as completely as possible, and then endeavour to induce a healthy growth in the new one. These two indications are best fulfilled by the use of the curette, and by subsequent injections of strong solution of iodine or iodised phenol. Why should we spend months and years in making applications to a membrane which may be removed in a few minutes, with the certainty of its being speedily replaced by at least as good, but probably a better one? That the new membrane may be diseased is true, but this objection will apply to every form of treatment, and speaking generally we may say that the success which has attended any therapeutic agent has been in direct proportion to its power of destroying the diseased membrane. This explains to us the marked benefit derived from the use of powerful caustics, especially the fuming nitric acid. In Dublin we have had remarkable success with this agent, but it is inferior to the curette in three ways. 1. It necessitates previous dilatation of the cervix. 2. Its action is rendered uncertain by hæmorrhage and other discharges. 3. It destroys the tissues upon which we depend for diagnosis. My present practice is to curette in every case of disease affecting solely or chiefly the uterine mucous membrane, which does not yield to attention to general health, douching and astringents, and I can strongly recommend it to others as having the following advantages, which I may briefly recapitulate. (1). It is efficacious both as a diagnostic and as a therapeutic agent; and (2) its employment is safer and simpler than any method which involves the dilatation of the cervix.

ON MARTIN'S METHOD OF DEALING WITH THE PLACENTA AND SAC IN LAPAROTOMY FOR EXTRA-UTERINE PREGNANCY.

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ONE of the most interesting questions in connection with the treatment of advanced extra-uterine foetation by laparotomy is the method of procedure in regard to the placenta, upon which the failure or success of the operation is believed largely to depend. My object in this paper is to draw attention to the plan proposed, and successfully adopted by Dr. A. Martin, of Berlin, according to which it becomes possible to remove the placenta with the foetus, at any period after its formation, without any serious risk of hæmorrhage.

Most recent writers on this subject, including Thomas, Hicks, Barnes, Kœberlé, and Tait, are agreed that the placenta should in most cases be left behind on account of the severe hæmorrhage which frequently attends its removal, instances being indeed very numerous where death has resulted from this cause. That it is a point on which the experience of competent observers differs very widely may be gathered from the fact that Schroeder removed the placenta as early as three weeks after the death of the foetus without experiencing any untoward result, while Depaul, on the other hand, removing the organ four months after the activity of the placental circulation had had time to diminish by reason of the death of the foetus, had the misfortune to lose his patient from hæmorrhage. This is a by no means isolated experience.

The disadvantages of leaving the placenta behind are (1) the tedious and protracted convalescence; (2) the danger of death from hectic and exhaustion owing to long-continued suppuration of the sac and its contents during the process of disintegration and throwing off; (3) the possibility of secondary hæmorrhage such as occurred, for example, in a case related by Braxton Hicks.

Parry, of Philadelphia, writing in the year 1876, states that the frequency of secondary hæmorrhage after spontaneous separation of the placenta, as compared with that after its forcible separation, is as one to five.

Most authorities are agreed that the organ may be safely removed some months after the death of the foetus, when the vessels traversing the placenta have atrophied and contracted, the venous sinuses having become thrombosed, and the whole organ very much diminished in size; but it was reserved for Dr. Martin to devise a means by which the placenta may be removed at any period with hardly any greater risk of hæmorrhage than attends an ovariectomy or an extirpation of the uterus.

The reasons which led Dr. Martin to work at this subject may be given in his own words, quoted from a communication read before the International Medical Congress held at London in 1881. He says: "It is, however, evident to all that convalescence is considerably endangered by this procedure (avoidance of the placental site) for even if the sac, as such, were closed, and the diligent irrigation of the sac should prevent stagnation of the secretions in the cavity, still it is clear that the recovery is thus retarded greatly, and the patient liable to such dangers as accompany the processes, even with strictest antiseptic precautions." He acknowledges that the ligation of separate bleeding points on the placental site is not feasible, but by ligation *en masse* "large bleeding surfaces can be tied quickly and safely, so that we need not fear secondary danger from the hæmorrhage."

It might be objected that the placenta may be fixed to the intestines, or some part from which it is irremovable; but to this Martin replies that it is more of theoretical than practical importance; not that he denies the possibility of its occurrence, but, not having met with a single case of this nature in eighteen laparotomies for extra-uterine foetation, he comes to the conclusion that, in discussing the question broadly, too much stress must not be laid on these rare and exceptional cases, in which, if necessary, and if the placenta cannot be removed without danger of fatal hæmorrhage, it may be left *in situ* and allowed to disintegrate.

I had the privilege of being present at the operation on the following case of Dr. Martin's, in which the successful removal of the placenta, which I wish to emphasise, is well illustrated, as well as the method of treating the sac by partial resection, a procedure generally employed by Dr. Martin in these cases. For the notes of the case I am indebted to Dr. Czempin, house surgeon at Dr. Martin's clinic.

The patient was a married woman, and sterile up to last March. Since that time she had complained of pain in the hypogastrium, especially on the left side. She had menstruated regularly for fourteen years; but in March, after menstruating at the commencement of the month, there was again some loss a fortnight later, while throughout the whole of April she did not menstruate at all. In May there was slight hæmorrhage on two occasions, but none between that time and her admission to the hospital in July.

The vagina was fairly capacious; the cervix behind the symphysis pubis; the body of the uterus was short, and behind the uterus a tumour, rather larger than a man's fist, was felt on the left side, and diagnosed as tubo-ovarian.

On July 7th the operation for removal of the tumour was undertaken. Chloroform was administered, and the abdomen opened by an incision four inches long in the middle line, when the peritoneal cavity was found full of recent and old blood-clot—the tumour having evidently burst. The intestines were spread out on the wall of the abdomen, and covered with a damp cloth, after which the clots were easily removed from the pelvic cavity with sponges. To the left side of and behind the uterus was seated a tumour corresponding to the one felt on examination; on attempting to loosen the latter from its connections a rent occurred in the anterior wall, and through it a four-month-old foetus and some blood-clots escaped. The foetus was still attached by the umbilical cord to the placenta, which remained in the cyst. Introducing the hand into the cyst it was possible to remove the whole placenta without any severe hæmorrhage. A large portion of the sac was next resected, and the remainder stitched together with continuous catgut suture, after introducing a drainage-tube through the pouch of Douglas into the vagina, so as to shut off the sac as much as possible from the abdominal cavity. The abdominal wall was then united by silk sutures. The operation lasted eighteen minutes. The patient recovered without a bad symptom, the temperature never rising above 38.2° C. The tube was removed on the thirteenth day after the operation, and on the sixteenth day the patient left the hospital convalescent.

In another case upon which Dr. Martin operated at the end of the sixth month of pregnancy, the placenta was seated upon the anterior wall of the sac, which was formed by the back wall of the uterus and the left lateral ligament. After the removal of the foetus hæmorrhage took place in spurts, quickly filling the sac. As soon as Dr. Martin recognised the nature of the case he cut off the communication with the uterus by three deep sutures, carried by means of curved needles through the broad ligaments, and embracing the left side of the uterus. The placenta was then removed and found to be very friable, but entire; no hæmorrhage followed its removal. The sac was treated by resection, and the

operation was concluded in an hour and a quarter. The patient made a perfect and speedy recovery.

The method of dealing with the sac of an extra-uterine foetation employed by Dr. Martin is different from that of many operators. Instead of stitching the sac to the abdominal incision, he removes as much of the walls as possible, drains through the pouch of Douglas into the vagina, and unites the edges together at the highest part of the sac, thus being enabled to close the abdominal wound entirely. By this means healing by first intention is possible, drainage is obtained through the most dependent portion of the sac, and recovery is much more speedy.

During the last six months I had an opportunity of examining a patient on whom Dr. Martin had operated some months previously for extra-uterine pregnancy in the manner here described. The uterus was fairly mobile, and the only remains of the patient's abnormal burden was a thickened cicatricial band, about the size of the little finger, extending backwards from the cervix, on the left side of the uterus.

Three years ago Dr. Martin described his method in a paper read before the Copenhagen Congress, but it was the opinion of Werth and most of the authorities present that time was needed to test its efficiency.

Dr. Martin has now had nearly twenty cases in which he has put in practice his method of dealing with the placenta and the sac, and he considers that the results quite justify him in maintaining its superiority over the methods hitherto in vogue.

ABSTRACT OF AN ADDRESS

ON

THE RELATIONS OF GYNÆCOLOGY TO GENERAL THERAPEUTICS.

Delivered before the British Gynecological Society.

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Physician to the Chelsea Hospital for Women.

After thanking the Fellows most cordially and sincerely for the honour they had conferred upon him, the President proceeded to make a few suggestions as to the objects of the Society.

He drew attention to the importance of avoiding the error of cultivating this specialism to the exclusion of a more general consideration of the subject, asserting that a specialist, in the only true sense of the word, was one who was a good all round surgeon and physician, and something besides—one who paid special attention to the study of gynecology, and who consequently attained superior knowledge of it, and possessed greater skill in dealing with it.

He referred to the narrow views of specialism held by some, whose opportunities of studying disease from a general standpoint should guard them from that fallacy, citing instances of menorrhagia, which, without sufficiently inquiring into the probable causes, and endeavouring to ascertain the conditions which led up to this result, the practitioner was too apt to treat empirically by some accredited formula, such as sulphuric or gallic acid, ergot, or hazeline.

Stress was laid on the importance of ascertaining the condition of the heart, liver, kidneys, and other organs, so that we should not overlook the existence of some mitral incapacity, hepatic congestion, or renal degeneration which possibly might account for the menorrhagia, and necessitate general in place of local treatment. A few grains of calomel, some saline aperient, abstinence from alcohol, and attention to simple hygienic details often proved of more service in checking any inordinate menstrual flow than the most elaborate prescription for uterine hæmorrhage.

So with dysmenorrhœa, which was but a symptom of many and various conditions, not only of the uterus and its so-called appendages, but also of the general health. In place of gravely recommending patients to submit to some surgical operation for the relief of pain, all that was necessary, in many instances, was to relieve the anæmia, due often to imperfect nutrition, improper clothing, and neglect of ordinary hygienic precautions.

The tendency of gynecology for many years past had been to advance in a surgical direction, and unquestionably much had been gained by this. Cases which scarce a generation ago were regarded as hopeless, over which medicine had no power, were now rescued from their impending fate, and restored to health and usefulness. The triumphs of abdominal surgery were still the wonder of the age. Ovariectomy alone had been the means of saving countless thousands of lives. Removal of the uterine appendages—whether in the case of bleeding myoma, or of chronic incurable diseases of the ovaries or tubes—had enabled the surgeon to convert useless, suffering, and miserable invalids into useful members of society, able to earn their own living, or to fulfil the duties of their station, with comfort and freedom from suffering. The treatment of extra-uterine gestation by abdominal section, bold in its conception and successful in its issue, appealed alike to the profession and the public.

Shortening of the round ligaments, raising the prolapsed ovaries and attaching them to the parietes by a plastic operation, repairing the ruptured perineum, removing the hypertrophied cervix uteri, or restoring it to its normal condition, when extensively lacerated, by the operation of trachelorrhaphy—all these and numerous other operations of a like nature might well be quoted as evidence of what surgery had accomplished in the domain of gynecology. Might we not hope that in time, when gynecology was systematically taught in our medical schools as an integral part of medical education, we should be enabled to prevent the development or retard the progress of numerous conditions which now inevitably eventuate in surgical interference?

Our practice, in many instances, did not keep pace with our knowledge. As a fact, we knew that the process of involution of the uterus, subsequent to delivery, took at least six weeks under favourable circumstances, and still longer in anæmic, underfed, or unhealthy patients, where the hygienic surroundings were unsatisfactory; and yet we kept still to the traditions of the past, and allowed our patients to get up after the ninth day, provided there was no hæmorrhage or elevation of temperature to suggest a more prolonged recumbency.

Could it be doubted that we had here a most potent factor in the production of uterine disorders? The heavy, subinvolved uterus not only dragged upon the already weakened and distended ligaments and supports, giving rise to prolapsus uteri and other displacements, but the ovaries also, in place of remaining in a position of safety, became prolapsed, and gave rise to considerable discomfort.

Even the growth of uterine myoma, apart altogether from the more direct methods of treatment, might be lessened or retarded by attention to numerous details as to diet and hygienic management, such as abstinence from alcohol, lessening the amount of nitrogenous food, preventing congestion of the pelvic organs by wearing appropriate clothing, and refraining from unnecessary fatigue or exertion at the ordinary monthly periods, regulating the bowels, and improving the tone of the general health by means of such remedies as quinine, arsenic, strychnine, and other agents of this class.

The extreme importance of forming a correct diagnosis was then insisted upon. We should at all times endeavour to ascertain the truth, the whole truth, and nothing but the truth. It was not sufficient to detect a retroflexed uterus and treat this, when possibly some old-standing pyosalpinx or cirrhotic condition of the ovary was in reality the chief cause of the patient's suffering. Instances were not infrequently met with where the ovaries and tubes had been removed, and rightly so, for some well-marked pelvic trouble, and yet the condition of the patient some months afterwards was not anything like as favourable as we were led to predict—and why? Because some chronic uterine trouble, coexistent with the ovarian mischief, had been overlooked or not attended to, and now interfered with the perfect convalescence of the patient, thus robbing the gynecologist of his full measure of credit, and, in some cases, unquestionably bringing the operation of removal of the appendages into needless discredit.

The reflex symptoms due to uterine derangements were then considered and their importance insisted upon, as deserving of more attention by the practitioner than generally met with. The synergic action between the stomach and the uterus, both as regards secretion, sensation, and motor action, were amongst the most remarkable phenomena of reflex nervous action. Nature gave us a very palpable illustration of this in the morning sick-