

[In our experience the patient is less apt to suffer from permanent vesical inflammation than from urethritis and irritation at the neck of the bladder, due to the rough or unskilful use of glass catheters.—H. C. C.]

Removal of Ureteral Calculus per Vaginam.—GRADENWITZ (*Zentralblatt für Gynäkologie*, 1904, No. 12) reports the following case: The patient, aged forty-three years, had suffered for three years with colicky pains, beginning in the right kidney and radiating over to the left. She had passed two phosphatic calculi. On vaginal examination a small stone was felt in the bladder, which was easily removed per urethram after moderate dilatation. Four weeks later the patient re-entered the hospital on account of a return of the colicky pains. It was now possible to palpate a stone, the size of a cherry-pit, impacted near the left ureteral orifice. Cystoscopic examination was negative, and the daily excretion of urine was about two pints. Three months later only half this quantity was excreted, and catheterization of the left ureter showed that no urine escaped from that kidney, though the fact of hydronephrosis could not be established.

Under narcosis the usual transverse incision anterior to the cervix was made, the bladder was dissected upward, and the lower portions of the broad ligaments were divided between ligatures, although the uterine arteries were not tied. The stone was fixed by pressure through the abdominal wall, and after further blunt dissection the ureter was drawn down into view; incised, the calculus (uric acid) was removed, and the incision was closed with fine sutures. The patient's convalescence was afebrile, the daily amount of urine at once became normal, and four months later there was no evidence of further trouble.

Histology of Parametritis.—BUSSE (*Monatsschrift für Geb. u. Gyn.*, Band xviii., Heft 1) calls attention to the fact that so-called pelvic exudates differ widely anatomically. In some cases there is a simple œdema of the parametric tissues, in others fibrinous inflammation without marked increase in the leukocytes, such as is noted in the more acute forms. Suppuration follows, with later hypertrophy of the connective tissue and accompanying degenerative changes, especially fatty.

The Action of Oophorin.—MATHES (*Monatsschrift für Geb. u. Gyn.*, Band xviii., Heft 2) asserts that ovarian extract causes an excretion of the phosphates, which is less marked in women whose ovaries have been removed. In general, castration appears to diminish the salts in the body.

Leukocytosis in Diseases of the Pelvic Organs.—DUTZMANN (*Monatsschrift für Geb. u. Gyn.*, Band xviii., Heft 1), continuing his studies of this subject, presents the results in 2000 blood-counts, made in 223 patients. His conclusions are as follows: Leukocytosis is a valuable guide to the presence of pus in the case of pelvic exudates, and furnishes an indication for incision. The iodine reaction of the white cells serves to confirm the diagnosis in a doubtful case of supposed abscess.

In diseases of the adnexa the leukocyte-count not only assists the diagnosis, but guides the surgeon in his choice of the abdominal or vaginal route. In cases of fibromyoma, carcinoma and ectopic gesta-

tion leukocytosis is often the only indication of complicating purulent disease of the adnexa, or possible suppuration of an hæmatocele. Tubercular pus does not cause an increase in the number of leukocytes, and gonorrhœal only moderate, a fact explained by the greater resistance of the peritoneum to the specific organisms of those diseases. A high leukocytosis attends torsion of the pedicle of ovarian cysts, though pus may be absent; the iodine reaction is absent, however.

In septic infection the leukocyte count is especially valuable as regards prognosis, a persistent high leukocytosis being favorable, while a decline is to be regarded in the contrary light. In puerperal sepsis the proper time for interference may be judged accordingly. In eclampsia with hyperleukocytosis the attacks are less frequent, while a decline is noted in a less favorable case. The writer infers from this that in eclampsia there is a true infection (?)

Ovarian Hemorrhage.—ROUSSEAU (*Jour. méd. de Bruxelles*, 1903, No 50) reports 6 cases, the following being the most interesting:

Case I.—Three days after the beginning of menstruation the patient was seized with a severe pain in the right groin radiating down the thigh. Similar attacks followed at intervals of two months, and a tumor the size of the first developed in the cul-de-sac, which, on opening the abdomen, proved to be a large hæmatoma of the ovary.

Case II.—The patient had a sudden attack of pain, with tenderness and resistance over McBurney's point. Bilious vomiting and elevation of temperature. Several similar attacks followed during the next few months, the diagnosis of recurrent appendicitis was made, and on section a small hemorrhagic ovarian cyst was found with a twisted pedicle, the appendix being normal.

Case III.—The patient had a violent attack of abdominal pain, with vomiting and rapid increase of a pre-existing ovarian neoplasm. On section the abdomen was found to be full of blood which had escaped from a cancerous cyst. All the patients made a good recovery.

Operation for Prolapse of the Ovary.—MAUCLAIRE (*Semaine Gynéc.*, 1903, Nos. 35 and 36) describes the following operation for the relief of retroversion associated with prolapse of the ovaries which resists ordinary treatment: After opening the abdomen a slit is made in the upper part of either broad ligament midway between the uterus and the pelvic wall, the fimbria ovarica divided in order to free the prolapsed ovary, and any adhesions are separated. Any necessary conservative work is done. The ovary is drawn through this opening, which is contracted with sutures, so that the gland cannot slip back again, and, finally, the end of the tube is sutured to the anterior surface of the broad ligament near the ovary. Hysteropexy is performed to keep the uterus in an anterior position.

[Barrows, of New York, describes a similar operation, which he calls "shelling" the ovary. Both seem to be open to the objection that the gland is not left in its normal relations and that its blood supply may be consequently interrupted.—H. C. C.]

Cancer of the Ovary in a Child.—KUSNETZKI (*Jour. Akuschi Shensk. bolesnej; Zentralblatt für Gynäkologie*, 1904, No. 13) reports the case of a girl, aged fourteen years, who had never menstruated. She had an