Lecture

ON

VESICO-VAGINAL AND RECTO-VAGINAL FISTULA.

DELIVERED AT THE SAMARITAN HOSPITAL,
MAY 24TH, 1861.

BY
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OPERATION.

Anæsthesia. I have always given chloroform. Dr. Bozeman and some others prefer operating without it. Supposing there is no unusual objection to chloroform in the general condition of the patient, I think she ought to be spared the mental and bodily suffering inseparable from such an operation.

Position of the Patient. Some operators recommend us to place the patient on her back, just as we place a male for lithotomy; others place her on her elbows and knees; while Dr. Sims adopts an intermediate position, letting the patient lie on her side, but well over on to the abdomen. I lay down no general rule, but simply place the patient in that position in which the fistula can be best seen and most conveniently pared; and in most cases that is the lithotomy position, but occasionally the prone or semiprone position proves better. If the lithotomy position be chosen, lithotomy-bandages to tie the hands and feet together are very useful, especially when it is not desirable to have many assistants. I have found the leather straps and hooks used by Mr. Prichard of Bristol in lithotomy a very useful substitute for ordinary bandages; they do not bruise either ankles or wrists, and never slip.

Fig. 4.

Exposure of the Opening. I show you a number of spatulas, speculums, and other contrivances for keeping the labia apart and dilating the vagina.

The duck-like speculum of Sims, as modified by Bozeman, is that which is the most generally useful. I need not trouble you by a description of it, as it is here before you. (Fig. 4.) It is, of course, held by an assistant. Great assistance is often obtained by passing a soft metallic bougie, or an uterine sound, from the urethra and bladder through the fistula, and bending it into the vagina; thus pulling the fistula forwards as if by a blunt hook. And occasionally a vulsellum will be required to draw the uterus downwards. I need not say that the patient should be so placed that the light should be thrown as brightly as possible into the vagina. We have contrived here a sort of gigantic ophthalmoscope (which you may call metroscope or hysteroscope, if you please), by which light from a gas-lamp is reflected from a perforated mirror into the vagina, and the operator can see well through the central perforation. We have a good light here, and I have not yet had to use it; but it might be of great use in some private houses, where a good light could not be had without fear of overlookers; or even here in some dark wintery days.

For *Fixing and Paring the Edges* of the fistula, a good supply of hooks, forceps, knives, and scissors, is required. A pair of long hooked forceps, and a

Fig. 5.

Fig. 6.

Fig. 7.

Fig. 8.

small knife with a long handle, frequently answer the purpose. Sometimes a straight knife, at others knives with various curves, are found convenient. Here are those most generally useful. (Figs. 5, 6, 7.)

Occasionally such a small hook as this becomes handier than forceps (Fig. 8); and a double instead of a single hook may also be useful. Sometimes it will be found easier to fix the edges by passing a thick suture (one not likely to tear) of lead wire through them before beginning to pare. In this way the edges are drawn together, and held down so that they may be easily pared. The same thing may be done by passing the curved tubular needle (to be described presently) through both edges, which are then held down until pared. By any of these plans, whichever may prove most convenient in the particular case on the table, the edges may be fixed and pared in the oblique or bevelled manner I insisted on just now. If, by transfixing one edge, and carrying the knife first in one direction and then in the opposite, a complete ring can be removed which includes the whole border of the fistula, it is very satisfactory, as we thus become quite *certain* that the whole of the borders are completely removed. But it is not very often that this can be done; and then the greatest care must be taken that every morsel of mucous membrane is removed, and two perfectly raw surfaces are ready to be brought together; for if any small portion of mucous membrane be left, it will be quite enough to prevent union.

Passing the Metallic Sutures is the next step. The tubular needle of Mr. Startin is almost always the most convenient instrument for doing this. Here is the latest improvement of this needle (Fig. 9), as made by Mr. Hilliard. Mr. Startin introduced the simple pointed tube. This was passed through both edges of the fistula, and the wire, which had been previously pushed through it nearly up to the point, was then pushed on, caught and held with forceps, and the needle withdrawn, leaving the wire in its place. Simple needles of this kind variously curved are most useful instruments. To avoid a little delay sometimes caused by the wire hitching at the curve or point of the needle and the bending, Mr. Price devised a sort of railroad and

sliding forceps to carry the wire along. Mr. Hilliard added to this the reel at the end of the handle to keep up a constant supply of wire, and this really becomes an useful addition to a needle, which, in its simple form however, is also very useful. In some very rare cases it may be more convenient to pass silk sutures, by means of short curved needles carried by needle-holders first through one border of the opening and then through the other; and then, by attaching a wire to each thread, to draw the wire into place as the thread is withdrawn, just as we find it so convenient to do when uniting the raw surfaces of a cleft palate. In whatever way we do it, it is essential that the sutures should not be more than a sixth or a fifth of an inch from each other, and that each should perforate the mucous membrane at least a quarter of an inch beyond the outer border of the raw surface. In this drawing (Fig. 10), which represents the wires as passed in a case of recto-vaginal fistula which I closed last year at one operation, the upper wires are seen passing at about the proper distance from the pared edge, but the lower ones are too close—so close that they would be apt to cut through when drawn together. I should have told you that a short blunt hook, such as I now show you (Fig. 11), or one with the short curve placed at a right angle, becomes useful to fix the spot where the point of the needle is to emerge after traversing the second pared edge. It is pressed against the spot, and the needle at once passes before it instead of pushing the mucous membrane out of place. So this little instrument of Bozeman's (Fig. 12) may sometimes assist in drawing the wires forwards without cutting the edges. It is pressed against the point of exit, and the

Fig. 9.

Fig. 10.

Fig. 11.

Fig. 12.

wire is drawn over the bridge at the end of the shaft, the bridge receiving the pressure of the wire, and preventing it from cutting through the living tissues.

[To be continued.]

Illustrations OF HOSPITAL PRACTICE: METROPOLITAN AND PROVINCIAL.

ST. MARY'S HOSPITAL.

ON SIMPLE, OR NEUROLYTIC PARALYSIS.

By C. HANDFIELD JONES, M.B., F.R.S., Physician to the Hospital.

THE following cases seem to be worth recording, if only as simple narratives of fact. Discussion as to their true pathology will find its place in the comments which I shall offer.

CASE I. M., aged 56, male, was seen April 2nd, 1861, having been ill fourteen days, since exposure to cold. He had a catarrhal affection when the paralysis came on. He suffers with wearying, aching, dragging pain about the right shoulder, with loss of power in the abductor muscles of this joint. The arm hangs close by the side of the body, and cannot be raised or abducted except by a jerk of the shoulder. The deltoid and trapezius and other muscles about the shoulder are not wasted, but are more excitable and sensitive to the interrupted current than those of the opposite side; a moderate current causes much pain in these parts, and well-marked contractions of the deltoid especially. He complains of some especial pain in the hollow of the neck, behind the sterno-cleido-mastoid muscle. Two years ago he had similar enfeeblement of the same shoulder, but not nearly to the same extent as at present; it lasted nine months. This morning he could not feed himself with a spoon, nor tie his cravat, nor put on his coat. His vision fails at times, and he has had other signs of disordered nerve-action, as tremblings, twitchings, etc. He looks and is very weak and thin. Skin warm. Pulse good. The urine used to be very thick; the last three weeks it has been clear and of good colour. Gums very spongy and relaxed; until the last nine years he used to be a martyr to toothache. He was ordered to take, three times a day, a draught of ammonia, citrate of iron, carbonate of ammonia, tincture of nux vomica, and infusion of calumba; to have compound camphor liniment rubbed into the shoulder; and to have Faradisation applied.

April 8th. His general state is improved; that of the shoulder not much so. A spot of about the size of a shilling, near the acromion, is extremely sensitive to the current. He was ordered one-sixteenth of a grain of strychnine and a drachm of tincture of cinchona, three times a day.

April 17th. He is decidedly improved, and can abduct the arm more.

May 13th. He is now quite recovered, and has full use of the arm. At times he has felt sensations in his legs of weakness and semi-paralysis. No galvanism has been employed lately.

COMMENTS. The prominent points in this case were loss of voluntary power in the abductor muscles of the right shoulder, wearying, dragging pain in the same, general debility, and general enfeeblement of nervous power; absence of cerebral symptoms, and some preced-

ing catarrh. The patient remarked more than once that he had threatenings of paralysis in his legs. The loss of voluntary power over the deltoid and other muscles was very marked, though the electric contractility and sensibility of the fibres was fully preserved, and no atrophy had occurred.

It seems to me impossible to consider this paralysis as merely muscular, or to locate it elsewhere than in the nervous system. From some cause the mandates of the will could not be transmitted to the motor organ, which was *per se* capable enough of action. It remains to be considered where the nervous lesion was situated, and of what kind it was.

As to the first point, all that can be affirmed is that, the brain and greater part of the spinal cord were probably unaffected; seeing that there were no proper cerebral symptoms, as impairment of memory, intellect, and volition, and that the paralysis was so limited. It is most likely that the seat of the disorder was either at the spinal origin of the nerves supplying the muscles, or in their peripheral course. From the circumstance that local Faradisation was of little avail, while a nervine tonic succeeded well, the former opinion seems nearest the truth.

As to the kind of lesion, I think we may exclude pretty certainly all organic changes, as degenerative softening, sclerosis from newly formed fibroid tissue, embolia of the blood-vessels, or inflammatory exudation. Had any of these existed, beyond doubt the treatment that proved successful would either have done harm or at least would have failed. It is only in a state of simple loss of power, or inertia, that it could prove beneficial. Had what is called white softening existed, it seems to me very questionable whether a powerful stimulant to the diseased and weakened tissue would not have rather tended to precipitate it into graver disease, than to restore it. I can understand that rest, good diet, cod oil, and iron might benefit such a case, but hardly strychnia. The marked debility of the general system is quite in accordance with the view of a simple loss of functional power. It appears to me that there is nothing contrary to reason and experience in the view here taken. Reason suggests that it is very possible that an organ may become so exhausted, its nutrition be so feebly performed, that it is incapable of fulfilling its function. Experience tells us that something like this daily happens with every one of us when the fatigued brain refuses to think, and the elevators of the upper eyelids can no longer keep the lids from drooping. Sleep occurs when the grey matter of the hemispheres fails in its activity and requires repose; and at this very time, as we know from the experiments of Mr. Durham and others, the circulation in the brain slackens and becomes materially less. It is not that the brain does not act for lack of blood, but it receives a less supply of blood than in the waking state, because its delicate tissue is unfit to act, and needs repose. Is it unreasonable to believe that some enfeebling influence may induce a prolonged state of exhaustion and functional incapacity? The well known case of Lord Stowell is an excellent illustration of the enfeeblement of the brain which may be produced by overtasking it, and of the temporary restoration of its power under a stimulant. It is worth remark that this patient was suffering from catarrh when his paralysis commenced.

CASE II. J. G., aged 45, a valet, was admitted on Feb. 11th, having been ill two days. He usually has good health. He does not admit drinking habits, but there is some question about this. Is much exposed to wet in following sportsman. He got very wet before this attack, which came on suddenly; he was unconscious at first for a few minutes. He is now very giddy, and so weak on his legs that he can barely stand alone, and was brought to the hospital in a cab. The head is rather hot, not painful; he has aching pains in the neck and