HISTORY OF OVARIOTOMY IN ITALY.

By T. SPENCER WELLS, F.R.C.S.,
Surgeon to the Queen's Household, etc.

IN the BRITISH MEDICAL JOURNAL of March 16th, 1878, I published a short account of a case sent to me by my friend Dr. Peruzzi of Lugo, and I arrived at the conclusion which I expressed in these words: "It is very desirable that the specimen should be carefully examined. If it be really an ovary, it will certainly appear that the first case of ovariectomy in Europe was that by Emiliani of Faenza, in 1815. I have written to Dr. Peruzzi, suggesting that the specimen should be examined by some competent morbid anatomist."

Dr. Peruzzi cordially acted upon my suggestion, and I had the pleasure of meeting him in Paris last September, and I examined the specimen with him and Dr. Marion Sims, in the laboratory of Professor Ranvier, with whom the specimen was left for a more prolonged examination. Dr. Peruzzi has lately sent me Professor Ranvier's report, of which the following is a literal translation.

"A tumour, after long preservation in alcohol, has been submitted to me by Dr. Peruzzi for an histological examination. This tumour was brought from the museum of the Medico-Chirurgical Society of Bologna. The surgeon who extirpated it—Dr. Emiliani of Faenza, in 1815—thought it had been formed by the ovary, but nothing can be distinguished which resembles the Graafian follicles; it is nearly homogeneous (*assez homogène*). Microscopical sections, made in different parts of the morbid mass, were first placed in water; then they were submitted to the action of picrocarminate of ammonia; lastly, they were put up as preparations in glycerine. Owing to the prolonged

action of alcohol (sixty-three years) on the specimen, coloration by the picrocarminate is feeble, but it is sufficient to render the elements distinguishable. In all the sections which have been made, we only observe fibrous tissue and blood-vessels. The fibrous tissue is characterised by the connective fasciculi, interlaced in different directions, and by connective cells. The arteries are recognised by their muscular coat, which is well preserved. The veins and capillaries are dilated and filled with blood; the white and red corpuscles are still recognisable, which proves that the preservation of the tumour is relatively good.

"In none of the preparations that I have made are there any glandular channels, nor cysts, nor Graafian follicles. Still it might be possible that the morbid tissue had originated (*pris naissance*) in the ovary;

but then it would be necessary to admit—which is not improbable—that it has caused the complete disappearance of the characteristic elements of that organ.

"L. RANVIER.

"Paris, September 22nd, 1878."

The exact size and form of this tumour are well represented in the annexed woodcut. The length is 9 centimetres (3½ inches); greatest breadth, 5 centimetres (2 inches); circumference, 15½ centimetres (6 inches).

Dr. Peruzzi writes to me that he does not consider this report affects the question of priority in favour of Italy having the first claim to the performance of ovariectomy in Europe. Nor does he think the clinical history contradictory. The tumour was found the day after the injury, and it is impossible that it could have formed in that short time. It must, therefore, have existed before, and contributed to, the peritonitis which followed the injury; and we know how often ovarian tumours are accidentally discovered.

All this is incontestable. But I do not think this case can be regarded as a case of ovariectomy in the sense in which this operation has been regarded, from its first performance by McDowell to the present time. Until Battey's recent proposal to remove "normal" ovaries, or ovaries only slightly enlarged, no ovariectomist ever contemplated the removal of an ovary not measuring more than three inches by two inches. The removal of such a tumour could have no more bearing upon the rise of ovariectomy than the removal of a hernial ovary from the inguinal canal. Emiliani, no doubt, believed he had removed a "scirrhous ovary", and it is certain that he removed a fibrous tumour which may or may not have originated in the ovary. Professor Ranvier writes with extreme caution; but I gather from his report that, as the specimen was sufficiently well preserved for arteries, veins, capillaries, and both red and white blood-corpuscles to be still recognisable, it is, to say the least, very remarkable (presuming the growth to be ovarian) that no Graafian follicles or any characteristic ovarian structure is preserved.

THE OLD PRINCIPLE OF THE NEW ELASTIC BANDAGE.

By SAMPSON GAMGEE, F.R.S.E.,

Surgeon to the Queen's Hospital, Birmingham; Ex-President of the Birmingham and Midland Counties Branch of the British Medical Association.

No surgeon can have failed to read with the deepest interest in these columns (October 26th) Dr. H. A. Martin's memoir "On the India-Rubber Bandage for Ulcers and other Diseases of the Legs". Our Boston brother may justly claim to have introduced and established the use of a new surgical appliance of unquestionable value; but its principle of action is old. Dr. Martin very energetically rebuts a suggestion which was made at the recent Bath meeting by Mr. Solomon that "the India-rubber bandage is only a very slight modification of the domett bandage" used by "colliery surgeons in the treatment of chronic ulcers". "There is no analogy", Dr. Martin assures us, "between India-rubber and cotton, nor is there any real resemblance between the effects of bandages of these two substances in the treatment of ulcers of the leg." With much deference, I submit that the resemblance amounts to very close analogy. Dr. Martin's India-rubber bandages, with which Messrs. Salt and Son have supplied me, are of beautiful structure, and most readily adapt themselves to the limb so as to exercise gentle uniform compression. In principle, the condition is practically identical of two limbs, of which one is bandaged with Martin's India-rubber, and another nicely strapped with plaster and rolled with Churton's bandage. Both are excellent methods of exercising that uniform compression of which the therapeutic value was first adequately taught, towards the close of the last century, by Thomas Baynton, surgeon, of Bristol. His unpretending little volume* is one of the gems of surgical literature—simple, truthful, and convincing. John Scott's more ambitious, yet excellent, though almost forgotten, work† inculcated the same lessons, which, in our generation, have had such apostles as Seutin and Velpeau.

Far from me to wish to detract from the legitimate and intrinsic merit of Dr. Martin's contribution to our practice. I rather hope to furnish additional reasons for its adoption, by showing that its value depends on old and proven, though insufficiently recognised, scientific principles.

* *Descriptive Account of a New Method of Treating Old Ulcers of the Legs.* By Thomas Baynton, Surgeon, of Bristol. The second edition. Bristol: 1799.

† *Surgical Observations on the Treatment of Chronic Inflammations in various Structures, particularly as exemplified in the Diseases of the Joints.* By John Scott. London: 1823.