There can be no doubt that the crotchet hook had penetrated the vaginal roof, through the posterior fornix, (a) judging from this case alone, for two reasons: (1) the position the crotchet hook occupied in the peritoneal cavity, and (2) the length of the crotchet hook, $4\frac{1}{2}$ inches, (b) associating this case with the report of a similar case before the Royal Medical and Chirurgical Society¹ in May, 1855, by Mr. Erichsen and Mr. T. Bryant, where a pointed cedar pencil, $5\frac{1}{2}$ inches long, lay for eight months within the abdomen after having penetrated the right posterior fornix-vaginæ and transfixed two coils of small intestine. When contrasted with the crotchet hook, the extra inch in length of the cedar pencil would account for the latter having reached a higher level on the anterior abdominal wall, through which, by incision, Mr. Erichsen removed the pencil, death ensuing four days later from septic peritonitis and faecal extravasation. If the circumstances attendant upon the intraperitoneal entrance of the foreign body in either of the cases were considered, it would appear very probable that the crotchet hook ($4\frac{1}{2}$ inches) or the cedar pencil ($5\frac{1}{2}$ inches) was first completely lodged within the vagina, the upper end raising or propping up the posterior fornix and the lower end resting on the pelvic floor or perineum; whilst a sudden, perhaps almost violent, change in the patient's posture raised the intra-abdominal pressure and drove the foreign body through the vaginal roof. My patient from a squatting posture raised herself to reach over a table top and then knelt down; Mr. Erichsen's patient was disturbed during her manipulation of the vaginal foreign body. My patient had used a blunter instrument; she had the advantages in diagnosis of the x-ray photography and in treatment, of pressure from her doctor not to delay, and in her case of operation by the vaginal route.

The only other example of a primarily vaginal foreign body in any way resembling those I have described I find mentioned by Dr. Freund,² of Strassburg, who discovered accidentally when operating, by abdominal section on the left Fallopian tube, a portion of the shanks of a hairpin which had penetrated the uterus and tube.

REFERENCES.

¹ *Medico-Chirurgical Transactions*, xxxix. ² *Centralblatt für Gynäkologie*, December 17th, 1887.

TWO CASES OF INTRACTABLE UTERINE HÆMORRHAGE FOR WHICH VAGINAL HYSTERECTOMY WAS PERFORMED.

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MR. BLAND SUTTON in the *BRITISH MEDICAL JOURNAL* of April 8th, p. 839, draws attention to cases of persistent uterine hæmorrhage which do not yield to the curette, and which are not characterised by any marked naked-eye changes in the uterus. Histological examination however shows changes in the uterine wall, and he applies the term "fibrosis of the uterus" to this condition.

I have met with two such cases, in each of which I performed vaginal hysterectomy, and as in one of the cases a careful histological examination was made which bears out the views of Mr. Bland Sutton, I have thought that it may be of interest to briefly narrate the cases.

CASE 1.—The first was a woman, aged 46, who was admitted to the Queen's Hospital, Birmingham.

History.—She had had eight children, the last eight years ago, and since the birth of the last child there had been six miscarriages, the last one being eighteen months ago. When not pregnant during the last five years she had been almost constantly losing blood, and for six weeks before admission there had been no intermission of the bleeding. She had been treated by rest in bed, drugs, and curetting had been several times performed, but with no permanent effect.

Operation.—As the patient was getting very anæmic and was having fainting attacks it was decided to perform vaginal hysterectomy, and this was done on August 14th, 1897. The patient made a good recovery and there has been no further vaginal hæmorrhage.

The main interest of the case lies in the result of an examination of the uterus. To the naked eye this organ appeared normal. A careful microscopic examination was kindly made by Dr. Douglas Stanley, Pathologist to the Queen's Hospital, whose report, dated November 11th, 1897, was as follows:

"I have examined the sections of uterus. The endometrium

shows considerable alteration of the epithelial cells, which are round or irregular and proliferative, forming a deep layer, in which are found vessels with poorly-developed walls. Under this there seems to be some fibrotic degeneration of the uterine tissue, and here the vessels show evidence of chronic inflammatory thickening; further away from the mucous surface there seems to be no alteration of the tissues."

CASE II.—P. G., aged 35 years, I saw in consultation at her own home in May, 1897.

History.—She had had three children, the last confinement having taken place eighteen months previously; this was brought on prematurely by a fall, and she had complained of pain in the right side of the abdomen ever since. She menstruated profusely one month after the confinement, and since then she had suffered from somewhat severe menorrhagia.

Operation.—On May 23rd, 1897, I curetted the uterus. This was followed by some improvement in the menorrhagia, but it later became as bad as before, and as she was losing strength and having fainting attacks it was decided to perform vaginal hysterectomy. This was done in the Queen's Hospital on November 5th, 1898. The ovaries and Fallopian tubes were apparently normal, and were not removed.

The patient made a good recovery, and there has been no further hæmorrhage.

The uterus after removal appeared somewhat enlarged, but otherwise no abnormality was visible to the naked eye. No histological examination was made.

In both these cases the menorrhagia commenced as a sequela of parturition or miscarriage, and they both bear out the views enunciated in the above-mentioned paper of Mr. Bland Sutton that the change in the uterine wall is secondary to "infective chronic metritis."

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

TREATMENT OF CORYZA.

I HAVE found by repeated experience that coryza can be aborted by using locally a solution of belladonna tincture (*P.B.* 1899) in water. The strength used by me is $\frac{3j}{\text{iss}}$ in $\frac{3j}{\text{ss}}$ of water. The method of using it is as follows: The nose having been well cleared out and a Wallas's irrigator containing about a dessertspoonful of the solution applied to one nostril, close the other nostril and the mouth, and, while gradually raising the distal end of the irrigator, make a long inspiration until the air, in bubbling through the solution, carries with it a coarsish spray. Afterwards spray the other nostril in the same way and then, having well cleared out both nostrils, repeat the process. Thereafter the coryza will cease, that is to say, if the treatment has been commenced on the first or second day of the attack. In cases of longer standing it may be necessary to repeat the application more than once or twice. When the coryza has lasted already for some time, and, consequently, the mucous membrane has become thickly coated with a tenacious mucus, it is necessary to remove this accumulation by irrigations of alkaline solutions (sodium bicarbonate with sodium baborate, etc.) before using the belladonna.

The above treatment checks immediately the coryza of hay fever in many cases.

Wimpole Street, W.

WILLIAM E. BURTON.

A NEW METHOD OF CLOSING THE PERITONEUM AFTER LAPAROTOMY.

HAVING on many occasions had to reopen the abdominal cavity for the treatment of ventral herniæ, constriction of intestine, and other pathological conditions the result of laparotomies, I have almost invariably found that the intestine or omentum had become densely adherent to the site of the previously cut surface of the parietal peritoneum. In many cases symptoms of intestinal obstruction, most probably from peritoneal adhesions, have come under my notice where skilled operators had previously adopted the most modern methods of suturing the membrane.

After careful consideration I have discovered a method which has answered admirably in my hands. I open the peritoneum by an incision say 4 or 5 inches in length; being a very elastic membrane, I stretch the opening with my fingers should I require more space.

Having done what is necessary in the abdomen my plan of