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