did about two pints of dark blood clot; the uterus immediately contracted and was drawn out of the wound; two pins were passed through the cervix, and, while Mr. Warlters was adjusting and tightening Koeberlé's *serre-nœud*, I enucleated from its adhesions in the pelvis a dermoid ovarian cyst rather larger than an orange. The uterus and tumour were cut away; the abdomen washed out with sterilised water and sponged dry; the wound was united round the stump, no drainage tube being used. The operation was completed in half an hour.

The shock which followed was very severe, and was vigorously treated with artificial heat and brandy. The pulse remained feeble for many hours. She slowly rallied; then followed complete suppression of urine for sixty-eight hours, so that I began to fear lest the ureters had been included in the clamp. However, by the greatest care in the after-treatment, and especially at this time, after prolonged hot sponging, the kidneys began gradually to act. At first only 4 ounces of urine were passed in twenty-four hours; next day 8 ounces; then 13 ounces, then 15, and so on until the normal amount was reached. Portions of slough were cut away, and the clamp came off on the seventh day.

She had the best nursing, and the most careful attention to dieting and after-treatment, her convalescence extending over six weeks, after which her recovery was complete, and she went to the seaside.

At the present time—January, 1893—she is in perfect health.

NOTES OF A CASE OF VAGINAL MYOMECTOMY PAR MORCELLEMENT.

By JAMES MURPHY, M.A., M.D.,

President of the North of England Branch of the British Medical Association.

I HAVE been waiting for several years to find a case of uterine myoma suitable for removal by the vagina by the method of *morcellement*—taking it away piecemeal—invented and practised almost daily by my friend and former teacher, M. Péan. I have had the advantage of having assisted M. Péan in at least twenty similar operations, and to see him do the operation is to me one of the most interesting sights in the whole field of surgery, and shows him as the original, brilliant, and dexterous surgeon that he is.

I am indebted to my friend Dr. Drummond, of South Shields, for the opportunity of doing my first case, as he was good enough, in January, 1892, to place under my care a patient with the following history.

History and Condition before Operation.—Mrs. S., aged 42, mother of one child, aged 18, had suffered from a myoma in the posterior wall of the uterus for some years. For the past few months it had caused her great inconvenience from its pressure on the rectum and bladder, necessitating the almost constant use of the catheter. The pain was severe and the tumour was growing. Some hæmorrhages had occurred, but the reasons for removing it were—increasing growth, pain, and the rectal and bladder troubles caused by its pressure. On examination, a large tumour could be felt in the posterior uterine wall blocking the pelvis. The os was represented by a slit high above the pubes, and the tumour presented in the vagina a condition very similar to a pregnant retroverted uterus. On examination of the abdomen the tumour reached nearly to the umbilicus.

Operation and After-history.—On February 3rd, 1892, she was placed in the lithotomy position, her legs supported by Clover's crutch. I then incised the capsule of the tumour from before backwards, stripped it off as far as I could, then, applying a powerful forceps to the tumour, snipped off a portion the size of a Tangerine orange, with a strong scissors. I then removed a similar portion at each side, and in this way, always working from the circumference to the centre, removed piecemeal more than three-fourths of the tumour, when I was enabled to enucleate the remaining portion. As there was considerable oozing of blood, I plugged the cavity with some wood-wool, a small portion of which I unfortunately overlooked in removing the plug next day. This had the effect of sending the temperature up to 104° on the sixth and seventh days; otherwise she made an excellent recovery, and the uterus now feels like an ordinary multiparous uterus, and she is in perfect health.

REMARKS.

The accompanying excellent drawing, for which I am indebted to the kindness of my friend Dr. Baigent, explains the mode of operating. From the position of the myoma, situated as it was in the posterior uterine wall, and protruding into the vagina and completely filling up the pelvis, it would have been impossible to have removed it by abdominal section and extra-

peritoneal clamp, and to have removed it through the abdomen by first tying the vessels in the broad ligaments, and then removing the whole mass, both uterus and myoma, would have left an enormous opening between the abdomen

and vagina, difficult, if not impossible, to close; whereas by removing it as here recorded, the peritoneum is not opened and the uterus is left behind.

THE GRAPHIC METHOD APPLIED TO THE DIAGNOSIS OF OBSCURE ANEURYSMS.

By W. SOLTAU FENWICK, M.D.LOND., M.R.C.P.,

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AND

WALKER OVEREND, B.A.Oxon., B.Sc.,

Late Radcliffe Fellow, Oxford.

In a paper read before the Medical Society of London recently Dr. Richardson drew attention to a method of intrathoracic auscultation which he proposes to employ as an aid to diagnosis in cases of commencing stricture of the œsophagus, in certain diseased conditions of the stomach, and in cases of aneurysm of the larger thoracic arterial trunks. It so happens that during the early part of the year 1890 we made a series of experiments in the same direction. In the first instance it was the great difficulty experienced in the diagnosis of an aneurysm of the descending portion of the arch and of the thoracic aorta which induced us to employ an intrathoracic method. By its means we hoped to obtain graphic records of movements communicated to various parts of the œsophagus. We also imagined that the method might prove serviceable in the diagnosis of aneurysm in the upper part of the abdominal aorta, and, when introduced into the rectum, in the recognition of aneurysm of the common and internal iliac trunks.

The apparatus consisted of a long soft rubber œsophageal tube, to the end of which a piece of very thin elastic membrane, capable of inflation, was firmly secured. At the opposite end the tube was connected with a Marey's tambour and with a

short piece of rubber tubing, for the purpose of filling the apparatus, including the fine membrane, with air. At times, also, instead of the tambour, the tube was joined to a binaural stethoscope for auscultation. The œsophageal tube was graduated in inches, and we could readily determine, from measurements made on the dead body, the exact situation of the extremity of the tube by reading off the scale at the level of the teeth. The tube being passed into the œsophagus and the apparatus filled with air we were able to record the movements communicated through the œsophagus to the terminal bulb at any level of the chest, the lever of the tambour writing on a revolving drum.

The first observations were made upon persons presumably in health, the difficulty of retching and vomiting being partially overcome by painting the back of the throat with cocaine and by operating only when the stomach was empty. Subsequently we intubated the œsophagus more satisfactorily in patients suffering from dilatation of the stomach, who were accustomed to the passage of a tube for the purposes of lavage.

It was found that no appreciable movement of the lever took place until the tube had reached a distance of about 10 inches from the teeth, and that the maximum effect in healthy persons was obtained at a distance of 14 to 15 inches.

Figs. 1 and 2 represent tracings from a healthy individual

Fig. 1.—Intrathoracic tracing from a normal case at 12 inches from the teeth.

Fig. 2.—Intrathoracic tracing from a normal case at 14 inches from the teeth.

at distances of 12 and 14 inches from the teeth respectively. The larger and ampler undulations are due to variations of pressure induced by the respiratory movements, the lever sinking during inspiration and rising again in expiration. The smaller waves superimposed upon the larger are vascular in origin, and are probably impressed upon the elastic bulb by actual contact. The exact meaning of the two elevations to each cardiac beat we have not attempted to decipher, but it seems probable that the first is due to the contraction of the ventricles and the second to the pulsation of the descending aorta. This might, of course, be determined by the comparison of a cardiogram of the apex beat written simultaneously and in conjunction with the above.

We now pass to the results obtained from cases presenting an aneurysm in the descending portions of the aorta within the chest. In the first, the patient was a labouring man, who had suffered previously from syphilis, and was admitted into the London Hospital with the signs of compression of the left bronchus. The symptoms and physical signs pointed unmistakably to the existence of an aneurysm of the aorta, probably situated in the descending portion of the arch. There was no dysphagia. The passage of the tube gave rise to considerable dyspnoea and retching.

In Figs. 3 and 4 are shown two tracings from this patient.

Fig. 3.—Intrathoracic tracing from a case of aneurysm of the descending portion of the thoracic aorta 12 inches from the teeth.

Fig. 4.—Intrathoracic tracing from the same case at a distance of 15 inches from the teeth.

In the former, at a distance of 12 inches from the teeth, there is nothing worthy of comment. In the latter, 3 inches lower down, it will be noticed at once that the curves are much increased in amplitude, especially when the lever falls during inspiration.

In another case (Fig. 5) of a similar nature, the tracing recorded at about fourteen inches from the teeth presented characters almost identical with the foregoing, the shape and amplitude of the smaller waves being much augmented, while no such deviation from the normal could be detected a few inches either above or below this spot. In each case the end of the tube was subsequently disconnected from the tambour, and inserted into the end of a binaural stethoscope. In the former patient a loud double *bruit* was almost painful in its intensity; while in the latter there appeared to be a continuous roar, no distinct intermission being audible.

It may be mentioned that when the tube was inserted into the stomach, and the elastic bulb distended with air, a slight secondary undulation of the lever was still discernible on the tracing, while the respiratory curves assumed an inverse character, the lever rising during inspiration and falling during expiration. This effect was probably dependent upon a rise of pressure within the stomach caused by the descent of the diaphragm.

Having procured such marked evidence of increased pulsation in the neighbourhood of aortic aneurysms, and bearing in mind the ease by which simple hypertrophy of the heart could be discriminated, it seemed probable that the method might prove of some practical value in the diagnosis of obscure cases. In this expectation we have been disappointed. Up to that time we had intubated the œsophagus in a large number of cases of suspected aneurysm without any prejudicial effects, and we concluded that the cautious introduction of a small soft tube could not possibly give rise to any danger. In one case, it is true, the patient had strained a good deal after the tube had been withdrawn, and had eventually spat up a few teaspoonfuls of blood; but as this symptom had occurred previously, we did not lay any particular stress upon

Fig. 5.—Intrathoracic tracing from a case of aneurysm of the descending thoracic aorta, 14 inches from the teeth.

the fact. In our final case, however, where every possible precaution had been adopted, and where the signs of aneurysm were at that time somewhat obscure, the straining and retching caused by the tube brought on an immediate attack of hæmorrhage, which frightened the patient and occasioned us the gravest misgivings. After this incident we carefully reconsidered the question, and finally decided to abandon the method. Although it is rational in device, easy of performance, and undoubtedly serviceable in diagnosis, the extra risk to life, in our opinion, cannot compensate for its probable advantages. We think, therefore, that the introduction of a tube, however fine or flexible it may be, in cases of suspected aneurysm is dangerous; and we give this brief account of our experiments as a warning to investigators who may subsequently wish to follow up this line of research.

NOTE ON A GROUP OF SYMPTOMS COMMONLY ATTRIBUTED TO DISLOCATION OF THE NECK.

By WILLIAM THORBURN, F.R.C.S.,
Assistant Surgeon to the Manchester Royal Infirmary.

For some years I have been familiar, from verbal description, with a series of symptoms, not uncommonly met with among the Lancashire colliers as a result of injury to the head or neck, which symptoms are, I believe erroneously, generally assigned to some form of luxation of the cervical vertebrae. No case of the nature referred to has come under my personal observation, at least in its typical stage, and I have tried in vain to obtain information upon this condition other than is contained in the following remarks. The present note is thus intended mainly to call the attention of others to the subject, in the hope that thereby some satisfactory explanation may be brought to light.

The condition referred to is generally spoken of in Lancashire as "having the neck knocked out." The head is said to be twisted by a blow or fall; the patient "goes black in the face" and appears to be choking; some bystander forcibly straightens the head or "puts the neck in;" and recovery apparently always ensues.

The only patient who has personally described such symptoms to myself was a woman, aged 38, who stated that, about nine weeks before I saw her, she had fallen down a narrow staircase of some thirteen steps, striking her head at the bottom in such a way as to bend the neck forwards and to force the head between the knees. Her sister ran to her, and says she found her black in the face; she seized the head and threw it back. The patient was then put to bed, and could not walk for five weeks. A medical man who saw her told her

that the head had been "put out" and then "put in again." While confined to bed she had a succession of "fits," and her head became drawn to one side; for some days she seems to have been comatose, and to have had unconscious evacuations, and for more than a week she could not move her right arm. When I saw this patient she had most typical symptoms of hysterical hemianæsthesia, with spasmodic torticollis, very marked contraction of both fields of vision, and other symptoms, all of which were unquestionably functional only. The existence of these hysterical conditions naturally renders the description of little value, were it not so precisely similar to that given by others in whom there has been no suggestion of functional neurosis.

My friend, Dr. J. P. Williams, who has had a large experience of practice among the Lancashire colliers, has kindly given me the following description of the usual account of symptoms as detailed to himself:

From the accounts I have heard, I gather that, immediately after the accident, the subject's head is turned towards one shoulder, and cannot be brought back to a natural position by his unaided efforts; that he struggles for breath, goes black in the face, and appears to the onlooker likely to die from suffocation. I have not, however, heard of any case which has actually ended fatally. The condition is relieved by someone holding the patient's head between his knees and forcing the shoulders downwards, when the head returns to its natural position with an audible click, and the symptoms of suffocation pass rapidly away. I have not heard of any secondary symptoms following the injury.

Like myself, Dr. Williams has never actually seen a case, nor do I know any medical man who has, but, through the kindness of Dr. Buckley, recently house-physician to the Manchester Royal Infirmary, I have obtained the following account from an intelligent eye-witness of one of these accidents:

D. Q., a farm labourer in the employ of Mr. U., was loading hay on a lorry when he overbalanced and fell, striking the ground with his forehead. The fall was about 2½ yards. Mr. U. was standing near, and at once went up to him, and found him lying with his head on the ground and his legs up, leaning against the wheel of the lorry, which was standing still at the time. He pulled him away from the lorry, and found him unconscious, not breathing, and face very blue. He thought the neck was dislocated, and at once got behind his head and pulled at the jaw, trying to reduce it, and almost immediately he says the man began to breathe, and he gradually came round. Altogether Mr. U. thinks the man was unconscious about four minutes. Then his nose bled profusely, and he noticed both eyes were bloodshot, most marked on the nasal side of each eye; right eye more than left. Q. complained very much of a sore stiff neck and arms, and walked about with neck and arms very rigid. This has gradually improved, and now, six days later, he seems to be quite well except for slightly stiff neck and slightly bloodshot eyes.

So many similar descriptions have reached me from various sources that I cannot but accept the existence of a train of symptoms such as those above mentioned, although I have no satisfactory explanation to offer. The essential features of these cases appear to be twisting of the neck and suffocation, with intense venous congestion of the face, which may, as in the case last quoted, lead to ecchymoses; and it seems to me most probable that we are really concerned with either a dislocation of the hyoid bone occluding the glottis or a lateral