safe in these cases, for the silk is apt to cut through the succulent broad ligaments and cause hæmorrhage. But the operation is safer than it looks; there is no need to seek out bleeding points and tie them, packing with sponges, and the subsequent use of a drainage-tube (which may be safely withdrawn in twenty-four hours) being all that is necessary. There is very little reaction, and complete restoration to health is a matter of two or three weeks.

RUPTURE OF THE PERINÆUM: PERINEORRAPHY.

By A. WYNN WILLIAMS, M.D.,
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SEVERAL communications have appeared on the above subject of late in the pages of the JOURNAL, which, in my opinion, are somewhat perplexing. As it was I who introduced the operation as now performed at the Dorset House Branch of the Samaritan Hospital, I may perhaps be permitted to give a correct description of it. The operation was first performed by me in the year 1881, then one of the acting medical staff, and proved to be so successful that it was adopted by all my colleagues; and I believe I am correct in stating that, since then, no other operation for a like purpose has been performed in that institution. From the perusal of the various letters in the JOURNAL by Dr. Percy Boulton and others, it would appear that he (Dr. Boulton) considers the operation introduced by me, and as now performed by him, to be identical with that of Dr. Langenbeck; others, again, have said that Mr. Pridgin Teale performed a similar operation, also the late Sir James Simpson. At the most, these were only isolated cases. I maintain that there is a marked difference both in the commencement and in the completion of the operation, as performed by Dr. Langenbeck, etc., and myself. One gentleman stated that he had actually seen Dr. Emmet, of New York, perform a similar operation. When Dr. Emmet was in London, he very kindly came to my house with a friend; and, after hearing my description and examining a drawing which I had had taken by the late Dr. Westmacott, who assisted me in several private cases, Dr. Emmet at once said that the operation was entirely different from his, and that he had never seen a description of it. He explained his operation as consisting in the removal of a semilunar portion of the floor of the vagina, and stitching the cut edges together. He, or his friend, whose name I forget, made the remark, "How singular it is that there should be so much jealousy amongst the members of the medical profession in London!"

The operation, as performed by myself (a description of which will be found in the JOURNAL, under the head of Displacements of the Uterus, a paper read by me at the annual meeting of the British Medical Association at Liverpool), I will again attempt to describe; and will probably, with the aid of the woodcut, succeed in doing so.

The patient is placed on her back, the knees and thighs flexed and kept separate by means of an iron bar with knee-straps, and another round the neck and buckled at both ends to the bar—I believe the invention of Dr. Routh. By this means, the patient is kept perfectly immovable. An anæsthetic having been administered, the labia being held aside by an assistant, a horizontal incision is made on one side of the vulva, where the original fourchette commenced, nearly an inch in length. Thence a longitudinal incision along the edge of the vulva is made, and the mucous membrane is carefully dissected off to the full extent of the rupture. The same process is then gone through on the opposite side, and the mucous membrane is dissected back and removed with a pair of scissors. The edges of the fissure in the rectum are then vivified, care being taken at the same time to lay bare the ends of the ruptured sphincter ani, if ruptured; indeed, it is often advisable to cut through the sphincter ani.

The next step is to make two linear incisions on each side of the floor of the perinæum to the extent of an inch or more, as required. Then, with much care, the fingers being in the rectum, a slight incision is made in the ruptured and puckered end of the perineal body (ably described by Dr. Savage). This body is then seized with a pair of forceps by the assistant, and put on the stretch; while its separation from the floor of the perinæum is continued to the extent of the two lateral incisions. This is most easily done either by the handle of the scalpel, or even with the fingers.

The cutting portion of the operation being now completed, the requisite number of silkworm-gut sutures are inserted, and the fissure in the rectum closed; the ends of the sutures, cut short, being left in

the rectum. The perineal body or flap is then put on the stretch, and, if possible, brought up as high as the first horizontal incisions in the vulva. A long curved needle, with handle, is then passed through the external integument, care being taken to bring the point of the needle through the vivified portion internally, then through and across the vivified portion of the extended perineal body, and out again in like manner on the opposite side; care being taken that the point of the needle should at no time pierce the mucous membrane. The first suture of strong silver wire is inserted a little above the anus. Two more will generally be found sufficient. The last suture is one of silkworm-gut, and is introduced by means of a long slightly curved needle. The point is first inserted through the vivified end of the sphincter ani on the left side; then through the perineal body, and back again through the sphincter ani on the right side, and for the present left loose. The silver wire sutures are then tightened and twisted; and, lastly, the assistant introduces his finger into the vagina, and presses the perineal body firmly against the rectum, whilst the ligature passed through the ends of the sphincter ani is tied. If necessary, one or more superficial gut sutures may be inserted between or above the wires. A pad of lint, dipped in a weak solution of iodine, is then applied, and retained in position by a T-bandage.

In what does this operation differ from that of Dr. Langenbeck? In the first place, Dr. Langenbeck commenced his operation by the vivisection of the "spur" to the extent of five lines, intended to form a flap to lie on or over the rupture in the perinæum, and fixed down by two or three sutures on each side; then sutures are inserted into the fissured rectum, and drawn tight.

In the operation as performed by myself, I commence at the anterior and upper portion of the vagina, carry the vivisection right down to the end of the fissure, separate the perineal body from the floor of the vagina, put it on the stretch until it reaches the whole length of the vivisectioned parts; pass the sutures through the labia and it, as also the sphincter ani. Thus the perineal body is fixed on the ruptured perinæum, and between the vivisectioned labia; thus not only "preventing the fluids from coming into contact with the newly united parts," but giving a solid and firm support to the whole vagina, and also, by shortening the floor of the vagina, tending to draw the uterus upwards.

In cases of prolapsus with or without rupture, this operation, or, rather, the stitching the perineal body between the labia, gives such a firm support, that I have never failed to retain the uterus within the vagina, either without or with some kind of pessary. An India rubber ring, made with a watch-spring, I prefer.

The late Dr. Marion Sims witnessed me operate on a patient for complete prolapsus, who had been unsuccessfully operated on twenty-four years previously. Dr. Sims appeared rather sceptical as to the utility of the operation, stating he had never seen a similar operation performed, and would like to know the result. With the assistance of a ring, she lives in comfort. As to Mr. Tait's operation, not

having witnessed it, I can say nothing, except that it appears to me that it does not replace the various parts in their original position, or give a sufficient support to the perineum.

THE TREATMENT OF CHRONIC ULCERS.

By WILLIAM STUART LOW, L.R.C.P. (Edin.), etc., Yealand Conyers.

So much doubt has been expressed, diffidence entertained, and practitioners so frequently stigmatised as rash or timorous, according as they attempt or not to heal chronic ulcers, that a clearer understanding of their treatment and its effects is much to be desired. That there is no danger in the perfect cure of long standing and much discharging ulcerated surfaces, I maintain; and I cite the following case in evidence.

R. S., male, aged 48, had suffered for twelve years from a very extensive ulceration of the right leg. During this time, a great variety of treatment had been tried—rest, bandaging, baths, and numerous internal medicines. I found the case one of extensive serpiginous ulcer, almost one mass of broken surface on each side of the knee, back of the calf, and popliteal surface, and even extending to the posterior surface of the thigh, at some points granulating, and at others sloughing, bleeding on the slightest injury. The surfaces were deep, and the edges raised and hard, with much surrounding induration. The discharge was very offensive, and this especially so from the grumous pus expressed from numerous sinuous channels ramifying about the limb.

My patient being in easy circumstances, I had full liberty as regards any expense I might incur, and determined to make one last endeavour. I attacked the whole surface by means of a thorough ablution with a lotion of the solution of bichloride of mercury, of the strength of one drachm to eight ounces of water; this was practised daily, syringing most carefully every part of the wound, and with speedy benefit. The discharge rapidly lessened, the fetor diminished, and the sloughing ceased. New granulations sprang up all over, although not without considerable loss of blood from recurrent attacks of hæmorrhage as the dead tissues separated and the feeble granulations gave way. The dressing consisted simply of lint wrung out in the bichloride lotion of similar strength, and applied directly to the wounds.

The second feature in the treatment that I am anxious to emphasise, is the utility of iodoform as a local anæsthetic. This was very marked, relieving the pain sorely complained of in many irritable spots, contributing greatly to the comfort of the patient, and facilitating exceedingly the daily dressing. The iodoform was used freely in the form of a fine powder, dusted upon the painful spots. It proved valuable also in quickly inducing healthy action in the indolent portions of the ulcer, and, as an antiseptic and deodorant, maintained a perfect sweetness of the discharges.

I observed, in the local employment of powdered iodoform, however, that its use must not be persisted in too long, or the healthy action obtained is soon undone, the granulations breaking down under its continued action, and much bloody discharge staining the dressings; indeed, a blood-stained dressing, where iodoform had been applied, became the indication to cease its employment there. While preparing the wound for cicatrisation, by stimulating the surface, it rather retarded the growth of the cuticle, and simple dressing with bichloride lotion proved more efficacious. Lastly, its application to an inflamed surface should be studiously avoided, as it tends greatly to aggravate it.

The beneficial effect of these remedies is more remarkable, when I state that this patient rested his leg but little. Rest was a part of my prescription that he stoutly resisted, daily walking short distances, driving out, and going up-stairs. It was here that the third important point in the treatment proved invaluable; the use of resilient pressure, in the form of a Martin's elastic bandage; this was daily applied over the other dressings, from toes to thigh.

During the interval of six weeks since commencing these measures, the progress has been uninterrupted, and the cure is now complete; and I trust such encouraging results will animate many to essay the successful therapeutics of chronic ulceration.

CHARBON IN FRENCH PORK.—Charbon has never been experimentally communicated to pigs. M. Villain, principal inspector of the Paris butcher-shops, seized some doubtful looking pork offered for sale at the Halles (Central Market). M. Nocard examined it, and detected bacteria of charbon in the blood. A rabbit and guinea-pig were injected with the blood, and both died.

PATHOLOGICAL MEMORANDA.

CAUSATION OF CARDIAC POLYPI OR THROMBI.

IN the epitomised version of my remarks upon a case of thrombus in the left ventricle, at the January meeting of the Leeds and West Riding Medico-Chirurgical Society, there are two inaccuracies for which I hope I may disclaim responsibility. The chief mass of the thrombus was not "laid flat on the surface" of the apex of the ventricle, but was interlaced, as well as adherent, in the usual way. Certain detached masses were, however, adherent to even surfaces, and were clearly not at all dependent for their position upon any interlacing. "The interior of the chief (?) cardiac cavities" did not "contain puriform fluid," but only the interior of the cyst-like softening thrombus in the left ventricle contained it.

I ventured to doubt the sufficiency of the ordinary theory of the formation of cardiac polypi, inasmuch as while they are very rare, their supposed cause (feeble or dilated ventricle) is very common. In four cases examined by myself, obvious endo-myocarditis existed in three, with formation of cardiac aneurysm in two of them. In another case (fifth), a mass nearly an inch in length, three-fourths of an inch in breadth, and a quarter of an inch thick, had grown from the auricular surface of the mitral valve, and projected into the auricular cavity. This was of course merely an overgrown "vegetation." Apex-polypi or thrombi appear to me to originate in a similar manner; and their rarity seems due to the rarity of endocarditis in this position.

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CLINICAL MEMORANDA.

MORBID SOMNOLENCE.

ON January 6th, 1886, about 1 P.M., a gentleman called upon me, asking me to go and see his "domestic," who, he said, had failed to waken that morning, and was now fast asleep. All ordinary means had failed to rouse her. On going to the house I found a stout, florid, healthy girl, apparently about 18 years of age, sleeping, or apparently sleeping, quite calmly. Her mistress told me that the evening before she had suffered from toothache, and that she might have taken an overdose of laudanum. She presented none of the symptoms of narcotic poisoning. I examined the pupils, and found them both markedly dilated. I then shook her, but with no effect. Upon my slapping her cheeks, she put up her hands to cover her face, and began to weep, but other than that she showed no signs of becoming awake. I, with some assistance, got her out of bed, and walked her up and down the floor, when, after a few turns backwards and forwards, she gradually opened her eyes, looked dazed, but shortly came to herself. I ordered her a strong cup of coffee, and after that a cold bath. I asked her to come to me in the evening, when she told me the following story. She is aged 15, a strong full-blooded country girl. Her family history is good. She herself had gone through the usual infantile ailments, but never had any illness of long duration. She had not yet menstruated, and had never felt any indication of it. She had always lived in the country, and had only come to town about a couple of weeks ago. She complained of nothing; indeed, at the time she was speaking to me, she was not conscious of any ailment, and was quite at a loss to account for her excessive somnolence. About a month ago she felt this extreme drowsiness coming over her, but then thought nothing of it. I found that she had distinct anæsthesia of the right side, and pain under the right breast, and headache; she never had "fits" of any kind. She had never felt this pain so severe as to complain of it, but she had noticed that she was not quite so handy with the right hand as with the left. There was no ovarian pain.

On the morning of January 13th, I was again called to see her, on account of sound sleep. Her mistress had tried the somewhat rough and ready remedies of my former visit, but with no effect. The most remarkable feature of this second attack was that, though seemingly sound asleep, as soon as I spoke to her she cowered; and, on being ordered, in a peremptory tone, to walk about the room, she got out of bed, walked across the floor backwards and forwards, avoiding chairs and tables, turning when I told her, and all the while in an apparent sleep. I washed her face well with cold water, which gradually awakened her. She told me afterwards that she heard my voice quite distinctly, but could not speak or open her eyes, and, when ordered to walk about, she felt compelled to obey me.

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