Fortunately for those afflicted with uterine tumours, it now matters little which of the old ways of operation is the best; whether the ovaries can be removed or not, whether the extra- or intra-peritoneal method be the better way of performing hysterectomy, or whether the convalescence lasts in the one case six weeks, or in the other twenty days, the treatment introduced by Dr. Apostoli must take precedence of all others. The success of this treatment is a great fact, and in saying that I accept *totò animo* his teachings, I do not speak without some experience of his practice. We have already—my son and I—in scarcely five months, applied electricity in strong, accurately measured doses upwards of 1,200 times, in considerably more than over a hundred patients, the majority in cases of uterine fibroids. The labour has not been small—indeed, it has been very hard—and it is not easy to get the science of the subject into an old head. On the other hand, it has opened out a delightful study, which increases in interest every day the deeper we get into it. When I came back from my holiday in the beginning of July, there were waiting for me several cases for hysterectomy or for the removal of the ovaries for bleeding fibroids, and there have been others since. These have all gone home without operation, with menstruation almost normal, and improving after their return, with the tumours in every case reduced in size, with pain gone, and with a freedom to walk about and enjoy life such as they were long strangers to. In one case only has there been a return of hemorrhage. The tumour had gone down two-thirds, she was apparently well, and, unwilling to detain her longer in town, she was allowed to go home too soon. All were more than pleased to have escaped the risks and miseries of a surgical operation that at once put their lives in peril. We—every one of us—consider far too lightly the misery that such operations cost our patients and their friends.

Should these improvements be permanent (and we have Dr. Apostoli's word for it that if the treatment be carried out long enough such is generally the case, and, so far, I am able to endorse almost every statement that he has made) it follows that the field for hysterectomy for the removal of ovaries for fibroids is narrowed down to the smallest limits. I have never been in favour of hysterectomy, simply because its death-rate is so high, and because it is performed for the removal of a tumour that rarely kills. So strongly do I now feel on this subject, that I would consider myself guilty of a criminal act were I to advise any patient to run the risk of her life—and such a risk—before having given a fair trial to this treatment, even were I sure that the mortality would not be greater than that which hysterectomy has given me in my private cases—under 4 per cent.

Twenty-Six Cases of Hysterectomy.

Number.	—	Date.	Age.	Weight.	Remarks.	Result.
39	Hospital	Jan. 1885	40	61	Ovaries could not be removed	Died
40	"	April "	37	63	Ditto.	Recovered
41	Dr. Coleman	Sept. "	40	19	No adhesions	"
42	Hospital	" "	41	3	Ovaries could not be removed	"
43	"	Oct. "	38	21	Ditto.	"
44	Dr. Young	" "	37	12	Omental adhesions	"
45	Dr. Gowans	Nov. "	26	1	No adhesion—uterine cavity not opened	"
46	Hospital	" "	28	6	Omentum and colon adherent	"
47	"	Dec. "	34	11½	Omental adhesions, and to large intestine	"
48	"	" "	42	—	No adhesions	"
49	"	Feb. 1886	38	10½	Ditto.	"
50	"	March "	30	10	Deaf and blind from anæmia—kidneys diseased	Died
51	"	April "	29	11½	Parietal and pelvic adhesions	Recovered
52	"	" "	39	8	Ovaries could not be got at—formerly insane—acute mania	Died
53	Dr. McVail	" "	38	20	Heart pushed upwards—frequent attacks of syncope	Recovered
54	Hospital	May "	40	8½	Broad ligaments largely opened up	"
55	"	June "	40	4	Ovaries could not be removed	"
56	"	Aug. "	40	3½	Ditto.	"
57	Dr. "	" "	38	19	Broad ligaments opened up	"
58	Hospital	Dec. "	45	13½	No adhesions	"
59	"	Jan. 1887	37	4	Ovaries could not be removed	Died
60	Dr. Lightfoot	Feb. "	38	3	Very extensive omental and intestinal adhesions	Recovered
61	Dr. Young	April "	51	20	Omental. Cavity of uterus occluded and distended by fluid	"
62	Dr. Moore	" "	29	5	Very firm pelvic adhesions	"
63	Dr. Whyte	" "	29	—	Sarcoma of body of uterus	"
64	Dr. Wallace	Aug. "	38	5	Very firm pelvic adhesions—ovaries large and very adherent.	"

NOTES

ON

AN EXCEPTIONAL CASE OF APHASIA.

By SIR GEORGE E. PAGET, K.C.B., M.D., F.R.S.,
Regius Professor of Physic in the University of Cambridge.

THE patient was a clergyman of studious, temperate and somewhat sedentary habits, and of the highest intellectual powers, with singular gifts of speech, preaching, and lecturing extempore, with rapid delivery, never hesitating for a word, and yet never wanting in exactness. He worked unsparingly, writing much. His temporal arteries were prominent and tortuous. He was 64 years old at the time of his first seizure. He was found shortly before 8 A.M., sitting on the side of his bed, rubbing his right leg, conscious but quite speechless. After an hour he had recovered the power of saying "yes" and "no," but no other words. His right hand and arm were paretic and ataxic. After nine hours the ataxy was less marked, and he could manage to speak a short sentence. Next day his power of speech seemed quite restored, and there were scarcely any traces of the paresis or ataxy.

After this attack, he abstained for a time from work; but, on returning to it, was not so perfectly fluent as formerly in preaching. A second seizure occurred nearly 2½ years after the first. This, like the first, occurred before 8 A.M., soon after his leaving bed, and before he was dressed. He was heard to fall in his dressing room, and his wife, going to him instantly, found him unconscious and muttering; but in a few moments he completely recovered consciousness and speech. When I saw him half an hour later I found paresis, ataxia, and impaired muscular sense in his left arm. He had not the slightest difficulty in expressing his thoughts, and inquired in a tone of surprise, "Where is my left arm?" It was out of his sight, being turned back under his head on the pillow. After seven hours the ataxia was no longer perceptible, and the next day he was convalescent. After this attack he reduced his work, gave up his church preferment and preaching, but continued his writing, chiefly by dictation, on abstruse subjects, and with force and clearness.

Passing over events which have no immediate connection with aphasia, we come to his third and last seizure. This occurred nearly three years after the second. It was a violent attack of cerebral hæmorrhage, occasioning complete paralysis and analgesia of the right side, almost entire loss of sight and hearing, consciousness being wholly suspended for some days, and afterwards very imperfect. He lived three years after this attack, but never again spoke an intelligible word, except on one occasion, "Do, do," when apparently becoming conscious of his inability to move his right leg. He sometimes talked—if it may be called talking—long and earnestly, with modulation of voice and expression of face as if he had conception of what he was uttering, but in the utterances was no articulate or intelligible word. Though sight and hearing were impaired, he preserved the sense of taste. After two months sensibility was restored in the right hand, and some power of movement.

He was kept alive by skilful and tender nursing, but the right arm became contracted, and two and a half years after the last seizure he nearly died of pneumonia (left). After this his strength and nutrition failed, bedsores formed, contracture came on in both legs, most marked in the right; respiration was often of the Cheyne-Stokes type, and six months after the pneumonia he died exhausted.

The point of special interest has yet to be mentioned. This gentleman was naturally left-handed. Yet, as the narrative shows, his aphasia accompanied right hemiplegia, and did not accompany the left hemiplegic attack. In this the case differs, I think, from any yet recorded. The general fact has been that aphasia has accompanied paralysis of the preferentially used hand, accompanying right hemiplegia generally, left hemiplegia rarely, and then only in the cases of left-handed persons. In the case related, the aphasia followed the ordinary rule of right-handed persons, though the patient was naturally left-handed.

The explanation of the anomaly may, I think, be found in the fact that, though left-handed for other actions, he wrote with his right hand, and was in the habit of writing much. It was not due to any association between speaking and gesticulation, for he had not the habit of gesticulating.

The case has a bearing on the debated question whether the ordinary location of the faculty of speech in the left cerebral hemisphere

be due to congenital predominance of that hemisphere or results from the education of the right hand. For my own part, I believe that both these causes have their influence. But the case is an additional argument on the side of education, and it points to writing as the most potent of these educational influences. The ordinary rule of the organ of speech being in the same hemisphere that serves for the voluntary movements of the naturally predominant hand—this ordinary rule was reversed, and the reversal is the more remarkable because the congenitally predominant hand had remained the preferential hand for all actions except writing. The habit of writing much seems the only assignable cause for this reversal. And it may be held to be an adequate cause, for the memory of words will naturally go with the movements of the hand that writes them; and the process is simplified by using one and the same cerebral hemisphere for recollecting the words and for directing the hand in setting down their symbols.

It has been suggested, and with some reason, that it might be better for us—that we should be capable of more mental labour, with less fatigue—if we employed both hemispheres instead of throwing all the work on to one. The case I have related would not support this view, for the gentleman was capable of an enormous amount of mental labour. His only relaxation was chess.

The degree in which the education and employment of the right hand for writing operate in inducing the use of the left hemisphere for speech might be tested by inquiring more particularly into the circumstances of cases of aphasia with left hemiplegia in left-handed persons. Has this ever been noticed in persons much engaged in writing?

BRITISH MEDICAL ASSOCIATION.

FIFTY-FIFTH ANNUAL MEETING.

PROCEEDINGS OF SECTIONS.

SOME STATISTICS OF THE OPERATION FOR THE RADICAL CURE OF HERNIA.

Read in the Section of Surgery at the Annual Meeting of the British Medical Association in Dublin, August, 1887.

By W. MITCHELL BANKS, M.D., F.R.C.S.,

Surgeon to the Liverpool Royal Infirmary, and Professor of Anatomy, University College, Liverpool.

I REGARD it as a very great honour that you should have allowed me the privilege of taking part in the present discussion. In order to make the most of the short time at my disposal, it seems more profitable to lay before you a statement of what I have done in the matter of the radical cure of hernia than to enter into a general criticism and review of the whole subject. The operation which I have adopted is this. In inguinal hernia, the sac, after being cleanly dissected out, is opened, and all bowel is replaced and adherent omentum tied and cut away. The sac is then well pulled down, ligatured as high up in the canal as possible, and removed. Finally, the pillars of the ring are brought together by two or three silver sutures, which are left in position. In femoral hernia the cleaning and removal of the sac constitute the whole operation, and no attempt is made to close the femoral aperture. In ventral and umbilical hernia use is frequently made of the whole or part of the sac as a kind of plug to stop the aperture, which is generally large, and in which it is seldom possible to adopt any means of approximating the edges which seems likely to be permanent. I have adhered to this method of procedure for two reasons, first, because, in order to judge of the value of any given operation, it must be done many times by the same man, who is then in a position to judge accurately of its good qualities and its defects; and, secondly, because the operation is the simplest that has been yet devised. This is a most important point, because an operation that can only be done by the inventor thereof, or by a few highly trained operators, can never in the nature of things become popular. Hernia is a universal disease, and any operation for its cure must be such as can be safely and easily done by any surgeon of average experience and ability. I make no pretence whatever to originality in this matter. In whole or in part the operation was done frequently before I did it. All that I have done has been to conduct a surgical experiment upon the plan just referred to.

The results of that experiment, so far as it has gone, are now laid before you in an analysis of 106 cases, 68 of which were cases of hernia without strangulation, while in 38 strangulation was present. It

will be seen at once that, as regards the question of mortality, we must keep these two classes of cases quite distinct. As regards the effect of the operation from a curative point of view, however, we can draw the same conclusions from both. Again, you will note that I have divided the non-strangulated cases into two groups, the first in which the hernia were of moderate size, and the second where the hernia were very large or even enormous in size. It is most necessary to make such a distinction, because, in the first group, the operation is for the most part comparatively easy, while the accidents are only those that may happen in any surgical proceeding, even of a very simple nature. As a result the mortality is not great, and in future may be rendered very small indeed. But in the second group the hernia were of great size, so large that no truss or other known means of support was of any avail. The patients were, therefore, completely unfitted for all the ordinary duties of life. A brief description of two or three instances may be given.

One patient was a labourer, who, being quite unfitted for work, had become an inmate of a workhouse, where he lay, a burden to himself and others. Another was a wine merchant, who, by reason of his complaint, had been obliged to give up his occupation. In the house he could only go about in a dressing gown. He rarely ventured outside, and when he did he had to wear a large overcoat to conceal his deformity. A third was a glassblower, reduced to perfect helplessness, and obliged to depend upon his wife for his means of support.

Now these great hernia are most serious things to tackle. The operation is usually difficult and prolonged, and the dangers to be met and overcome are both numerous and various. It is not, therefore, to be wondered at that the concomitant risk to life is also serious; and my only reason for attempting such hazardous cases was that the patients were useless creatures, passing a wretched life, for an escape from which they were gladly willing to incur even the greatest risks.

With regard to the cases of strangulated hernia, the operation for a radical cure has been added to that for the relief of mere strangulation. And this addition, so far from adding to the dangers of the ordinary operation, has, I venture to think, greatly lessened them. These thirty-eight cases are, of course, not the whole number operated upon during the past six years or so. There were many where the bowel was gangrenous, and could not be returned, or where the patient, being old and weak, and the hernia large, I was afraid of adding to the pressing danger of an exhausted condition, that of a prolonged and tedious dissection of the sac, which would have necessitated a long period of anaesthesia and exposure on the operating table.

With regard to the mortality of Class I, one death (No. 35) was clearly due to the operation pure and simple. The patient was a weakly child, with a large irreducible hernia. When I got to the bowel I found it was the cecum, which had slipped bodily down into the serotum. The operation for its reduction was difficult and tedious, and the child never recovered from the shock. I may here remark, in passing, that of all the forms of hernia with which I am acquainted, those in which what may be called a landslip of cecum takes place present the greatest obstacles to return of the bowel, and involve the greatest risk to the patient.

The other fatal case (No. 34) occurred in a patient the victim of locomotor ataxy. Any operation might have precipitated a fatal result in such a man, and I have often thought that it was unwise to have attempted any operation at all upon such a subject. The *post-mortem* examination showed no traces of peritonitis. On the other hand it revealed an important point, namely, that the high ligature of the sac was so effectual, that hardly a dimple remained on the abdominal surface of the peritoneum to show where the hernial aperture had once been.

Turning to Class II, that of the very large hernia, in this the mortality, I regret to say, was very great. In one instance (No. 68) the amount of bowel in the sac was so large that it could not by any means be reduced into the abdomen. It seemed as if the abdominal cavity had diminished in size, while the bowel in the sac had become greatly hypertrophied. After long and unavailing efforts to get the bowel in the abdomen, the operation had to be abandoned.

Of the thirty-eight cases of strangulated hernia three proved fatal. Of these one was a man who was practically moribund from collapse, but in whom the stripping of the sac was so easy that no delay of moment was caused by it; he died a few hours after the operation. Another was an old bronchitic man of 77. With my better experience of to-day, I would content myself with simply opening the sac, replacing the bowel, and stitching up the hole in the sac. But a mortality of three in thirty-eight all round is certainly an improvement on