I was not disappointed in this, and becoming subsequently acquainted with the success of Dr. Bozeman's operation, founded, but greatly improved, upon that of Marion Sims of New York, and having already witnessed one case of complete cure of a large urinary fistula (A. T., case viii, operated on June 10th, Mr. Brown's Pamphlet), on which I had been consulted before operation, I was induced to place this case under Mr. Baker Brown."

The patient was operated on November 1st, 1858, at the London Home, in the presence of Dr. Davis and several other practitioners. The edges of the opening, now reduced at least three-fourths of its original dimensions, extending transversely, situate at the junction of the urethra and neck of the bladder, were first pared, the patient being under anæsthesia. The edges were then brought together by silver wires, silk threads, previously passed through, being used as their conductors, and then removed. The two halves of each wire were then passed through a hole in an oblong plate of lead, suitable to the opening to be covered. This plate was then with a special instrument pressed firmly upon the opening, the wires made tense. A shot, perforated by one aperture, was then passed over the two halves of each wire, pressed firmly up to the plate, and nipped with a well adapted pair of pincers, so as to obliterate the aperture of the shot upon the wire. Thus the plate was fixed securely in its place, and the surplus wire being cut off, the operation was complete. The patient was operated on in the position for lithotomy, and the vagina was well dilated by a special speculum and by tenaculum forceps, held by steady assisting friends. After the operation the patient was placed on her side, with an elastic catheter in the bladder, attached to a caoutchouc tube and bottle; the bowels were constipated by opium, having, previously to the operation, been well opened by aperients. Full diet was ordered.

On the eighth day the plate was removed, and a linear cicatrix was visible in place of the former aperture; no leakage whatever observable.

Two days afterwards, it was evident, that a minute aperture yet remained, and a second operation was performed, from which Dr. Davis was unavoidably absent. The result is, that the cure is now quite complete.

CASE IV. *Vesico-Vaginal Fistula, Five Months Duration: Operations: Cure.* T. C., aged 19, married, was taken in labour on October 29th, and was delivered with forceps on October 31st, after a hard labour. There was a good deal of irritation of the bladder afterwards; and in a few days all her urine came away without any control on her own part, and continues to do so now in all postures alike.

She was admitted into the London Home on December 2nd, 1858. An examination showed an opening of the size of a florin, situated about half an inch from the os uteri. The edges were very unhealthy, having an ash-gray look, and evidently inclined to slough. The whole vagina was very sore and excoriated. She had a good deal of constitutional depression with headache, with tenderness and swelling in the left inguinal region deep in the pelvic cavity, shivering, constipation, and much wasting. She was given decoction of cinchona with dilute nitric acid, generous diet, and opiates at night.

She gradually improved much in general tone, and the vagina became more healed. The edges of the fistula cleaned. The cicatrization of the vagina contracted; and several bands formed which dragged upon the opening. On January 3rd, 1859, she was put under chloroform, and I divided these bands, and plugged the vagina with oiled lint, which was changed every day. This gave much more room.

January 23rd. I performed Bozeman's operation, the patient being placed on her hands and knees, without chloroform. A leaden button and six sutures were used.

January 24th. Some urine had escaped.

January 26th. The pulse 140; the tongue dry. She was ordered to have some blue pill and extract of colocynth.

January 27th. The bowels were well opened, and she was much improved. There was an escape of urine.

From this time she improved in her general health, and on February 4th, I removed the button. The fistula was found to be healed in the middle in such a way as to leave two openings, one the size of a fourpenny piece, and the other of a large bougie. As the vagina was rather irritable, and the general

tone low, she was put upon tonics for a short time previous to another operation.

February 21st. She was placed under chloroform on her back, and I proceeded to operate. I intended to close each opening separately, but as I progressed with the operation, I found it would be much easier to close them under one button. I, therefore, did so with four sutures with a long straight needle carrying the silver wire itself, which I had used in some of my earlier operations, and which in certain cases is easier to use than the short needle in the *porte aiguille*.

She went on very well, and had no escape of urine or any untoward system, and on March 2nd I removed the button, and found the opening entirely closed.

March 7th. She could retain her urine at pleasure. In every respect she was perfectly well.

March 9th. She left the Institution quite well.

17, Connaught Square, Hyde Park, March 1859.

LABOUR COMPLICATED BY RETROVERSION OF THE UTERUS.

By GEO. GREAVES, Esq., formerly Surgeon to the Manchester and Salford Lying-In Hospital, etc.

THE following case may be thought worthy of being recorded, because a mode of treatment, hitherto, I believe, not described, was successfully employed.

On November 17th, 1856, I was requested by Mr. J. R. Chick to see with him a case of labour, rendered difficult, as he believed, by retroversion of the uterus. The patient, Mrs. R., aged 40, was in labour of her sixth child. She believed herself to be about six months advanced in pregnancy. On examination, I found that Mr. Chick's diagnosis was correct. There was, between the posterior wall of the vagina and the rectum, a large rounded tumour, which had already advanced to within an inch of the perineum, and descended still lower with every pain. I had considerable difficulty in finding the os uteri; but was at length able to feel it above the symphysis pubis. I found the os dilated to the size of a half-crown-piece; and through the membranes, which were still entire, I was able to distinguish the head of the child, and to ascertain that the anterior fontanelle was the presenting part. An examination *per anum* confirmed the opinion as the position of the uterus, to which the other phenomena necessarily led; and I thus learned that I had before me the difficult task of delivering a woman, six months gone with child, whose uterus, instead of being in the normal position, was placed with its fundus all but resting on the perineum, and its mouth, directed upward and forward, and resting on the symphysis pubis.

My attention was first directed to the bladder. By using a flexible male catheter, I withdrew about a pint of urine, which had been secreted since Mr. Chick had emptied the bladder an hour or two before. The patient said that her bowels had acted freely on the previous day; but as I had found in the rectum some scybala flattened by the pressure of the uterine tumour, I thought it right to give an enema, to remove any possible accumulation in the higher part of the rectum. This was done by means of a flexible tube, introduced to the extent of seven or eight inches. Nothing but the enema came away. I next endeavoured to correct the position of the uterus. The mode in which this is usually directed to be done is by making upward pressure, with one or two fingers of one hand introduced into the rectum, on the fundus of the uterus, while by a finger or fingers of the other hand in the vagina the os uteri is brought down. The first proceeding is a safe one, and may be effectual; but it appears very doubtful whether the requisite force could be applied to the os uteri without dangerous bruising or even laceration. However anxious I might have been to attempt it, anything like traction exerted on the mouth of the womb was in this instance out of the question. When I again introduced my finger into the vagina, I could no longer reach any part even of the cervix uteri. The os had become so far dilated as to allow the child's head, still covered by the membranes, partially to protrude. By the violent action of the abdominal muscles, the scalp of the child was being forced downward between the symphysis pubis and the body of the uterus, and was there felt as a fleshy tumour. The mouth of the womb was positively higher than when I first examined; being, as I have said, out of reach of the finger.

+ I am happy to be able to state that the above case of A. T., Case vii, about which I had been consulted previous to operation, and which was discharged cured by Mr. Baker Brown on June 29th, continues cured, on November 30th. The husband then informed me that his wife continued quite well, and was never in more robust health, and that she had not the slightest return of her former complaint. (J. H. D.)

Although, however, the soft parts covering the vertex of the fœtus were beginning to descend toward the outlet, I could entertain no hope that a spontaneous righting of the position of the uterus would take place, or the child be safely born by the natural expulsive efforts, for with every pain the fundus descended, and there was reason to fear that it might be forced through the vulva, pushing before it the posterior wall of the vagina. The prospect of such a form of *prolapsed uteri* was by no means an agreeable one. As there could be no doubt of the death of the child, the thought presented itself of perforating and bringing down the head by some form of *crochet*. But no suitable instrument was at hand, and there was no time to be lost in sending for one.

In this emergency, a mode of treatment occurred to me which formed the only novelty in this case. The child's head, although the scalp was to some extent forced down behind the symphysis pubis, was still, during each pain, distinctly perceptible, through the abdominal parietes, above the pubes. I thought that, while with two fingers of the left hand in the rectum, making steady upward pressure on the fundus of the

POSITION OF THE PARTS, AND THE MODE OF TREATMENT EMPLOYED.

- A. Fundus uteri.
- B. Os uteri; child's head protruding, covered by membranes.
- C. Bladder.
- D. Rectum.
- E. Promontory of Sacrum.
- F. Symphysis Pubis.

uterus, I might be able, by counter-pressure with the right hand laid flat upon the abdomen immediately above the pubes, to rectify the malposition of the uterus. By this manipulation, persisted in for a few minutes, I succeeded beyond my hopes. I first felt the fundus recede a little, and then, almost with a bound, the uterus righted itself; the tumour of the fundus vanished from the rectum, that of the head from the hypogastrium, and, in a minute or two more, the fingers introduced into the vagina met the child's head arrived almost at the os externum. Delivery was speedily accomplished. The uterus contracted, but rather irregularly, so as to retain the placenta, which had to be removed by the hand. Regular contraction ensued, not a single unfavourable symptom succeeded, and in a few days the patient was convalescent.

There was not much to be learned of the previous history of this case. About ten weeks previously, Mrs. R. had suffered from retention of urine, with symptoms of peritonitis, and was relieved by the catheter and a few leeches. There can be no doubt that retroversion had then taken place, and continued

until, the increasing bulk of the uterus rendering its new position intolerable, it was excited to efforts prematurely to throw off its burthen. That these efforts were so long delayed, must be attributed to the capacity of the pelvis, which certainly was of more than average size. The appearance of the fœtus proved that at least six months had elapsed from conception.

Of the various modes of treating a retroverted uterus named by writers on the subject, that said by Dr. Ramsbotham (*Obstetric Medicine and Surgery*, 3rd edit., p. 629) to have been "suggested by Bellanger and Lallemand, and spoken of with praise by Boivin and Dugès," comes the nearest to that employed in this case. It is to pass a sound into the bladder, to act as a lever upon the os uteri, so as to press it down. We must agree with Dr. Ramsbotham that such a procedure is in the highest degree objectionable, from "the palpable chance of injury" to the urethra and bladder, or even to the uterus itself. To the method employed by me, the same objection cannot, I think, be made. If it do no good, the pressure of the open hand through the abdominal walls can scarcely do harm.

The proposal made by several writers, while pressing up the fundus of the uterus, with the fingers of the other hand to draw down the cervix uteri, is founded on the same principle. It is the application of a mechanical remedy to a strictly mechanical affection. The advice to use the force thus applied to the os uteri "in the most gentle manner" (Ramsbotham, *op. cit.*, p. 627) shows the dread entertained, by those who have recommended it, of possible mischief to the uterus. It may be questioned whether sufficient traction could thus be made, without inflicting serious injury. Both these recommendations show that others besides Burns (*Principles of Midwifery*, 8th ed., p. 258) have seen that in pressing on the fundus alone, "our efforts tend rather to press the os uteri farther up, than to raise the fundus into its place." It has been felt that means were wanting of causing the uterus to revolve on the centre of its long diameter.

It may be possibly said that due allowance has not, in narrating this case, been made for the rupture of the membranes which must have occurred immediately before the revolution of the uterus. In a similar case, it would probably be right to endeavour thus to reduce the bulk of the uterine mass before attempting its replacement. On this occasion, the end was doubtless attained by the additional pressure to which the ovum was subjected.

BELLADONNA IN INCONTINENCE OF URINE.

By T. T. GRIFFITH, Esq., Wrexham.

As the multiplication of successful results best substantiates the claims of any remedy to confidence, I beg to enclose for insertion the following case of long continued incontinence of urine cured by belladonna.

Master B., aged 4, of a delicate strumous constitution, had been subject since early infancy to nocturnal incontinence of urine, which the ordinary means had failed to correct. I saw him first on December 31st, 1858, and prescribed the following:—

R Extracti belladonnæ gr. iiss; alcohol 3ss; syrapi tolutani 3i; aquæ destillatæ 3v. M. Fiat mistura cujus capiat cochleare i minimum ter die.

Directions were given to take him up, late at night, and early in the morning.

The good effects of these means were soon apparent; and to make the special influence of the belladonna more clear, the complaint returned during its omission for a few days. Its good effects were, however, soon re-established, by taking it again regularly; and its use being no longer necessary, it was gradually discontinued. A week ago, I received from the little patient's father the following satisfactory report. "My little boy has quite recovered from his weakness; and if ever he does suffer from it, a single dose of the medicine quite corrects it."

DONATION OF DR. MUETTER TO THE COLLEGE OF PHYSICIANS OF PHILADELPHIA. Early in January last, Dr. T. D. Mütter perfected his agreement with the College of Physicians, by which he gives to that institution his museum, together with his plates and diagrams, to serve as a basis for the "Mütter Museum." Besides this, he endows the College with thirty thousand dollars, to defray the expenses of the museum and to establish lectureships. The College is bound, on its part, to have a fire-proof building completed within five years, for the accommodation of the collection.