astonished at the ease with which the ligaments were found in my first case. The next case I saw was a most difficult one, there being no external rings as far as touch or the eye could make out. This case was operated on by Dr. Conant and it was very instructive to me. Knowing his anatomy so well he was not at a loss what to do but cut down directly into the canals and found the ligaments.

On the assertion of one of the best anatomists I make the statement that the round ligaments are *never absent* in a developed woman. After an experience with twenty odd cases I assert that the ligaments can *always* be found if the operator knows his landmarks and the subject is not undeveloped. The ligaments may be so small before being drawn out that it is necessary to catch them with artery forceps to prevent losing them, and I have seen them as large as my little finger. They are found in a fat subject as easily as in a thin one.

Cut boldly down to the aponeurosis, which cannot be missed. Stop all bleeding as you go along so that your aponeurosis may be kept white and glistening. Clean up the fascia and then with the index-finger on the spine the ligament will be found without any difficulty.

Attention to cleanliness should be the same as if coeliotomy was being done as it may be necessary to free the ligaments from adhesions throughout the whole length of the canals and the peritoneal cavity may be opened, then, too, healing by first intention is the desideratum. The following is the way in which the patient, instruments, ligatures and sponges are prepared.

Forty-eight hours before the operation one ounce of castor oil is administered. The day before the operation the patient is kept in bed and fed on gruel. On this day she is given a hot bath, the lower abdomen and pubes are thoroughly washed, first with soap and water, then with ether, and finally with a 1 to 1000 solution of corrosive sublimate. A compress of absorbent cotton thoroughly wet with a 1 to 3000 solution of corrosive sublimate is fastened on the abdomen and pubes by a binder and T-bandage, and allowed to remain until the operation. Two hours before the operation two ounces of whiskey are given by the rectum; and one hour before administering the ether, one one-hundredth grain of atropia is given by the mouth. In over a year's experience with atropia it has been found that when it is administered as above, seven-tenths of the patients do not vomit on coming out of the ether, and in part, or wholly it prevents the filling up of the mouth and fauces with mucus.

Just before being placed on the table the urine is drawn. Everything about the patient is clean. The abdomen and pubes are again washed with soap and water, the lower abdomen and pubes are shaved, and the parts again washed with a solution of corrosive sublimate, 1 to 1000, the hands and arms of assistant and operator are thoroughly washed with soap and water, then scrubbed in a 1 to 1000 solution of corrosive sublimate. Special care is taken to clean the finger nails. Towels wrung out of a solution of corrosive sublimate (1 to 1000) are placed about the field of operation.

The instruments after being thoroughly cleaned with hot soapsuds and wiped dry, are baked in the instrument pan, in an oven for three hours at a temperature of 330° F.

Catgut, silk, and silk-worm gut can be used in suturing the ligaments to the rings. Catgut is the only one of these that is absorbed. The catgut, silk, and silk-worm gut, are placed in ether for ten days; then they are put in glass jars containing a 1 to 1000 alcoholic solution of corrosive sublimate. They are kept in this solution one month before being used, and are used directly from this solution.

The sponges are made, as directed by Dr. J. W. Elliot, of wool tied up in suitable pieces of fine muslin, from which all starch has been removed. They are kept for weeks previous to an operation in glass jars containing a 1 to 1000 solution of corrosive sublimate.

Cut so that the lower end of the incision shall stop just over the pubic spine. Separate the nerve from the ligament, being careful not to injure it by rough handling or by sewing it to the pillars of the ring. Until experience has taught just how far it is safe to draw out the ligaments it is well to make a vaginal examination, the ligaments being kept taut before they are fastened. The slack of the ligaments may be cut off near where it is fastened to the rings and entirely removed, or it may be folded into the wound and fastened there by the sutures that close the incision, or it may be tied in a hard knot to the slack of the opposite side and both buried and sewed into the incisions that have been prolonged so as to meet. I prefer the first method as the ligaments are so often crushed and bruised in getting them out that their vitality is so much destroyed that suppuration takes place. After the sutures are tied, silk-worm gut being used to close the incision, iodoform is thickly sprinkled over both lines and kept in place by strips of baked gauze secured by collodion. Then several layers of baked gauze are placed on the lower abdomen and pubes, and on these several sheets of wadding. The whole is kept in place by an abdominal binder and perineal straps. The patient is kept on her back for a week, at the end of which the worm-gut is removed.

CASE I. R. G., married, aged twenty-three, entered the hospital March 24th. She complained of backache, pain in lower abdomen, burning sensation during micturition, and a profuse vaginal discharge. There was a history of gonorrhoeal peritonitis. Examination showed vaginitis, retroflexion with adhesions, and prolapse of both ovaries and tubes. Removal of both ovaries and tubes was advised, but she declined.

April 12th. Dr. Conant and myself worked one hour in breaking up the adhesions. Then the uterus was held up in place and the round ligaments drawn out and fastened to the rings. The ligaments were adherent throughout the canals, and were torn almost to shreds in freeing them.

In forty-eight hours there was redness and tenderness in line of right incision; temperature 102.4°. Next day tenderness was more pronounced; menstruation begun; and the temperature dropped to 101.8°. Two days later, the temperature still continuing high, Dr. Conant advised opening up the wound. The right ligament had been so much crushed that its vitality had been destroyed, and it was the starting point of the suppuration. The ligament had sloughed down to the point where it was fastened to the pillars of the ring. The wound was kept packed with iodoform gauze, and slowly healed up.

Examination two months after the operation found the uterus in good position.

CASE II. O. G., married, aged forty-two, entered the hospital April 14th. Had had eleven children and two abortions. Last child was born in 1888. She complained of backache, dragging and sagging in lower abdomen, headache, and constipation. Examination showed left lateral laceration of the cervix, retroversion and ruptured perineum. The vaginal walls were lax, and shortening of the round ligaments was advised in preference to three operations on the vagina. The anterior lip of the cervix was hypertrophied, extending through the vulva.

April 19th. Three-quarters of the anterior lip was amputated, the vaginal mucous membrane covering the stump being sutured to the membrane lining the canal. The uterus was replaced, and the round ligaments shortened. The right ligament was adherent throughout the canal.

Sixteen days after the operation a silk-worm suture that had been used in ligating an artery worked itself towards the surface and produced a superficial abscess. The results were good. She is to return in the fall to have the lacerated cervix sewed up.

CASE III. E. H., married, aged thirty-five, entered the hospital May 8th. She complained of backache, sagging and dragging in lower abdomen, and leucorrhœa. She had had four children, and one abortion at three months in January.

Examination showed laceration of the cervix, rectocele, ruptured perineum, and prolapse of left ovary. The uterus was drawn over to the right side of the pelvis. She had been treated for some time in the Out-patient Department, but the uterus could not be pushed away from the right side of the pelvis by packing.

May 12th. Operation. The cervix was operated on first; then Hegar's operation was done on the posterior wall; and finally the round ligaments were drawn out, the uterus being forced beyond the median line towards the left. A good result was obtained from each operation. When examined three months afterwards, the uterus was found in the median line and in its proper position.

CASE IV. M. M., married, aged twenty-nine, entered the hospital May 24th. She complained of sterility, backache, dragging in both ovarian regions, constant leucorrhœa, constipation, and painful menstruation during the first day of the flow. She had been married two and one-half years and had not been pregnant.

Examination found retroflexion with prolapse of left ovary, which was adherent to the uterus at junction of body and neck. The left tube was in the posterior cul-de-sac. The right ovary was adherent to the upper part of the uterus, and there was stenosis of the cervical canal. After using the packing for a few times the uterus was replaceable, but owing to the fixed position of the ovaries, a pessary could not be worn.

June 4th. The cervical canal was dilated, and after all adhesions had been separated, the round ligaments were shortened. Good result.

CASE V. M. R., single, aged thirty-five, entered the hospital June 1st. She complained of severe dysmenorrhœa, obliging her to keep her bed the first day of the flow; pain in back for past two months; dragging in lower abdomen; pain in left ovarian region; leucorrhœa since puberty; and constipation.

Examination showed retroflexion with adhesions, and left ovary prolapsed and adherent.

June 9th. Operation. It was with the greatest difficulty that the adhesions were broken up and the

uterus replaced. Dr. Conant worked at least three-quarters of an hour in accomplishing this. After the adhesions were separated, it took me seven minutes to find and draw out the left ligament, and ten minutes to find and draw out the right ligament.

Eleven days after the operation a superficial abscess formed on the left side. The result was perfect as far as the position of the uterus was concerned. There was no elevation of temperature.

CASE VI. K. G., married, aged thirty-four, entered the hospital July 24th. She complained of sterility, painful menstruation, and backache. Examination showed conical cervix, stenosis of cervical canal and retroflexion with adhesions.

July 26th. Cervix dilated, and round ligaments shortened. Adhesions yielded readily. Result perfect.

CASE VII. C. K., married, aged thirty-four, entered the hospital October 4th. She complained of sterility, burning in left ovarian region for two years, and leucorrhœa since marriage. On examination a conical cervix and retroversion with adhesions was found. An attempt to dilate the cervix was made, and the round ligaments were shortened. There was no trouble in overcoming adhesions. Good result.

CASE VIII. C. B., married, aged thirty-three, entered the hospital September 15th. First labor February last. Face presentation. Instruments were used after hours of severe pain. Child was still-born. Long and tedious getting up. A few days after confinement urine escaped per vaginam. In a week or ten days leakage through the vagina ceased.

Examination showed retroversion with adhesions, extensive bilateral laceration of the cervix, and a cicatrix on the left side of the vagina, extending from the cervix almost to the vulva. At its middle it was firmly fastened to the bone. After packing for some time the uterus could be replaced, but owing to the cicatrix a pessary could not be worn.

October 16th. Emmet's operation was done on the cervix, and the round ligaments were shortened.

In this case there were no external rings to be seen or felt, and the ligaments were adherent throughout the canals. Two weeks after the operation an abscess was opened on the left side.

November 14th. Nine sutures were removed from cervix. Union perfect. Examination found the uterus in normal position.

## Reports of Societies.

MASSACHUSETTS MEDICAL SOCIETY,  
SUFFOLK DISTRICT.  
SECTION FOR CLINICAL MEDICINE, PATHOL-  
OGY AND HYGIENE.

ALBERT N. BLODGETT, M.D., SECRETARY.

MEETING of December 17, 1890.

DR. W. N. BULLARD read a paper upon

THE CARE OF CHRONIC PAUPER EPILEPTICS.<sup>1</sup>

In opening the discussion of this subject, DR. L. W. BAKER, of Baldwinville, Mass., called especial attention to the necessity for the care of epileptics. To any one familiar with the manifestations of epilepsy, there could, it seemed to him, be no question as to the desirability of providing separate accommo-

<sup>1</sup> See page 25 of the Journal.