TRACHELORAPHY.

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THE operation for the cure of laceration of the cervix uteri is at present exciting some interest, and the paper of my friend and neighbour, Dr. Tilt, in the JOURNAL of November 25th, suggests that those gynecologists who have been performing the operation, might with advantage express themselves on the subject.

I would begin by agreeing with Dr. Tilt that, in cases of slight cervical fissure, the operation is unjustifiable. As Dr. Tilt says he has "not once seen a case of extensive laceration since attention has been directed to it," it is probable that he has never performed the operation.

I have treated four cases of this kind during the last twelve months; three were private cases and one in hospital. Of these four cases, three were completely lacerated up to the vaginal *cul-de-sac* on the left side only, so that the outline of the cervix was that of a horse-shoe. In the fourth case, bilateral rupture had occurred, and the uterine lips were everted; there was considerable uterine hyperplasia, due to chronic interstitial inflammation, which had gone on ever since confinement six years previously. This patient had been under other well known men. Every kind of intra-uterine medication had failed to give any relief, and the patient was made sterile.

Here are four typical cases for the operation. In each case the forceps had not been used. Three out of the four were primiparæ, the fourth a multipara; and in her case I am inclined to think that a small fissure at the previous confinement had been considerably increased at the last, as extensive laceration with the attendant symptoms is a bar to future pregnancy.

As to the operation, I have found it necessary to pare each side of the rent for a quarter of an inch, removing any cicatricial tissue, especially at the angle or fork of the fissure, and to stitch these flaps so formed together with silver wire. There are three ways of doing this, and I have tried them all. By far the easiest is to draw the cervix down outside the vulva, but this should only be done when the uterine ligaments are sufficiently lax to allow of it without using any undue force.

I have never chloroformed my patients, and they have not complained of pain. The uterine tissue bleeds freely, and it is very tough. The bleeding ceases when the flaps are brought together with the sutures; and, as there is no difficulty in the dissection, which I do with a tiny hook to hold the tissue, and a small knife, both on long handles, the great "crux" of the operation is the stitching. When the uterus is drawn down outside, this is easy; but, when in the normal position, it is one of very great difficulty. I have done it through a Ferguson speculum, one-half the ordinary length, and in the way usually recommended by Emmet with the duck-bill speculum. I prefer a long needle of a certain curve, mounted on a handle, as being most manageable, and less likely to turn at a critical moment. The penetrating part of the needle should be finer than most mounted needles, and of the curve of two-fifths of the circle of a shilling, the eye being at the end.

The stitch must go deeply through the uterine flap, and the needle threaded afterwards, drawn back, and the wire twisted with a "twister". The number of stitches depends on the case, two or three being usually required at a side.

I am inclined to think all this manipulation is rather easier through the short Ferguson speculum than through the duck-bill. The latter allows of more play of the handles of the instruments used, but it in no way fixes the parts to be stitched, which the other speculum does. This, however, depends again on the dimensions of the Ferguson speculum, since small sizes would very much cripple the operator. There must be an inside diameter of one and three-quarter inches for play of instrument, and the total length only two and a half inches, including the rim. So much for the operation.

The local after-treatment consists in keeping the vagina clean by syringing daily; and the stitches are removed on the ninth or tenth day. I have kept my patients in bed, fed them on a light diet, and kept the bowels regular after the fourth day, allowing the urine to be passed as required. The results, so far, are three complete cures and one failure, the flaps not uniting in this case. This I shall do again shortly; and I saw another case, a few days ago, which I shall be pleased to show to Dr. Tilt either before or at the time of operation.

It is too early to speak of cure, perhaps; and, therefore, I would rather say that the parts are restored, the uterine symptoms relieved, and the patients declare they feel well. It remains to be seen, if they become pregnant, whether the uterine neck will bear the strain of dila-

tation without again giving way. As to acute inflammation of the womb and endometritis in young unmarried women, it is certainly very common; and I have several such under my care at present.

CLINICAL MEMORANDA.

HEART-AFFECTION IN DIPHTHERIA.

Now that attention is being attracted to this condition, perhaps the following lines may be of some interest. While I was assisting Dr. Lindsay, one of the most careful and accurate of clinical observers, in an extensive country practice in the west of Scotland, he drew my attention to this affection, and wondered why it had never been so prominently brought forward as it deserved to be. What pathological change occurs in the ventricular wall I am not prepared to say, but that some change does occur in certain cases of diphtheria, seems now to be generally credited. Leyden of Berlin found alterations in the muscular substance of such a character, as to justify the opinion that they were inflammatory. These alterations were fatty degeneration of the muscular fibres, with multiplication of the intermuscular nuclei. From such a condition, is it surprising that dilatation of the heart results in some cases? The following cases may be quoted as illustrations. One morning, in February 1881, I was called to attend Mrs. F., a primipara, in her confinement. The labour was an ordinary one, not more tedious than an average case of the kind, but afterwards there was a certain amount of hæmorrhage, sufficient to make it advisable to stay with her for some time. As the pulse was small and irregular, I examined the heart, and detected a murmur over the left ventricle. On inquiry, I found she had never had rheumatic fever, and she attributed the heart-symptoms—such as palpitation, dyspnoea—to an attack of diphtheria a few years before. As this, if true, was a case in point, I asked Dr. Lindsay, who had then attended her, about it. He stated that the heart-affection certainly showed itself during the course of the diphtheria. About the middle of August of last year, diphtheria broke out in a shepherd's family, whom I was then attending. The mother and a little boy, aged 8 years, were affected first, and afterwards another boy, about 11. They all got over the attack, and were able to move about. But about a fortnight after the seeming convalescence, the younger boy complained of dysphagia, particularly of liquids; and all fluids returned by the nose. The voice was nasal, and on asking him to say "ah," the veil of the palate was found to be immovable; the lower extremities were paralysed. The important thing, however, was the detection of a soft apical systolic murmur, which had not existed before in the first days of the illness, as I then had carefully examined the heart and lungs. The contractions of the heart were irregular and tremulous. The pulse was very weak. In spite of treatment with nuxvomica, cinchona, and a dietary of wine and milk, about a week after the oncoming of these symptoms, while trying to rise in his mother's arms, he, as the poor woman termed it, went off in a faint and died. As I could not obtain a *post mortem* examination, this is incomplete and unsatisfactory. The murmur might have been due to anæmia, part of the general debility, or even to abnormal innervation of the organ. Reading it, however, in the light of the first case, it is quite plausible that death was the result of acute dilatation.

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THE CAUSATION OF HIGH TEMPERATURES IN
TYPHOID FEVER AND THEIR REDUCTION.

As it is a question of first importance how to reduce promptly high temperatures in typhoid fever, I venture to state that further attention to the causation of these morbid temperatures is most likely to reward our investigation of the subject; and, as one step in that direction, I have to record the effect of counter irritation when employed for the relief of local inflammations, either at the epigastrium or various parts of the abdomen, or over the thorax. The reduction of temperature which follows their use is of the most satisfactory kind, as it is of a more permanent character, and impresses me with the opinion that all such local inflammations in typhoid cases are themselves the immediate and the most active causes of high temperatures, and these disturb the brain and produce delirium. Let any one who may differ in opinion from me carefully diagnose the inflammatory condition of the epigastrium—*e.g.*, during the prevalence of delirium—and then treat it with ordinary counter-irritation (*emplastrum lyttæ*), and judge its effects in twenty-four hours' time; and, if no other organ besides the stomach be inflamed at the same time, I believe he will be agreeably surprised at the amount of relief to the brain as well as the stomach, and will also notice the prompt