and all the patients died of secondary hæmorrhage with the exception of two, who died before the usual period when this came on. So many branches come off from this part of the vessel that no satisfactory clot is formed. On the left side Sir Astley Cooper failed to secure the vessel, and is said to have wounded the thoracic duct. This deterred me from attempting ligature even with our modern absorbable ligatures on the method which aims at the non-division of the inner and middle coats.

REMARKS ON MACEWEN'S METHOD.

With regard to Macewen's treatment of aneurysm, I need only refer to his papers in the *BRITISH MEDICAL JOURNAL* for 1890,⁵ and to two cases since published.⁶ His success, especially in one case of subclavian aneurysm, encouraged me to try it; and there is no doubt it considerably lessened the pulsation over the greater extent of the aneurysm, and promised well for a short time; but the rapidity with which the effect was produced seemed rather to indicate that the needles had simply acted as foreign bodies and produced some soft clot.

In connection with this method of treatment the following questions seem to me to arise. In an aneurysm of any size is not the wall always rough enough to start the formation of laminated clot without scratching? Is the exudation of leucocytes from the injury to the wall and their conversion into fibrin likely to produce more laminated clot than the deposition of leucocytes on the rough wall of the aneurysm? In Macewen's own cases the good result seems to have been far too gradual to have been due to clotting from the presence of the needles acting as foreign bodies, but it is well to remember that there is always that element present in the treatment as well as the injury to the aneurysmal wall.

ON THE MODE OF PERFORMING THE OPERATION OF VENTRO-FIXATION OF THE UTERUS, OR HYSTEROPEXY, IN CASES OF INTRACTABLE RETROFLEXION.

By JAMES BRAITHWAITE, M.D. LOND.,

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As, in consequence of the interesting paper which was read by Drs. Leith Napier and F. F. Schacht at the Newcastle meeting of the British Medical Association¹ upon the subject which forms the title of this short paper, it is probable that the operation will be more extensively and more successfully performed than it had previously been, I venture to bring forward what is, I think, a further improvement in its mode of performance.

Dr. Napier's improvement was to pass several sutures, about four on an average, as low down on the anterior sur-

A, interior of peritoneum; B, fundus uteri; C, edge of uncut peritoneum; D, D, D, transverse sutures; E, E, longitudinal sutures; F, abdominal wall wound; G, unopened portion of peritoneum seen from its outer surface.

⁵ Vol. ii, pp. 1107 and 1164.

⁶ *BRITISH MEDICAL JOURNAL*, 1893, vol. i, p. 117; and *Glasgow Med. Jour.*, 1891.

¹ *BRITISH MEDICAL JOURNAL*, vol. ii, 1893.

face of the uterus as possible, so as to get the greater portion of it adherent to the abdominal wall. This makes the union firm and permanent, and renders it applicable to cases of intractable prolapse as well as simply to retroflexion, which is a very important point. It also does away with the objection of Dr. Howard H. Kelly, of Baltimore, U.S., whose important article on the subject appears in the *Johns Hopkins Hospital Reports* published recently, that the adhesion produced elongates, so that soon the uterus is merely suspended by a band.

I have, since Dr. Napier's paper was read, done ten of these operations, with the following divergence from his plan. The central incision in the abdominal wall is made as usual low down, and with its lower end not more than an inch, or even less, above the pubes; but I have only cut through the peritoneum itself in the upper half of the incision; in the lower half it is left intact, with as much fascia and cellular tissue as possible, the muscles however being drawn aside. Two fingers of the left hand are then passed in, and the uterus pulled up to, and held firmly in contact with, the uncut peritoneum exposed in the lower half of the wound. The fundus is then just visible above the edge of the peritoneum. The anterior surface of the uterus is now fastened to the peritoneum by silkworm gut sutures nearly as done by Drs. Napier and Schacht.

This plan of operating seems to me to have several advantages. Two sutures can be placed from above downwards at the extreme edges of the anterior surface of the uterus, in addition to the usual transverse ones. This ensures a more complete and extensive coaptation of the peritoneum.

It must also, I think, be admitted that it is better to make a small opening into the peritoneum if it will do as well as a larger one, as the risk is thereby diminished, and that there is some risk is seen by Dr. Napier's cases.

The operation also as described is easier and more quickly done, in fact it only takes a few minutes to place the sutures when once the uterus is held up to the peritoneum, the proceedings being much simplified. It is also unnecessary to pass a temporary suture through the fundus, as recommended by Dr. Napier, in order to drag upwards and maintain in position the uterus whilst the permanent sutures are placed.

Lastly, I may ask what is the use of dividing, and so to a certain extent mutilating, the very part to which you are going to fix the uterus? There is no object gained by it.

My cases have done extremely well, but the success of the operation has been thoroughly established by Drs. Napier and Schacht.

A CASE OF CHLOROSIS AND AMENORRHOEA WITH SYMPTOMS OF BRAIN DISEASE.

By G. CRAWFORD THOMSON, M.B., M.R.C.S.,
London.

CASES of double optic neuritis with general brain symptoms and diplopia, ending in complete recovery without anti-syphilitic treatment, are of sufficiently rare occurrence to justify the publication of the following instance:

Miss —, aged 23, school teacher, was first seen by me on March 13th, 1892. She was a total abstainer. No history of previous disease, especially with regard to acquired or hereditary syphilis or tuberculous disease, in herself or family. Her mother and mother's sister died of cancer. Menstruation commenced at the age of 16½, and was regular to 20; since then up to the day I saw her it had been very irregular and scanty, sometimes stopping for as long as three months. She dates back her present illness to July, 1891, when she began to complain of general weakness, loss of appetite, headaches, giddiness, attacks of vomiting, and drowsiness. The headaches came on especially after moving, for instance after going upstairs, and sometimes kept her in bed all day, also at times preventing sleep at night. They were frequently accompanied by severe vomiting, which was independent of meals, and most often in the morning. Attacks of faintness and giddiness were exceedingly frequent, so that the patient had to leave the class she was teaching on their account, seizing hold of anything within reach to prevent her falling; they even came on in bed when turning from one side to the other, and mostly ended in vomiting. Besides, she noticed that her sleep was more heavy and disturbed by bad dreams. On October 28th, 1891, coming home for a walk, everything appeared double—for instance, on holding up one hand she saw two. The diplopia lasted with more or less severity for about four weeks.

Her eyes were first examined on November 25th, 1891, by Dr. Julius Jacobson, to whom I am indebted for the following notes: Extreme pallor of face, especially of conjunctivæ and lips. Right eye vision ½, left

eye vision $\frac{1}{2}$ to $\frac{3}{4}$. No error of refraction. No muscular derangement. Fields and colour perception normal. Things seen by the left eye appeared smaller than by right (micropsia). In both eyes optic neuritis presenting the typical "choked disc." The difference in refraction measured by the ophthalmoscope between retina and top of swollen disc equal to 4 D. Haemorrhage near disc in left eye. Macula lutea normal.

On December 7th, 1891, she was admitted to St. Mary's Hospital under the care of Mr. Critchett; and on December 10th she was also examined by Dr. (now Sir William) Broadbent. She left the hospital on December 22nd. There was a constant improvement in her sight and general health until the beginning of February, 1892. During the whole time the treatment consisted of iron, strychnine, and simple aperients, as she had been suffering continually with constipation. Neither mercury nor iodide of potassium had been given. She came to see me because some of the old symptoms, especially the headaches, had reappeared, when she presented the typical appearance of a patient suffering from chlorosis. She was put by me on iron and arsenic, from which time she made an uninterrupted and complete recovery, which has lasted now without any relapse for more than twelve months. Menstruation became normal at the beginning of 1893, and has remained so since; she has now the appearance of a perfectly healthy girl, in good spirits and able to fulfil all her duties with energy and pleasure. Her vision in both eyes is normal, both discs have cleared completely without showing any trace of former mischief.

It is apparent that the combination of symptoms which the case presented from November, 1891, was one pointing to brain disease, and although the treatment which was suggested by the accompanying evidence of extreme chlorosis proved successful, I still feel inclined to take this view of the cause of the double optic neuritis; looking upon it as brought on by some basilar meningeal disease of probably inflammatory character. Leber¹ was the first to regard this class of cases as "latent meningitis," and this view has been taken up and strengthened by Haab.² Although in this way the appearance of the optic neuritis becomes explainable as caused by central mischief, the connection between the latter, chlorosis, and irregular menstruation still remains obscure. It seems to me an unwarranted scepticism to look upon the combination of symptoms as a mere coincidence as some do. From a clinical point of view, a disease which appears during well pronounced chlorosis, uncomplicated with any other mischief, and which disappears together with the chlorosis after treatment directed against the latter, may rightly be looked upon as either due to the anæmia or to the irregularity of menstruation; but as for the explanation of this connection, we may still say what Foerster³ said in 1876, that as far as the connection between optic neuritis and disorder of menstruation is concerned, we only know that it exists. In my case the differential diagnosis⁴ between brain tumour and transitory brain mischief was difficult for three reasons: (1) The general brain symptoms were most in evidence; (2) the optic nerve presented the typical "choked disc," which at one time was considered pathognomonic of brain tumour; and (3) the diplopia. Cases of the same kind with the diplopia have been published by Oursel⁵ and Ray,⁶ while the appearance of neuritis with more or less severe brain symptoms without diplopia in disorders of the menstruation are of more frequent occurrence.

CARDIAC FAILURE IN INFLUENZA.

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THE extreme nervous prostration and vascular congestion of tissues which obtain in severe cases of influenza conduce to the gravest feature of the disease—failure of the action of the heart. The congestion, however, is really the result of the nerve affection, for, the sympathetic system being as much involved in the prostration wave as the cerebro-spinal, there is

to a greater or less extent paralysis of the vaso-constrictor fibres which maintain the tonicity of the arterioles; and undue dilatation of vessels, as a matter of course, means vascular congestion of tissues. For this reason, hæmorrhage from various mucous membranes, effusions into serous cavities, sudden and profuse diarrhoea, apoplexy or meningitis, congestion passing into inflammation of organs, may occur during the course of the disease; while the ordinary symptoms of uncomplicated attacks, sweating, pink eye, headache, etc., may also be traced to the same cause. That cardiac failure and sometimes fatal syncope, sudden or gradual, should tend to occur under such conditions is not to be wondered at. Manifestly this failure may arise from two causes, which may operate separately or in combination. The heart itself may be the prime factor at fault. Its own muscle, its ganglia, or its vagal centres may so suffer from the wave of nerve prostration as to cause impairment of its function. Or, secondly, the unusual fall in the blood pressure which is the necessary result of the general vascular dilatation, the great loss of weight of the column of blood against which the systole of the heart is directed, may be such that the heart, accustomed as it is to feel a given resistance to its energy, relieved of this sense, runs riot, beats against insufficient resistance, exhausts itself, and tends to stop in diastole. The following are cases illustrative of the heart failure to which I refer.

CASE I.—J. S., shepherd, aged 35, strong, healthy man, while engaged watching his sheep in the winter time, suddenly became unconscious; he remembered nothing till he found himself lying on the snow and his dog licking his face; he had been insensible for at least twenty minutes. When I saw him an hour later he was suffering from all the symptoms of the onset of influenza. After a severe illness, complicated by pneumonia, he eventually recovered.

CASE II.—R. B., gasfitter, aged 26, married, a healthy young man and a good athlete, with no constitutional weakness, early one winter's morning rose to go to his work. A short time afterwards he was found insensible, lying over a low stone "dyke" at the side of the road. An uncomplicated attack of influenza followed, characterised by excessive prostration.

CASE III.—M. R., healthy young woman, aged 18, after returning from a horseback ride, influenza being epidemic in the district, was suddenly seized with faintness and prostration. The heart and pulse gradually failed, coma ensued as if from cerebral effusion, and death took place ten hours after the onset of the seizure. The failure of the heart was only explicable on the hypothesis that it was the result of a wave of intense prostration, such as sometimes ushers in an attack of influenza.

CASE IV.—Mrs. W., healthy married woman, aged 39, the mother of a healthy family, in the course of asthenic influenzal inflammation of right lung, was attacked by palpitation and heart weakness. Failure of the heart set in, and death ensued three weeks after the onset of the illness.

CASE V.—W. G., gentleman's servant, aged 54, on reaching home after a long drive on an excessively cold night, fell heavily on the floor, was helped to bed, and for the next few days was the subject of extreme prostration. Heart failure then set in, accompanied by drowsiness, which developed into coma, such as might arise from serous effusion into the ventricles, and death took place four days after the onset of symptoms.

CASE VI.—Mrs. R., aged 52, mother of healthy family and a woman of strong constitution, was seized at bedtime with intense pain in the lumbar region. For the two following days she was unable to draw up her legs in bed. Gradually the pain left the back, and the symptoms of a severe attack of influenza followed. Pulmonary congestion developed into pneumonic consolidation at the bases of both lungs. The heart became weak and irregular; at one time she was pulseless and collapsed; under treatment, however, she rallied, and in a month's time was able to seek a change of air. This last case is interesting in reference to treatment. When pneumonia set in, one or two small poultices with mustard were applied, but soon discontinued for a wet cold pad between the lower angles of the scapulae posteriorly. As there was evident danger of heart failure, although the tincture of digitalis had been given regularly, two granules of Nativelle's digitalin, $\frac{1}{16}$ grain in each, dissolved in water, were administered by the stomach. Twenty minutes afterwards, the patient appeared to be sinking rapidly; the pulse at the wrist could hardly be felt; it was small, weak, and fluttering; the features, hitherto suffused, were blanched and drawn; the temperature in the axilla, taken with two different thermometers, registered only 95° ; the intellect was dull; the breathing short and superficial; only one sign was wanting to make one believe the patient moribund; there was no cyanosis. Under appropriate restorative treatment the signs of collapse abated; half an hour later, the heart and pulse were firmer than before the administration of digitalin. The blanching of the face, the loss of the pulse, and the fall in the surface heat (95°) were certainly the result of the digitalin by causing vasomotor constriction. The dose, $\frac{1}{16}$ grain, was not large, only moderate; given as it was, its action was certainly in this case much too sudden on the vaso-constrictor mechanism. The action of the drug on the heart, which was apparently manifested after the symptoms of collapse had passed, could not be said to counterbalance the serious primary symptoms which followed its administration.

Digitalis and its active principles must be used with caution. The sudden increase of blood pressure caused by vaso-constriction would in many cases of inherent heart weakness be certainly fraught with danger to the individual.

But the important question arises as to whether the action of digitalis upon the heart is not the mere consequence of

¹ *Die Krankheiten der Netzhaut und des Sehnerven*, 1871.

² Heinrich Wunderli, *Klinische Beiträge zur Ätiologie und Heilung der Sehnervenzündung*. Thesis, Zürich, 1890.

³ *Beziehungen der Allgemein-Leiden und Organ-Erkrankungen zu Veränderungen und Krankheiten des Schorgans*, 1876.

⁴ I may here mention a case exactly like the above with the exception that up to three weeks before death, when the last examination was made, no trace of optic neuritis could be found, although frequently looked for. She was seen by some of the most eminent neurologists, who considered the disease functional. She died suddenly during sleep. The post-mortem examination revealed a large tumour of the cerebellum.

⁵ Contribution à l'étude des affections oculaires dans les troubles de la menstruation. Thèse de Paris, 1885.

⁶ Eye Diseases from Suppression of Menses, *American Journal of Medical Science*, 1882, p. 383.