

The patient was placed on alkalis for his hyperchlorhydria for three months without any benefit. An appendectomy was advised. Operation showed that the appendix was intact but unusually long and chronically inflamed. There was a stricture 4 cm. (1½ inches) from the distal end. Another pathologic feature of the case was the kinking of the ileum by a short, firm fold of mesentery opposite the true mesentery. Division of this gave a looseness to the ileum and freedom of drainage which had not existed before. After the removal of the appendix the patient made a complete recovery.

CASE 2.—Mr. T., aged 41, complained for five years of digestive disturbance. Two or three hours after meals he experienced epigastric distress, belching sour gas. He was easily tired, had backache and was quite nervous. Bowels were normal. Physical examination proved absolutely negative. An examination of the stomach contents showed that he had hyperchlorhydria. Palpation over the whole abdomen elicited no pain. Continuous deep pressure over the appendiceal region induced a feeling of distress in the epigastrium which the patient asserted to be similar to his digestive disturbance, complained of two or three hours after meals. On removal of the pressure, the distress experimentally produced subsided. Diagnosis, chronic appendicitis. The patient was placed on alkalis for his hyperchlorhydria, which seemed to keep him comfortable. Just as soon as he discontinued the alkali his digestive symptoms recurred. I advised the removal of the appendix. At operation the appendix was found to be 8 cm. (3 inches) long and retroceally adherent. The meso-appendix was very short, rendering ligation difficult. The appendix had a sharp kink in the middle; the distal end showed marked change, with thickening and infiltrated walls. The case proved to be one of chronic interstitial appendicitis with thickening of the walls. The patient made a complete recovery, all stomach symptoms entirely and permanently subsiding.

CASE 3.—Miss D., aged 40, had complained of indigestion for fourteen years. She belched gas, had backache, tired quickly, slept poorly and was very much constipated. Physical examination was negative. A continuous pressure over the appendix induced distress in the left hypochondrium. At no time during the past fourteen years had she been well. At operation it was found that the appendix looked quite normal, but that it was somewhat confined by old adhesions. The main pathologic showing was the evidence of long-standing adhesive inflammation, confining the ascending colon from the cecal extremity past the hepatic flexure. Not only was the intestine confined by the membrane, thus limiting its mobility, but it was also divided by several bands of this exudative membrane into what might be called compartments. The operative measures consisted in removing the appendix and freeing the ascending colon and hepatic flexure. The patient has made a complete recovery.

CASE 4.—Mrs. K., aged 36, had had stomach trouble all her life. Her appetite was reported to be poor; there was severe distress immediately after meals, belching of gas, flatulency, backache and nausea and headaches; she tired quickly; bowels were constipated. Physical examination proved negative. By a firm continuous pressure over the appendiceal region a pain was induced in the epigastrium; the harder the pressure, the more severe the pain. Inasmuch as the patient had been under the care of several good physicians, I explained that it was useless to endeavor to relieve the difficulty by medication. At operation the appendix was readily exposed; it was found to be 11 cm. (4 inches) in length and somewhat thicker than normal. The mesentery extended the whole length, was short and bound the appendix down to the cecum. Surrounding the appendix were a few slight adhesions. One fairly firm adhesion extended from the tip to the parietal peritoneum, covering the psoas muscle. The walls of the appendix were slightly injected. On palpation the organ was felt to be stiffened, but not markedly so. Around the base of the appendix there was an irregular area in the wall of the cecum which was decidedly thickened and slightly injected; this measured approximately 6 by 8 cm. (2 by 3 inches). The patient made a complete recovery, all digestive disturbances subsiding.

32 West Adams Avenue.

PROTECTION AND REPAIR OF THE PERINEUM *

GREER BAUGHMAN, M.D.

Professor of Histology, Bacteriology and Pathology, Medical College of Virginia; Pathologist to the Memorial Hospital
RICHMOND, VA.

It will not be necessary in discussing this subject to review the entire anatomy of the muscles and fascia, because the anatomy of this region is well known; but in order to make the point that I desire to make in protecting the perineum, it will be necessary to say a word about the superficial fascia.

This consists of two layers, the one continuous with that over the buttocks, thighs and abdomen; the inner layer descends from the abdomen, narrowed to the width of the pelvis, but spreads out so as to envelop the anterior triangle at its base. The abdominal fascia is firmly adherent to Poupart's ligament, and the perineal portion to the outer margin of the ischiopubic rami and the inferior margin of the septum, while the pubic portion is attached along a curved line of the bone, which indicates the origin of the muscles of the anterior part of the thigh. A tubular portion extends backward from the margin of the inguinal ring on each side of the vagina and is known as the pudendal sac; when enveloped with skin it forms the labia majora.

It is not my intention in this paper to discuss seriatim the well-known and generally employed methods of perineal protection, but to outline the system of protection that in my hands has been most successful. I do not assert that I am the first who has ever used this plan—I refer here to that part of the plan that brings more stretching tissue to the perineum—but I have never seen this method used and have never been able to find any description in literature of the method of increasing the quantity of stretching tissue.

I deliver the woman in the lithotomy position with knees bent and feet resting on the bed until the expulsion of the head is about to occur. As soon as the head (I shall discuss vertex cases alone in this paper) begins stretching the perineum, I begin to bathe the perineum with sterile water and compound solution of cresol, using sterile pledgets of cotton and having my hands protected with rubber gloves that have been boiled. As the head begins to appear at the vaginal orifice, I push the anterior vaginal floor backward and upward and at the same time push the occiput toward the bregma, attempting as far as possible to flex the head more and more. If the perineum seems very tight when the head no longer recedes with pains and the perineum is on the stretch, I give obstetric anesthesia, because I want the woman entirely under control for the final delivery. After the patient has been given a little anesthetic I have the nurse extend the legs and at the same time evert the feet, turning the toes out and heels in, bringing the thighs as close together as possible while giving me a place to work. This brings the buttocks on each side inward and makes available more tissue for the perineum. I then push the vulva back from the child's head with sterile moistened pledgets, beginning at the sides and always working between pains. While doing this I am attempting to flex the head as much as possible and to deliver the apex of the vertex between pains. As soon as the apex of the vertex is delivered I have the anesthetic pushed or tell the woman to yell if no anesthetic is used, so that I may have her attention

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diverted from the vulva. I direct the nurse to continue the position in which the legs are together, with the feet, legs and thighs rotated outward as much as possible, and I try to make my delivery between pains. I give the shoulders of the child the same sort of attention that I give the head, except that more room is needed between the thighs for work in the delivery; therefore I usually support the perineum by drawing forward the buttocks on each side, with my hand.

The advantage of extending the legs and rotating the thighs out is that skin from the buttocks and superficial fascia is put at the disposal of the stretched perineum in a much better way than the obstetrician can do by using the hand. What the perineum needs is more tissue, not more pressure from without. In pressing against the perineum with the legs flexed on the thighs and the thighs flexed on the abdomen we simply render the perineum more bloodless and increase the tendency to tear.

If the perineum seems so tight that a tear is apparently inevitable, then it is best to nick the vagina at the sides. Dr. Kienster says that when the perineum is stretched to its fullest extent the skin and mucous membrane are pulled over the muscles from 2 to 3 cm., so that a cut into the stretched perineum, or better, into the sides of the stretched vagina to that distance on each side, will not cut any muscular tissue.

In the cases that I report in the accompanying tabulation, the patients were seen in private practice or in

DISTRIBUTION OF PERINEAL TEARS IN ONE HUNDRED AND EIGHTEEN DELIVERIES

Instrumental deliveries:		Per Cent.	
Primiparas	12	21.8	
Tears	10	83.3	
Multiparas	6	9.5	
Tears	2	33.3	
Total instrumental deliveries	18	15.3	
Deliveries without instruments:			
Primiparas	43	78.2	
Tears	3	6.9	
Multiparas	57	90.5	
Tears	2	3.5	
Total deliveries without instruments	100	84.7	
Total number of cases	118	...	
Total number of tears	17	14.1	
Unconverted occipitoposterior cases	4	...	

consultation, and were delivered according to the plan here laid out. Under instrumental deliveries are included versions.

Olshausen reports unavoidable tears of the perineum in primiparas in 15 per cent. of his cases, Schroeder reports that great care must be taken in primiparas to have as small a number as 15 or 20 per cent. of tears.

I have always repaired the perineum immediately, but must confess that until I adopted the method of repair which I have used in this series of cases, my results were far from brilliant. In the series of seventeen cases I have had but two failures; one was in the most intractable woman that it has ever been my misfortune to attend. The other failure was a tear into the rectum, and even here a moderately good result was obtained with perfect control of the feces and some muscle union. The method was suggested to me by my honored colleague, Dr. Charles R. Robins of Richmond, Va., who outlined the following plan in 1909:

METHOD FOR REPAIRING TEARS OF THE PERINEUM

The procedure is simple; the most important things to consider are a good light and a good exposure of the torn area.

The patient is placed on her back with the thighs flexed on left abdomen and held in place with a suitable support like the Robb-Kelly strap. The vagina is cleansed of clots and the upper part of the vagina packed with sterile gauze or cotton, so as to make the field of operation as bloodless as possible.

Then a good light is thrown into the vagina. It is essential for the operator to see what he is doing because the parts are so distorted and bruised that it requires some discrimination to be able to recognize what parts belong together. Robins recommends sewing the mucous membrane and submucous fascia of the vagina to the mucous membrane and submucous fascia of the opposite side of the tear with a continuous chromicized catgut suture. Care must be taken to catch the muscles with the suture. The suture begins at the upper part of the tear in the vagina and is continued down toward the vulva, uniting the mucous membrane and fascia with a continuous running suture, the operator trying to match the part of one side to that from which it has been torn. This restores the shape of the vagina (the vaginal sheath). After the vulva has been reached, the suture and needle are laid in the vagina to be used later to unite the skin with a continuous suture. If there happens to be another tear in the vaginal sulcus or median line, which is almost always the case after the use of forceps, that tear is sewed, the mucous membrane and fascia to the mucous membrane and fascia of the opposite side of the tear with a continuous suture just as on the other side, and when the vulva is reached, the suture is temporarily laid aside.

Then the crown sutures of silkworm gut are put in from the skin surface just as they usually are done, slanting downward and backward; but the rectum should not be entered, as sometimes happens, unless one feels in the rectum with a gloved hand. It is well to pull the wound well forward with the sutures before tying, to see that the perineum is well cared for; then they are tied. The catgut suture that was stopped at the opening of the vulva is then picked up and with a continuous suture the denuded surfaces are brought into apposition and the suture continued down the skin.

If the rectum has been torn, the sphincter ani may be caught and brought together by a silkworm gut suture introduced in the skin just above the rectum, passing through the muscle and out at the other side through the skin. A similar suture just above the mucous membrane of the rectum, introduced from the skin, passing around the tear in the rectum and coming out on the skin of the opposite side, will draw the mucous membrane down like a purse-string.

When the sewing is aided by a good light the result is well-nigh perfect.

The continuous suture brings the denuded and torn surfaces so close together that there is no seeping of lochia or of infectious material and the muscle sutures have a chance to hold.

26 North Laurel Street.

EARLY PARESIS

IMPORTANCE OF ITS RECOGNITION; DIFFERENTIAL DIAGNOSIS; MEDICOLEGAL CONSIDERATIONS

ALFRED GORDON, M.D.

PHILADELPHIA

The clinical picture of paresis in the period of its full development is so characteristic and typical that its recognition presents no difficulty in the large majority of cases. The same cannot be said of the prodromal, or earliest stage of the disease, in which the symptoms may be so slight that they can easily be overlooked. Although from its very onset the affection is insidious and slow, it is invariably progressive in its evolution. In some cases the process may be so slow that the earliest manifestations are not recognized and proper measures are neglected, which may lead to deplorable consequences. The patient is permitted and even encouraged to be at large, to travel, to exercise, to undertake great enterprises, to teach, to transact business, to govern and even to make laws. It is only when grave and irreparable errors are committed that attention is drawn to the patient's condition and alarm is sounded.

As an illustration I shall cite the case of a young man who was addicted to venereal excess for several