time subsided; but from that date she never was perfectly free from suffering, till of late, though naturally of very active habits, she had been compelled to give up taking exercise nearly altogether; for years, too, she had been off and on under medical treatment, without even obtaining permanent benefit. She suffered from constant headaches (these occasionally were very severe), from indigestion, flatulence, and constipation. She was unable to walk; for, on attempting to do so, she was always seized with pain, referred to a point corresponding to the fundus of the uterus. This pain lasted for some time, then she would obtain relief; and immediately after, invariably perceived a copious viscid discharge to exude from the vagina. These attacks of pain and subsequent leucorrhœal discharge occurred even when she remained quiet; though then the intervals between them were considerable. Walking, however, always brought them on. I subsequently satisfied myself that these attacks of pain were due to the efforts of the uterus to expel the copious secretion which collected in it.

On making a vaginal examination, I found that the cervix was conical, and the os so small that I could not introduce an ordinary sound, but had to use a fine probe; the fundus was large and heavy, and slightly painful to the touch; there was no abrasion; but, though pressure with the fingers on the fundus caused but little pain, sexual intercourse was always productive of suffering.

I decided on treating this case by applying nitric acid to the fundus, but as this was impossible in the contracted state of the cervical canal, I introduced a length of No. 3 sea-tangle bougie into uterus, and after the lapse of twenty-four hours was, on withdrawing it, enabled to introduce a platinum cannula, and through it apply the fuming nitric acid. The result was for the time very satisfactory. She improved wonderfully, and lost most of her distressing symptoms, and I saw no more of her for four months, when she again consulted me, saying that she was as bad as ever; and, on making a vaginal examination, I found that she had relapsed into her former condition—the os uteri was as small and the catarrh as copious as ever. On considering this case, I became convinced that till I gave free exit to the pent-up viscid discharge no permanent benefit would follow; and believing that division of the cervix would alone effect this, proposed the operation to her. She at once agreed to submit to it, and I accordingly performed it, dividing the cervix bilaterally, in the manner described in a previous lecture. The result has been most satisfactory. She recovered without any drawback, has ever since steadily improved, and now, after the lapse of several years, is quite free from suffering, is able to take long walks, and leads a most active life.

After the divided surfaces have healed, and that no danger of exciting inflammation exists, it is generally necessary to apply carbolic acid, or some other caustic, up to the fundus; in fact, I always keep the patient under observation for some weeks subsequent to the operation. The length of time during which it is necessary subsequently to continue intra-uterine medication must depend on the previous duration of the disease, as well as on the severity of the symptoms. In the case just related, I applied carbolic acid several times to the fundus subsequent to the operation.

In this case, the patient has remained sterile; indeed, I had no hope that conception would follow in her on the cure of the endometritis; the disease was of too long standing. As a rule, I object to perform the operation of dividing the cervix, simply with the view of removing sterility; conception doubtless sometimes does occur after the operation, not because the cervix is rendered patulous, but because the membrane lining the interior of the uterus being rendered healthy, conception becomes possible. The following case is an example of this.

Mrs. K., aged 26, had resided in India, and ever since her marriage, five years ago, has never become pregnant. Menstruation was normal and nearly painless. She suffers, however, constantly from backache and much discomfort in the left ovarian region; is quite unable to take exercise, as walking brings on pain. She was specially anxious to have a family, and returned from India, and sought advice, more with the view of having sterility removed than for the relief of her sufferings. On examining her, I found the cervix to be conical, and the fundus acutely anteverted; there was also a good deal of uterine catarrh. The probe passed to the depth of nearly three inches. As this case was by no means a severe one, and evidently not of long standing, I decided on endeavouring to avoid dividing the cervix, and accordingly introduced an anteversion pessary, punctured the cervix, applied carbolic acid to the fundus, gave bromide of potassium in full dose, and found the patient's condition steadily to improve. All her symptoms subsided; the flexion, however, remained unaltered. After a time, I sent her to Ems, where she remained for some weeks, and returned in a very satisfactory state. Her husband, who during this time had remained in India, now joined her, and they travelled about for a couple of months. On returning to Dublin, just a month before they were to start for India,

she called on me and said she had again of late begun to suffer as much as ever, and on examining her I found her to be in exactly the same condition as when I had first seen her five months before. I at once told her that all she had done had been useless, and that there was no chance of a cure except she submitted to have the cervix divided. She readily consented. I divided the posterior wall of the cervix only, this being the operation I always perform in cases of anteversion. She sailed for India in four weeks from the date of the operation, soon after became pregnant, went to the full term of utero-gestation, and gave birth to a healthy child.

I have given these two cases in detail, because they show how useless any attempt to cure endometritis in sterile women is, unless, as a preliminary step, free exit be afforded to the discharge which invariably collects to a greater or less extent in the cavity of the uterus. And if I have succeeded in impressing this fact on your minds, your failures in your future practice will be lessened very considerably.

ON THE CURE OF DYSMENORRHOEA, STERILITY, AND CERTAIN AFFECTIONS OF THE UTERUS, BY A NEW FORM OF ELASTIC INTRA-UTERINE STEM.

By ROBERT GREENHALGH, M.D.,

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THERE is great difference of opinion among gynecologists as to the utility and safety of intra-uterine stems—a difference made manifest in a recent discussion at the Obstetrical Society. Notwithstanding the very adverse opinions as to the use of these stems expressed at this discussion, I am convinced that there is an increasing tendency to employ them, as exemplified in the many modifications which have been made in their construction since the year 1844, when they were first introduced to the notice of the profession by Sir James Simpson, and by the large number of these instruments sold by the instrument-makers to practitioners specially engaged in the treatment of the diseases of women. For my own part, being at a loss to imagine how certain mechanical affections of the uterus can be otherwise satisfactorily treated, I am constrained to assume the necessity of some such contrivance.

Before I describe my thoroughly efficient intra-uterine stem, the outcome of many failures and partial successes, it may be interesting to many little conversant with this subject to take a cursory glance at some of the steps which led to the adoption of intra-uterine stems. It is recorded that Aëtius recognised a contracted os uteri as a cause of sterility, and he is supposed to have treated this strictured condition with sponge-tents; but, passing over the dim records of ancient surgery, we come in recent times to the late Dr. Mackintosh of Edinburgh. This acute observer, in the second volume of his work on the *Practice of Medicine*, gives a graphic account of the sufferings wrought by persistent dysmenorrhœa, sets forth the insufficiency of all methods hitherto devised for its cure, and then makes the remarkable suggestion that many cases of painful menstruation might be due to some obstruction, for which condition "mechanical dilatation appeared to be the only remedy". For some years he hesitated to carry this conception into execution. At length, in the year 1826, he put his idea to the test, with such success that he was emboldened to repeat the experiment in numerous cases. In the year 1836, he thus records his experience: "In twenty-seven women, twenty-four cures have taken place, and of these eleven have since had children": an amount of success never since exceeded, if equalled. "The instruments employed to produce the dilatation were the common metallic bougies, of different sizes, from that of the ordinary small silver probe to No. 14." During the year 1844, Sir James Simpson published in the *Edinburgh Medical Journal* (page 734) an account of his permanent metallic stems of various sizes, which, he stated, "gave much less pain to the patients, and less trouble to the practitioner; were more certain and expeditious in their effects". He further stated "that he found the stricture occasionally at the os internum or opening between the cavities of the cervix and body, and not at the os tincæ": a statement the correctness of which I, in common with other observers, have since fully verified. In fact, the obstruction in the majority of cases is situated nearer the os internum. In cases where the external os uteri is small, particularly where the neck is conical and elongated, with a canal scarcely admitting the introduction of an ordinary sound, the menstrual flow scanty and of short duration, mostly indicative of

faulty development, leading to dysmenorrhœa or sterility, little or no good is to be expected either from purely mechanical treatment or from incision. The use of the jointed galvanic stem is indicated in cases like this, and in many instances it has proved most useful.

For some time I used Sir James Simpson's stems with considerable success; but, finding they were apt to become corroded and to slip out and to impede the escape of the secretions from the interior of the uterus, I devised, about the year 1862, stems made of vulcanite with numerous perforations. These stems, lighter and less liable to be misplaced, less liable to corrosion, permitted a readier escape of the secretions. I further modified them by reducing the size of the bulb, substituting for it a flat oblong shield. Finding, however, that these forms of stem are liable every now and then to become misplaced, I contrived a metallic expanding stem, which I ultimately discarded for one of vulcanite. A figure of this vulcanite stem, which now I use only after the division of the cervix uteri by the metrotome, will be found at page 404 of Dr. Marion Sims's *Clinical Notes on Uterine Surgery*. The advantages I claim for this form of stem are, ease of introduction; by its expanding limbs, pressure is made upon the cut surfaces, whereby bleeding is prevented; being perforated through the centre, a ready exit of the secretions is permitted; it is not liable to be misplaced; it can be retained until the healing process is complete; by it, all exposure and frequent painful and irritating dressings of the parts are avoided; and, lastly, being made of unabsorbent material, little or no risk from septicæmia is incurred.

In the year 1844, Sir James Simpson described the operation of division by a "lithotome caché" of any fibres that may be causing contraction of the internal orifice; "the incision commencing at the union of the cervix with the body of the uterus, and passing gradually more and more into the substance of the cervix. As it descends, the blade is brought out at the outer and lower edge of the cervix at the point of reflexion of the mucous membrane upon the wall of the vagina. The instrument is then turned, and a similar cut made on the other side." A short experience of this instrument, although used with the greatest care, convinced me of the uncertainty of its action.

In 1862, Messrs. Weiss and Son, at my suggestion, made at first a curved, and subsequently a straight, double-bladed metrotome, which can be used without the speculum, can be regulated with the nicest accuracy, and by which both incisions can be completed simultaneously. This instrument has been objected to by a recent critic on account of its "automatic machinery"; and he erroneously remarks that the blades spring out one on each side and make their incisions *whilst the instrument is being withdrawn*; whereas the blades are

Fig. 1.—Metrotome.

made gradually to protrude by gentle traction on the handle, gradually cutting through to a small extent the internal os; the cuts increasing in depth through the cervix and external os uteri nearly up to the junction of the neck with the vaginal walls. The blades are retained *in situ* by the sheath while regulating the position of the uterus and the directions of the incisions until the completion of the operation. The extent of the incisions can be regulated with the greatest precision by the adjustment of the blades, which are quite independent of each other. Those who have had experience in its use can testify to the accuracy of this description of my metrotome. (Fig. 1.)

In addition to these advantages, this instrument secures rapidity of action, and avoids exposure by the speculum and injury to the parts: important points these, especially where the operation is needed on an unmarried woman.

To the fear expressed by the same critic that hæmorrhage and septicæmia are likely to result from this operation, I have to answer that, among a large number of operations, although no plugging was had recourse to, in four cases only did hæmorrhage occur, which was speedily arrested by tannin and the plug; that not a single case of septicæmia resulted; and only one death ensued, in the case of extreme ante flexion in my early experience of the metrotome, in a patient who succumbed to tubercular peritonitis, from which she had previously suffered. This case I reported in an early volume of the *Obstetrical Transactions*. All the patients were greatly benefited, the large majority cured; and many, who for several years had been sterile, have since borne children. This form of metrotome I still occasionally use.

Dilators of various kinds, resembling the sound, and capable of

expansion after introduction within the canal of the cervix, have been used by many practitioners to stretch the canal at any part of its course, though the instruments I have seen seem adequate to dilate only the two distal thirds of the canal. Dr. Priestley's dilator, described in the *Medical Times and Gazette* for March 1864, is perhaps the best; but a fair trial of it has convinced me that such contrivances have little or no advantages over the metallic bougies recommended by Dr. Mackintosh. The sponge and sea-tangle tents, perforated through-out and shortened, have not answered my expectations, since they frequently occasion much pain during the process of swelling, and have every now and then produced so much irritation as to lead occasionally to metritis and pelvic inflammation and abscess. There can be no doubt, however, that each method, when cautiously used in well-selected cases, has sometimes proved effective, though not to an extent to justify us in placing a large amount of confidence in its results.

Often disappointed by all the aids just referred to, and by the modifications of stem recommended by others, and, as experience extended, becoming more and more impressed with the necessity for mechanical treatment, I devised in the year 1872 an India-rubber stem, at first solid and subsequently tubular, armed near the end with two wings, between which was an oval opening in the long axis similar to the end of Mr. B. Holt's catheter. This form of stem I used over a considerable period in numerous cases, and found it a great improvement upon the other forms. Being of softer material, it adapted itself better to the canal, was less liable to slip out or to inflict injury, and could be used without interfering with the marital relation. Finding, however, that the wings added to its size and to the difficulty of introduction, and that when *in situ* they failed to expand in the body of the uterus as I had anticipated, that they occasionally became detached, and that the opening frequently got blocked by the secretions, I sought to overcome these disadvantages. Two years ago, I succeeded in designing a stem with manifest advantages over every other pattern. The stem consists of pure India-rubber tubing, No. 13 catheter gauge, easily admitting the introduction of a large Simpson's sound, two inches and one-eighth in length, tapering at its upper or uterine end, and armed with an oblong shield measuring one inch and three-quarters from side to side and one inch and a quarter from back to front. In this shield are ten perforations to facilitate cleanliness. Three-sixteenths of an inch from its upper extremity is a bulb two inches in circumference, with four diamond-shaped slits, which collapse when stretched on a dilator to facilitate introduction. When the stem is inserted and its retention is secured, and the dilator removed, this bulb at once expands in the body of the womb, while permitting a ready escape of the uterine

secretion. The whole being cast in one piece, there is no chance of the separation of any part of it. (Fig. 2.)

There are two points in connection with the use of the India-rubber stem to which I am particularly anxious to direct attention, in addition to the advantages already referred to. Firstly, although soft, elastic, and easily bent while out of the uterus, it becomes sufficiently firm

Fig. 2.—Stem.

when pressed equally on all sides by the canal of the cervix to gradually overcome all flexions, except in cases where the uterus is bound down to the surrounding parts. Secondly, its action is not purely mechanical. It has been observed by myself and others that, in many cases where the stem has been worn for some time, the enlarged and

firm uterus has become greatly reduced in size, and so soft as closely to resemble that organ in the early stage of subinvolution: effects probably due to the freer exit of the secretions and the mucous discharge, which usually persists during the retention of the stem.

Having described the form of stem, I shall now briefly allude to the cases in which I have found it most useful; premising, however, that mechanical treatment should never be undertaken till the removal of all indications of active disease, and the uterus is reduced to a minimum of sensitiveness by the use of rest, local depletion, hot vaginal injections, soothing suppositories, and other measures; and, further, until the sound has been passed once or oftener to ascertain how far the uterus is tolerant of local interference. Moreover, at the commencement of treatment, I usually enjoin one or more days' rest in bed. After this preliminary treatment, I first introduce a small silver stem; and in two or three days, if loose, I substitute one of larger size, when the canal is usually sufficiently dilated to admit the introduction of the India-rubber stem. By this gradual dilatation, which occupies usually about a week, the largest stem can be more easily introduced, and far less irritation is likely to follow than when the introduction is more speedily effected—an operation frequently not easy and occasionally impossible.

Should the stem have a tendency to slip out, which is sometimes the case, it can be easily retained *in situ* by pressing upon the shield a plug of cotton-wool, saturated with glycerine, tied crosswise with fine twine to facilitate removal.

I may here remark that early experience taught me never to use sponge or sea-tangle tents, nor dilators, with a view to more rapid dilatation, by which considerable pain is occasioned, and irritation, and sometimes inflammation, is set up, thereby rendering the case temporarily unfit for the stem-treatment.

The most fitting time to introduce the stem is shortly after a menstrual period, its retention being determined by the peculiarities of each individual case, the effects produced, and the end to be obtained. In my cases, the time varied from fourteen days to eleven months. The best time for removal is about a week before the next expected period. When retained for a considerable time, the discharges are apt to become offensive, notwithstanding the daily use of the vaginal douche. Still I have never known any evil result beyond this temporary annoyance to the patient.

I have now used the India-rubber stem for more than four years in a large number of private and hospital cases, and in two cases only—cases of chronic metritis with retroflexion, in which a spring vaginal pessary was worn—have I had to withdraw it on account of the onset of irritation. Both patients were highly sensitive women, and had undergone but little previous treatment. I have found these stems most useful in the following cases:

1. Dysmenorrhœa;
2. Flexions—ante- and retro-flexion of the uterus;
3. Strictures of the orifices and canal of the cervix;
4. Sterility, congenital and induced;
5. Certain cases of subinvolution;
6. Certain cases of interstitial fibroid of the uterus.

The following cases, sketched in outline, may serve as illustrations of stem-treatment.

CASE I. *Congenital Dysmenorrhœa: Sterility: Cure.*—Mrs. A., about thirty years of age, married about five years, always suffered more or less severely from paroxysmal pain a day or two before and during the menstrual flow, which was scanty and clotted. Her sufferings of late had become greatly aggravated, so as materially to affect her general health, and lead her medical attendants to fear the development of phthisis, to which she was strongly predisposed. The uterus was found slightly prolapsed and anteverted, congested and very sensitive, with a copious muco-purulent discharge. In spite of protracted general and local treatment, the dysmenorrhœa still persisted. The sound passed easily with but little discomfort three inches and a quarter into an enlarged cavity, doubtless due to distension by coagula, the expulsion of which gave rise to the pain and kept up local irritation. The stem-treatment was now adopted with marked improvement to both general and local symptoms. At the end of three months, Dr. Hobart of Cork removed the India-rubber stem, and soon afterwards she became pregnant, went to the full period, and was delivered, after a somewhat protracted labour, of a fine child. About a year after, she gave birth to a second child, and when last I saw her she was about two months advanced in her third pregnancy, and was enjoying very fair health.

CASE II. *Congenital Dysmenorrhœa: Extreme Antelexion: Cure.*—I was requested by Dr. Baldock to visit Mrs. P., aged 22, married six weeks, for severe dysmenorrhœa, which had caused her more or less

suffering since the commencement of menstruation, seven years before. Of late, her sufferings had become so agonising as to require, in addition to other means, the frequent use of hypodermic injections of morphia. Her general health had become greatly impaired, and she was almost constantly confined to bed. The uterus was considerably enlarged, was much congested, exquisitely tender to the touch, and acutely antelexed, the fundus being somewhat beneath the level of the cervix uteri, which was directed downwards and forwards. The sound was passed, with much difficulty and pain, three inches and a quarter into an enlarged uterine cavity, when it was found the womb could be straightened. Its withdrawal was followed by a copious discharge of pent-up blood and mucus. In spite of absolute rest, careful dieting, good nursing, hot hip-baths, vaginal injections and suppositories, depletions from the uterus, and other means, carefully carried on for many weeks, her symptoms, general and local, became more and more aggravated, when my advice was again sought. Notwithstanding the unfavourable nature of the case for mechanical treatment, it was resolved to put it to the test. A small silver stem was introduced, then a larger and a larger, and ultimately the India-rubber stem was passed. Dr. Baldock wrote to me some weeks afterwards: "There was first a good deal of pain and discharge, which gradually subsided, and a good period followed." He adds: "The uterus is not quite in a normal position, but very considerably different to what it was. The case may certainly be given in support of the use of stems in uterine flexion."

CASE III. *Congenital Dysmenorrhœa: Menorrhagia: Extreme Antelexion: Cure.*—Miss —, about twenty years of age, had always suffered more or less pain, with a somewhat free loss at her menstrual periods, which commenced about six years ago. These symptoms had much increased of late, together with pains more or less constant in and about her hips, at times extending down the thighs, which had prevented her taking exercise, and led to great impairment of her general health. She was much troubled with leucorrhœa. As a local examination was strongly objected to, she was requested to rest almost constantly upon a tilted couch, to remain in bed during her periods, to use a hot vaginal douche night and morning, and to adopt such means and take such remedies as were calculated to alleviate her pain, moderate the losses, keep the bowels and secretions in order, and improve her general powers. After many months of such treatment, she appeared greatly improved in every respect; but as soon as she began again to move about all her symptoms returned. An examination was now permitted, when the uterus was found considerably enlarged and firm, thrown far back in the pelvis, and acutely antelexed. With some difficulty and pain, the sound, considerably bent, was passed three inches and a quarter into the enlarged body, when it was ascertained that the organ could be replaced. The graduated stems, and subsequently the India-rubber stem, were introduced and worn for some months. Five months after all treatment had been discontinued, I received a most grateful note from my patient, in which she stated: "I have been presented. I have also been to several balls, at one of which I danced fourteen times; and in spite of all this I am perfectly well—better than I have been for more than six years."

CASE IV. *Congenital Dysmenorrhœa: Extreme Antelexion: Sterility: Cure.*—Mrs. B., aged 39, married eleven years, had always suffered from pain at her menstrual periods, and now of late it had become "agonising", usually coming on some hours before the flow, which had varied much from scanty to profuse, so as seriously to impair her health. The uterus was low, congested, tender, and acutely antelexed, the fundus being below the level of the cervix. After some preliminary general and local treatment, the sound was passed with extreme difficulty three inches and a half into an enlarged cavity. Its introduction was followed by vomiting, fainting, and severe pain, which, however, gradually subsided when a small silver stem was introduced, followed in a few days by one of larger size, and subsequently by the India-rubber stem. This stem was worn three months, and when withdrawn the uterus was found healthy and in its normal position. After some months, she became pregnant. Mr. Bateman of Richmond delivered her of her first child in her forty-first year. She has since enjoyed good health.

CASE V. *Induced Dysmenorrhœa: Retroflexion: Cure.*—Mrs. C., aged 32, since her marriage two years ago had suffered severely at her periods, which had always been slight, and had now become "intolerable", occasioning great functional derangement of her digestive and nervous systems. "I am", she wrote "a martyr to neuralgia at those times; cannot sleep, and vomit everything I take." The uterus was highly congested, exquisitely tender, and retroflexed. Her health was much improved by general and local treatment, when my spring-pessary was introduced without effecting any material improvement in the position of the organ, and with no relief to her sufferings. The stem-treatment was now resorted to, and carried out over a period of

five months, with the ultimate cure of her local affection and restoration to health.

CASE VI. Stricture of Internal Os Uteri: Sterility: Cure.—Mrs. D., one of eleven children, aged 28, had been married five years. Her husband, aged 32, was one of seven children. She enjoyed good health; menstruated every three weeks and three days, the flow lasting four days, moderate in quantity, bright without coagula; it was accompanied by slight local discomfort. There was no constitutional disturbance. The uterus was normal in position and texture; the external os was round and of average size. The sound passed with ease up to the internal os, where it was arrested. Failing on two occasions to overcome the obstacle, I advised the use of the hot vaginal douche, and belladonna suppositories night and morning. After this treatment, I succeeded in passing a small whalebone sound two inches and a half, for which, on withdrawal, I substituted a very small silver stem, soon to be followed by a larger one, which she wore several days. Then the India-rubber stem was introduced and retained for about five months, with little discomfort but great increase to the menstrual flow. Scarcely six months had passed, when she became pregnant, went to the full period, and was safely delivered of a fine child. She has since had excellent health.

CASE VII. Congenital Sterility: Cure.—Mrs. E., aged 28, one of six children, married six years, was well developed. Her husband, aged 29, was one of four children. She enjoyed good health, menstruated normally, and had no detectable disease of the uterus or of the ovaries. The uterus appeared somewhat small and flaccid; but a sound passed two inches and a half easily without pain. She wore for two months an India-rubber stem with slight discomfort and with increase to the menstrual flow, after which the uterus was found somewhat larger and firmer. Two months after the removal of the stem, she became pregnant, and passed satisfactorily through a normal labour at term.

CASE VIII. Induced Sterility: Cure.—Mrs. D., aged 36, had two children within two years of marriage, the last eight years ago. She had good labours and recoveries. The uterus was somewhat congested and low in the pelvis. Cured by ordinary treatment. Not becoming pregnant during the succeeding eighteen months, she again applied for advice on the score of sterility. No disease being detected, the stem-treatment was adopted. At the end of three weeks, the stem was forced out during a period, which was shortly followed by pregnancy, terminating normally at term in the birth of twins.

CASE IX. Subinvolution: Sterility: Cure.—Mrs. T., aged 38, had one child twelve years ago, a year after marriage, severe labour, fair recovery; but since then menstruation had been irregular, usually deferred and scanty, with slight discomfort. General health good. The uterus was enlarged and indurated, low in the pelvis; the os was transverse and patulous, exuding tenacious muco-pus; the cervix was abraded. The sound passed three inches in the normal direction with some difficulty and pain through the strictured internal os. Under the influence of rest, local puncturing, iodised cotton and glycerine, and the hot vaginal douche, the uterus was brought into a normal state. More than a year having passed without pregnancy resulting, she again applied for advice, when a succession of stems were introduced, and worn for a period of four months with great increase in the menstrual secretion. She became pregnant immediately on the removal of the stem, went to the full period, and was favourably delivered of a fine child. A period of nearly three years elapsed, when she again sought my advice, was similarly treated, and with like successful results, giving birth to her third child in her forty-second year.

CASE X. Fibroid in Anterior Wall of Uterus: Dysmenorrhœa: Sterility: Cure.—Mrs. G., aged 31, married upwards of five years, had suffered for many months from profuse and protracted menstruation with intense dysmenorrhœa, producing serious derangement of her health. The uterus was enlarged and firm, much anteflexed. A fibroid tumour, about the size of a small walnut, could be detected at the junction of the neck with the body of the uterus. The sound passed three inches and a half with great difficulty and pain through the internal os uteri. As little or no improvement took place in her general or local conditions after many months of treatment, I commenced the use of the stems, which shortly lessened and ultimately removed all pain and greatly moderated the hæmorrhages. She wore the India-rubber stem for seven months. About eight months after its withdrawal, she became pregnant. During her pregnancy, the tumour could scarcely be detected. She went to the full period, and was delivered, after a somewhat protracted labour, by Mr. Pocklington, with the forceps, of a living child. She has since, I am informed, made a perfect recovery.

CASE XI. Fibroid of Uterus: Dysmenorrhœa: Menorrhagia: Cure.

—Miss H., aged 36, had enjoyed good health till eighteen months ago, when she began to suffer from more profuse, prolonged, and oft-repeated losses of clotted blood, accompanied with severe periodic pains, symptoms which had of late greatly increased and made "sad inroads" on her general health. The uterus was much enlarged, very dense, with nodular deposits about the lower segment of the body. The sound passed with some difficulty and slight pain through the internal os four inches and a quarter into an enlarged cavity. As all remedies, both general and local, had failed to do more than temporarily ameliorate her symptoms, the stem-treatment was adopted with speedy good results. After wearing the stem five months, it was removed, and shortly after her former symptoms began to recur. Again the stem was introduced, and worn for eleven months, since which, upwards of two years, she has menstruated normally. She is now in excellent health, and no trace of the former mischief can be detected.

In two cases, the anteflexion was so extreme that, although the India-rubber stems were worn for many months, still they were found bent. In one, the patient was free from dysmenorrhœa at the end of many months, and may still so remain for aught I know.* As to the other, a hospital patient, from whom Dr. Godson removed the stem, I have no particulars. I have reason to believe, from a subsequent examination, that in one of these cases the uterus was bound down by adhesions to the surrounding parts. In a few cases, where there had been a tendency to a free loss during menstruation, the flow was much increased and the period prolonged, but never to the extent of inducing me to suspend treatment. In nearly all the cases, while the stem was in position, there was a more or less free secretion of mucus, in a few occasionally tinged with blood, which ceased on removal of the stem. I could have largely added to the number of cases treated during a period of nearly five years; but I have deemed it more useful and instructive to restrict myself to the narration of a few typical cases.

A friend, after having read through this paper, remarked that it would be as well to record one or more unsuccessful cases; but, as not one case of failure has at present come to my knowledge in which the stem-treatment has been carried out, I am, happily, unable to comply with his suggestion.

ON HEMIANÆSTHESIA OF SPECIAL AND GENERAL SENSATION.

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Now that attention has been frequently and strongly called to the anæsthetic phenomena of hysteria, it may be of some service to examine into the question of hemianæsthesia from whatever cause, and to compare other varieties of this condition with that due to hysteria.

I think it unnecessary to occupy time with arguments to prove the authenticity of the phenomena in question, and to show that they are not the result of "expectant attention or duplicity". It is only surprising that any prominent member of the profession should still be found to maintain such a position in public speaking and in print. I leave all such to settle their account with Professor Charcot, than whom no calmer or more dispassionate observer could be found, and I would refer them to the first volume of his published *Lectures on the Diseases of the Nervous System*.

Besides hysterical anæsthesia, a loss of sensation of the same order has been described in two conditions: 1. Chronic alcoholism; 2. Organic brain-disease. To these I would add a third condition—viz., lead-poisoning; and I will begin by narrating a case of this description which came under my own observation in Paris. The hemianæsthesia from alcohol and from lead-poisoning appears to be closely allied to the analogous condition in hysteria; because it is not apparently due to any gross lesion of the brain, and may therefore be classed with the so-called functional modifications of sensation; and because, in many cases of the alcoholic form at least, the recovery was rapid and complete.

CASE I.—P. L., male, aged 52, was admitted into l'Hôpital Temporaire, under the care of M. Lépine, on May 18th, 1877. From twenty to thirty-four years of age he had been a soldier. He denied syphilis. After leaving the army, he worked as a jeweller, and had nothing to do with lead; but, about six months ago, he began to work in some white lead works. At the end of seven weeks, he had a severe attack of

* I have recently heard that this lady became pregnant, went the full period, and was safely delivered of a living female child about two years ago.