

ment. If it is very large, one-half or three-quarters inch in diameter, it may be advisable either to ligate or to clamp and sever it, which renders it more mobile. If exsection from the bladder is thought desirable it may now be done, one layer of sutures being placed first and a second if deemed necessary after the exsection is made and the first layer of sutures tied. A ligature is then placed on the free end of the ureter if a clamp was used. The patient is next changed to the supine position and opposite the lower pole of the affected kidney a transverse (Konig) incision, four inches or longer, is made through the extra-peritoneal portion of the abdominal wall. Its inner end need not be inside the semi-lunar line. The kidney is now freed and brought out through this incision, its vessels clamped or tied, and by gentle traction on the kidneys the fingers are aided in separating the ureters from surrounding structures down to the plevis, and it is easily pulled out of the wound. If careful dissection has not been accompanied by escape of pus from the kidney or ureters or from a perinephritic abscess, little attention to drainage will be needed. In two of his cases he has had to use both loin and vaginal drainage. In others, a piece of gauze was pushed by a uterine sound downward along the course of the ureters, through the vagina and vulva, only a strip being left in the abdominal portion of the cavity created by the operation. The loin wound was in these cases completely closed by buried animal sutures. The gauze was usually removed fractionally by daily pulling it down after the second day. If loin drainage is required it is frequently preferable to employ the stab-wound space for it, closing the Konig incision completely. The article is illustrated.

VAGINAL HYSTERECTOMY.

R. Elmergreen, Milwaukee (*Journal A. M. A.*, October 23), offers a new technic for vaginal hysterectomy which he asserts will prevent cystocele following the operation. The advantages of the vaginal route over the abdomi-

nal, are not altogether psychic and esthetic. When drainage is necessary in septic cases and the Fowler position is used, its mortality is practically nil. It should be the operation of choice also in cases of cancer of the fundus without glandular involvements, or metastases, and in elderly women who have passed the climacteric and those who have a thick and pendulous abdomen, unless especially contraindicated. The absence of shock, the early convalescence, and the lack of visible mutilation are strongly in its favor. It is contraindicated with a naturally small or atrophied vagina, fixed uterus or one that cannot be drawn down enough to ligate the lateral vessels, in advanced cancer, with large fibroids or those situated high in the plevis; and when there is a well-based suspicion of other pathologic conditions in the plevis which require attention, the abdominal route is preferable. Elmergreen gives his technic in detail, with illustrations. He utilizes the stumps of ligaments left after the extraction of the uterus, to form a new plevic floor, arranging them so that the large anterior stump containing the vesicovaginal septum, is placed well behind the others. They are then tied and sutured. The large stump area of anchorage of the posterior surface of the bladder securely wedged behind the stumps of the broad ligaments now snugly retracted high in the plevis, will overcome the cystocele effectively and permanently. He believes that anterior colporrhaphy as an adjuvant to this operation is altogether unnecessary. Two cases are reported in which cystocele and prolapse had existed for many years and were thus completely removed. The author's conclusions are given as follows: "1. Vaginal hysterectomy is only indicated in a limited class of cases. Among these I would mention cancer of the cervix, and cancer of the uterine canal in both cervix and fundus, with movable uterus; extreme prolapse of uterus and bladder; extreme retrodisplacement with metritis in women who have passed the climacteric. 2. Whenever applicable, vaginal hysterectomy has many advantages over abdominal hysterectomy."

tomy, not the least of which is the avoidance of shock, and the corresponding quick recovery in elderly patients. 3. Women are singularly tolerant to operative traumatism inflicted on the pelvic organs by the vaginal route. 4. Vaginal hysterectomy has no horrors to most women suffering from cancer of the uterus, and the operation may serve as a psychic lever to turn patients toward surgical aid in the early stages of this dreadful disease. 5. The technic of vaginal hysterectomy often presents great difficulties; but these are seldom unsurmountable. 6. Injury to the uterine, and hemorrhage, both primary and secondary, can be avoided by modern methods. 7. Cystocele and prolapse of the bowel can be completely overcome by this method."

THE SURGERY OF THE OVARIES.

J. O. Polak, Brooklyn (*Journal A. M. A.*, October 23), asks whether the remote effects of conservative operations on the ovaries are such as warrant us in resecting a diseased organ. The reasons advanced in favor of such procedure are first the preservation of the function and second the avoidance of the artificially produced menopause with its troublesome nervous symptoms. He himself believes that the field of ovarian resection is a very limited one but there are ideal and selected cases in which it may be advisable. He finds from the study of 1,970 cases that there were only 32 known pregnancies, and the study of 300 cases in his personal service in which resection was done with a large number of secondary operations necessitated has given him further light on the subject and enabled him to make some deductions. Over 12 per cent of the entire number have required ablation of the second ovary or the part left. Twenty-six pregnancies have occurred in the 240 women that could become pregnant or over ten per cent which is higher ratio than usually reported. One patient contributed three pregnancies and two abortions but this was a specially favorable case. In all the

patients excepting the ones reoperated upon an early operative menopause has been avoided and 106, or more than a third of the entire number, are free from pelvic pains of any kind. In 219 out of the 300 one ovary was entirely removed and the other partly and it is noteworthy that 17 of the 26 pregnancies occurred in patients with one ovary removed and the other extensively resected. But two patients who become pregnant had microcystic ovaries when operated upon thus supporting his former view that such diseased ovaries had better be removed entirely. If the return circulation in a resected ovary is impeded in such cases by the misplacement of sutures the cystic formation becomes very rapid and extensive. He is convinced from his secondary findings that many recurrences of cysts and pains are due to omission to secure the resected ovary high enough in the pelvis to maintain an equalized blood supply and to keep it free from adhesions. Removal of the tubes tends to shorten the broad ligaments and cause some degree of retroversion. It is his custom to suspend the uterus in every case of double salphinectomy, no matter what the previous position of the uterus has been. This he thinks minimizes adhesions and maintains the ovary in a better position for its circulation. His general conclusion is, that multiple cystic degeneration is least favorable to conservative procedure while ovaries containing retention cysts of the corpora lutea, large mononuclear cysts, fibroids and dermoids may be conserved by resection with considerable hope for the patient's future well being.

DERMATOLOGY.

Testing of Needles Used for Insoluble Mercurial Injections. By L. Lafay (*La Clinique*) April 23, 1909. Pages 262-264.

This able authority calls attention to the necessity of testing the long needles thus used for leaks along the sides. The injected material should be deposited in the muscular tis-