

the eyes, and a slight conjunctivitis. On the twenty-ninth day the pupil was dilated and unaffected by light; there were also great cephalalgia, vertigo, and nausea. $V. = \frac{1}{10}$. Ophthalmoscopy showed the papilla much injected and ill-defined in outline, with a peripapillary injection extending four or five mm. from the disk; veins large and tortuous; arteries enlarged; urine healthy; no history of syphilis. Dr. Terson examined the patient and pronounced it optic neuritis. The case went on to atrophy of the nerve and complete abolition of vision.

From a study of the cases reported up to the present time, we find that the principal parts of the eye to suffer from a metastasis of the mumps to that organ are the lid, conjunctiva, and optic nerve, and also in my case the third pair of nerves. The exophthalmos present in my case I think due mainly to the paralysis of the ocular muscles, allowing the cushion of the orbit, by its elasticity, to push the ball forward, though it seems highly probable that there was at the same time a serous infiltration of these tissues, as there was of the conjunctiva and lid. The disease may be unilateral and of varying degrees of intensity. The prognosis of the affection seems to be, in the main, good, the only case terminating in blindness being that of Talou. This, however, suggests the possibility that some of these atrophies of the optic nerve, especially when unilateral, which are accidentally discovered, and the origin of which cannot be traced to any of the hitherto recognized causes, may be due to a metastasis of mumps in childhood.

As regards pathology, anything in the way of explanation must, from the paucity of accurately observed data, be merely speculative. Hatry and Talou look upon the eye trouble as consecutive to a cerebral complication. It seems to us, however, that this could not be possible in all the cases reported. It is hoped, however, that the publication of these cases may be the means of calling the attention of both the physician and ophthalmologist to a new field for their combined observation and study.

ON RECENT GYNECOLOGY.

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THIS century has been, and continues over more and more to be, a period of rapid development, not in medicine alone, but in every department of human activity. Standing in the whirlpool of religious, political, mercantile, and medical change, one is disposed to think the times are revolutionary, and have overstepped the limits of law or of the ordinary or justly expected rate of change or of progress. But it may not

be so. The next generation of philosophers will then be equally astonished and puzzled in the embroilment of their time, and will look back on the distant view of what they may regard as the pleasant settled peace of ours.

The increase of medical science, in mere bulk, in recent and specially in our own times, has compelled men, and as it goes on will increasingly compel men, into what are called specialties. In an important sense this is an evil, but it is an inevitable evil. Human time is limited; the powers of our mental faculties are limited; and it is a vain lament that we cannot, when very hungry and thirsty, devour and assimilate the fine food which science so copiously and daintily prepares for us. The time of Admirable Crichton is left far behind; but the advantage and superiority of the medical man who has most of his quality will always remain. Hope of remedy for the Babel confusion lies in the discovery of a common tongue. The deserts and mounds of chips of knowledge may be brought into subjection to general, and yet more general, laws, and the utmost perplexity of details be reduced to order and made an easy study.

At a period now remote, medicine was itself a specialty. When the universities were founded, one chair was enough for it and all its departments. When hospitals were founded, there was no classification of patients. A century ago the whole library of midwifery and diseases of women was comprised in a few volumes; and there was no library of gynecology; while it is surely now no exaggeration to say that a single year produces as much obstetric and gynecological literature as all the ages before the century began. In London, midwifery and gynecology are now, but only now, beginning to be taught systematically; it is recognized that thirty or forty lectures are inadequate for the display of the subject. The diseases of the fetus and of newly born children await a fuller development, lying now in the position of a mere appendage to midwifery. Medical jurisprudence is separated from midwifery. Gynecology, or diseases peculiar to women, long a neglected appendage to obstetrics, is nobly struggling into recognition and importance. Already it owns a large and growing library, special departments in great hospitals, and minor hospitals of its own. And yet it has not, in Great Britain, special teachers.

It is not to be wondered at that in these circumstances, a contemporary should find himself in a maze of difficulties when he attempts to estimate the present position of gynecological science, and to appraise the numerous novel proceedings which spring up luxuriously on the newly turned soil. Time and research will try and purify the science; wisdom and experience will cleanse the field of practice from innumerable weeds; and, as we have already said, the retrospective glance of the medical historian, seeing the diligence, the progress, and the achieve-

ments of our time, may, only by special inquisitiveness, discover the weedy part of the growth which now entangles and embarrasses and perplexes us. Activity is not necessarily, and certainly not all, progress. An American orator has recently discoursed to the New York Academy of Medicine on the great power of mere restlessness and of love of money. It is gentler and nobler motives that impel the triumphant ear of true stable gynecology.

There is a well-known ancient distinction between medicine and surgery, as imperfectly defined as it is ancient. Medicine has always taken precedence, and will always take precedence, for the head and its work are nobler than the hands and their work; and yet who can draw the line between the work of the one and of the other? Where is the opening for jealousy to intrude between the physician and surgeon? Both have ample scope for the highest powers of the mind. Young men, men of enterprise, men of action, turn naturally to surgery. Maturer years, study, research turn to physic. Wisdom in a physician, skill in a surgeon. Gynecology is partly medical, partly surgical; and its practitioners fall into the two ranks, or nearly so. Every gynecologist is, to some extent, a surgeon; but it is rare to find the qualities of physician and surgeon highly developed in the same individual. In the great field of general medicine, the distinction is here and there maintained between the two sets of practitioners; in the lesser field of gynecology, there is as yet scarcely room for both anywhere; and there is, consequently, at least an appearance of jealousy between those affecting gynecological medicine and those affecting gynecological surgery.

If it is difficult to separate by a definite boundary medicine from surgery, it is still more so to draw a line between ordinary and general medicine and gynecological medicine, and between ordinary or general surgery and gynecological surgery. A lasting distinction will not be made on any preconceived plan, nor fostered by any arguments. We have no record of any plans or any arguments in the new ancient separation of general medicine and surgery; it will grow up on Darwinian principles. The fittest for the times will survive. Science will send forth branches in unforeseen directions. The public will have the practitioner who suits them best. The ovariectomist or hysterectomist who is most successful will sweep most into his net, whether he be a general, or a gynecological surgeon; and so it should be. In the interior of hospitals, especially of the great old establishments, there seems to be room enough for gynecological medicine, and gynecological surgery has found a considerable unchallenged area for its work. But the surgeons have, in some of them, claimed ovariectomy and hysterectomy, refusing to resign them to new gynecological members of the hospital staff. The surgeons have the advantage of ancient position and respected rights. The gynecologists have the advantage of youth, growth, and prosperity.

The matter may be left, without anxiety for the future, to its destiny, which is not as yet manifest. Whichever way the ultimate decision, in hospital or in private practice, may fall, no evil will accrue to gynecology or to surgery. Meantime, the great ovariotomists and hysterectomists of Great Britain show, neither in their history nor in their renowned progress, any more special connection with or devotion to obstetrics and gynecology than do their purely surgical colleagues. They seem disposed rather to fall into general surgery than to adopt gynecological surgery. Much has been said of the special adaptation of obstetricians and gynecologists to their special departments of surgery, and a little force may be permitted to this argument in favor of gynecologist's claiming to themselves the field of gynecological surgery. But there is only a little force in it; there is only one set of surgical principles. One man may find it suit his genius to devote himself to the eye, another to the ear, another to the bladder, another to the ovaries, another to the uterus. But it is not necessary to hand over the surgery of the liver to a Murchison, or of the uterus to an Arthur Farre, or of the lungs to a Williams.

The reviewer of modern gynecological literature must express his admiration of the zeal and the diligence of the students and the consequent copiousness of the production; and undoubtedly the best is from Germany. The *Archiv für Gynaekologie* is a repertory of gynecological science, hitherto not approached in excellence by any other production, and is fit to be proudly placed beside any other scientific journal of the world. But we must look at the second-rate and the more bulky, as well as at the first-rate and more condensed, and we are bound to notice the failings.

It is almost needless to remark, that the more of science and the more of scientific method, the better the literature. Without truth there is no science, and without love of truth there is no scientific method. In gynecology there are lamentable aberrations from truth, inexcusable, not even to be palliated, and scarcely to be mentioned.

Quite in a different category are erroneous assertions, foolish exaggerations, and bad science. The world lives on theories, and bad science implies bad practice. Without truth there can be no science; without high morality there can be no good practice, and little progress in practice. Morality, accuracy, and good science must, therefore, be fostered as the bases of good practice. If examples of foolish assertion and bad science are wanted, we have only to refer to the history of "ulceration," with its speculums and caustics, now happily shrivelled into just proportions. Or we may refer to the history of displacement and the ridiculous spurious epidemic of displacements and of pessaries. Or we may look at the injury to women, apparently wholly inverted, from trachelorrhaphy, founded on such absurd statements as that at least one-half of

the ailments among those who have borne children are to be attributed to lacerations of the cervix. Or we may turn to the cures by oöphorectomy and by the Weir Mitchell method; to a very great proportion of which the cynical yet true remark may be applied—the women had no diseases and they were cured. “*Quidquid delirant reges, plectuntur Aehivi.*” To think on these matters does not cause pain and indignation such as are excited by the previous category, but it causes sadness, and stimulates the desire to improve gynecological science and practice.

A third category demands consideration, and even respect, on account of its imposing character. We have said that the world revolves on theories; and the more general the principle involved the more important are the dependent theories. Long looking for a philosophical basis for the facile adoption of practices, dangerous out of due proportion to the dangers of the relative diseases, we failed to find any, however much we might shrewdly suspect its existence. At length, in a transatlantic address, it made its appearance from the mouth of an eminent gynecologist. It consists in the asserted importance, if not even the paramount importance, of pain as compared with life; or, in other words, for the relief of continued suffering, a considerable proportion of lives of the sufferers may justly be sacrificed.

An analogous question has been raised in regard to operations of complaisance—that is, for conditions involving no danger to life, and has been discussed by Velpeau. Such operations are for the removal or diminution of deformity and disability, and their establishment has been deliberately sanctioned or forbidden under the venerable principle, that life is of higher value than anything else.

The extension, in our times, of dangerous operations of complaisance and of dangerous operations for relief of pain, is, of itself, almost sufficient evidence that the stringency of the principle is not felt now as it once was. And it is for medical philosophy to decide as to the propriety of this loosening of the venerable restriction.

Justice demands the execution of individual criminals; statesmen send their fellow-countrymen to death in hosts; but, in these cases, there is solemn public judgment, and the nature of the objects aimed at is quite different from that of the aims of medicine. The judge and the statesman look to the interests of the public; the surgeon to the interests of the individual alone.

The obstetrician is permitted, on his own responsibility, to destroy fetal life. In most cases there is the preliminary question, easily solved, of the comparative value of the two lives, that of the fetus and that of the mother. This being settled, the obstetrician may, unchallenged, destroy fetal life to save maternal life. When the decision is not simple, both the profession and the lawgivers look upon destruction of life with the utmost jealousy. It may be remarked that there is, at present,

a strong and widespread fear that, even within professional circles, sufficiently jealous guardianship of embryonic and fetal life is not duly maintained, and, in passing, we may express our feeling of debt to Goodell for his eloquent remarks on this subject in a recent lecture.

Surgery has to consider individuals only, and is still generally held bound to act under the old-established principle of the paramount value of life. But there are many difficulties, for danger is a matter of degree, and diseases and individual cases have great difference in respect of danger to life.

All operations are dangerous to life; and we have no scale of the danger of diseases and the correlated justifiable danger of the relative operations. But such a scale has already some beginnings, and we do not despair of reaching valuable approximations in precise numerical form.

In most cases there is, fortunately, no difficulty. It is easy to decide in favor of ovariectomy. It is easy to decide against oophorectomy in most of the cases in which it is at present, or has recently been proposed. It is difficult to come to a decision in most cases of proposed hysterectomy, and we may refer to the records of experience by Thomas Keith for just remarks and wise counsel on this subject.

The physician may have an easy decision to insist on operation, or to insist against operation; and in such circumstances he is content to stand alone. But, in cases of difficulty, he may often, with advantage, lay the question before his patient for her opinion, and be even content to let it be decided by the patient.

The preceding remarks are made with reference, exclusively, to the saving of life. But now we have to consider the new doctrine of the value of pain, and we find ourselves in insurmountable difficulties, solved only by recurrence to the old and venerable and safe principle of the value of life.

If pain becomes the test, then the patient, not the physician, is the judge. If pain is the test, then any case may be operated on. Who will define pain for this purpose? Who will define endurance? Who will prescribe just limits of endurance? Who will skillfully detect those

“Opprest by some fantastic woes,
Some jarring nerve that baffles their repose,
Who press the downy couch while slaves advance
With timid eye to read the distant glance;
Who with sad prayers the weary doctor tease;
To name the nameless over-new disease;
Who with mock patience dire complaints endure,
Which real pain and that alone can cure?”

The recent progress of gynecology has been mainly surgical. Much has been done in gynecological pathology whose practical application in

relief of suffering or management of disease is of great value, and of wide applicability, but the triumphs of surgery, though comparatively limited in utility, engross the general gaze. This gynecological surgery does not stand isolated, but forms part of general surgical progress, and some leaders in the gynecological department, as Mr. Lawson Tait, perform exploits on the male, and in regions remote from those of gynecologists.

We have spoken of surgical progress and also of surgical license, and dismiss the latter with the remark that, if the motive is pure from selfishness, there is only a little room for rebuke. A generous surgical enthusiasm is like any other, attracting admiration as it pursues its boisterous career, although here and there it overflows the limits of sobriety. The main current is beneficent, and time will soon bring moderation and the stoppage or withdrawal of the overflowings.

Generous ambition, and fair rivalry, and the spirit of the times, have given the impetus to the accelerated progress of gynecological surgery. Here, and in all we have written, we regard only the great doings, the real progress, with its errors of enthusiasm. But the spirit of the times has thrown to the surface much else of surgery, included under the designation of minor gynecology. Of this there is not a little that is praiseworthy, but not enough to call for a laudatory review. The good is overwhelmed by the fussy residue, which has its natural and full and longed for equivalent in copiousness of filthy lucre. The child and the parent of crude physiology and cruder pathology, it delights in new tools and new remedies, or remedies with new names; speculums, caustics, pessaries, pads, and metrotomes, all of never-ending variety, meddling and muddling; inventing and making cures; exciting the disdain of the nobler brethren; a frivolous theme scarcely worthy of the pen of an able editor of a journal of the very latest Parisian fashions.

Recent gynecology, whether major or minor, owes much to the spirit of the times; but major gynecology has had powerful prospering favorable gales from recent discoveries. We may safely affirm, that without the anesthetics of Amoretti, and the antiseptics of Lister, recent gynecological surgery could not have attained its great position. To foresee the danger unattended by the agony makes a ready, willing patient. To foresee the great source of danger, and to provide against it, embolden the surgeon.

Among the more adventurous spirits of gynecological surgery there is a risk of obliteration of the distinction between feasibility and advisability. They have proved that any operation is feasible, and now they have more difficult tasks; as, for instance, to show what operations are advisable, and how they may best be done, and when they may best be done. At what period in a case should ovariectomy be undertaken? Are there any cases besides those of uterine hemorrhage immediately

imperilling life in which the operation of Battey should be done? What are the cases in which hysterectomy should be practised for fibroids? What part should age take in favoring or discouraging operation in cases of hemorrhago? Is hysterectomy ever advisable in cases of cancer of the portio vaginalis, or in cases of cancer of the cervix? What are the limits of the use of hysterectomy in cases of cancer of the body? In what cases of extruterine fetation is laparotomy to be resorted to, and when?

Major gynecology is too young to have laurels; its laudable zeal scarcely requires fostering. Minor gynecology requires pruning and direction, and even preliminary education, rather than fostering.

ON THE DILATATION AND HYPERTROPHY OF THE HEART, WHICH ARE NOT PRODUCED BY CHANGES IN THE VALVES.

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THAT all the examples of cardiac hypertrophy and dilatation which we meet with in practice are not due to valvular lesions, is a proposition which every one will admit. That attention has been called to such non-valvular cases by a number of authors is evident to any one who reads medical literature. And yet the recognition of these cases, and their treatment, have not become matters of ordinary practice. It has seemed to me, therefore, that it might be well to group together the cases of cardiac dilatation and hypertrophy not due to valvular disease; to subdivide the group into its appropriate classes; and to state the characteristics of each class.

With the information now available the following seems to be the most convenient classification:

1. Hypertrophy and dilatation due to excessive and prolonged muscular exertion.
2. Hypertrophy and dilatation due to morbid changes in the lungs.
3. Hypertrophy and dilatation associated with the infectious diseases, with anæmia, and with pregnancy.
4. Hypertrophy of the left ventricle with lesions of the arteries.
5. Hypertrophy of the left ventricle with cardiac neurosis.
6. Dilatation of the ventricles with inflammation or degeneration of the walls of the heart.
7. Dilatation of the ventricles occurring without discoverable cause.

1. HYPERTROPHY AND DILATATION DUE TO EXCESSIVE AND PROLONGED MUSCULAR EXERTION.—Our knowledge of this form of cardiac