As to treatment, quinine, digitalis, antipyrin, etc., seem to be worse than useless, but tepid or cold washing, whenever the temperature reaches 102° , is certainly of very great use; ice on the head, milk diet, and a small quantity of stimulants towards the end of the illness have been prescribed in my case. I also gave acetate of ammonia, with the view of increasing elimination by the kidneys.

ON ACUTE ANTEFLEXION OF THE UTERUS IN THE LATER MONTHS OF PREGNANCY.

By JAMES BRAITHWAITE, M.D.LOND.,
Obstetric Physician to the Leeds General Infirmary.

A CASE of pregnancy was sent to the Leeds Infirmary in September, 1892, with a letter from two medical men of experience, saying that they believed the case to be one of extra-uterine gestation.

The patient was aged 34, and had had five children, the last two years ago. In April, 1892, the patient believed herself to be again pregnant. In July she began to bleed a little every day but in small amount, and this hemorrhage continued up to the time of her admission in September. There was a large rounded central abdominal tumour reaching half a finger's breadth above the umbilicus, and occupying the greater portion of the abdominal cavity below. Whether this was the womb or not it clearly contained a living child, for its movements could be felt by the hand. Vaginal examination found a rounded swelling anteriorly, and the uterus apparently lying behind it, and with no continuity with it so far as the finger alone could ascertain. The finger, pressed up between the tumour and the cervix, did not arrive at any point of union. The uterus also seemed to be movable independently of the tumour to the moderate degree which its cramped position behind it admitted, for it was pressed against the sacrum. This, as it will be seen, turned out to be a mistake, but at the time it gave me this impression. The cervix was very dilatable, and I passed an index finger up, and at a height of about 2 inches reached the top of a very elongated cervix. The finger could then be turned forward into the cavity of the uterus, and the fetal head, covered by the membranes, was felt. Labour came on the same day, and was concluded satisfactorily.

I certainly thought on first examination that the child was not in the uterine cavity. In the year 1888 I was associated with Mr. E. O. Croft, of Leeds, in a similar case.

Precisely the same condition was found as in the case already described, and much doubt existed whether the child was really in the womb or not. The cervix, or the uterus, lay directly behind the tumour and parallel to it, and no continuity, or but a doubtful one, between them could be detected. I dilated the cervix sufficiently to admit of the passage of the finger, which at the height of fully 2 inches reached a ledge anteriorly, over which it could be passed somewhat downwards and forwards into the uterine cavity. The ledge was formed by the angle between the cervix and body, and it was necessarily pressed downwards to admit of access to the uterine cavity. I ruptured the membranes, and the labour was completed the same evening or next morning by my friend, but it was difficult.

At the beginning of November, 1892, I admitted another case into the ward, precisely like the other cases related. It should be noticed that in these cases there was anteversion only, without more version than enough to draw the cervix upwards a little. Secondly, that the cervix was somewhat elongated and pressed between the body of the uterus and the sacrum. It was not carried up almost out of reach as in the ordinary anteversion with pendulous belly, but it was a little elevated. Thirdly, all the cases were primiparæ, and, as might be expected, in none of them was there what is known as pendulous belly with separation with the recti muscles. Indeed, the two conditions—acute flexion and pendulous belly—are inconsistent with each other, for it is the absence of yielding in the abdominal walls which favours the flexion.

Although there are many references to anteversion with pendulous belly, there are, as far as I can discover, on record only two cases of the condition which forms the subject of this paper. Matthews Duncan, in his *Diseases of Women* (1886, p. 397), says that in advanced pregnancy we have two kinds of anteversion; one, common pendulous belly, the other extremely rare; he adds, "I have seen only one case of it in a primipara." In this case the uterus was anteverted, and could not be replaced as in common pendulous belly. It was, in Duncan's opinion, not displaced secondarily, but grew into this peculiar shape and position.

A second reference to it is in the *American Journal of Obstetrics* (February, 1890, p. 156) in which a case is recorded as one of "dextro-torsion of the pregnant uterus simulating extrauterine pregnancy." This case is precisely like those I have related except that the body of the uterus fell to the right side instead of directly anteriorly. The writer of this

paper is Dr. W. H. Wenning, of Cincinnati. The case is exactly simulated extrauterine gestation that after numerous consultations and examinations Dr. Wenning and his friends proceeded to abdominal section.

On opening the body Dr. Wenning says, to use his own words, "general surprise and consternation seized us all," for nothing was found but the pregnant uterus bent like a retort.

Dr. Wenning made a complete search into the German literature of the subject and he states that Küstner¹ relates a similar case to his, except that the patient was in an earlier stage of pregnancy. Barnes, in his *Diseases of Women* (1873, pp. 671-672) observes: "In some rare cases of early pregnancy the fundus has been locked behind the symphysis pubis in complete anteversion, forming a counterpart to the retroversion of the gravid uterus."

This anteversion of the early months has, however, no direct connection with the present subject, which is the resemblance such cases in the later months have to extrauterine gestation and the difficulty of diagnosis. It is probable that this condition is more common than has been supposed, and its similarity to extrauterine gestation must be remembered.

In every case, however, of advanced or full term abdominal ectopic gestation which I have seen—and I have now operated upon six—the uterus lay in front of the sac containing the child, not behind it. This is a most important point in the diagnosis, but there can be no absolute certainty until the finger is passed up the dilated cervix.

TOTAL EXTIRPATION OF THE UTERUS.

By MACPHERSON LAWRIE, M.D.,
Physician to the Sanatorium for Diseases of Women, Weymouth.

MRS. F., aged 66, a widow, consulted me during November, 1892, on account of pain in the region of the uterus, and a vaginal discharge. These symptoms had been in existence for about one year. The discharge was at first muco-purulent, but for three months had assumed a hæmorrhagic character, and the pain had become very severe. The periods ceased at the age of 50.

On November 20th the uterus was dilated, and an indurated, nodular mass found to occupy the upper part of the uterine cavity. This was thoroughly scraped away with the curette.

This operation was followed by great relief, but in three months the symptoms returned. The uterus was again dilated, and the growth, which had attained greater size, was again thoroughly curetted. For a second time the patient's condition was much improved, but in six weeks the old symptoms began to return. A third time the uterus was dilated. The growth was found to have developed more rapidly. With a strong, sharp curette the growth and underlying tissues were completely scooped out, till almost the whole thickness of the uterus at that part had been removed.

Severe constitutional disturbance took place after this operation, but the results seemed all that could be desired for some four or five months, when she wrote to say that the pain had recurred in a most severe form, and was accompanied by considerable hæmorrhage. It was now quite useless to propose any further palliative measures, and she consented to face the risk of complete removal of the uterus.

The operation took place on October 25th, 1893. The patient had never had any children, and the vagina was so narrow that it was necessary to divide the perineum and recto-vaginal septum down to the bowel, and afterwards to stretch the enlarged vagina by means of retractors.

The uterus was somewhat higher than usual in the pelvic cavity. The os could be distinguished towards the upper extremity of the vagina. After dragging down the uterus by means of a pair of single-toothed forceps attached to the posterior lip, it became possible to make out the cervix invested by the bladder in front. A firm hold of the posterior part of the cervix was obtained by means of a strong vulsellum, the uterus pulled down as far as possible, and the vulsellum given to my friend, Dr. Smyth, who was assisting in the operation, to hold. The vaginal mucous membrane was

¹ *Handbuch der Geburtshilfe*, Band 11, p. 541, 1889.

next cut across in the anterior fornix with scissors, after it had been ligatured in three parts to control hæmorrhage. The mucous membrane was then peeled from the under surface of the bladder as far as the anterior lip; the process of separating the bladder from the cervix proved difficult and tedious; the bladder was dilated, its coats were thin, and it was unusually adherent. The index finger and a blunt instrument, shaped like a large spud, were chiefly employed, with occasional application of the scissors; at one part the separated bladder was so thin that the sound could be seen through its coats.

When the separation had been carried out as thoroughly as possible without interfering with the plica vesico-uterina, the vaginal mucous membrane covering the posterior surface of the cervix was cut across, and, after some dissection behind the uterus, a small opening was made through the peritoneum into Douglas's pouch. This opening was subsequently enlarged, and by passing two fingers into the peritoneal cavity and over the fundus of the uterus, it was found possible to press down the peritoneal fold between the uterus and bladder, and cut it through by means of a pair of scissors held in the other hand.

The uterus was now completely separated from its attachments in front and behind, and only held on each side by the broad ligaments. These structures were transfixed with No. 4 Chinese silk ligatures, which were firmly tied and the uterus cut away. By gentle traction on the ligatures the whole field of operation was brought into view, and all hæmorrhage effectually controlled. The cavity was thoroughly douched and cleansed. The wound in the perineum was brought together with five silkworm gut sutures, and the vagina packed, as far as the upper limits of the broad ligaments, with iodoform gauze. Before removing the patient from the table the bladder was filled with water, and found quite intact.

The after-history of the case was uneventful. She had almost no fever except on one occasion, when the temperature rose to 101°. The pulse varied between 90 and 100. The iodoform gauze was renewed twice, and then not replaced, and the vagina was well washed out daily after the first few days. The catheter was used every four or six hours for the first three days; on the third day the bowels were well opened, and the urine passed voluntarily.

Microscopical examinations, by Surgeon-Major J. Smyth, confirmed the diagnosis of epithelioma.

A CASE OF SEBORRHOEA PSORIASIFORMIS.¹

By STEWART STIRLING, M.D., F.R.C.S. EDIN.,
Edinburgh.

THE case was one of the more uncommon forms of the seborrhœic process, simulating psoriasis and syphilis, and would naturally, according to Unna, have been included in his large group of dermatoses called *eczema seborrhœicum*.

The patient, a young man 27 years of age, was first seen by me in July 1892, at the Edinburgh Skin Dispensary. The history was that the rash had been present for two years. It commenced by a few small, reddish, slightly itchy spots about the size of herring scales over the breast bone, followed after a year by fresh spots on the back, between the shoulders, and in the axillæ. Four months later, after an attack of pleurisy, the eruption came out more abundantly over the thorax and arms, a few spots appearing at the same time on the forehead near the border of the hair, and on the thighs. The patient had had no form of skin affection previously, except a profuse "dandruff," which had existed for many years. There was no family history of skin disease. His case had been pronounced on several occasions to be syphilitic, but he denied ever having had syphilis. The eruption, as examined by me in July, 1892, consisted of numerous round, oval, and irregular spots or patches—coalescing somewhat—of a dusky red or raw ham colour, varying in size from a pin's head to half an inch in diameter, densely distributed over the trunk and arms, especially on the front and back of the chest and in the axillæ. The larger patches were well defined, slightly raised, hyperæmic, and thinly covered with soft, loosely adherent, greyish-white scales. The smaller spots gave a rough impression to the finger, and looked like stains on the skin. A few dull red greasy spots were present on the forehead near the margin of the scalp, and some isolated spots were observed on the thighs and legs. There was a tendency to grouping and to symmetrical arrangement. A few of the lesions here and there, especially on the arms and upper part of the back, had a distinctly yellowish tinge.

On a hasty inspection the first impression was that of a

papulo-squamous syphilide, but there were found no syphilitic manifestations and absolutely no specific history. Syphilis having been excluded psoriasis suggested itself, but there was the absence of the usual localisation of psoriasis on the elbows, knees, and scalp, and the presence of dusky-red patches topped with soft grayish-white scales contrasted with the brighter red colour and the dry silvery-white scales of ordinary psoriasis. There were also diffuse dry seborrhœa of the scalp and hyperactivity of the sweat glands of the body; and lastly the eruption was attended with itching, which had become more severe and which was worse at night.

The treatment was at first not quite satisfactory, the eruption proving very obstinate and showing a constant tendency to recurrence. Under both arsenic alone and Donovan's solution the number of spots increased. Perchloride of mercury had no apparent effect. Of the local remedies employed Hebra's "spiritus saponatus alkalinus" for the scalp and a strong ointment of resorcin and sulphur precipitate for the body were found to be the most efficacious. The resorcin was suspended sometimes because of its irritating effect upon the skin and replaced by mild tarry applications. While the lesions were clearing up there was a tendency to the formation of ringed patches. After treatment for two months and a-half the eruption had almost entirely disappeared, leaving no evident stains, and the patient discontinued his attendance at the dispensary.

After an absence of five months, the patient presented himself again, in February, 1893. The disease had recurred, but in a somewhat altered form. Again there was well-marked seborrhœa of the head, and the rash had assumed a new phase, both as to its distribution and the character of the individual lesions. The lesions now occupied the lower half of the trunk, especially the sacral region and the abdomen, extending upwards on the thorax towards the axillæ. The face, arms, and front of the chest were unaffected, and only a few scattered spots were present on the upper half of the back. Several spots were located about the thighs; but on the legs—especially the calves—there were numerous patches, and a few larger areas from the coalescence of smaller patches. These last presented a deeper red colour than the rest of the eruption. The individual lesions on the trunk consisted of round or oval, circumscribed, slightly elevated, crimson-coloured patches, with pale yellowish borders. They varied in size from a split pea to three-quarters of an inch in diameter, and had a tendency to coalesce. The smaller spots had the appearance of stains, and were not perceptibly raised. The patches were covered with thin, greyish, fatty scales, again contrasting with the dry silvery-white scales of psoriasis. It would thus almost appear that from the brighter red or crimson colour, and the more uniform shape of the patches, the disease had in its progress gradually acquired a greater resemblance to true psoriasis.

With regard to the treatment of this relapsed or progressive stage, after several unsuccessful attempts with resorcin, sulphur, and tar, the disease yielded to an ointment of chrysarobin, tar, and mercury for the trunk, and a varnish of chrysarobin with traumaticin for the legs. The seborrhœa of the scalp was treated with Hebra's "spiritus saponatus alkalinus." The chrysarobin treatment had to be suspended on account of the painful erythematous eruptions it caused on the trunk. Arsenic was tried again, but it aggravated the disease. Under the chrysarobin treatment the patches gradually cleared up, those over the sacrum forming rings and segments, leaving yellowish stains, which soon disappeared.

The differential diagnosis of this case is founded entirely upon its clinical aspects. While the patient was under observation, it appeared to me that he presented an amalgamation of symptoms which I had not seen before, and on referring to the literature of the subject, I was unable to discover any reported cases which exactly (or very nearly) corresponded with the one under consideration.

The interesting cases described by Drs. Brooke and Wickham in the *British Journal of Dermatology* for 1889 and 1892 respectively, although evidently closely related, presented important points of difference in their clinical features. I had no difficulty in my mind in excluding from the diagnosis syphilis and true psoriasis, and of associating the lesions found on the body with antecedent and coexisting seborrhœic manifestations. Although accepting to a great extent Unna's description of seborrhœic eczema, I confess that after careful and prolonged study I was constrained to abandon that view of the case, as I had failed to discover any of the eczematous manifestations believed by dermatologists to constitute part of the process. All these were conspicuous by their absence. There was no marked infiltration of the skin, no tendency to the formation of vesicles or papules, and the "disposition to respond to irritation by exudation"—one of the features by which Unna defines eczema—was absent.

¹Read in the Section of Dermatology at the Annual Meeting of the British Medical Association held in Newcastle-on-Tyne, August, 1893.