REPORTS
ON
MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

ROYAL INFIRMARY, NEWCASTLE-ON-TYNE.

PROCIDENTIA UTERI IN A GIRL AGED 17: VENTRIFIXATION.

(By THOMAS OLIVER, M.D., F.R.C.P., Physician to the Infirmary.)

History.—A healthy-looking girl, aged 17, came under my care on November 7th, 1899, complaining of a "fall of the womb." At the age of 13 she went into domestic service. The family consisted of six, there being four grown-up sons. The wife was an invalid, and was confined to bed. The patient had to do the house-cleaning, cooking, washing, and waiting upon her mistress. The work was very heavy, frequently continuing from 7 A.M. until 11 P.M. Despite this she remained in her situation for two years and a-half. After being three months at service she commenced to menstruate, and some little time afterwards experienced uneasy sensations in the lower part of the abdomen. At the age of 14 she felt a swelling in the vagina which all but protruded through the orifice. This remained very much the same until nine months before admission, when after putting in a load of coals the mass appeared outside the vulva. Menstruation was regular for the first few months, when it ceased altogether without any apparent cause or injury to health, and was absent for nearly a year. Since then it has been regular, the loss being rather considerable. There has been no trouble with the bowels nor bladder other than the inconvenience and sense of dragging associated with the procidentia.

Condition on Admission.—The uterus projected 3 inches beyond the vulva; the os was well defined; the mucous membrane of the cervix was dry and wrinkled, and there was a small ulcer just to the right of the entrance into the womb. She was able to replace the uterus herself, but it came down again when she began to walk about. The sound while slightly caught at the internal os, passed into the uterus in a backward direction to half an inch beyond the bend. After replacing the uterus the vagina was found to be extremely roomy, and capable of receiving a large-sized apple. Lying in Douglas's pouch on the left side could be felt a rounded body, tender on pressure, apparently a prolapsed and enlarged ovary. There were no signs of hernia. The right kidney was slightly enlarged and mobile. The heart and lungs were healthy.

Operation.—The case was clearly not one for the use of pessaries. The age of the patient, the toneless condition of the vagina, the extremely relaxed condition of the uterine ligaments, and the fact that the girl had to work for her living, all pointed to surgical rather than mechanical treatment as being the more appropriate. Accordingly I asked my colleague, the late Mr. Williamson, to perform ventrifixation of the uterus. This he did by the ordinary method, stitching the womb to the internal surface of the abdominal wall. The patient made an excellent recovery.

Remarks.—Dr. J. D. Duncan reported in the BRITISH MEDICAL JOURNAL, February 18th, 1899, the case of a girl aged 16 years, who was suffering from complete prolapse of the uterus, and was successfully treated in the Cumberland Infirmary, Carlisle, in a manner similar to that which I have mentioned. In his case, as in my own, the interesting points are the youth of the patient, and the fact that each was a nullipara, and was engaged in domestic service. No such strain as that caused by pregnancy had been brought to bear upon the pelvic floor. My patient had been exposed to the hard work and heavy lifts, the long hours and drudgery, of a general servant. I have had no experience of the treatment of prolapsus uteri by the injection of a solution of quinine into the broad ligaments, recommended by Parsons, and as my experience of the treatment of the displaced uterus by shortening the round ligaments has not been satisfactory, I preferred recommending ventrifixation of the organ, which on this as on previous occasions but in older patients has been most successful.

REPORTS OF SOCIETIES.

OBSTETRICAL SOCIETY OF LONDON.

ALBAN DORAN, F.R.C.S., President, in the Chair.

Thursday, July 5th, 1900.

PORRO-CÆSAREAN HYSTERECTOMY.

Dr. AMAND ROUTH read a paper entitled Porro-Cæsarean Hysterectomy with Retroperitoneal Treatment of the Stump in a Case of Fibroids Obstructing Labour; with Remarks upon the Relative Advantages of the Modern Porro Operation over the Sänger-Cæsarean in most other Cases requiring Abdominal Section.

When the patient was first seen the pelvis was occupied by a large fibroid, and the cervix uteri was out of reach above the symphysis. During the thirty-fourth week the pelvic fibroid was rather suddenly drawn up out of the true pelvis; as it was found that the head was arrested just above the lower segment of the uterus by two opposing fibroids, a Porro-Cæsarean operation was performed, in preference to a panhysterectomy or to Cæsarean section with removal of the appendages. When the abdomen was opened in the middle line, the left broad ligament came into view, with the largest fibroid on its right. The incision into the uterus had therefore to be made posteriorly to the left broad ligament, and was directly over the placental site. The placenta was stripped off, the membranes incised, the child extracted, the placenta and membranes removed, and the uterus brought out through the abdominal incision. The operation was then completed by Baer's method. Both mother and child had an uneventful recovery. The author said it was a point worthy of discussion whether supravaginal amputation of the uterus (Porro's operation), with retroperitoneal treatment of the stump, was not safer for the patient in skilled hands than a Sänger-Cæsarean section with sterilisation in all cases of permanent obstruction to labour requiring abdominal section, except perhaps those due to cancer of the supravaginal cervix. When it had been decided that a viable child had to be delivered from a living mother by abdominal section, all cases would resolve themselves into three groups: (1) Those where hysterectomy (Porro, or panhysterectomy) with retention of one or both ovaries was absolutely indicated; (2) those where a Sänger-Cæsarean operation (with or without sterilisation) was absolutely indicated; (3) those capable of being treated by either operation. It was agreed that a Porro (or panhysterectomy) was absolutely indicated in the following cases: Obstructing fibroids, cicatricial stenosis of the vagina where the lochia cannot escape, septic endometritis, decomposed fœtus (osteomalacia owing to the fact that removal of the appendages was often curative), uterine hæmorrhage from uterine inertia during Cæsarean section, after much previous manipulation of the uterus in attempts to extract *per vaginam*. Sänger-Cæsarean section without sterilisation was, on the other hand, absolutely indicated, instead of a "Porro," where it was considered desirable for the woman to have a chance of another child; and Sänger-Cæsarean section with sterilisation was required (?) in cases of cervical cancer, when the supravaginal cervix was involved. There only remained, therefore, a third group of cases where a Cæsarean section with sterilisation was usually done, but where it would, in Dr. Amand Routh's opinion, be quite as reasonable to do a modern "Porro." This third group included all cases of sufficient pelvic contraction, and it was in such cases that the relative value of a modern "Porro" operation as compared with a sterilising Sänger-Cæsarean operation demanded serious consideration.

Dr. GALABIN preferred to call the operation performed by Dr. Routh a Baer-Cæsarean, or simply a Cæsarean hysterectomy, as the original operation of Porro was hysterectomy with the uterine stump fixed in the abdominal wound, instead of being covered by peritoneum and dropped into the abdomen as Dr. Routh had done. He thought the best operation had been done, and had performed a Porro's operation in a similar case five years previously. He did not think pregnancy added to the difficulties of such a hysterectomy, and was led by this experience to recommend it as the best operation when fibroids obstructed labour, and also as an alternative to the ordinary Cæsarean section apart from fibroid tumours. In several other cases of pelvic fibroids complicating pregnancy, he had found that the fibroids became elevated during the first stage of labour, and had enabled forceps to be used to complete delivery. He asked Dr. Routh whether there was much hæmorrhage before the ovarian and uterine arteries were tied, and whether the elastic ligature was used.

Dr. WILLIAM DUNCAN believed that abdominal hysterectomy with intraperitoneal treatment of the stump was much less dangerous than any Cæsarean section, except in cases of cancer of the cervix, where he would prefer to treat the stump extraperitoneally. He preferred to leave both ovaries instead of only one, as he had several times noticed that when one ovary was removed various unpleasant "menopause" symptoms supervened, although never so severely as when both ovaries had been removed.

Dr. P. HORROCKS preferred to speak of Cæsarean rather than of Sänger-Cæsarean section, because the evolution of asepsis had led many operators to abandon Sänger's main improvement, which was to sew the peritoneum completely over the deep

sutures. Although he believed that Dr. Routh had done quite the best thing in his case, he did not think it was possible to formulate rigid rules for all cases, for it often happened that it was found best to do something quite different from what was intended before the operation was begun. Speaking generally he preferred Cæsarean section to Porro, sterilising the patient by snipping half an inch out of the middle of each Fallopian tube. This operation was, he considered, easier and safer for the patient. If possible he always left both ovaries when performing hysterectomy, although he had never found that climacteric atrophic changes ensued if only one were left behind.

Dr. W. R. DAKIN believed that if one ovary were left behind after hysterectomy the effect was the same as if both were left. He agreed with Dr. Routh that the woman escaped certain risks if the uterus was removed instead of being merely sutured and the patient sterilised, and alluded especially to the risks of infection of the peritoneum through an imperfectly-sutured wound, and of adhesions between the uterine and abdominal wounds which might cause strangulation of the bowels. If the woman wished to have a family, all members of which were to be delivered through the abdominal wall, it was another matter. He had observed no greater shock after supravaginal hysterectomy in these cases than after an ordinary Cæsarean section, but agreed that it was wise not to decide how the operation was to be finished till the child was actually extracted from the incised uterus. He had recently operated with successful results to both mother and child, where the true conjugate was only $2\frac{3}{4}$ ins. In a previous pregnancy labour had to be induced at the sixth month. The patient agreed to an abdominal operation but wished at the same time to be sterilised. At the operation, after extracting the child, he found the uterine vessels were standing out so clearly and were so easy to ligature, that he decided it would be a much shorter procedure to remove the body of the uterus, treating the stump by the retroperitoneal method, than to suture the uterine wound and to ligature and excise a part of each tube. He thought this would be the decision most often arrived at under similar circumstances.

Dr. HERBERT SPENCER agreed that the best operation had been done in this case, and he had himself performed Porro's operation under similar circumstances eight years ago. While the intra-abdominal treatment of the stump shortened the convalescence and lessened the risk of hernia, it did not always prevent septic peritonitis by infection of ligatures through the vagina (Klotz), nor the risk of adhesion of bowel to the seam causing intestinal obstruction, which had occurred in one of his own cases. He did not consider that Porro's operation should be done in all cases of permanent obstruction, such as contracted pelvis. He much preferred the conservative Cæsarean section. He would, however, have nothing to do with sterilisation by tying or cutting the tubes, which, besides exposing the patient to additional risks, was very unreliable in its effects, and was at least debateable from the moral standpoint. The conservative Cæsarean section was a very successful one and left no stump for intestines to adhere to, the wound in the puerperal uterus lying up against and becoming adherent to the abdominal wall, so that in a subsequent operation the peritoneal cavity was sometimes not opened at all. He had recently performed Cæsarean section under local anæsthesia upon a patient whom he had delivered by Cæsarean section twice previously. As both the children previously thus delivered had subsequently died, the advantage to the mother of having a third and this time a very healthy child was obvious. He had also successfully repeated Cæsarean section in another case.

Dr. COLLINGWOOD ANDREWS had had opportunities of comparing the progress of cases of hysterectomy during pregnancy where both the extraperitoneal and intraperitoneal methods of treating the stump had been adopted, and greatly preferred the latter method.

Mr. A. C. BUTLER-SMYTHE thought that the operation performed by Dr. Routh was only possible in a hospital, or where skilled assistance was obtainable. Wherever a Porro's operation was required, as in cases of fibroids, he considered the retroperitoneal treatment of the stump far preferable to the old method, but he would leave the precise details of the operation to be decided when the abdomen was opened, and the child extracted. That was also the time to consider whether the woman should be allowed to run the risk of another pregnancy.

Mr. J. H. TARGETT said he considered that a non-sterilising Cæsarean section was very rarely justifiable, while between a supravaginal hysterectomy and a Cæsarean section with sterilisation, the balance would usually be in favour of hysterectomy, because it would be more rapidly performed, and prevented the risk of hæmorrhage and subsequent sepsis. When the pregnancy was complicated with fibroids the advantages of supravaginal hysterectomy were obvious.

As evidence of an additional risk in the after-history of cases where Cæsarean section without sterilisation had been done, he showed a specimen of a uterus which he had removed from a woman who had had Cæsarean section performed by him two years and a-half previously for impacted shoulder presentation. When readmitted she was in a state of collapse, and when the abdomen was opened, the child and placenta were found free in the peritoneal cavity, and there was a large rupture in the anterior uterine wall along the scar of the previous operation. The patient fortunately recovered.

The PRESIDENT believed that the retroperitoneal operation was best, provided that, as in the present case, the obstetrician had already performed it more than once on non-pregnant subjects, and in hospital practice with plenty of assistance. Country practitioners with large midwifery practices, but without experience of abdominal section, had, as in a case within his own knowledge, had excellent results after the old Porro-Cæsarean operation, which was easy and could be done quickly. On that account Lepage performed the old operation in a hospital on a case of labour at term, complicated by fibroids, where there was free hæmorrhage, saving mother and child. Weiss and Schuhl reported the removal of the uterus in two cases of spontaneous rupture during labour occurring in a hospital. In one case the elastic ligature and pins were used, and the patient recovered; in the second, which was lost, the retroperitoneal operation was undertaken, but this case was septic. Panhysterectomy had the disadvantage of being yet lengthier than retroperitoneal hysterectomy.

Dr. AMAND ROUTH, in reply, agreed that the nomenclature was not altogether satisfactory, but thought that all cases of hysterectomy during late pregnancy (except panhysterectomy) were of the nature of a "Porro," the treatment of the stump being a detail capable of many renderings. He did not consider that the old "Porro" operation was suitable for cases of advanced cancer of the cervix, owing to the great strain on the friable supravaginal cervix, which would almost certainly give way. He did not think it made any difference to the patient's after-history whether one or both ovaries were left. Most of the speakers had, with certain reservations, approved of his view that hysterectomy was in most cases preferable to Cæsarean section with sterilisation, and, as the President had stated, if haste was essential the old "Porro" was indicated, otherwise the modern retroperitoneal hysterectomy. Dr. Herbert Spencer's contention that, wherever possible, Cæsarean section without sterilisation should be performed, so as to allow another pregnancy to occur, was not in his opinion justifiable. The patient might at full term be far away from skilled assistance, and would, moreover, run all the risks mentioned in his paper, both during the puerperium and subsequently. The adhesions which Dr. Spencer stated occurred between the uterine and abdominal incisions constituted one of the dangers, and involved the risk of intestinal obstruction. He preferred catgut to silk for suturing the muscle of the stump, owing to its quicker absorption, which therefore caused a smaller chance of subsequent infection. He had not found the elastic ligature necessary, but had quickly tied or clamped the uterine vessels.

SPECIMENS.

The following were shown:—Dr. G. F. BLACKER: Frozen sections of an early (ten weeks) pregnant uterus.—Dr. PETER HORROCKS: A pregnant uterus with fibroids, removed at the fifth month by abdominal hysterectomy.—Mr. J. H. TARGETT: A pregnant uterus ruptured at full term through the scar of a previous Cæsarean section, removed by abdominal hysterectomy.—Dr. AMAND ROUTH: A pregnant uterus with fibroids, removed at full term by abdominal hysterectomy.—Dr. WILLIAM DUNCAN: Multiple myxomatous polypi from cervix uteri.

ASSOCIATION OF REGISTERED MEDICAL WOMEN.—At a meeting on July 3rd Mrs. SCHARLIEB, M.D., M.S., President, in the chair, Miss GOUGH, L.S.A. (China), sent a short report of a midwifery case presenting unusual difficulties in delivery,

owing to the large size of the child.—By kind permission of Dr. JOHN TURNER (Essex County Asylum, Brentwood), Miss DE STEIGER, M.B., showed some lantern slides of preparations of various cases of cortical disease, specially illustrating the "Nissl" bodies found *post mortem* in the large cells of the cortex of the brain.—Miss ELLABY, M.D., showed some slides illustrating different stages in the development of the eye, also some of glaucoma, and other diseases of the eye.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

G. ANDERSON CRITCHETT, M.A., F.R.C.S.E., President, in the Chair.

Friday, July 6th, 1900.

"HOLES" AT THE MACULA.

MR. F. M. OGILVIE read a paper on one of the results of concussion injuries of the eye—"holes" at the macula. He had collected all the published cases presenting this lesion, and he divided them into two large classes: (*a*) those in which there was no detachment of the retina, and (*b*) those in which detachment was present. He showed lantern slides of the appearances of the fundi in all these cases which invariably followed concussion injuries, such as blows from blunt objects, from stones thrown from catapults, while one most interesting case he had previously shown to the Society in which the injury was due to a bullet which apparently hit the back of the eye in passing through the orbit. He advanced several theories to account for the holes which, as a rule, were about 1½ dioptre in depth. He summarised the conditions brought about as follows: (1) The lesions are definite and central; (2) they are the direct result of violence; (3) the injuries are permanent; (4) the general disturbance of vision is not great; (5) they are the result of concussion injuries only.

Mr. ADAMS FROST endorsed all that Mr. Ogilvie had said regarding the appearance of the lesion, and in view of the fact that no case had as yet been examined pathologically he suggested that possibly a similar condition might be brought about by a like injury in the eyes of animals or in eyes recently excised.

OPTIC NERVE TUMOUR PREVIOUSLY REPORTED.

Mr. C. DEVEREUX MARSHALL read some further notes of a case reported to the Society in November, 1899. The patient was a woman, aged 46, upon whom he operated at the request of Mr. Poulett Wells on November 30th, 1897, when the contents of the orbit were thoroughly removed. She remained in very fair health until shortly before her death, which took place on May 4th, 1900 (2½ years later). Owing to the kindness of Mr. Austin Reynolds, who attended her up till the time of her death, which occurred very suddenly, Mr. Devereux Marshall was enabled to obtain a *post-mortem* examination. The necropsy was made on May 6th, and the following was the condition found:

On removing the calvaria the middle meningeal vessels were found to be distended, and the Pacchionian bodies very large. The cerebral convolutions were very much flattened. The optic chiasma had entirely disappeared and its place was occupied by a large diffuse and very soft tumour, about the size of a bantam's egg. So soft was it that its actual limits could not be defined, and the greater part of it could easily have been washed away with a moderately strong stream of water. The centre of the growth was the right optic tract, and it spread along the chiasma, involving the optic tract and optic nerve on the left side, both of which were considerably enlarged. The tumour reached the pons on both sides, invaded the lateral and third ventricles, and on the left side the optic thalamus and corpus striatum. The growth was so very diffuse that it appeared that the third, fourth, fifth, and sixth nerves on both sides were more or less included in it. On both sides the under surfaces of the temporo-sphenoidal lobes were invaded. The tumour was still further broken down by recent hæmorrhage in the vicinity of the left optic tract. No separate deposits were found in the brain, and the growth had evidently spread by continuity only. In the thorax nothing abnormal was found, except that the mitral valve was very much thickened. In the liver a few cysts were found containing clear fluid, but it was otherwise healthy, and there was no sign whatever of any new growth. The spleen, pancreas, and uterus were free from disease, but the kidneys were slightly granular, and the capsule tore the kidney tissue in separating. The aorta was somewhat atheromatous. The microscopical appearance of the growth closely resembled those of the original nerve tumour. The main substance of it was made up of a network of irregular branching cells, in which were small spaces mostly circular, similar to those described as being present in the original nerve tumour, and which were thought to be channels from which the nerve fibres had disappeared. Seeing that this also was a growth mainly involving the medullated nerve structures, probably the same explanation of the spaces held good. Here and there in the growths were strands of a dense fibrous tissue in which blood vessels were seen in section.

Briefly, the neoplasm seemed to be due to an immense overgrowth of the connective tissue framework of the nerve, mainly the neuroglia, but also of the more fibrous prolongations from the pial sheath. The optic nerve on the opposite side was much enlarged, and on examining it microscopically the sections were seen to present precisely similar appearances to those of the right nerve, which was described in the first paper. Mr. Devereux Marshall added that in the last volume of the *Transactions* would be found a paper by Bullar and himself, the basis of which was a case of optic nerve tumour somewhat similar to the one described that evening, and at the present time (three years after removal) the patient was alive and well. In that paper the question of prognosis was fully discussed, and the conclusion arrived at from published cases was that the disease, although of not a very malignant type, could by no means be considered innocent, and it was advisable to remove it as thoroughly as possible. This remark was justified by the present case, which, although removed as completely as possible, yet the nerve was affected further back than the orbit, and this was of course the way by which the growth reached the brain.

PSEUDO-GLIOMA.

Mr. PERCY FLEMMING read a paper on three cases of ophthalmitis (pseudo-glioma) in children.

Case I recovered after a four months' illness, the main symptoms being irregular pyrexia, vomiting, head retraction, and diarrhœa. There was a history of convulsions and ear discharge, but no history of syphilis or acute specific fever. Case II died with typical posterior basic meningitis and pus in right middle ear. (This patient had an attack of chicken-pox four weeks after the eye became affected.) Case III died after an illness very similar to Case I, and *post mortem* was found to have basic meningitis; middle ear healthy.

These cases, considered in relation with others published, might be taken to indicate that meningitis was the common cause of this particular form of ophthalmitis, and, further, that middle-ear disease was a likely cause of the meningitis. The following objections were urged against this view: (1) The fact that these cases in children rarely ended fatally; (2) pseudo-glioma was a rare complication of posterior basic meningitis, as was also optic neuritis; (3) the usual unilateral character of the affection. Mr. Flemming considered that the eye condition was part of a septicæmic or pyæmic process, which in most cases was limited to the eye, such cases recovering; whilst in others the meninges might be affected by the same process, these cases terminating fatally. The otitis might be the starting point of the infection, and in any case of ophthalmitis (pseudo-glioma) it was most important to have the ear examined, and even to puncture the membranes though apparently healthy.

ALVEOLAR CARCINOMA OF EYELID.

Mr. KENNETH SCOTT and Mr. JOHN GRIFFITH read a paper on a case of alveolar carcinoma of the eyelid, which was removed from an Egyptian. The specimen on examination proved to be a carcinoma of the Meibomian glands.

CARD SPECIMENS.

The following were shown:—Mr. E. W. BREWESTON: Case of pseudo-glioma.—Mr. W. T. HOLMES SPICER: Sections of conjunctiva from a case of spring catarrh.—Mr. W. H. JESSOP: Tuberculous ulceration of the conjunctiva.—Mr. W. ADAMS FROST: Peculiar crescentic opacities in the cornea.—Mr. TREACHER COLLINS: A case of congenital notch in each lower lid with defective development of the malar bones.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

ALEXANDER G. MILLER, M.D., F.R.C.S.E., President, in the Chair.

Wednesday, July 4th, 1900.

RESIDUAL URINE IN CASES OF ENLARGED PROSTATE.

THE PRESIDENT read a clinical note on this subject. He said there was no harm in an enlarged prostate *per se*; the danger lay in accumulation of residual urine, and in what that might lead to. He gave notes of a case, a medical man aged about 70, with enlarged prostate, and residual urine to the amount of three ounces. He advised the patient, after making water, to try again, so as to make sure of emptying the bladder. The result was a decided improvement in every way. He practised making a second effort thrice daily. He had seen equally successful results in other cases. The argument:

How does residual urine occur? (1) There is some obstruction to the flow. (2) The bladder tone is not so good in old men. (3) There is an indisposition to make an effort to empty the bladder. The cause of residual urine was far more frequently neglect rather than inability to empty the bladder. This, of course, was in early cases. The practical deductions from this were: (1) Residual urine was due at first to neglect to empty the bladder. (2) Accumulation of urine was due to this becoming a habit. The advice he gave to old men with enlarged prostate, and commencing residual urine, was, after passing water in the usual way (without effort), try again after a minute or two. Let this be practised as frequently as possible till only a small quantity can be squeezed out, say one drachm. When that point had been reached once or twice daily would suffice. By doing this a habit of emptying the bladder would be acquired, and the accumulation of residual urine probably prevented, and the evil day of catheterism postponed.

PARALYSIS OF THE VERTICAL MOVEMENTS OF THE EYE, WITH CONSERVATION OF THE LATERAL CONJUGATE DEVIATION.

Dr. ALEXANDER BRUCE read notes of a case of paralysis of the upward and downward movement of both eyeballs without ptosis and with conservation of the lateral conjugate deviation of both eyes, as well as of the power of convergence.

This condition was associated at first with a tendency to fall directly backwards, when the patient was placed in the erect position or made to sit erect in bed. Subsequently a progressively-increasing torpor ascribed to an accumulation of fluid in the ventricles from closure of the aqueduct of Sylvius developed. A *post-mortem* examination revealed a small vascular tumour growing from the grey matter round the aqueduct of Sylvius, and projecting to about the size of a bean into the third ventricle. The tumour had also grown in a downward direction in the substance of the Sylvian grey matter as far as the level of the posterior corpora quadrigemina. A small similar tumour was found growing from the left septum lucidum into the lateral ventricle, and there was a considerable excess of fluid in the lateral ventricles.

The symptoms were evidently, in so far as the eye was concerned, to be ascribed to the gradual involvement of the third nuclei, and to the absolute escape of the sixth nuclei, which were remote from the causal lesion. The escape of the elevators of the lids, as well as the almost complete escape (until almost the end of the progress of the case) of the internal muscles of the eye and of convergence was remarkable. The tendency to fall, or more strictly speaking to bear, backwards was constant during the patient's stay in the Royal Infirmary, and was very difficult to explain. It might have been due to the pressure of the tumour on the walls of the third ventricle, to which equilibrating effects have been ascribed by Hamilton and others.

LANDRY'S PARALYSIS.

Dr. ALEXANDER JAMES made a communication on this subject. The influenza organism affected injuriously practically all the systems of the body, and when it affected the nervous system it could bring about a manifestation of one or other of practically all the symptoms of nervous-system disease. Oculo-motor paralysis, one used to be told, wherever it was found, must be ascribed to syphilis. That judgment must be modified since we had made the acquaintance of influenza. During the past winter and spring Dr. James had seen in 3 cases the effects of the action of the influenza poison on the nervous system in a way which he had never seen before, in inducing a rapidly-progressive paralysis of limbs and trunk from below upwards, in the manner described as Landry's paralysis. He described one of these cases in detail:

A housekeeper, aged 23, residing in London, but on a visit to friends in Edinburgh, was admitted to Ward 23 of the Royal Infirmary on January 31st, 1900, complaining of pains in the head and back. She looked very ill, was at times delirious, and she had been ailing for two weeks. Bright's disease, heart disease, and insanity were points in her family history. Her work was not too hard, and her surroundings were comfortable. She had influenza in May, 1899, but made a good recovery. Before admission to hospital she had become very weak, very sleepless, calling out continuously and apparently meaninglessly, and required constant attendance. On admission, her temperature was 103°, pulse 130, regular, and of fair strength, respirations 22. She would not answer questions, but kept moaning and crying out. She lay on her back and did not move either arms or legs; the urine and fæces were being passed almost involuntarily. Cutaneous sensibility to touch and pain was little impaired. The pupils were dilated. Voluntary motor power in arms and legs was lost, and the muscles were flaccid. There seemed no diaphragmatic paralysis. Cheyne-Stokes breathing was present save when she was deeply asleep. Superficial and deep reflexes in legs and trunk were absent. Swallowing was becoming impaired. She complained of a lump in her throat, and of pain behind the sternum on one of the occasions when she responded to questions. At 8 P.M. on the day of admission she appeared rather better; the temperature was 99.4°, and the pulse 130. Shortly after this curious nodding and shaking movements of the head occurred, and she began to cry out "murder." Digitalis and chloral were given, and she soon fell asleep, and awoke at 11 P.M., expressing herself as better. She looked more sensible. She went to sleep again, and about 1 A.M. the nurse observed that her breathing was very quiet. She died quietly a few minutes after.

Dr. ROBERT A. FLEMING described the *post-mortem* appearances in Dr. James's case. There was some bronchopneumonia limited to the root of the left lung. There was cloudy swelling of liver and kidneys, and the spleen was acutely congested. The brain was œdematous, and the grey matter of brain and cord was congested. Microscopic examination showed: (1) Tracts in cord and nerve roots unaffected; (2) marked engargement of blood vessels, and many minute hæmorrhages in the anterior cornua of the cord and in the medulla; (3) the multipolar cells in the cord were mostly atrophied and stained deeply with basic dyes, especially so the cells in the lumbar and cervical enlargements; (4) many of the nuclear cells in the medulla were swollen, showed eccentric position of nuclei and chromatolysis, and the cells stained faintly and homogeneously. The peripheral nerves were not examined.

CASES AND SPECIMENS.

Dr. NORMAN WALKER showed two cases of late syphilides, and a case of ringworm of the ear.—Mr. DOWDEN showed a boy of 5 after operations for tubercle of upper ulnar epiphysis.—Dr. LOGAN TURNER showed a case of asthma associated with chronic suppuration in the left frontal and maxillary sinuses.—Dr. WILLIAM RUSSELL showed a case of myxœdema in a man of 58.—Dr. W. RUSSELL showed (1) the brain from a recent case of aphasia and hemiplegia. There was a cyst in the left hemisphere due to an embolism. (2) The brain and heart from a case of long-standing aphasia and hemiplegia due to thrombosis.—Dr. PEARSON for Dr. GEORGE GIBSON showed (1) a patent ductus arteriosus from a patient who died of pneumonia; and (2) microscopic specimens of the filaria sanguinis in the proboscis of the mosquito.—Dr. HARVEY LITTLEJOHN showed (1) traumatic rupture of heart unaccompanied by external signs of injury or fracture of ribs; (2) two stomachs from cases of carbolic acid poisoning; (3) a liver and *post-mortem* digestion of stomach and uterus from a case of acute yellow atrophy. The patient, a young woman, died thirty-six hours after delivery of an illegitimate child, and there was the question whether the case was not one of phosphorus poisoning.—Dr. R. A. FLEMING showed (1) tuberculous pericarditis; (2) hearts with patent foramen ovale; (3) fatty degeneration of the heart.—Dr. BRUCE showed the brain from a case of aphasia with right hemiplegia. The patient understood what was said to him, spoke volubly and unintelligibly, had no word deafness, but was entirely word blind and retained the power of tune. There was softening along both margins of the Sylvian fissure, in the island of Reil, and in Broca's convolution.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

A. V. MACAN, M.D., President, in the Chair.

Friday, May 25th, 1900.

SPECIMENS.

DR. ALFRED SMITH showed a specimen of ruptured tubal pregnancy removed from a patient aged 33, who had given birth to a full-term child six months previous. Menstruation returned one month after confinement, and continued regularly up to time of rupture.—Dr. SMYLY read notes on a case of ectopic gestation and exhibited the specimen.

PANHYSTERECTOMY AT FULL TERM.

Dr. KIDD described a successful case of panhysterectomy performed on the pregnant uterus at full term.

A primipara, aged 40, was admitted to the Coombe Hospital, at 9.30 P.M. on January 14th, 1900. She had been in labour from early on the preceding day. The medical men in charge could not reach the presenting part owing to the whole of the true pelvis being blocked with myomatous growths. When examined some presentation like an arm could just be touched, but no definite diagnosis could be made. She was much exhausted, her pulse was 120, her temperature only 98°, and she had vomited. There was no fœtal heart to be heard, and she had felt no movement for some time before admission. An abdominal incision was made, extending from 2 inches above the pubes to 2 inches above the umbilicus. The broad ligaments were first ligated, and then cut, then the round ligaments, then the peritoneum on the outer surface of the uterus was divided transversely and stripped down, taking the bladder with it; the uterine vessels were tied, and when the peritoneum had been stripped down posteriorly the vagina was cut across, as close to the presenting head and arm as possible. The vagina was inverted and sutured, turning in the mucous membrane, the broad ligaments were brought together, and in the middle line the peritoneum attached to the anterior surface of the bladder was sutured to the peritoneum on the posterior wall of the vagina, completely covering over the stump of the vagina, and leaving the pelvis quite clean and dry; the ligatures on the uterine vessels were drawn down before the peritoneum was stitched over them. Convalescence was uninterrupted. Her temperature at no time exceeded 100 4°.

After Dr. Macan and Dr. Smyly had made some remarks, Dr. Kidd replied.

The Dublin Method of Effecting the Delivery of the Placenta.

Dr. Henry Jellett read a paper on this subject, in which he maintained that the method of obtaining the delivery of the placenta by external manipulations as opposed to its manual removal or its delivery by traction in the funis, was originated in Dublin; that Credé's method when originated in Germany was identical in principle with the Dublin method, and that it rapidly came to assimilate itself to the Dublin method in its most important details; that, consequently, there was no difference between the Dublin method and Credé's method, and that inasmuch as the method originated in Dublin many years before the time that Credé discovered it for himself, its name was and ought to be "The Dublin Method."

Dr. Smyly thought that there was a distinction between Credé's method and the Dublin method. The fault of Credé's method was that it was too active, and if they expelled the placenta too soon they might leave portions behind leading to *post-partum* hæmorrhage and subinvolution. As Professor Spiegelberg had said, the Dublin method was superior because it was not so active, as it waited till the placenta had been expelled from the uterus, and it then expelled it from the vagina.

Dr. Cole-Baker took exception to the word "pressure," which was a vague term. Once the placenta had left the uterus it could not be called a method of expression. If they pushed the uterus down, and thereby pressed out the placenta, it was a method of detrusion, not expression.

Dr. Macan wished to emphasise the fact that the Dublin method began before the third stage of labour, namely, the moment the child's head was born. He was convinced that in the great majority of cases the third stage of labour should be left alone as well as the second stage.

Dr. Jellett, replying, said he had purposely omitted any reference to anything before the third stage, because there was an impression that the Dublin method included not only getting rid of the placenta, but also expelling the child.

West London Medico-Chirurgical Society.—Officers and members of Council for 1900-1901:—*President:* Dr. F. F. Schacht. *Vice-Presidents:* Dr. Seymour Taylor, Dr. Neville Wood, Dr. F. J. McCann,* Dr. F. H. Low,* Mr. C. Andrews,* Dr. J. A. Coutts,* Dr. J. Crombie,* Dr. S. A. Bontor.* *Council:* Mr. F. R. Mallard, Mr. F. Savery, Mr. E. Bartlett, Dr. D. R. Pearson, Mr. G. E. Twynam, Mr. H. W. Chambers, Mr. G. D. Robinson,* Mr. H. Webb,* Dr. T. R. Atkinson,* Mr. S. W. Fincham, Dr. A. Baldock, Mr. M. H. Taylor. *Treasurer:* Mr. T. Gunton Alderton. *Secretaries:* Dr. G. P. Shuter, Dr. Leonard Dobson.* *Librarian:* Mr. C. B. Keetley. *Editor of Journal:* Mr. H. Percy Dunn. *Editorial Secretary of Journal:* Mr. McAdam Eccles.

* Did not hold similar office last year.

REVIEWS.

RECENT WORKS ON THE NATURE AND TREATMENT OF DIABETES MELLITUS.

The Clinical Experiences of the late Professor Külz.

By the lamented death of Dr. Külz in his 50th year, the medical profession was deprived of an indefatigable worker, and those interested in the subject of diabetes lost a collaborator who had already given to the world many evidences of his industry and originality, from whose growing experience much more was to be hoped. It was known that Dr. Külz had been accumulating for many years a valuable series of cases dictated by himself and carefully studied throughout the time they were under observation. This valuable material was placed by Külz's widow at the disposal of Professor Rubner, and after some consideration Professors Rumpf and Sandmeyer and Dr. Aldehoff, all of whom had been closely associated with the late Professor Külz during his life, undertook to edit the series for publication. As it was obvious that no publisher would undertake a book which consisted merely of a series of cases, however carefully compiled, these have been in the first place shorn of all redundancies and arranged in four groups. Then these groups have been analysed and critically considered under various aspects by the editors, so that the work as now published[1] is a valuable manual of the clinical history of diabetes, and a store of information upon many interesting points.

Grouping of Cases.

In dividing the cases into groups, the editors recognise that they are departing from Külz's doctrine of the indivisibility of diabetes, but we believe most readers will regard their reasons as sufficient. The four groups are: (1) Those passing no sugar on strict diet; (2) those passing no sugar or merely traces on strict diet, but with evidences of kidney disease (albuminuria); (3) cases still passing sugar on strict diet; (4) transition cases. The total number of cases dealt with is 692, of whom 526 were males and 166 females. It is quite impossible in the space of this review to do justice to a tithe of the subjects discussed by the editors; we can only pretend to draw attention to a few special points. We are told that Dr. Külz was fond of ridiculing the practice of speaking of a diabetic as passing so much per cent. of sugar, which, he said, was as foolish as for a man to say that his income consisted of so much per cent. in the funds. The only proper method of thinking about the amount of sugar excreted is the total quantity eliminated in twenty-four hours.

Group I.—Sugar Eliminated by Strict Diet.

By many careful examinations of the cases in Group I, which it may be remembered were rendered free from sugar by strict diet, the effects of the addition of 100 grams of white bread to the breakfast meal was studied in many cases, and it was observed that the resulting sugar excretion never lasted more than six hours, and took place chiefly in the first three or four hours after breakfast. It was also apparent that as a rule patients assimilated carbohydrates better after breakfast than later in the day, but there were exceptions to this rule. It was also found that the same quantity of bread was assimilated better if given in divided portions at three meals than if given all at once at any time. In the various experiments with diet, 100 grams of white bread = 60 grams of grape sugar = 120 grams of black bread = 70 grams of rusk = 300 grams of potatoes = 1½ litre milk = 1½ litre light beer. Many experiments were made to determine whether the capacity for assimilation varied for the different articles of carbohydrate food, the result being to show that there are great individual differences, and that these can only be determined in each case by careful trials. The capacity for assimilation seemed as a rule to diminish by the continued use of carbohydrates, so that from time to time it is necessary to return to restricted diet for short periods. The influence of exercise in favouring assimilation of carbohydrates was very well marked in the patients of this group.

Group II.—Concurrent Renal Disease.

In the second group, where there was evidence of kidney disease, the experiments gave very similar results.

Group III.—Sugar not Eliminated by Strict Diet.

This group comprised the most severe cases in which the strictest diet failed to remove the sugar from the urine. Contrary to the doctrine that a diabetic has lost all power for assimilating carbohydrates, it has been maintained in modern times with much more reason that every diabetic retains the power of assimilating a certain amount of carbohydrate, and it is justly held to be the duty of the physician to determine that quantity so that the patient may not be deprived altogether of these elements of diet. Külz set himself to answer this question, and found that out of 179 cases in this group, only 21 cases, or 11 per cent., gave room to doubt their capacity for assimilating some carbohydrate, and even in these further investigations showed that only four, after treatment and careful regulation of diet, persisted in their incapacity. It is noteworthy that some of the cases in this group got worse on strict diet and improved where a certain amount of carbohydrate was allowed. The individual differences in respect of the assimilation of various sorts of carbo-

[1] *Klinische Erfahrungen uber Diabetes Mellitus* [Clinical Experiences on Diabetes Mellitus]. Von Dr. E. Külz. Jena: Gustav Fischer 1899. (Roy vo, pp. 566. M. 14.)