incompatible materials should suffer arrest in the fine capillary meshes of the air-cells?

All that I am pleading for are grades of pyæmia. The acute or more rapid forms, with multiple abscesses in the lungs, are, in point of causation or pathology, well understood; but wherefore withhold a like etiology—minute arterio-capillary pluggings—from those cases of phthisis which follow fever, ague, protracted cases of rheumatism complicated by bed-sores, and those other debilitated blood-states in which embolism and thrombosis are known so frequently to arise?

If you find the term embolic phthisis still too hypothetical, call this variety blood-poisoning phthisis; but remember all its principal clinical facts. The lung-symptoms are always of sudden access. They follow or occur as complications upon some other grave disease. The fever is continued, but the morning temperature is usually higher than that of the evening. Lobular pneumonic symptoms are speedily and generally extensively exhibited; but, unlike ordinary scrofulous phthisis, early bronchial catarrhal symptoms, cough, and hæmoptysis, are not forthcoming. You will find this form of disease very little amenable to treatment. I do not say it never suffers arrest, for I believe that it does, and that I have seen such cases; but they are exceptional, not to say most rare. It happens more often to dark sallow-skinned than to lymphatic persons. The treatment which I have found best adapted to the general condition is sustenance such as can be taken; stimulants, for these are requisite in lieu of food which the stomach will not support; and, as medicine, a mixture in which infusion of digitalis, nitrate of potash, and the watery extract of opium, are the potent ingredients.

ON THE ORIFICES OF THE UNIMPREGNATED UTERUS, AND THEIR SURGICAL TREATMENT.

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IN the throes of departure from my winter retreat at Mentone, I have hitherto failed to notice Dr. Matthews Duncan's strictures on the above subject (BRITISH MEDICAL JOURNAL, March 8th). An interval of repose, however, affording me the required leisure, I again revert to this important question.

Dr. Matthews Duncan's explanation of his practice in dilation of the uterine orifices forms a most necessary corollary to his "scientific" papers. The former certainly left on the reader's mind the impression that he was a much more enthusiastic "dilator" than he proves to be. Thus, he repudiates the existence of actual strictures of the uterine orifices comparable to those of the male urethra; he admits the usual permeability of the uterine canal to the bougie or sound, and rejects dilatation as a panacea for sterility; indeed, he accepts a greater degree of natural permeability of the entire uterine canal than I myself am prepared to admit. Thus, I can generally introduce, with a little firm continued pressure, a small wax bougie, warmed, bent to the natural curvature of the uterine cavities, and used with a speculum; but I also constantly find, in the same cases, the uterine sound, or a larger bougie—even a 6 or an 8, still more, a 12 or 13—arrested at the os internum, whether introduced with or without the assistance of the speculum. Dr. M. Duncan, indeed, appears all but to confine dilatation to spasmodic or pseudo-membranous dysmenorrhœa, and that all but empirically, without seeing exactly how it acts. If so, I am still at a loss to know what are the classes of cases in which the uterine sound is bent in overcoming resistance, or in which the resistance overcome is equal to a pressure of four pounds. I repeat that, in my opinion, in uterine practice such a degree of force is altogether unjustifiable, whatever the nature of the case, even experimentally. To use it, is to court disasters and catastrophies.

Satisfactory as Dr. M. Duncan's explanation of his practice appears to me, satisfactory as it is to me to learn that he mostly agrees with the doctrines I teach, I must be allowed to add that he does not explain in what respect it is that he considers the views and statements contained in the paper I read last August before the Association at Birmingham, "anatomically, physiologically, and pathologically wrong". I consider that I have a right to ask whether these words were written hastily, without deliberation, or whether they are the true expression of his sentiments. In the latter case, the questions at issue are certainly of sufficient weight and scientific importance in gynecology to demand due discussion and consideration. I would also remark that it is on these very views that my own practice and teachings are founded. I will recapitulate in a few words the opinions which I entertain and teach respecting the uterine orifices.

1. *Anatomically*, the uterine cavities are two in number; the cavity

of the uterus, triangular; the cavity of the cervical canal, infundibuliform. The cavity of the cervical canal is limited—externally, by a contraction of the os externum, usually patulous, and easily dilatable; internally, by a more decided contraction, which separates it from the uterine cavity, and is called the os internum. This internal contraction, I maintain, is formed by the circular fibres of the cervix, and constitutes a species of sphincter, although no positive sphincter, like that of the anus, is anatomically demonstrable. This double sphincter reproduces, anatomically, the sphincters which close the other large splanchnic cavities—the stomach, the intestines, the bladder.

2. *Physiologically*, these sphincters, especially the uterine one, are vital, close and open by a vital contraction; and a more or less vital contraction and closure is the usual condition during life. After death, this vital contraction ceases, as well as that of the sphincter ani, and must not, therefore, be looked for. These sphincters open for menstruation, probably for conception; and the internal one closes on the contact of a foreign body, such as the uterine sound. They are also more or less susceptible of contraction, according to individual idiosyncrasy. Thus in a perfectly healthy woman (in the interval of menstruation) having a perfectly healthy uterus, the uterine sound or a bougie (No. 8 or 10) separates the lips of the os internum with ease, passes into the infundibuliform cavity of the cervix, where lateral motion is generally possible, and reaches the os internum, one inch and a half from the os externum, there to be arrested, generally speaking, by its vital sphincter-like contraction. Sometimes slight pressure will pass it into the uterine cavity, sometimes it will not. Nothing short of unjustifiable force will succeed; although in these same cases a smaller wax bougie, warmed and bent, will generally pass.

3. *Pathologically*.—Such being the case anatomically and physiologically, the healthy os internum in the perfectly healthy uterus usually resisting the passage of the uterine sound or of a moderate sized bougie, it is a most egregious pathological error to consider this mere impediment to the entrance of the sound, apart from other morbid phenomena, a pathological condition warranting dilatation or division. So far from resistance to the sound at the os internum being a sign of disease, it is a sign of a healthy natural vital state of the parts. The free and easy passage of the sound into the uterine cavity, without pressure or force, is, on the contrary, generally an evidence of an actually morbid state of the organ. The extension of inflammation of the mucous membrane of the cervical canal to the cavity of the uterus, relaxes and paralyses the os uteri internum; so do endometritis itself, or any morbid state that enlarges the body of the uterus; metritis, acute or chronic; non-involution of the uterus after labour or abortion; or a fibrous or other growth developed in its tissues. Inflammatory hypertrophy, however, of the cervix may mechanically approximate, partly close, the entire cervical canal. The hypertrophy removed, the canal relaxes of itself.

Such are the views and statements which Dr. Matthews Duncan has stated to be *seriatim* wrong. I repeat that it is of the most vital importance that the real anatomical and physiological condition of women should be cleared up and firmly established as a basis of pathological work. If the above views be right, any healthy woman in the kingdom, casually examined, may be pronounced pathologically wrong, and treated for strictures which do not exist, dilated or divided—a really frightful state of things. Indeed, I firmly believe that hundreds are so treated every year, conscientiously, but under the influence of mistaken ideas as to the anatomy and physiology of the uterus. Indeed, many who have written and practised during the last few years seem to look on the uterine canals as comparable to the waste-pipe that carries off the water from the roof of a house, and to them nearly all uterine pathology is centered in fancied or real obstructions; just as another class of modern gynecologists have got into their heads that the uterus, the most movable organ in the economy, the "animal in animal" of the ancients, is a mere joint, like the knee- or elbow-joint, liable to dislocations, twists, and turns of every kind, and that nearly all uterine pathology lies in these fancied and exaggerated displacements.

Under the influence of these fallacies and errors, I am constantly seeing errors in practice, cases of constitutional lifelong dysmenorrhœa (or painful ovulation) divided or dilated by one, treated by pessaries left for a year or two by another, irrespectively of all constitutional considerations, and with no beneficial result whatever. The dependence of menstruation on ovulation, of ovulation on the nervous system, of the nervous system on diathesis, on hereditary and health antecedents, is often entirely ignored; and in one of the most complex branches of pathology, imperfect surgical notions are often substituted for rational treatment or non-treatment. In many of the cases thus surgically mistreated, actual lesions, important lesions, inflammatory and nutritive, are not unfrequently overlooked and ignored.