Dec. 7th, 1868, p. 502), the hæmorrhage was alarming, and the patient nearly died under the operation, from the quantity of blood which passed down the trachea. In another of Navratil's cases (No. 32), (*Ibid.*), the patient suffered from high fever after the operation, and expectorated a quantity of blood and pus; œdema took place round the wound, and the patient was in a very critical state.

In Schröter's case (*Medizin. Jahrbuch*, Wien, 1869, vol. xvii, 2nd Heft, p. 81), the operator observed that, after dividing the thyroid cartilage, "holding open the borders of the wound with blunt hooks gave rise to such paroxysms of coughing and caused so much fresh hæmorrhage, that the examination could only be carried out for a short time;" and, further, "that the sputa consisted of pure blood even well into the night, and on the following day the expectoration was still coloured." By a clerical error in my thyrotomy table, it was stated that this patient died in seven hours instead of eleven days, as it should have been. I regret this error extremely; because, though original y occurring in an abbreviated tabular statement, it was subsequently 'accepted as a fact, and repeated in the text.

It is certainly remarkable that Mr. Durham, who has devoted nearly a page to the exposure of this clerical error of mine, and who has given up another page and a half to the description of Schröter's case, besides referring to it on another separate occasion (*Op. cit.*, p. 29), does not once mention the prolonged and dangerous hæmorrhage which occurred, and which must have greatly prejudiced the issue of the case, even if it did not, as I believe it did, directly lead to death.

Mr. Timothy Holmes remarks with regard to his case (*Surgical Treatment of Children's Diseases*, 2nd edit., p. 311), "that the parts over the larynx were found to be peculiarly vascular." After the hæmorrhage caused by the preliminary incision had been stopped, the thyroid cartilage was divided. "The bleeding that followed was very considerable."

Again, the reporter of Mr. Davies-Colley's third operation (*BRITISH MEDICAL JOURNAL*, Sept. 28, 1872) remarks, "that the boy at one time ceased to breathe, blood having apparently run down the trachea into the bronchial tubes, and the chloroform acting powerfully on the lungs. But after artificial respiration had been carried on for several minutes the little patient recovered."

Mr. Durham even tries to qualify the only deaths he has at all admitted in the following words: "In each of these [cases] the fatal result was brought about in a manner by no means special to the operation, but, alas! of far too common occurrence in general surgical experience."

Upon this I have only to remark that when blood-poisoning ceases to follow operations, no doubt many surgical procedures will be adopted which are not at present in vogue; but that until that time arrives, septicæmia remains one of the contingent risks of all operations. On the other hand, the life of the patient is not imperilled by this danger when laryngoscopic treatment is adopted.

In referring to my observations on the mortality of thyrotomy, Mr. Durham has produced a very erroneous impression as regards my treatment of the subject. He has made it appear as if, whilst comparing the mortality of laryngoscopic treatment with that of thyrotomy, I have concealed the circumstance that the laryngoscopic cases in my essay were all benign, and that the thyrotomy table included some cases of cancer. By inference he leads his readers to suppose that I have made an unfair comparison between the two sets of cases. Mr. Durham remarks as follows:—"Considering the prospect of the operation in relation to the preservation of life, Dr. Mackenzie says, in division of the laryngeal cartilages, there is always some immediate danger to life, and nine out of the twenty-eight cases on record terminated fatally." If Mr. Durham wished to do justice to my views, it is strange that he quoted an isolated passage, and did not add the remarks on the same page (94) viz., "In six of the nine fatal cases in the thyrotomy table the disease was cancerous (or semi-malignant)."

So far from attempting to conceal the inclusion of malignant cases, I called special attention to their admission, not only in the passage referred to, but also in almost the same words when speaking of recurrence*, where I not only gave prominence to the inclusion of cancer cases, but pointed out the pathological character of the growths as a cause of their great disposition to recurrence. I also called attention to the inclusion of cancer cases at the head and foot of my thyrotomy table. It is certainly remarkable that Mr. Durham, who objects to my mode of dealing with the subject has himself adopted precisely the same plan, without any of the precautions which I have taken. In the fourth volume of Holmes's *System of Surgery*, page 584, Mr. Durham has published a table showing "the general success of different methods of

operating." In this table "operation through the mouth," that is, laryngoscopic methods of treatment are compared with "operations after external incision;" but Mr. Durham has not called attention to the inclusion of cancer cases amongst the operations after external incision. It will be seen, therefore, that whilst Mr. Durham finds fault with me for a mistake which I have not made, he has himself made the very mistake that he imputes to me.

[To be continued.]

ON THE TREATMENT OF SUPPOSED STRICTURE OF THE CERVIX UTERI.

By WILLIAM CUMMING, F.R.C.P.E., Edinburgh.

TRUE stricture of the cervix uteri is rare; not so rare, certainly, as is stricture of the urethra in the male who has not had gonorrhœa, but nearly so. Incision of the cervix, or hysterotomy, therefore, for the cure of stricture, should be one of the rarest operations in obstetric surgery. But of late years it has not been so; and it may be a legitimate inquiry, what purpose it has served when the consequences seemed to sanction its use, which unquestionably they often do.

1. There may be, or rather there is often, a quasi-stricture at the internal os, when there is congestion, hypertrophy, or other disease of the lining membrane of the uterus. This condition is relieved temporarily—it may even be cured permanently—by the hæmorrhage resulting from the incision. In my own experience, the relief generally is only temporary.

2. The same condition of quasi-stricture exists when there is hypertrophy of the body of the uterus—in many instances induced by the efforts to expel the clotted menstrual and the accumulating leucorrhœal discharges. In such cases, the hæmorrhage, coupled with adequate general treatment, reduces the hypertrophy, prevents accumulation, and helps to restore the healthy state of the lining membrane, and so relieves the supposed stricture.

3. The preceding condition is almost invariably connected with enlargement and congestion of the ovaries, either as cause or as effect; and the same hæmorrhage reduces and relieves this.

But the operation, if effectually and thoroughly performed, is one of very considerable risk, especially when followed by the introduction of sponge- or tangle-tents. The interesting mechanical, or rather dynamical, experiments of Dr. Matthews Duncan prove with what force these bodies act; and it is not difficult to estimate (if it were not sufficiently and disastrously confirmed by experience) the mischief that must in too many cases result from the laceration and irritation of the delicate textures cut into by the incision. How often this mischief has succeeded the operation, probably no one knows. Is, therefore, the operation altogether unjustifiable? I do not say so; but, as a *cure* of this quasi-stricture, it should be almost the rarest operation in surgery. Is it justifiable as a cure or relief of the conditions I have alluded to above? I believe not, for three reasons: 1. Because it does not, as a rule, either cure or more than temporarily relieve these morbid states; 2. Because it is always attended with danger; and that danger is increased the nearer the incision approaches to the internal os and the various plexuses adjoining, where the supposed need for the operation exists; 3. Because there is a much more simple, and, in my opinion and experience, less dangerous, treatment that may be employed with a larger probability of success. I cannot say utterly without risk, because every gynæcologist knows that, while there are some uteri to which almost anything may be done with impunity, there are others to which nothing can be done without startling, even fatal, results. I have known the gentle introduction of a moderate sized bougie lead to violent metritis, extending to the appendages, and not recovered from without permanent mischief; and I have also been cognisant of the same leading to acute suppuration of the ovary. But these results are so rare that, except as warnings to be both preparatory and cautious, they need scarcely be taken into account; and my present belief is, that if the gentle depletion I am disposed to advocate were employed before using the bougie, such complications would, probably, never occur.

Assuming, therefore, that true stricture is extremely rare, and that incision of the ora and cervix uteri, with subsequent dilatation by tents, is unnecessary, and may be, and often is, injurious, but that the hæmorrhage resulting from it is beneficial, I have long practised, with fair success, scarification of the os uteri, followed by dilatation with graduated bougies. By scarification the amount of blood abstracted can be limited; as much or as little can be taken away as is thought necessary (which with leeches cannot be done); congestion of the lining membrane of the womb and of the ovaries is relieved and the pas-

* The following is the expression used by me:—"In six other cases, the patient died at the end of a few months; and in nearly all of these, recurrence had taken place. They were all, however, of malignant or semi-malignant character, and therefore the tendency to reproduction was no doubt very great."—*Op. cit.*, p. 97.

sages are relaxed. By this means the bougie is more easily introduced; certainly requires less force in its use; does not rouse or increase irritation of the canal and interior of the uterus, probably even soothes them: and if there be any deposition of lymph environing the cervix, facilitates its absorption.

It is satisfactory to observe that there is now a tendency to return to the more simple and less meddlesome treatment of uterine disease, and to discourage heroic modes, the details of which are sufficient to make one's hair stand on end.

SPINA BIFIDA CURED BY INJECTION.

By J. R. WATT, M.B.,

Consulting Surgeon to the Fever Hospital, Ayr.

THE following case of spina bifida occurred in my practice some time ago, and was considered an excellent opportunity for testing Dr. James Morton's method of treatment by the injection of a solution containing ten grains of iodine and thirty grains of iodide of potassium in an ounce of glycerine: this, with Dr. Morton's cases, make three treated in this manner, all of which have been successful.

On June 28th, 1872, Mrs. M. R., an anæmic woman, was delivered of her third child, a small and weak boy of full time. In the position of the third, fourth, and fifth lumbar spines, was a sessile semi-transparent flesh-coloured fluctuating tumour, as large as an ordinary sized hen's egg, and so sensitive that simple contact of the finger brought on fits of crying, during which the investing membrane became very tense. On firm pressure with the finger, a vacant space, bounded at the sides by bony ridges about half an inch apart, was found in the usual position of the vertebral spines; and, when viewed by the transmitted light in a darkened apartment, cords were seen passing near the surface. A pad of cotton-wool was placed over it under a firm binder, and the child was duly seen for a week. It moaned almost constantly, slept little, and took the breast badly. Its legs dangled, and no voluntary attempt was made to move them—slight movement of the toes being the only reflex action from tickling its soles, and the sphincters seemed very weak.

On August 2nd, the tumour was much larger, measuring eight inches in circumference. The most prominent part was ulcerated superficially; the lower border overhung the sacrum. Two drachms of clear fluid were removed by Wood's syringe (which was used throughout), care being taken to avoid the nerve-cords. The cotton pad and binder were replaced; and the child was ordered to have half a teaspoonful of spirits in water every three hours.

On August 3rd, the tumour was one-half less; from the needle-aperture drops of clear fluid still oozed, and from the soaked condition of the pad and binder a constant escape must have gone on. The child looked much exhausted, but had had no convulsive symptoms.

August 11th. The tumour was as large as before interference. From its upper edge a second quantity of two drachms was removed. The child was kept with the face down on the nurse's knee, with the back uncovered; and the aperture closed in a short time.

August 17th. A third quantity of two drachms was removed, and half a drachm of Dr. Morton's solution was injected. The child cried immediately. The spirits and water was continued.

August 18th. The child had slept very little, and appeared very weak. The tumour was unchanged in size, and along the left border a faint blush was present, which faded in about four days.

August 26th. The tumour was slightly decreased; the membranes were lax, and the fluctuation-wave less distant.

September 13th. The tumour was nearly level with the back, and was replaced by a large half-dried resistant scab. The child was firmer; the legs never moved together, but when the soles are tickled one or other leg was drawn up a short distance. The sphincters were more under control.

February 21st, 1873. A cake of firm condensed tissue occupies the site of the tumour. The child was much grown, plump, and thriving.

It may be remarked that, even although the tumour and the cavity of the spinal membranes communicated, as shown by the nerve-cords in view, and the greatly depressed fontanelle after the first withdrawal of fluid, yet no irritation spread along the cord from the injected solution, and the result must be considered successful.

MUNIFICENT CHARITY.—It is said that the "tri-literal" benefactor of many London charities, whose gifts the week before last amounted to £10,000, is one of the nephews and heirs of the late Richard Thornton, who left about four millions of money. —*Guardian*.

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

MIDDLESEX HOSPITAL.

THREE CASES OF HÆMATOCELE.

(Under the care of Mr. HULKE.)

MOST hæmatoceles, it is well known, originate in hydroceles, and this by the bursting of blood-vessels distributed upon the inner surface of the tunica vaginalis, either from external violence, which may be so slight as hardly at the moment to attract notice or to escape it altogether, or in consequence of vascular fluxions attending a transient increase of the subacute periorchitis, in which the greatest number of hydroceles have their origin. Where the quantity of blood thus added to the serum already present in the cavity of the tunica vaginalis is considerable, the course and treatment do not materially differ from those of an uncomplicated hydrocele. The coagula which remain after the fluid contents have been drawn off usually shrink, and finally disappear without occasioning any trouble. Where, however, the contents are principally blood and the coagula are bulky, the size of the swelling can be but little reduced by tapping, and an incision will be required for their removal. It usually happens that small portions of blood-clot remain, and their putrefaction makes the discharges excessively fetid, and is apt to induce purulent œdema and necrosis of the cellular tissue of the scrotum. In order to avoid these contingencies, the incision for the removal of the clots should be carried to the bottom of the hydrocele so as to afford a free exit at the lowest point, and the cavity should be syringed with sulphurous or carbolic acids, and the dressings moistened with the same. The careful observance of these measures will greatly lessen the intensity of the local processes, and diminish the surgical fever—matters of some moment in all, and especially in aged and feeble patients. In spurious hæmatocele, where the blood escapes into the cellular tissue, it is more rapidly absorbed than when in the tunica vaginalis; and rest, with the use of a discutient lotion, is generally attended with a cure.

CASE I.—A man, aged 42, was admitted into Forbes Ward on April 22nd, 1871, with a non-transparent fluctuating swelling of the scrotum, seven inches long and fourteen in girth, hiding the right testis. He said that there had been some swelling here for a long time; but, as it was painless, he thought nothing of it until about a fortnight ago, when it became tender and red and larger. Twelve ounces of bloody serum were drawn off with a trocar, after which the testis was felt at the lower and back part of the scrotum; at its outer side and also above it were two hard masses, presumably coagula. When he left the hospital some time later, these had already lessened.

CASE II.—A painter, aged 31, was admitted into Forbes Ward on January 18th, 1868, with a pear-shaped scrotal swelling, hiding the testis, and reaching as high as the external abdominal ring. It was very tense, it fluctuated indistinctly, it was not transparent, and it had a bluish tint when the skin was tightly strained over it. He said that six months previously, he had had the swelling tapped at King's College Hospital, when clear water was drawn off. After this the swelling gradually returned, and a fortnight before he came to the Middlesex Hospital he was aware of an alteration in its shape. He had had a hydrocele on the other side radically cured. The swelling was tapped, but only a little bloody serum ran out; and, as the bulk of the swelling was not appreciably lessened, the tunica vaginalis was slit open, a large quantity of blood-clot scooped out, and a drainage tube was passed from the wound through the bottom of the scrotum. Suppuration followed. Putrefaction of the portions of the clot which were left was prevented by daily syringing the cavity with a solution of carbolic acid and by antiseptic dressings, and he left the hospital healed at the end of a month.

CASE III.—A labourer, aged 69, falling from a ladder upon a beam, bruised his external genitals. Soon after, when brought to the hospital, his scrotum and the left side of the body of the penis and glans were inky-coloured, and the scrotum, principally its left side, largely distended and tense, but the testis could be plainly felt in its normal place. The scrotum was kept raised upon a pillow, and lightly covered with solution of muriate of ammonia. Ten days afterwards, the ecchymosis and the distension of the scrotum were nearly gone, and now several veins in the spermatic plexus were felt firmly plugged with hard coagula.