The Maritime Medical News.
A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

Vol. VII.    HALIFAX, N. S., JULY, 1895.    No. 7.

Original Communications.

BELLADONNA IN SOME SKIN AFFECTIONS.

Read before the St. John Medical Society, 15th May 1895, by Dr. G. P. Dougherty.

The few remarks I am about to make this evening scarcely rise to the dignity of a paper, and I trust that you will deal leniently with this my first effort before your society. My attention was called to the use of belladonna in skin affections by an article published in the October number of the Therapeutic Gazette from the pen of Dr. Dunbar of Zurich. It was a paper read before the section of Dermatology held at Bristol, Eng., 1894. This communication was based on 35 cases of which 30 or about 85 per cent were relieved or cured. The detailed account given of some of the more striking cases indicates that relief seems to have come very soon after the exhibition of the medicine.

Dr. Dunbar made use of the remedy in such cases as exhibited irritation of the skin as eczema, prurigo, puritus and urticaria. Considering the amount of failure I had heretofore experienced while attempting to carry out the best authorized plans of treatment laid down in the text books on skin disease, I thought it advisable to give the belladonna treatment a trial. I first prescribed belladonna in a case of acute eczema of the face and hands, with subacute eczema of the lower extremities scrotum and penis. The patient, a laborer 45 years of age, consulted me first on the 6th of October 1894. There was at that time eczema of the thighs, legs, scrotum and penis. There was exfoliation leaving a reddened and thickened surface which was intensely itchy. The patient complained of loss of appetite and a furred tongue pointed to disordered digestion; I prescribed a grain pill of calomel to be taken for 3 consecutive nights and a Seidlitz powder the following mornings. A stomachic tonic was also ordered. Locally, I had the parts bathed with a solution containing 3 drachms of carbolic acid and an ounce of glycerine to the pint of warm water, after which a little oxide of zinc was to be dusted on. The treatment seemed to modify all the symptoms, but after a fortnight very little seemed to have been accomplished towards a cure. However, I ordered a continuance of the treatment and did not see the patient until the 2nd of November. On that occasion he was suffering from an acute attack of eczema of the face and hands. There was considerable swelling, particularly of the face. There was also an aggravation of the former affection of the lower extremities. I prescribed belladonna tincture in 15
min. doses, to be repeated every 4 hours during the day, telling the patient to extend the interval between doses to 6 or 8 hours directly any dryness and tightness of the tongue, roof of mouth and throat was felt.

The medicine was well borne and there was no necessity to prolong the interval between doses until the 3rd day. In the meantime a rapid amelioration of all the symptoms was manifested, which amelioration continued uninterruptedly until a cure was effected.

After the 3rd day the patient continued to take 45 min. in the 24 hours until about the 10th of December. He was then cured and has not had a recurrence. I have since employed belladonna in 5 cases, 4 of which I had occasion to observe the effects. And I may say that the results are highly satisfactory and gratifying. Of the 4 that were under observation two were cases of infantile eczema of the face or as it is sometimes called, porrigo larvialis. The children, one year and eighteen months old respectively, had received several weeks local treatment without much benefit, but responded very rapidly to the exhibition of belladonna. After 4 weeks treatment in the younger and 5 weeks in the other the medicine was discontinued. A simple oxide of zinc ointment was all that was used in addition to the belladonna after it had been prescribed. Of the other two cases mentioned above one was a moist eczema of both legs in a boy 10 years old. The other was a case of urticaria in a little girl aged seven. Both of these cases seemed to be benefitted by belladonna and are now after a few weeks completely cured. When we discover that belladonna is useful in complaints so common and I may add often so difficult to treat satisfactorily as eczema, etc., the question often arises: How is it that a drug so long in use was not known to possess the qualities lately ascribed to it by Dr. Dunbar? It is one of the strange things—granting it to be as I believe highly beneficial—that it has not its place among the prominent drugs recommended by good authority. There are instances, however, of newly discovered properties in old and long used remedies. As for instance, calomel as a diuretic in heart disease. "Belladonna was used" by the ancients to discuss scirrhus and heal cancerous and other ill conditioned ulcers. And much evidence of its usefulness in these affections is on record and even Dr. Cullen spoke in its favor. Dr. Ringer mentions a case of local sweating of the loins over a surface a little larger than the hand, perspiration exciting a copious eruption of eczema. Belladonna checked the perspiration and likewise cured the eczema.

---


At the Victoria General Hospital and Halifax Infirmary, during the service of Dr. Farrell.

The cases demanding operation which came under my care during the past winter at the Hospital and Infirmary present some points of interest and may serve to indicate to your readers the Progress of Surgery in our own Province. I will endeavour to give a short account of each case relating only the prominent and interesting points.

I may say in general that in all clean operations the most strict asepsis was carried out and I will not weary your readers with all the details of the antiseptic plan which is now so well known and forms part of the procedure of all intelligent practitioners.

Happily the day has passed by when
it is necessary to urge the importance and necessity of Surgical Cleanliness. The mighty revolution that has taken place in surgical practise, and the brilliant results that are following in its track have simply swept surgical opinion all over the world, into one stream of thought and antiseptic surgery is no longer a subject for discussion.

There are still some details of the best method of reaching complete asepsis on which there are differences of opinion. On the question of the use of drainage tubes various views are held and the best and safest material for ligatures and sutures is still under discussion.

In many of the operations sterilized silk was used exclusively and in most cases it acted well and remained sterile, but a sufficient number of suppurating ligatures occurred to make one fear the use of this material. My choice for internal ligatures and sutures is sterilized cat-gut boiled in alcohol previous to the operation. In most cases drainage tubes were used, but in abdominal operations and some others they were dispensed with.

In the abdominal operations the wall was sutured in three layers; first, the peritoneum, then the muscles and fascia and lastly the skin. The subcutaneous suture is a great improvement in closing the superficial wound.

The operations included 12 cases of Abdominal Section, 6 cases of Vaginal Hysterectomy, 5 cases of Amputation of Breast, 1 case of Median Lithotomy, 1 case of Osteotomy for advanced Club-foot, 3 Arthrectomies, 1 Radical cure of Hernia, 2 Amputations, 4 cases of Trachelorraphy and Perinorrhaphy. In all the cases but one I was assisted by Dr. Black, and the Staff of the Infirmary, and the House Staff of the Hospital.

The histories of the Hospital cases were prepared by Dr. Cogswell, the House Surgeon and those of the Infirmary by Dr. W. D. Finn.

CASE I. Large Dermoid Ovarian Cyst Ceciotomy; Recovery. — J. C., school girl, aged 11, admitted to surgical ward Oct. 26th, 1894. Family history good. Complained of an enlarged abdomen, 6 months standing. Developed slowly at first and without pain. Abdomen was aspirated four times while in medical ward, 150 oz., 170 oz., 185 oz. and 240 oz. respectively being withdrawn. Fluid straw colored, sp. gr. about 1008. It was not until the last aspiration that a tumor was positively diagnosed. Circumference of abdomen at the umbilicus 37½ inches.

Oct. 29th. Was operated on. A large cyst was found adherent in some places to peritoneum and omentum. These adhesions were broken down and pedicle which was attached to right ovary ligatured and cut. Silk used for ligatures and sutures. Sterilized water for solution. Cyst was multilocular and contained a large amount of fluid. It was also partly dermoid, containing a great number of teeth as well as hair, skin and a well formed nipple. Left ovary normal. Patient made a good recovery. Temp. did not rise above 100° F. Discharged from hospital Dec. 8th, recovered.

This case was one of great interest not only on account of the age of the patient (11 years), the immense size of the tumor and its dermoid contents but the diagnosis was very difficult, for after each tapping a large hard mass remained floating about in what appeared to be the empty peritoneal cavity. The weight of opinion before the operation favored the diagnosis of ascitic fluid with a solid peritoneal or retro-peritoneal mass. On opening the abdomen it was found to be a very large, watery cyst attached to a hard mass of cyst growth.

CASE III. **Retroversion of Uterus : Hysterorrhaphy : Recovery.**—Mrs. C., admitted to hospital Feb. 25th, 1895. Complained of all the symptoms of a retroflexion with incontinence of urine. Uterus was stitched to abdominal wall by three silk worm gut sutures. Sutures removed 3 days after operation. Symptoms relieved. Incontinence is much better.

CASE IV. **Large Uterine Fibroid : Abdominal Hysterectomy : Recovery.**—Mrs. C., age 28, admitted to hospital Nov. 14th, 1894. Complaining of metrorrhagia. Menstruation was regular until a year ago. Married at 22 years of age. Is mother of 3 children, youngest 2 years old. Had an abortion a year ago. Has had "floodings" during the past year, at times she has pains, simulating labor pains. On examination a large fibroid tumor was detected. Patient very anaemic from loss of blood. After all other methods had failed, an abdominal hysterectomy was done on Jan. 29th, 1895. On 31st abdomen become distended, and she had a good deal of pain. Bowels would not move, although several enemata were given. 3 days after operation bowels were got to move freely. On 4th day temp. rose to 103°. Wound dressed on 5th day. A little suppuration around stitches. Patient made a good recovery, was discharged Mar. 14th, 1895.

This patient was the first case we had of complete removal of the uterus through the abdomen. There was no cervical stump left, the cervix being separated completely from its vaginal attachments. The operation was a difficult one, especially in its later steps after the separation of the broad ligaments; on account of the tumor masses involving the cervix in their growth. For many days after the operation her symptoms gave us much anxiety. During her convalescence she had two or three onsets of fever with some tenderness in the lower part of abdomen. The cause was found to be some local sepsis as a number of pieces of silk were subsequently passed per vaginam.

CASE V. **Ovarian Cyst with Peritonitis : Coeliotomy : Death.**—E. B., aged 32, female, admitted to hospital Feb. 6th, 1895. Complaining of enlargement of abdomen. General health never very good. Menstruation was regular until a year ago. Has not menstruated since. Swelling in abdomen began 7 months ago. Increased very rapidly. No pain. Before coming to hospital was aspirated seven times, each time a large quantity of straw colored fluid was withdrawn. Patient poorly nourished, appetite poor. Abdomen greatly distended. No tympanitic note in flanks. Temperature ranged from 100°.2 to 102°, since her admission.

Feb. 16th. Patient operated on. A large quantity of fluid was found in the abdominal cavity as well as a large cyst attached to right ovary. The cyst was very adherent to peritoneum on right side. These adhesions were very thick and pulpy and with difficulty were broken down and cyst removed. The cyst was filled with a large quantity of serous material. The abdominal cavity contained very many masses of organized fibrin, and a large quantity of a thick creamy like fluid. As much as possible of this was removed and the wound closed. Patient was very weak. She did not rally after operation. On 17th temp. 104°, pulse 160. No pain. 18th, temp. 104°, pulse 100. Died.
At post mortem, considerable bloody fluid was found in abdomen, also some curdy like masses. The peritoneum on right side was covered with a dark colored exudate. Numerous cysts were found around the spleen and liver.

Case VI. Ovarian Cyst; Coeliotomy; Recovery.—Miss H. aged 50 admitted to Infirmary, Sept. 30, 1894, suffering from an ovarian cystoma. No history of tumors or phthisis in family. She was always healthy until two years ago, when she noticed a swelling in her abdomen, this did not increase until two weeks before her admission. She never has had any disturbance with menstruation—diagnosis, an ovarian cystoma. Operation Oct. 12, 1894. Found a simple ovarian cyst of right ovary, having no adhesions, and containing a very dark colored fluid. The walls of the cyst were very thick and the pedicle markedly short making it very hard to tie off. Silk was used. The right ovarian artery was ligated as a preventive measure against hemorrhage. Normal salt solution was used all through the operation. She had no bad symptoms at any time, sutures were removed on the tenth day. Got up and around on sixteenth day, went home well on Nov. 15, 1894.

Case VII. Double Salpingitis; Coeliotomy; Recovery.—Mrs. McL. married—admitted to Infirmary Jan. 16, 1895.

No history of cancer in family, but some cases of tuberculosis. About three years ago she began to be irregular at her menstrual periods, sometimes three or four months would elapse between. Had pain at these times, frequent micturition. No leucorrhea. Was constipated—appetite fairly good. Has suffered from piles and diminished secretion of urine. Has been a uterine invalid for long time and has had of late constant pelvic pain sometimes very severe. All these symptoms have become more marked since Nov. 15, 1894 at this time something broke and discharged by the vagina, yellowish in color. She has been subject to eczema of the face and hands for a long time.

Vaginal examination revealed a normal uterus, and on bimannual examination a hard mass was felt low down on right side of the pelvis—the ovaries could not be made out on account of adhesions. It was decided to open the abdominal cavity, operation Jan. 30, 1894. The omentum was found adherent to the anterior abdominal wall in its whole extent and to the top of bladder. It was so difficult to separate the omentum, that an incision into it was made so as to get into the pelvic cavity. So great were the adhesions that the bladder was the only organ that could be made out. Across the top of the pelvis was a fold of membrane uniting several layers of intestine, shutting off the pelvic cavity, except on the right side where the finger could be passed down into Douglas' cul-de-sac. Here it was found that the intestines were matted together and bound down by adhesions to 3/4 of the posterior uterine wall. The ovaries could not be made out on account of the extent and density of the adhesions. A small cyst protruded on the left side, this was removed some bleeding followed and it was decided to go no further. The abdominal wound was closed, peritoneum sutured with fine silk, muscles with chronic acid gut and integment with a subcutaneous continuous silk suture. She made a good recovery.

Case VIII. Dysmenorrhea; Oophorectomy; Recovery.—S. B., Oct. 29th, admitted to Infirmary Nov. 3rd, 1894. Family history good. She has always been of a very nervous temperament, has suffered very much from dysmenorrhea. Appetite poor, sleep broken. Has no cough or expectoration. Her distress at the menstrual period made her miserable, and in fact she has never felt well. She had had all kinds of medical treatment without benefit, and it was decided to perform an oophorectomy. Operation Nov. 9th. The ovaries were found slightly enlarged, otherwise everything was normal, ovaries removed; ligated with silk. Skin suture removed on the 12th day. She got up and around feeling much better at end of 3 1/2 weeks, then some small stitch abscesses occurred when silk, which was used for deep sutures came away, at present she is at home and has recovered her former good health.
CASE IX. Miss C., age 43, single, admitted to Infirmary Oct. 1st, 1894, suffering from seirrhus of right mammary gland.

Grandmother on maternal side died from cancer and other members of family had tumors—there is a marked malignant history in family. She has always been in good health. About two years ago, in June 1892, she noticed a lump in her right breast, the hardness of it attracted her attention, it gradually became larger and a little painful, but did not affect her health or prevent her working. On examination found a tumor of the right breast, very hard and stoney and some retracction of the nipple. On Oct. 1st, 1894, the breast was excised and the axilla cleared of glands—the ordinary antiseptic dressings were applied—the case did very well. A small ulcerating surface was present for a time in the line of the wound, but under action of nitrate of silver, locally every second day, it healed nicely. She went home well on Nov. 5th, 1895.

CASE X. Seirrhus of Breast; Amputation; Recovery.—M. W., admitted to hospital Oct. 6th, 1894. Family history doubtful. Had a tumor in her breast a considerable time which caused her much pain and suffering. She was ill-nourished and her general health poor.

Cancer of breast in a very advanced stage presented itself on examination. The breast tissue was wholly replaced by the cancer growth, with a dry cancerous ulcer on its surface. The axillary glands were very much involved. Operation, Oct. 11th, 1894. The whole breast and tissue surrounding it were freely removed and that part of the pectoralis major muscle upon which the tumor rested was taken away and the cellular tissue and lymphatics along the edge of that muscle. The axilla was then cleared of all its fat, cellular tissue and glands. Very little could be done to close the wound which was left to granulate. She remained in hospital all winter, improving in health week by week and the wound slowly healing. She left the hospital on April 10th, 1895, having been six months an inmate. She was then strong, fat and well. The wound completely cicatrized.

CASE XI. Mrs. R. married, age 35, admitted to Infirmary Dec. 10th, 1894, suffering from tumor in right breast.

There is a history of malignancy in family. Mother died from retro-peritoneal sarcoma. This patient was generally healthy, she occasionally suffered from asthma, has been married 12 years, has had 3 children. In July, 1894, she noticed a small lump in right breast, it gave her no pain until Sept. 1894, her general health was fairly good all the time. On examination of the breast, found a small hard tumor about half the size of a hen’s egg. No retracction of the nipple—no apparent enlargement of axillary glands.

On Dec. 12th 1894. Excised breast, cleared the axillary of any glands, a few of which showed signs of infiltration. The tumor in breast was sected deep down upon the pectoral muscle, and the muscular tissue upon which it rested was also cut away. The wound was dressed antiseptic--a continuous subcutaneous silk suture introduced, also a small drain at lower and outer part of wound, the latter was removed on 2nd day. Primary union resulted—removed sutures on 7th day and she went home on Dec. 24th, 1894, very well.

CASE XII. Seirrhus of Breast; Amputation; Recovery.—Mrs. R., age 62, admitted to hospital Feb. 15th 1895, complaining of an ulcerated sore on right breast with enlargement of axillary glands.

Previous history good. No history of malignancy in family. 7 years ago first noticed a small lump the size of a pea in right mammary region. This grew slowly for about 6 years, at times giving her slight pain. A year ago an ulcer formed, which has been discharging some ever since. Discharge has lately had an offensive odor. 6 months ago axillary glands began to enlarge. Operation on Feb. 19th 1895. The “complete” operation was done and wound left to granulate. Patient remained in hospital until April 24th. Wound was nearly all healed when patient was discharged. General health good. No sign of return.

CASE XIII. Miss. O. R., single, age 37, admitted to Infirmary April 9th, 1895, suffering from tumors in breast.

There is no history of tumors, phthisis, or Cancers in family. Her health has always been good—she has suffered from piles at times. About 15 years ago she
noticed a small lump in right breast, near the nipple. It did not pain until the winter of 1895. It was about the size of a pea, but has increased of late. There is no retraction of the nipple. During the past year she has noticed a small lump in left breast, about the same size as the other one. Her general health is good at present time. The breasts were incised over the seat of the tumors and they were extirpated. It was very hard to get under the growths as their deep attachment was very dense. They proved to be adenoma. Primary union resulted and she went home well.

**Case XIV. Cancer of Cervix: Vaginal Hysterectomy: Recovery.**—Mrs. M., age 32. Admitted to Hospital Dec. 7th, complaining of an offensive discharge from vagina. Menstruation regular until present trouble. Is mother of 7 children, 4 living, youngest 10 months old. No history of malignancy in family. 4 months ago first had a great deal of pain in back, 3 months ago had quite a severe "floodling." Has had "floodings" off and on ever since, between which she has a clay colored discharge which during last 2 months has had a very offensive odor. Examined and found the cervix to be enlarged, hardened and nodular. Os eaten away by deep ulceration. Given douches of Condy's Fluid. December 18th operation. Cervix was first curetted, irrigated and a plug of iodoform gauze packed in. External os was then closed by sutures which were left long in order to make traction on cervix. Parts irrigated thoroughly with 1 in 1000 bichloride solution. Uterus was then pulled down and first incision made in Douglas' cul-de-sac and an iodoform gauze plug inserted. An incision was then made in front of uterus, some difficulty being experienced getting the uterus separated from posterior wall of bladder. The broad ligaments were separated step by step from the uterus, the uterine and ovarian arteries secured and with some difficulty the whole organ with the ovaries was removed. The ligatures were left protruding from vagina. Parts irrigated with 1 to 2000 bichloride sol. and three iodoform tampons inserted in vaginal wound. Gauze and sterilized cotton pad externally with T bandage. For some time after operation complained of a good deal of pain relieved by morphia sulph. She had some tympanites and tenderness in lower part of abdomen with rise of temperature. For three days symptoms looked threatening but passed off. On the second day the outer tampon was removed. Dressings were soaked with a sanious discharge. On 4th day all tampons were removed and she was given a careful washing with Condy's fluid. On 4th day bowels were moved with an enema and subsequently there were no bad symptoms. Was troubled with incontinence of urine for some time following operation but fully recovered from this before she left the hospital. Discharged Feb. 6th recovered.

Returned to hospital about a month later and was examined. No appearance of return of growth. Sections were made of the cervix and uterus and the microscope showed the cancer cells.

**Case XV. Cancer of Cervix: Vaginal Hysterectomy: Recovery.**—Mrs. J. H., age 53, admitted to hospital Jan. 8th, 1895, complaining of an offensive vaginal discharge. Menstruation always normal up to the menopause two years ago. Is mother of twelve children; youngest nine years old. A paternal aunt died of tumor. Vaginal discharge began about a year ago, tinged with blood, then became greenish in color and very offensive. Complains of sharp shooting pains in pelvic region.

On examination a cancerous mass was found involving the os and cervix. There was considerable hardness on the right side as if the growth had extended into the broad ligament; uterus, moveable, but not freely so.
Operation Jan 13th, 1895. The first steps of the operation were as described in the last case. There was great difficulty in drawing the uterus down but after some manipulation the left side was completely separated. The right ligament was so involved in the disease that in drawing upon it, it tore away its attachments. A profuse bleeding then occurred from this ovarian artery. The hemorrhage was alarming and it was decided at once to open the abdomen which was done very quickly and the bleeding point secured. The patient was very weak and collapsed. The operation was rapidly completed and cardiac stimulants given hypodermically. It was some time before reaction occurred but after the first twelve hours she made a complete and uninterrupted recovery. Discharged March 4th.

Case XVI. Cancer of Cervix; Vaginal Hysterectomy; Death.—Mrs. L., age 37, admitted to hospital Jan. 24th, 1895, complaining of pain in pelvic region, and hemorrhage from uterus. Previous history good. No history of malignancy in family. For past 6 months has been troubled considerably with “floodings.” Is somewhat anemic, has lost considerable flesh lately. On vaginal examination a cauliflower like growth was found involving cervix, bleeds easily. Carcinoma of cervix diagnosed.

Operation, Feb. 5th. With all the steps as in the previous operations, the uterus was removed and with much less difficulty and in less time than in either of the other operations. The only complication was a considerable protrusion of omentum. On account of this two or three sutures were drawn across vaginal roof. She rallied well after the operation but vomiting persisted. On the second day the abdomen became distended. Tympanites and tenderness increased. Though the temperature did not rise high the pulse was weak and frequent. She grew weaker and died on the 6th day. Post-mortem examination showed omentum adherent in wound and pus in peritoneal cavity.

Case XVII. Cancer of Uterus; Vaginal Hysterectomy; Recovery.—Mrs. C., married, age 68, admitted to Infirmary on Feb. 23th 1895, suffering from cancer of uterus. No malignant history in family. Has had 8 children, youngest 27 years old. Menopause occurred at 47 years of age. Since then has enjoyed good health, except a little dyspeptic at times. As this was her only symptom she paid little attention to it, until 1894, when she consulted a physician. He told her that she had an ulcer, was treated for it. In Nov. 1894, she went to Boston had special treatment for it, operation of removal of womb was advised, but her health failing she returned home. Her native air has improved her health very much. She has had a vaginal discharge of a semi-bloody nature.

Examination of vagina, surface soft and natural. Cervix is large, hard and presents a dense mass of neoplasm and an ill looking cancerous ulceration of os. The uterus is movable. There is no evidence of disease outside of uterus except a little suspicious induration in each broad ligament. Uterus measures 3½ inches.

Operation, March 4th. Uterus and appendages tied off with strong silk. Found the organ much more ulcerated and destroyed than was suspected, so much so, that the cervix tore away from the body of uterus in drawing it down to place the ligatures. This caused some delay. Operation completed without further complication. She did well until her recovery. The ligatures were all away on the 18th day.

Case XVIII. Prociidentia Uteri; Vaginal Hysterectomy; Recovery.—Mrs. S., married, age 57, admitted to Infirmary April 4th, 1895, suffering from prociidentia uteri.
Family history good. She has always had good health, has had 12 children, all living, had one miscarriage 8 years ago. Menopause occurred 7 years ago. She has suffered for years from prolapse of uterus, it gave her great pain in walking or sitting down. She ascribes it to a perineal rupture 35 years ago. There is complete prolapse, the whole organ falling outside the vagina, with cystocele and rectocele—the uterus is normal in size and length.

On April 9th, 1895—performed vaginal hysterectomy; tied off uterine appendages with strong silk, the tissues were in normal condition—no adhesions. The operation was attended by no difficulty. Removed some sutures on 14th day, but two did not come away until May 6th 1895. She recovered and left for home on May 10th.

Case XIX. Epithelioma of Cervix; Vaginal Hysterectomy; Recovery.—Mrs. Ellen F., age 58 years, admitted to Infirmary May 15th, 1895, suffering from cancer of cervix.

No history of cancer or tumors in family. She was always healthy until last summer when she noticed some sanguineous flow from vagina, at times this was very bright. Menopause occurred about ten years ago. There is some odor from the vaginal discharge. She has lost flesh of late—bowels regular, appetite not very good.

Vaginal examination reveals, uterus the seat of a cancerous mass in and around the cervix and os—the uterus appears moveable.

Operation, May 30th, 1895. There was much difficulty in getting uterus down. Difficult also to apply ligatures. There was considerable hemorrhage. Three clamps were used where ligatures could not be applied and left on. These with the tampons were removed on the 4th day. Considerable shock for first twelve hours, when this passed off she steadily improved day by day. The last of the ligatures were removed on the 13th day. She is now sitting up and will return home in about a week.

Case XX. Ovarian Cyst; Coeliotomy; Recovery.—Mrs. W. J. T., age 43, admitted Sept. 1894.

Family history good. She has been married 13 years, has had 5 children—menses always regular—health good. In Nov. 1893 she noticed a lump in left side of abdomen and since that it has increased in size very rapidly. After examination ovarian tumor diagnosed.

Operation, Sept. 29th, 1894. Found a large, tense, multilocular cystoma, found the omentum adherent to the cyst at upper part, (she had had an attack of peritonitis some time previous to the operation). The pedicle was very long, arising from left side and was twisted twice upon itself and was placed markedly to the left. Used salt solution. Transfixed the pedicle with strong silk and tied it off. Silk was used in closing abdominal wound, all the tissues were included in the sutures. This patient had no bad symptoms, removed abdominal sutures on 10th day. At the 15th day she was sitting up, and went home well.

Case XXI. Anteflexion and Neurasthenia; Oophorectomy with ventral fixation; Improved.—Mrs. H. H., age 30, admitted to Infirmary Oct. 22nd, 1894. One sister died of phthisis. No history of cancer or tumors in family.

She was always healthy up to 10 years ago, when she had pneumonia—has been married 15 years, has had 2 children—no miscarriages. About four years ago began to feel indisposed and for 14 years has had trouble with her urine—vesical tenesmus. She was examined by a physician who told her she had uterine displacement, that the uterus was pressing on the bladder, had treatment with pessaries, and got some relief, wore the pessary for 6 months. About two years ago took a burning sensation in vagina, had piles, bearing down sensations. Menstrua-
tion regular as a rule, but sometimes diminished, at other times increased. Before her last period the flow was very slight and had considerable pain, bowels constipated as a rule. Was operated on for piles two years ago. Vaginal examination showed marked anteflexion of uterus but nothing else abdominal.

Operation, Nov. 3rd, 1894. Performed an oophorectomy—pedicles transfixed with silk, and abdominal wound with the same material. Used salt solution. The uterus was also lifted off the bladder brought up to anterior abdominal wall and fixed there by sutures. This patient made a good recovery, removed sutures holding uterus on Nov. 12th and those in abdominal wall on Nov. 15th.

This patient made a fair recovery, she was soon well from the operation and for a time her general health improved, especially after she was able to be up and about. The pelvic and vesical irritation were also much better for a time, but about the time that she was quite well and ready to go home she began to complain again and is still suffering from time to time.

Case XXII. Retrorversion of Uterus; Hysterorraphy; Recovery—Mrs. A., admitted to Infirmary May, 1894. She has been married seven years and has had no children, was never pregnant. Menstruation regular, has pain sometimes. For ten or twelve years has had pain in back, and bearing down sensations and never feels well about the back and lower part of abdomen. Bowels loose at times.

Vaginal examination shows the fundus tilted back and to the left, and resting on rectum, uterus tender on pressure but freely moveable; cervix and os normal.

Operation June 7th, abdominal cavity opened and the uterus brought up to the opening in abdominal wall, its surface vivified and silk worm gut sutures passed through it and the abdominal wall. Sutures were placed in the posterior wall so as to tilt it somewhat forward. These were tightened up and abdominal wall closed—peritoneum and muscles with cat-gut and ligament with silk. She did well until the fourth day when symptoms of intestinal obstruction showed themselves, it was thought that a small knuckle of gut had worked in between anterior wall of uterus and anterior abdominal wall. Injections were given and a mild laxative. A long intestinal tube was passed per rectum, but with no effect. At last the patient was put in the Trendelenburg position and the body strongly shaken. The result of this was that some flatus passed per rectum and the nausea and vomiting disappeared. At no time was there any abnormal pulse or temperature. The uterine sutures were removed on the 14th day and her progress towards recovery was uneventful.

Case XXIII. Cœliotomy for Myoma of Uterus with Oophorectomy; Recovery.—C. F., age 28, admitted to Hospital Nov. 2nd, 1895. Complaining of indefinite pains in back and sides. Menstruation regular, but attended with a great deal of pain. Has had a leucorrheal discharge during the past four years. On examination cervix was found to be somewhat elongated, and uterus anteflexed. In Douglas' cul de sac, a hard tumor was felt.

On Dec. 1st, a laparatomy was done. Both ovaries which were the seat of small cystic tumors, were removed. A myomatous tumor was found growing from the fundus of the uterus by a broad pedicle, this was removed and the uterine wound closed with silk. Wound suppurated some, but patient was doing fairly well until she contracted Scarlet Fever, and was removed to Infectious Hospital. Wound gaping
some when patient was moved. Returned to Hospital Feb. 22nd, wound still unhealed, but granulating nicely. Was discharged from Hospital, April 17th, 1895, abdominal wound completely healed, and her former symptoms relieved.

**Case XXIV. Dermoid Cyst: Cœlectomy: Recovery.**—Mrs. M., age 43, admitted to Infirmary May 29th, 1895. Family history good. She has been married 21 years, has had 6 children, youngest 12 years of age. Her menstruation was regular up to Feb. 1895, from this time on had a flow every two weeks, and for the past fortnight the flow has been small but constant. Bowels not regular. In August 1894, she felt a small lump in the right hypochondrium, and since that has been growing larger. Abdominal examination showed a tumor irregularly oval in shape, and apparently lying with its long diameter across the abdominal cavity.—Fluid at each end of the oval and a solid mass in the middle. Vaginal examination, found uterus in normal position, the cervix seat of old cicatrices; $\frac{3}{4}$ inches in length and apparently closely connected with the tumor—the sound in the uterus moving with every movement of the tumor. Uterine examination was followed by some flow.

Operation, June 4th. Abdominal cavity opened, and a multilocular cystoma of right ovary found. There were no adhesions—the cyst had a good pedicle, this was transfixed and tied off with strong silk. The left ovary was found degenerated (cystic) and was excised. The wound in abdominal wall closed—peritoneum and muscles and fascia were separately sutured with catgut, and integument with a continuous silk suture. She has made a good recovery without a bad symptom.

The tumor was found to be a dermoid cyst.

The point of interest in this case was the difficulty of diagnosis. Many of the symptoms on physical examination were those of a uterine fibro-cyst. The tendency to metrorrhagia and the apparent connection between tumor and uterus, made the diagnosis doubtful, but when the abdomen was opened we were presented with a very simple case.

**Case XXV. Ruptured Perineum and Lacerated Cervix: Operation: Recovery.**—Mrs. C., age 28, admitted to Hospital Dec. 17th, 1894. Complaining of pain in back and leucorrhoeal discharge. On examination a double laceration of cervix and a rupture of perineum found to exist.

Operation, Dec. 27th. Cervix and perineum repaired. Patient made a good recovery, and was discharged Feb. 1st, 1895.

**Case XXVI. Ruptured Perineum; Operation: Recovery.**—Mrs. S., age 31, admitted to Hospital Dec. 2nd, 1895. Perineum completely ruptured and there was a slit in posterior vaginal wall into the rectum.

Operation, Dec. 11th. Edges of tear in posterior vaginal wall first bared and sutured; then a modified Tait’s operation was done. Stitches removed Dec. 20th. Parts nicely healed. Discharged Dec. 29th all symptoms relieved.

**Case XXVII. Ruptured Perineum and Lacerated Cervix: Operation: Recovery.**—Mrs. H., age 23, admitted to Hospital Dec. 18th, 1895. Complaining of pain in back and leucorrhoeal discharge. On examination a double laceration of cervix with endometritis and a complete rupture of perineum found to exist. Dec. 27th, uterus curetted and cervix stitched. Jan. 18th, perineum repaired, Tait’s operation. Feb. 19th, discharged from Hospital recovered.
CASE XXVIII. Ruptured Perineum and Lacerated Cervix; Operation: Recovery.—Mrs. B., age 45, admitted to Hospital Oct. 25th, 1895. Complaining of "dragging down pains." On examination, perineum was found ruptured and cervix lacerated. Nov. 8th. The double operation was done. Perineum done by Tait's method. Dec. 18th, discharged recovered.

CASE XXIX. Talipes Equino-varus; Osteolomy: Recovery.—R. B., age 10, school girl, admitted to Hospital Oct. 1st, 1894. She had Talipes equino-varus of left foot.

On Oct. 6th, the tendo-achilles and plantar fascia were cut and foot straightened as much as possible. A plaster splint was applied. Had considerable pain. After operation wound healed nicely, but foot was not perfectly straight.

The advanced stage of distortion of bones made this procedure almost useless. It had no effect on the shape of the foot, and it was determined to do the more severe operation.

Operation, Nov. 24th 1894. A T-incision was made on the outer aspect of foot, and the tissues above and below including tendon nerves and vessels were lifted up and held aside. A wedge shaped piece of bone, without giving attention to joints, was taken across the tarsus and the foot brought forcibly into position. All with the most strict asepsis. Put up in splint and plaster. Some febrile reaction for two days. Made a good recovery, and the result was most excellent. In two months she was able to walk aided by a crutch with the sole of the foot flat on the floor. Discharged Jan. 31st, able to walk naturally with a stick.

CASE XXX. Osteo-Sarcoma of tibia; Amputation: Recovery.—C. B., age 11, admitted to Hospital Nov. 2nd, 1894. Complaining of a tumor on anterior aspect of tibia. Family history negative. Six months ago patient fell and struck his leg at seat of present tumor. A short time after this a swelling appeared. This was pouliticed and afterwards lanced twice. A small quantity of serous fluid was discharged each time. Patient was thin and pale when admitted. Leg somewhat wasted. Upper part of tibia enlarged and a bleeding fungus mass protruding. An osteo-sarcoma was diagnosed, and on Nov. 8th the leg was amputated above knee. Patient made a good recovery and was discharged from Hospital Nov. 30th.

CASE XXXI. Tubercular Arthritis; Amputation: Recovery.—C. C., age 18, admitted to Hospital March 1st, 1895. Complaining of sinuses in right knee. Patient had an arthrectomy performed for a tuberculous arthritis about a year ago. Wound healed nicely, but afterwards sinuses formed, which have been discharging off and on ever since. Sinuses have been curetted several times, but as they showed no tendency to heal and patient's general health was bad, it was decided to amputate above knee. Amputation was done March 20th. Wound healed, general health has improved very much. Discharged April 26th, recovered.

CASE XXXII. Tubercular Arthritis of knee; Arthrectomy; Death.—F. C., age 28, admitted to Hospital Nov. 24th, 1895. Complaining of sore knee. Had been troubling him for some time. The cervical glands were also enlarged and his general health was not good. The knee joint presented the ordinary appearance of chronic tubercular arthritis. No sinuses.

Operation, Dec. 16th. The joint was freely opened and all ligaments divided. It was found in much worse condition than was suspected. Joint filled with curdy pus. When this was cleaned out and tubercular foci in bone removed, deep abscesses were discovered running under the rectus above and on the tibia below. These were fully scraped and irrigated. Towards the end of this extensive oper-
Maritime Medical News.

July, 1895

Ation patient showed marked symptoms of shock. Everything quickly completed, and the usual restoratives vigorously applied, but he never rallied. He died about three hours afterwards.

Case XXXIII. Tubercular Arthritis of knee; Arthroectomy.—R. W., age 18, male, admitted to Hospital Oct. 11th, 1894. Complaining of swollen and painful knee. Previous history good. Family history negative. Patient dates his trouble to an injury received while skating three years ago. He fell and struck his knee. Did not hurt him much at time, but about six months afterwards it began to swell and hurt him to walk. Has been troubling him ever since. Has a spot of tenderness over inner aspect of knee. Movement of knee very limited. After having tried various local and constitutional remedies, patient was operated on Feb. 26th, 1895. An arthroectomy was performed. Wound healed at first, but a sinus formed on inner and outer aspect which has been discharging ever since.

Case XXXIV. Tubercular Arthritis; Arthroectomy.—A. M., age 18, male, admitted to Hospital Feb. 22nd, 1895. Complaining of swollen knee. Family history good. A history of an injury to knee four years ago. Has been troubling him more or less ever since. Tenderness on inner aspect of knee. On March 5th an arthroectomy was performed. Wound healed nicely, but sinuses have since formed and patient is still in Hospital.

Case XXXV. Inguinal Hernia; Radical Cure; Recovery; Complete Cure.—T. R., age 28, male, admitted to Hospital Oct. 4th, 1893, complaining of an inguinal hernia. Had been troubled with it since three years of age. Had used trusses until he was tired of them. Oct. 16th operated on. A long incision was made parallel with poupart’s ligament over the hernia. The cord was dissected away from sac and sac dissected out, and upper end ligatured with catgut. The cord was drawn out of the canal and canal closed, its edges above and below being drawn together with silk sutures. A new course was then made for the cord according to Halsted of Baltimore. Wound healed by first intention, but patient was afterwards troubled some with stitch abscesses. Was discharged from Hospital Jan. 2nd, 1895, recovered, and with complete cure of the hernia.

Case XXXVI. Rights Inguinal Hernia; Operation; Recovery; Complete Cure.—A. M., age 3 years. Child has been afflicted with hernia since birth. Trusses used but no beneficial effect. Operation June 1894, for radical cure. In this case, the spermatic cord was taken from its ordinary position and placed in upper end of opening, as in previous operation. The child did well, and at present date June, 1895, no return of hernia has occurred.

Case XXXVII. Vesical Calculus; Operation; Lithotomy; Recovery.—T. W. B., age 40, admitted to Infirmary, Jan. 31st, 1895. History of phthisis in family. Been healthy up to eight years ago, since then, has had vesical irritation. Slow mic- turition with occasional stoppage of the urine. Never had any pain until three weeks before admission—then he passed some blood. Consulted a physician and was relieved. Had another attack of pain and haematuria, was examined for stone and one was detected in bladder. At time of admission to Infirmary, calculus was impacted in membranous portion of urethra and bladder fully distended. On introducing catheter to relieve bladder the stone was pushed back into that organ. Decided to crush it next day, but on sounding, it could not be detected. Supposed it had been voided per urethrum during the night. The next night, Feb. 5th, it again lodged in the urethral canal. Feb. 6th performed median lithotomy—found stone about the size of a hazel nut and very hard, composed of uric acid. Passed catheter for three days—wound healed well and he made a good recovery. Was discharged on Feb. 14th, 1895.