

HELMUTH HOUSE REPORTS

FIFTH SERIES

FROM SEPT. 15TH, 1890, TO SEPT. 15TH, 1895



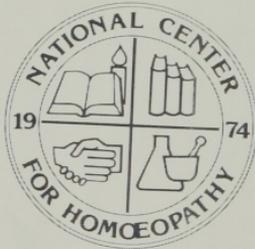
NEW YORK
G. P. PUTNAM'S SONS
27 AND 29 WEST 23D STREET
1896

NATIONAL LIBRARY
Bethesda, Mar

Gift of
The National Center for Homeopathy



The
Maesimund
Banning
Panos
Library



Gift of
AFH

LIBRARY
AMERICAN FOUNDATION FOR HOMOEOPATHY

LIBRARY OF
EDWARD RUSHMORE, M. D.
Plainfield, N. J.



HELMUTH HOUSE, 465 LEXINGTON AVENUE.

LIBRARY
AMERICAN FOUNDATION FOR HOMOEOPATHY

HELMUTH HOUSE

REPORTS

FIFTH SERIES

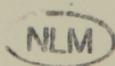
FROM SEPT. 15TH, 1890, TO SEPT. 15TH, 1895



NEW YORK
G. P. PUTNAM'S SONS
27 AND 29 WEST 23D STREET
1896

LIBRARY
AMERICAN FOUNDATION FOR HOMOEOPATHY

The Knickerbocker Press
NEW ROCHELLE, N. Y.



COMPLIMENTS OF THE AUTHOR

CONTENTS.

	PAGE
STAFF OF HELMUTH HOUSE	iv
I.—TABLE OF DISEASES	1
II.—TABLE OF OPERATIONS	8
III.—TABLE OF DEATHS	14
IV.—PRELIMINARY NOTE	15
V.—AMPUTATION OF THE TONGUE	17
VI.—SCISSORS	21
VII.—DEATHS AFTER LAPAROTOMY	22
VIII.—PSEUDO-ILEUS (PARALYSIS OF THE BOWELS)	26
IX.—WEAK AND RAPID PULSE NOT ALWAYS INDICATIVE OF HEART FAILURE	29
X.—PERITONITIS	32
XI.—SUPRA-VAGINAL HYSTERECTOMY FOR MYO-FIBROMA OF THE UTERUS	41
XII.—STATISTICS AND PERCENTAGES	50
XIII.—HERNIA	66
XIV.—THE NEW OPERATION FOR PROLAPSUS UTERI	68
XV.—CURETTING THE UTERUS	71
XVI.—LYMPHADENOMA	75
XVII.—HEMORRHOIDS	80
XVIII.—PROLAPSUS RECTI	87
XIX.—TUMORS	90
XX.—EXCISION OF THE MAMMA	94
XXI.—REGULATIONS AND CHARGES	98

STAFF

SURGEONS

WM. TOD HELMUTH, M.D., LL.D.

WM. T. HELMUTH, JR., M.D.

MATRON

MRS. ANNA L. KELLER

NURSES

MISS M. GARDINEER

MISS MARGARET KANE

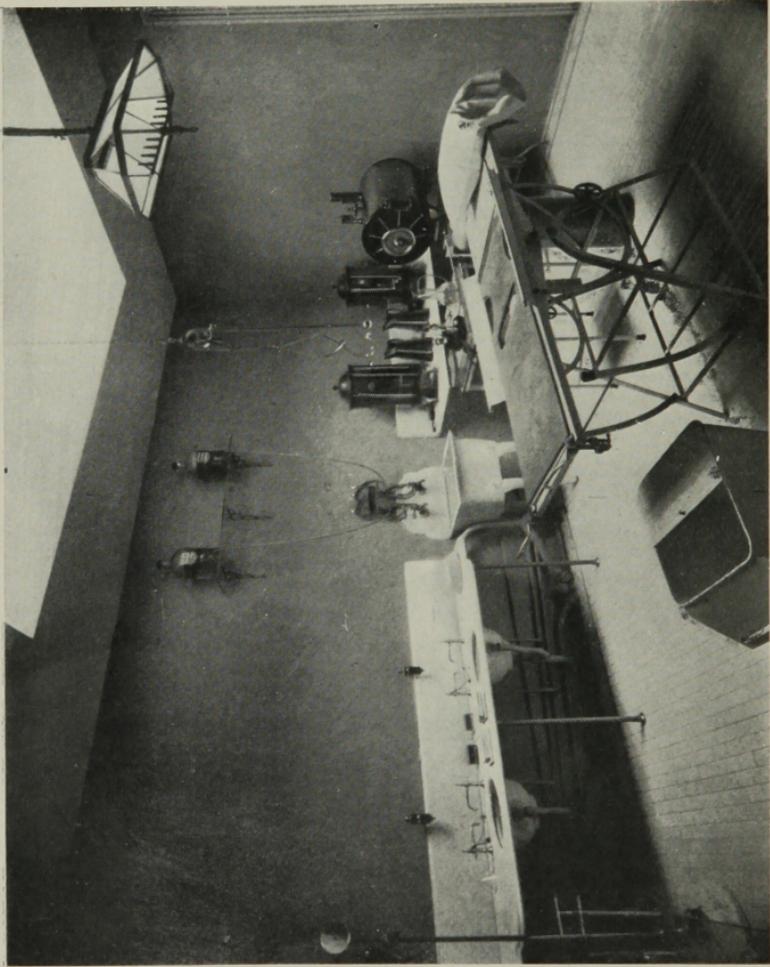
MISS BARBARA STICKLE

MISS DOLLY MCKAY

MISS ALICE GERRISH

MISS LIDA G. KERSHAW

MISS EMILY SIMPSON



OPERATING ROOM LOOKING NORTH.



I.—TABLE.

DISEASES TREATED IN HELMUTH HOUSE FROM SEPTEMBER 15,
1890, TO SEPTEMBER 15, 1895.

The Institution being closed for three months each year (June 15th to Sept. 15th), these tables show the work of the House for three years and nine months.

Abscess, total 17.	
“ axillary.....	2
“ ear, middle.....	1
“ forearm.....	1
“ hepatic.....	1
“ ischio-rectal.....	4
“ labia majora.....	1
“ mons veneris.....	1
“ neck.....	1
“ peri-nephritic.....	1
“ psoas.....	1
“ spinal.....	3
Alcoholism.....	7
Amenorrhœa.....	1
Anæmia from hemorrhage.....	1
Aneurism, total 8.	
“ aortic.....	1
“ arterio-venous.....	6
“ femoral.....	1
Anthrax.....	1

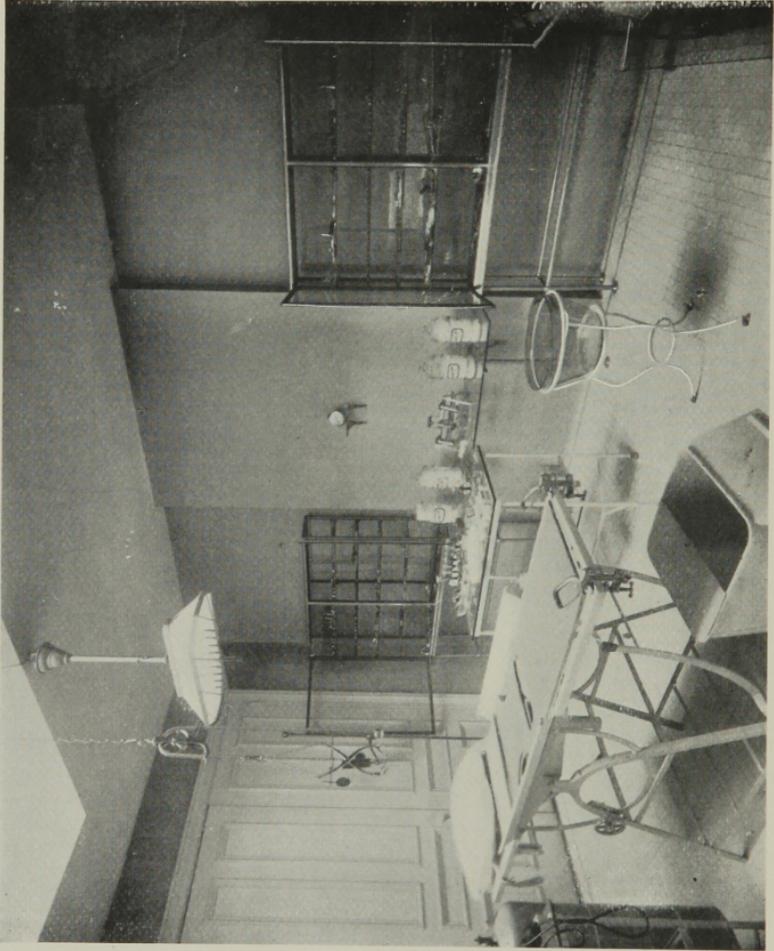
Brought forward.....	35
Anus, artificial.....	I
“ fissures of.....	3I
Appendicitis.....	3
Ascites.....	I
Biliary calculus.....	I
Bladder, exstrophy of.....	I
Brain, concussion of.....	I
Bursæ.....	4
Carbuncle.....	2
Caries of spine (Pott's).....	15
“ syphilitica.....	I
Coccygodynia.....	4
Condylomata penis.....	I
Cystitis.....	2I
Cystocele.....	5
Delirium tremens.....	2
Dislocations, total 4.	
“ both bones forearm backward.....	I
“ metacarpal finger.....	2
“ thumb.....	I
Dupuytren's contraction.....	2
Dysmenorrhœa.....	II
Ear, malformation of.....	I
Ectopic gestation.....	I
Eczema.....	2
Endo-metritis.....	12
Exostosis, subungual.....	I
Fistulæ, total 39.	
“ abdominal walls.....	4
“ ano in.....	5
“ fæcal.....	5
“ perinæal.....	3
“ recto-abdominal.....	I

	Brought forward.....	181
Fistulæ, recto-vaginal.....		4
“ salivary.....		1
“ scrotal.....		4
“ urethral.....		8
“ vesico-vaginal.....		4
Foreign body in eye.....		1
“ “ “ stomach.....		1
Fractures, total 18.		
“ acetabulum.....		1
“ axis.....		1
“ calcaneum.....		1
“ coccyx.....		1
“ Colles’s.....		1
“ femur.....		3
“ forearm.....		1
“ humerus.....		2
“ metacarpal bones.....		2
“ phalanges.....		1
“ Pott’s.....		1
“ rib.....		2
“ ulna.....		1
Glands, strumous.....		1
Gastritis.....		4
Gonorrhœa.....		1
Hemorrhoids.....		26
Herniæ, total 14.		
“ femoral.....		2
“ inguinal.....		8
“ umbilical.....		2
“ ventral.....		2
Hydrocele, total 13.		
“ cord.....		2
“ tunica vaginalis.....		11

Brought forward.....	281
Hydro-nephrosis.....	1
Hydro-salpinx.....	3
Hymen, imperforate.....	1
Hypospadias.....	2
Ingrowing nail.....	1
Intestinal obstruction.....	2
" perforation.....	1
Intestine, wound of.....	2
Joints, tuberculosis of.....	4
Kidney, movable.....	3
Lacerations, cervix uteri.....	39
Lipoma Nasi.....	2
Lupus.....	3
Membrana tympani, rupture of.....	1
Meningocele.....	1
Metritis.....	5
Metrorrhagia.....	17
Morbus coxarius.....	11
Morphine habit.....	2
Necrosis, total 12.	
" carpal bones.....	2
" femur.....	2
" inferior maxillary.....	2
" nasal bones.....	1
" rib.....	2
" tibia.....	3
Neuralgia (5th pair).....	1
" ovary.....	3
Neurasthenia.....	3
Oöphoritis.....	14
Opium poisoning.....	1
Orchitis.....	4
Palate, cleft.....	1

Brought forward.....	421
Paralysis, infantile.....	I
Paronychia.....	I
Pelvis, contracted.....	I
Perinæum, laceration of.....	15
Periostitis.....	5
Peritonitis.....	21
Phalanges, deformity of.....	I
Phthisis pulmonalis.....	I
Phymosis.....	15
Poisoning by Rhus tox.....	I
Pyo-nephrosis.....	I
Pyo-salpinx.....	5
Ranula.....	I
Rectocele.....	8
Rectum, total 22.	
“ carcinoma, cylindrical.....	2
“ contraction of.....	15
“ prolapse of.....	3
“ ulcer of.....	2
Rheumatism.....	2
Scar tissue (Adams).....	I
Scoliosis, rotary lateral.....	55
Scrotum, hæmatocele.....	I
Sounding for stone.....	3
Spina-bifida.....	I
Spinal concussion.....	3
“ irritation.....	6
Spleen, hypertrophy of.....	I
Sterility.....	3
Stomach, dilatation of.....	I
Stone in the bladder.....	6
Stricture, intestinal.....	I
“ œsophagus, organic.....	2

Brought forward.....	606
Stricture, urethra.....	18
Synovitis.....	5
Syphilis.....	1
Talipes, total 8.	
" equino-varus.....	4
" equinus.....	2
" valgus.....	2
Testicle, non-descent of.....	2
Tonsil, hyperplasia of.....	8
Tuberculosis, general.....	1
Tumors, Innocent, total 134.	
" adenoma breast.....	13
" " cervical.....	1
" angioma.....	19
" cystic-colloid.....	5
" " hydatid.....	1
" " mammary.....	5
" " meningocele.....	1
" " ovarian.....	12
" " sanguineous.....	1
" " sebaceous.....	14
" enchondroma.....	5
" fibro-cystic.....	3
" fibroma.....	10
" fibro-myoma.....	20
" lipoma.....	11
" lymphadenoma.....	3
" myxoma.....	3
" papilloma (bladder).....	5
" pseudocystis.....	2
Malignant, total 82.	
" carcinomatous, spheroidal-celled, hard.....	11
" " " soft.....	4



THE OPERATING ROOM LOOKING SOUTH.

Brought forward.....	798
Tumors, carcinomatous, squamous-celled.	
" " " diffuse	1
" " " face.....	2
" " " lip.....	5
" " " rectum.....	1
" " " stomach.....	1
" " " tongue.....	6
" " " uterus.....	15
" sarcomatous, adeno-, mammæ.....	6
" " " angeio.....	1
" " " round-celled, kidney.....	2
" " " secondary.....	6
" " " spindle-celled, breast.....	12
" " " testicle.....	8
" " " uterus.....	1
Torticollis.....	1
Ulcer, gastric.....	1
" varicose.....	5
Urethral caruncle.....	1
Urethritis.....	12
Uterus, anteversion of.....	3
" conical cervix.....	2
" hyperplasia of.....	1
" malformation of.....	1
" prolapsus of.....	10
" retroflexion of.....	19
" stenosis cervix.....	28
Uvula, elongation of.....	7
Vaginismus.....	11
Varicocele.....	8
Wounds, incised, lacerated, punctured, and poisoned.....	34
Total.....	<u>1009</u>



II.—TABLE.

OPERATIONS PERFORMED FROM SEPTEMBER 15, 1890, TO
SEPTEMBER 15, 1895.

Abscess, incision, curetting, and over-distension, total 13.	
“ buttock	1
“ labia majora.....	1
“ ischio-rectal.....	5
“ neck	4
“ peri-nephritic	2
Amputations, total 41.	
“ arm	1
“ breast.....	30
“ cervix uteri.....	3
“ thigh	3
“ tongue	4
Aneurism, total 7.	
“ aortic (injection).....	1
“ arterio-venous.....	4
“ palmar arch.....	1
“ radial	1
Anthrax	3
Anus, diseases, total 33.	
“ artificial.....	1
“ fissures of.....	27
“ fistulæ	5
Arthritis, chronic rheumatic.....	1

98

Brought forward.....	98
Bladder, instrumental exploration.....	1
" exstrophy.....	5
Bone-curettage.....	5
Bursæ.....	2
Castration.....	8
Cauterization of spine.....	3
Cholecystotomy.....	1
Circumcision.....	15
Coccyx, excision all bones.....	4
Colotomy, right inguinal.....	1
Colporrhaphy, anterior.....	5
" posterior.....	4
Cystotomy.....	2
Dislocations, total 3.	
" forearm backwards.....	1
" metacarpal.....	1
" thumb.....	1
Dupuytren's contraction.....	2
Ear, plastic operation.....	1
Fistulæ, total 28.	
" abdominal.....	5
" fæcal.....	4
" perinæal.....	5
" recto-abdominal.....	1
" recto-vaginal.....	1
" scrotal.....	3
" urethral.....	7
" vesico-vaginal.....	2
Foreign bodies, eye.....	1
" " stomach.....	1
Fractures, acetabulum.....	1
" axis.....	1
" calcaneum.....	1

Brought forward.....	193
Fractures, Colles's.....	1
“ clavicle.....	1
“ femur.....	3
“ forearm (both bones).....	1
“ humerus.....	3
“ phalanges, fingers.....	1
“ Pott's.....	1
“ metacarpal.....	2
“ radius.....	2
“ ribs.....	3
“ ulna.....	1
Hemorrhoids, total 26.	
“ Allingham's.....	2
“ American.....	15
“ clamp and cautery.....	9
Hernia, total 7.	
“ inguinal strangulated.....	1
“ Heatonian method.....	1
“ McBurney's.....	5
Hydrocele, total 12.	
“ excision of sac.....	5
“ injection (radical).....	6
“ palliative.....	1
Hymen imperforate.....	1
Hypospadias (Duplay).....	1
Hysterorrhaphy.....	2
Ingrowing toe-nail.....	1
Joints, curettage.....	4
Knee-joint, resection of.....	1
Laryngotomy.....	3
Laparotomies, total 83.	
“ appendectomy.....	3
“ cancer of omentum.....	1

	Brought forward.....	274
Laparotomies, splenic hypertrophy.....		I
“ intra-ligamentous cyst.....		I
“ exploratory incisions.....		7
“ hysterectomies, supra vaginal.....		22
“ intestinal obstruction.....		2
“ “ perforation.....		I
“ “ wounds.....		I
“ oöphorectomy.....		18
“ ovariotomies (tumors).....		21
“ tubercular peritonitis.....		5
Lipoma Nasi.....		2
Litholapaxy.....		5
Lithotomy, supra pubic.....		2
Lupus, Volkman's method.....		3
Membrana tympani, rupture of.....		I
Meningocele.....		I
Morbus coxarius.....		11
Myotomy.....		I
Necrosis, nasal bones.....		I
“ carpal bones.....		2
Nerve suture (musculo-spiral).....		I
Nephrorraphy.....		3
Nephrectomy.....		2
Osteotomy.....		2
Outerbridge's operation.....		3
Paracentesis abdominis.....		5
Paronychia.....		11
Penis, condylomata of.....		I
Perineorrhaphy.....		8
Periostitis.....		5
Phalanges (resection of), fingers.....		I
Poisoning, opium.....		I
Porro's operation.....		I

Brought forward.....	426
Pott's disease—jackets, aspirations, incisions.....	13
Ranula (excision).....	1
Rectum, total 29.	
“ American (not for hemorrhoids).....	8
“ dilatation of.....	17
“ excision of (carcinoma).....	2
“ prolapse of (purse-string).....	2
Resections, total 4.	
“ inferior maxilla.....	1
“ rib.....	1
“ tibia.....	2
Scoliosis, rotary lateral—splints, jackets, braces.....	55
Scrotum (gangrene of).....	1
Spina bifida.....	1
Spinal concussion.....	1
Staphylorrhaphy.....	1
Stomach, irrigation of.....	3
Talipes, total 6.	
“ equino-varus.....	3
“ equinus.....	1
“ valgus.....	2
Tonsiliotomy.....	7
Torticollis.....	2
Trachelorrhaphy.....	38
Transfusion (saline).....	2
Tracheotomy.....	2
Tumors, total 101, excluding breast amputations and laparotomies.	
“ Benign :	
“ adenoma.....	6
“ angioma, naevi and erectile.....	17
Tumors, Cysts :	
“ “ colloid.....	1
“ “ hydatid.....	1

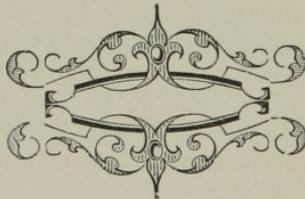
Brought forward.....	617
Tumors, Cysts :	
“ “ sanguineous	1
“ “ sebaceous.....	14
“ enchondroma	2
“ fibroid.....	7
“ lipoma.....	11
“ lymphadenoma.....	2
“ myxoma	4
“ papilloma (bladder)	2
Malignant :	
“ spheroidal-celled (hard)	3
“ squamous-celled.....	18
“ Sarcoma :	
“ “ angio.....	1
“ “ spindle-celled.....	6
“ “ round-celled.....	2
Urethra, caruncle of.....	1
“ dilatation of (female).....	9
“ “ “ forcible.....	15
“ “ “ gradual.....	12
Uterus, minor operations, dilatation of, discission, curettage..	68
Uvula, excision of.....	7
Vaginal hysterectomy.....	7
Vaginismus.....	10
Varix leg (excision of veins).....	4
Wounds, total 32.	
“ contused.....	9
“ incised.....	11
“ lacerated	7
“ poisoned.....	5
Total	<u>855</u>

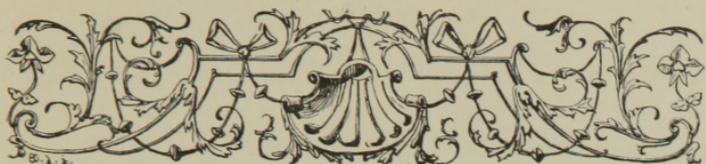


III.—TABLE.

DEATHS.

Cancer.....	5
Embolism.....	2
Exhaustion.....	1
Heart failure.....	4
Paralysis of intestines.....	5
Peritonitis.....	6
Septic pneumonia.....	1
Shock.....	5
Total.....	<u>29</u>





IV.—PRELIMINARY NOTE.

IT will be seen from the preceding tables, which exhibit about one half of my surgical work for the periods included between the respective dates (the balance being done in private practice or in other hospitals), that there have been treated at Helmuth House in three years and nine months, 1009 cases, giving an average of a little over 22 patients a month. This may be considered a fair average for a small private hospital.

No observant surgeon can operate upon and treat such a series of cases—passing through his hands in rapid succession—without drawing some deductions therefrom, which must be useful to himself and perhaps of benefit to others. In these pages I propose to diverge a little from the bald reporting of cases, that generally constitutes the bulk of such reports, by adding here and there the thoughts which have come uppermost in my mind while preparing these tables.

I often wonder how it happens that some surgeons can tabulate so many cases of a certain disease which

at the time is occupying the attention of the surgical world. I have read of over one hundred cases of a certain variety of fracture being treated by one surgeon in a short space of time; another has 50, 60, or 70 cases of appendicitis; a third reports hernia operations by the hundreds; a fourth has observed scores upon scores of cases of cancer or myo-fibroma of the uterus in a year, and has performed—I am afraid to say—how many hundreds of operations.* Now while congratulating these gentlemen on that great good-fortune which allows them to acquire an immense experience in so short a time, I deeply commiserate myself on my ill luck at the paucity of these cases falling to my care. To be sure when they *do* come, several often appear in rapid succession, and I curb my disappointment and remember the saying “that all things come to him who can but wait.”

* The latest numerical tabulation is that of a physician who in thirty years has treated 2,000,000 cases of insanity, or 182 cases every day.—*Med. Record*, Oct. 19, 1895.





V.—AMPUTATION OF THE TONGUE.

A RECORD of four amputations of the tongue, all for squamous-celled carcinoma, which with others done outside Helmuth House at different periods give at least fifteen cases from which to draw conclusions, and which show the varied changes made in these operations in the past few years. The first case was one of macroglossia, and was done with Chassaignac's *écraseur*, which was I think introduced in 1854. The two or three following operations, were performed with Hicks's instrument, then followed the use of the galvano-cautery with a fence of pins, but of late I have dropped all the varieties of *écraseur*, whether with cold or hot chain, and use only the scissors. The ligation of the linguals as a precautionary measure in removal of the tongue is in my opinion neither necessary nor advisable, and though the ligation of these vessels may be easy in the hands of a skilful anatomist and experienced surgeon (if the patient be thin), it takes considerable time, keeps the patient long under the anæsthetic, complicates the healing process, and

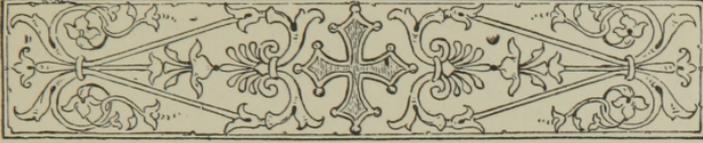
more or less adds to the severity of the shock. The distinguished Mr. Treves has timed himself in the performance of this operation in order to answer one of the objections made to it as a preliminary to ablation of the tongue, and has found that it occupied seven minutes to secure one, thus making about a quarter of an hour for the completion of this part of the operation. It is my opinion that very few men can tie both lingual arteries on the living subject in a quarter of an hour, even under favorable circumstances and upon a thin patient and at the best site, viz: as the vessels pass beneath the hyo-glossus. Even in the division of the platysma, a plexus of veins may bother one. Then follows the finding of the double-bellied muscle which makes the triangle called after its name, and which when found and cleared is the most important landmark and always gives confidence to the surgeon because he is sure that he is upon the right road. This brings him down to the floor of the space, viz: the hyo-glossus muscle, which has to be cut through to reach the vessel. After careful division of the fibres of this, touch by touch of the knife, the artery can be found, but not always as readily as might be supposed. All this time the hypoglossal nerve must be carefully avoided, the submaxillary gland held out of the way, and the tendon of the digastric drawn downward, making the operation one of delicacy and skill. When it is remembered that a similar procedure is to be *re-*

peated on the other side, before the main operation is undertaken, and that even after it has been done (according to Jacobson) it does not always prevent hemorrhage, we may safely argue that this preliminary ligation should be dispensed with. That it may be necessary when the tongue and the whole floor of the mouth is to be removed, there is no question, but in the majority of operations for excision of the tongue it appears to be inadvisable. If a preliminary laryngotomy be made, which can be done in a few moments, either a part or the whole tongue can readily be removed by Whitehead's operation. The scissors should be rather long so that they may readily be handled. There should be several pairs of them, sharp and blunt-pointed, curved upon the flat and at an acute angle. The essentials to facilitate the performance of the operation are a bright day, a good gag, an electric light which will work when you want it, and two good assistants. If but half the tongue is to be cut away, two ligatures at its tip should be used, one to manage the diseased, the other the healthy part. Free division of the frænum, the hyoglossus, and the palato-glossus is necessary, and the vessels are to be caught and tied as they spurt. In some instances it is difficult to tie the ligatures securely, in such cases the forceps may be allowed to remain. If the operation be done after a laryngotomy, one of the great difficulties and dangers of the operation is avoided, viz : the rapid accum-

ulation of blood within the oral cavity and the liability of its passing into the trachea and suffocating the patient. A good assistant, with his forceps in one hand and a mop or sponge in a long-handled holder in the other, can generally secure the bleeding vessel without much difficulty. In some instances a thread passed with a curved needle behind the vessel and tied, will be of service. The scalpel need not be used at all, except in opening the larynx. The surgeon should be careful in splitting the tongue to do so precisely in the median line, as the vessels on either side symmetrically enter the tongue and become smaller as they converge to its middle.

In one of the cases, which at the time of operation promised to be most successful, the patient on the second day began to present symptoms of septic pneumonia of both lungs. The temperature rose rapidly, crepitant râles developed over the entire surface of both lungs, and death soon resulted. This is the first case of this peculiar sequela that has occurred in my practice after an amputation of the tongue.





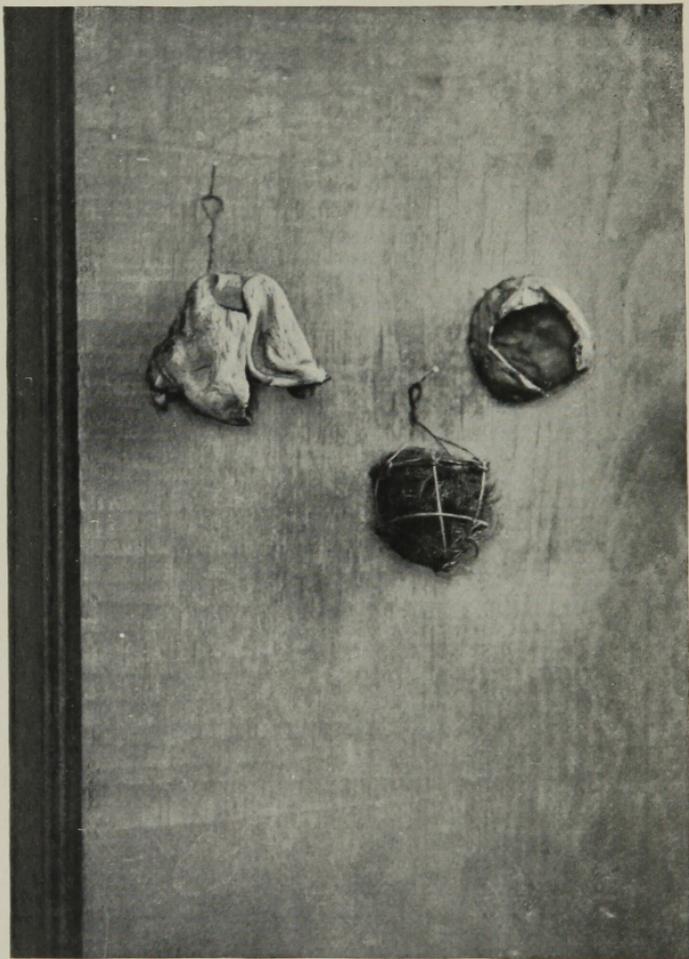
VI.—SCISSORS.

A PROPOS to the description of the foregoing operation, a fact worthy of consideration is noted, viz: the increasing employment of scissors in many operations. The value of this small instrument has no doubt been emphasized by the many new gynecological operations in which the use of the scalpel or bistoury is almost impossible. Knives are generally used for all perpendicular cuts, but the scissors can cut horizontally as well as perpendicularly, and can be directed with sure aim. A pair of blunt-pointed scissors, with rather long handles, their blades curved on the flat, is a safe, a sure, and efficient instrument. In the removal of large tumors of the neck, in vaginal and supra-vaginal hysterectomies, in cutting over important vessels, in operating in all cavities, mouth, abdomen, vagina, or rectum, a scissors is a very valuable implement, and though I dare scarcely say that it will supersede the traditional scalpel, that has carved through human flesh the path to glory for those mighty men in surgery who though "passed to the other side" still live for us to emulate, yet it bids fair to rival the usefulness of the knife in many operations in surgery.



VII.—DEATHS AFTER LAPAROTOMY.

THE deaths that occur after laparotomy are generally attributed to shock, peritonitis, heart failure, and septicæmia. I have expressed an opinion many times both to my assistants and medical friends, that deaths have resulted in my practice after abdominal sections which could not be fully understood, but which were placed to the credit of peritonitis or heart failure, for want of better terms, but which did not satisfactorily account to my mind for the peculiarity of the symptoms and the fatal terminations. Post-mortem examinations, instead of explaining, rendered them even more puzzling. Take for example a simple ovariectomy. All goes well at first; the shock has been slight and the patient has reacted; the pulse has reached 104, and the temperature curve touched $100\frac{4}{10}^{\circ}$. The expression of the face is good; the patient says she is well; she is cheerful and comfortable; complains that she is hungry and wants drink as usual. On the night of the third day the temperature rises a little and the pulse also, slight tympanites is present,



DOUBLE DERMOID CYSTS

($\frac{1}{8}$ Natural Size.)

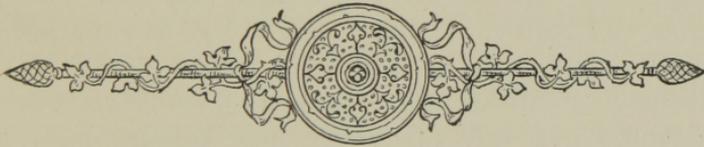
The figure on the left shows the thick cutaneous sac which contained the hair and caseous material as represented in the centre of the plate. The figure on the right shows the left ovary (having undergone calcareous degeneration) transformed into a ball with a complete and dense circumference of bone filled with hair and fat.

nausea occurs at intervals, the thirst which has been abating returns, and the patient has a bad night. The next morning everything looks unfavorable. The expression is altered and the abdomen much distended, there is some soreness about the wound, and vomiting is frequent. There is no further rise in temperature, and rather a feeble pulse. The distension increases, the introduction of the rectal tube brings but little flatus away, the pulse becomes weaker, the vomiting is either persistent, in mouthfuls at very short intervals, or in larger quantities every fifteen or twenty minutes. The substances vomited are first ingesta, then mucous or bilious matter, finally a substance resembling spinach. The patient gradually sinks and dies on the evening of the fourth or the fifth day in a state of collapse. We write down peritonitis, open the abdomen, and find a very slight rose-colored area in the peritoneum surrounding the site of the incision, but in no way sufficient to cause death, but the intestines are enormously distended with flatus, here and there showing marks of inflammatory action.

Let me report a second case. About a year and a half ago I made a supra-vaginal hysterectomy for a large myo-fibroma; upon opening the abdomen there were very many adhesions, with patches of dusky redness here and there over the intestines, marking the presence of previous inflammation. The patient recovered from the shock, but on the

morning of the second day the abdomen began to distend, the pulse went to 130, the temperature to $103\frac{4}{10}^{\circ}$. In the afternoon of the same day she began to vomit the characteristic green substance, followed by brown mucus. This continued all night, and on the morning of the third day there was a distinctly fæcal odor to the vomited matter. The pulse increased in frequency and became small. The temperature diminished to $101\frac{1}{10}^{\circ}$. The expression was bad, the skin clammy, the perspiration cold, no flatus had passed (though the rectal tube had been frequently used), and the abdomen became much more distended. Believing that there was an intestinal obstruction, either from a volvulus made in replacing the intestine which the peristalsis could not untwist, or that the gut might have been entangled in a previously existing adhesion, I opened the belly at ten o'clock at night. The abdominal wound had nearly closed, and to my surprise there were no appearances of recent inflammatory action. The peritoneum except in the immediate vicinity of the wound was not inflamed, nor could I find the slightest bowel obstruction. The patient died in about twelve hours after the second operation, and at a carefully conducted post-mortem examination neither twist, volvulus, intussusception, or bands obstructing the lumen of the gut could be found, neither were there present any marks of peritoneal inflammation sufficient to cause death. The bowels, how-

ever, had to be punctured in several places to allow the flatus to escape. I wrote "heart failure" in the certificate, because toward the end there were evident symptoms of that distressing condition, but there was always an indefinable conviction in my mind that there must be something behind all this which I could not explain. Further reading and observation now have convinced me that neither of the cases quoted above died from peritonitis, but that both were occasioned by paralysis of the intestines.





VIII.—PARALYSIS OF THE BOWELS.

THIS idea was first promulgated by John D. Malcolm, M.B., C.M. Surgeon to the Samaritan Free Hospital, London, who in a paper "On the Conditions and Management of the Intestines after Abdominal Sections" * called the attention of the profession to the diagnostic signs between peritonitis and paralysis of the intestines. Then Prof. Olshausen read a paper before the Obstetrical and Gynecological Society of Berlin on the same subject. † F. Verchère followed with a paper describing deaths from paralysis of the bowel after cœliotomy, stating "that it had always been confounded with peritonitis." ‡ And finally Mr. Malcolm published his late work § to which I am indebted not only for many new points referred to in these pages, but in elucidating certain facts that before—as I have already stated—were unin-

* *Medico-Chirurgical, Transactions* vol. lxxi.

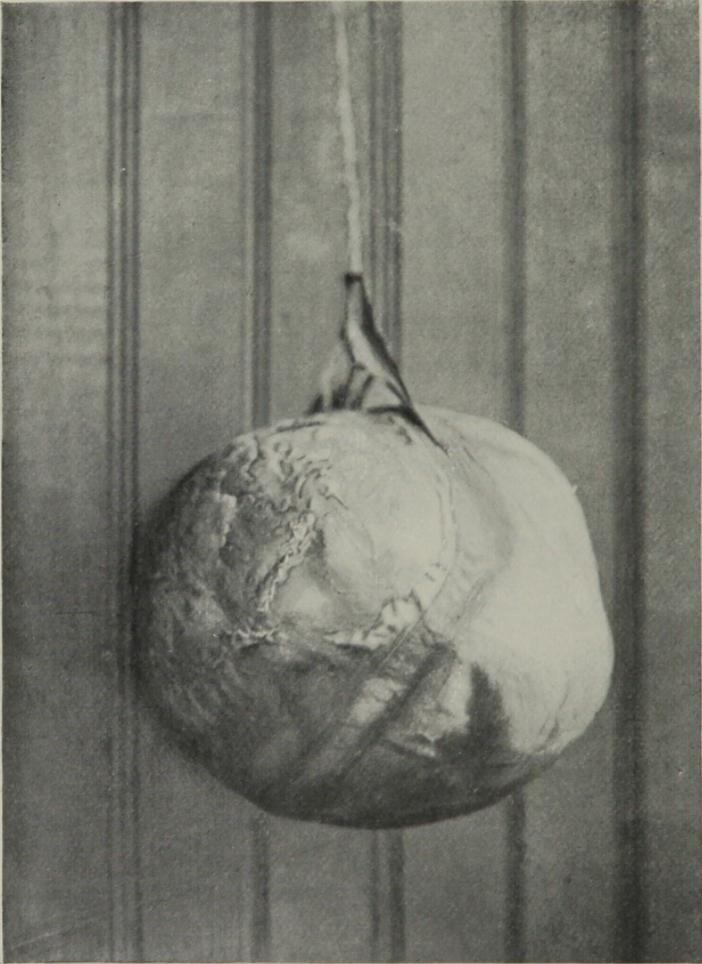
† *Centralblatt für Gynacologie.*, Jan. 1888. *British Med. Jour.* May 19, 1888.

‡ *Revue de Chirurgie*, July, 1888.

§ *The Physiology of Death from Traumatic Fever*, London, 1894.

telligible regarding certain deaths after cœliotomy. The priority of claim in clearing up these hitherto unsatisfactory lethal conditions belongs to Mr. Malcolm, although some further elucidation on the subject is given by other authors. It is obvious that paralysis of the intestines, if it continue for any length of time, will give rise to all the symptoms of obstruction of the bowel, a condition styled by Olshausen, pseudo-ileus—or a “hitherto undescribed cause of death from laparotomy.” Mr. Malcolm says: “In the exposure and manipulation of the intestine there is also abundant cause for its temporary paralysis. The muscular wall of the alimentary canal receives its nervous supply in great part from the branches of the large abdominal sympathetic nervous centre. These branches terminate in the wall of the intestine in Auerbach’s and Meissner’s plexuses, which are very rich in ganglionic cells, and the former of these contributes the nervous supply to the fibres of the muscular coat of the gut. The plexus of Auerbach, though under the control of the central nervous system, is also capable of being influenced by any kind of stimulation brought to bear directly on the walls of the intestine.” This is not only a rational explanation of certain deaths after laparotomy, but is in a measure proven by the immediate and permanent relief which often follows a saline purgative. It explains also the great significance of the expulsion

of flatus, on which experienced operators lay so much stress. The paralysis is beginning to be overcome; peristalsis is beginning to be restored, and the serious symptoms abate with marvellous rapidity. It is not by any means, however, to be understood that complete *mechanical* obstruction of the bowels does not occur after laparotomy, for this has been noted by me on several occasions, and I have had the satisfaction even in very advanced cases of untwisting the gut, have heard the gurgle, smelt the flatus and been assured that a life has been saved. By understanding this cause of death, the *importance of minimizing time* in all abdominal sections is made more apparent. Manipulation, exposure to a temperature below normal (unnatural positions of the intestines causing more or less obstruction to the circulation)—have a tendency to destroy peristalsis. Cold contracts muscular tissue whether in larger masses as found throughout the body or in the more delicate striæ of the intestines; it deadens sensibility and arrests functional activity. To restore many coils of inflated and displaced intestines into the abdomen requires often some forcible “tucking in,” and therefore while the operator must do of course all that is necessary for the welfare of his patient, no *unnecessary* manipulation should be employed.



DERMOID CYST.
($\frac{1}{8}$ Natural Size.)

Containing a long switch of red hair, much fatty material, 22 bits of bone of various sizes and shape and 9 teeth.



ONE VERY LARGE MOLAR, DOUBLE SIZE, AND FOUR OTHER TEETH, CONTAINED
IN A PORTION OF THE DERMOID CYST AS REPRESENTED IN PREVIOUS
PLATE.



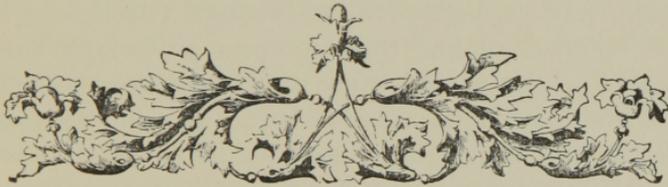
IX.—WEAK AND RAPID PULSE NOT ALWAYS INDICATIVE OF HEART FAILURE.

IN many of the cases of continued abdominal distension that occur after an abdominal section, a very small thready pulse is observed; sometimes it is so rapid that it cannot be counted. Such a condition has always been associated in my mind with a failure of the heart's action, recent investigations, however, seem to show that a very weak pulse at the wrist by no means always indicates that the heart is failing—indeed it may be beating with considerable strength while the wrist pulse may be growing imperceptible. After a paralytic condition of the bowels has existed for a considerable time, the vessels, as has been already stated, lose their tone and elasticity, in other words are paralyzed; there is stasis of the blood corpuscles, and a necessarily reflex contraction of the rest of the large arterial trunks is required to carry on the circulation. The heart calls upon its reserve force (for we may conclude the heart *has* in reserve a

great power) to help overcome this obstruction, and thus may be beating quite strongly while the smaller peripheral vessels show but feeble pulsation. On this subject Malcolm says: "It seems therefore that in all these conditions, in advancing inflammation, in shock, and *in abdominal distension following laparotomy* [italics mine], contraction of the arteries is brought about by a reflex physiological mechanism ; that this contraction of the arteries, while raising the blood pressure in the large vessels, accounts also for the smallness and feebleness of the pulse in such vessels as the radial ; and consequently that this condition of the pulse is due *not to cardiac weakness*, but to the relation which the cardiac strength bears to the obstruction produced by this contraction of the medium-sized and small arteries."

To understand how easily these reflex phenomena may be established, it must be remembered that the abdomen, its walls, its contents, and its great serous membrane, are covered with an interlacing network of nervous fibres of both systems. The seven lower intercostal nerves supply the skin, the external and internal oblique and the recti muscles, while numerous branches extend to the intestines and to the peritoneum. We have the solar, the cœliac, and the mesenteric plexuses, which are in close relation with the great sympathetic. When it is remembered that these same spinal nerves are intimately concerned with the motions of inspiration and expira-

tion, it will be perceived how easily and how rapidly reflex phenomena in other portions of the body will manifest themselves when the abdomen—its walls, membranes, intestines, vessels, and nerves have been handled, cut, torn, stretched, and misplaced, and also explains the well known fact that abdominal operations are more liable than any others to be followed by profound shock.





X.—PERITONITIS.

MANY years ago—in an address delivered before the New York Homœopathic Medical Society at Albany, speaking of the unsolved medical questions of the day, the author made this query—“Who can draw the line of demarcation between the inflammation that cures and the inflammation that kills?” This question I should like to ask again, and though perhaps through the light that the microscope has thrown upon pathology there may be at the present time more facilities to decide the question, still there hovers around the subject so many difficulties and so much uncertainty, that the varied questions involved in the consideration of inflammation are by no means solved. I used to say to my classes: “If we remove the ‘inflammations’ from the category of diseases, practically the doctor’s avocation is gone.” I am not quite sure from the recent investigations made in pathology and biology that the complete reverse of such a proposition may not be true; that if we

removed "inflammation from the category of diseases, whether the human race would not soon be devoured by some form of bacteria and become extinct." This seems to be the fact regarding peritonitis (as well as most of the disorders caused by bacteria)—that is, if it be caused by infection, and I believe at the present time the existence of an idiopathic case of peritonitis—I mean a non-infective case—is rare. Its existence is denied by some authorities. In such cases as these, inflammation stands up as a safeguard to her citadel; under its ægis, billions of cells array themselves against the invading micrococci; if the former gain the ascendancy the patient recovers; if the latter the patient dies, not, however, slain by his defender, the inflammation, but by the hordes of invading bacteria or bacilli. Here then certainly is an example of "the inflammation that cures," and if indeed myriads of death-producing germs are found to exist in every malady, then the inflammatory process, instead of being the great ogre embracing within its grasp the majority of all diseases, and to which two thirds of all occurring deaths are attributed, and which has been villified and abused for so many centuries, will in turn be recognized as the defender of the human citadel, and the prolonger of human life.

Immediately after a laparotomy, when the patient has recovered from the shock, if the skin of the belly become sensitive to the touch at other points than

immediately around the incision; if the abdominal respiratory movements become limited; if there be tension of the recti; if the patient complain of pain in the region of the great abdominal centres (which symptom is peculiar in this particular, that the suffering is reflex and does not originate at the point where the inflammation is progressing), and meteorism begins; then if the rigidity of the abdominal walls begin to relax and vomiting sets in—we may be pretty certain that peritonitis is developing. The temperature curve cannot be relied upon; it is so variable, in some cases going to 105° or 106° (this is generally the case when acute septicæmia is taking place), or it may remain from 101° to $102\frac{1}{2}^{\circ}$ during the entire attack. The vomiting is not excessive, but persistent; sometimes it is a mere gulping up of a greenish fluid mixed with mucus. Constipation is persistent. The idea that the tympanites is due to a mechanical obstruction of the lumen of the bowels and that the flatus accumulates above that point, is incorrect, for the distension is uniform, and is occasioned by a paralytic condition of the intestine occasioned probably by manipulation, exposure, and change of position. The vasomotor radicals are interfered with, the blood supply becomes deficient, and great distension results. This is proven by certain experiments. If a portion of the blood supply of an intestine be cut off, not entirely but *partially*, the bowels at once

begin to expand and extensive tympanites is the result. These are the well known symptoms of peritonitis and are familiar to every operator.

The majority of these forms of peritonitis are caused by the bacterium coli commune, although there are some cases in which the infection comes from within and results from the pyogenic cocci. With tuberculous peritonitis this report has nothing to do, as it does not occur after operation. There is, however, a certain variety of this disease which does not in my opinion receive the attention it deserves, and that is the so-called "*chemical peritonitis*." In such cases the micro-organisms themselves do not produce the inflammation, but the chemical products resulting therefrom are absorbed by the peritoneum, and violent inflammation results.

As a matter of diagnosis some points may be cleared up regarding deaths after laparotomy. If there be peritonitis, there is generally in the commencement of the disease a spasm of the abdominal muscles which always should be looked for. If there is a simple paralysis of the bowel beginning, this condition does not exist. There is much greater hyperæsthesia of the surface in peritonitis than there is in the true paralytic condition. The pain is greater (and more localized, being often referred to the site of the great nervous centres) in inflammation of the peritoneum than in the paralytic condi-

tion. The meteorism is greater in the latter, and the temperature is steadier, while in inflammation of the peritoneum the curve is higher and varies more. There is fever in peritonitis. There is none in "pseudo-ileus." There may be fæcal vomiting towards the last in the latter, but very rarely if ever is it found in peritonitis. The peritoneal inflammation advances rapidly, while I have known a case of paralysis of the bowel with occasional vomiting continue for weeks before simple exhaustion killed the patient. In looking over these, the chief causes of death from laparotomy, it will be found that the vaso-motor system bears an important part in most of them—shock, peritonitis, or paralysis of the intestines.

The treatment of peritonitis after laparotomy cannot be said to be very successful. If the disease be infectious,—and it has already been stated that certainly in the majority of cases it is so, if the bacteria are received through the medium of the wound, the antiseptic local treatment must be rigidly continued. The dressings must be watched carefully, while every surrounding object should also receive increased antiseptic treatment, floor, walls, ceiling, bed-clothes, etc. The medicines internally that have done for me the greatest service are aconite in the first stages, belladonna in the second, and arsenicum in the third. It is a good rule after every case of abdominal section to allow no food to be taken by

the patient for twenty-four hours. Hot water by the tablespoonful every hour or two may be administered, and the patient kept at perfect rest. On the second day rice water, well made and warm, may be given. The first two days' attendance upon a patient after laparotomy is harassing, and the constant cry for water is trying to the nurse and to the doctor. The patient is tormented with an almost insupportable burning, continuous thirst, occasioned not only by the operation itself, but from the anæsthetic. The patient is constantly importuning every one for "just a little cold water," "just a drop" which it is often hard to refuse. If the patient be given cold water in any quantity it is immediately rejected, the thirst is not diminished, and the renewed efforts at vomiting increase the weakness. Hot water by the mouth does sometimes temporarily relieve, and I have known hot water, a pint at a time injected into the rectum, produce most beneficial results. On the third day if no flatus has passed by the anus the rectal tube must be carefully used—and let me say here that the use of the long tube, of which so much has been written and which is alleged to have been passed several feet into the bowels, is often dangerous. The fact is that in my opinion it never enters the trap-like twist of the sigmoid flexure, and in many cases where it is said to have been passed high up, the tube has either twisted upon itself in a readily dilatable rectum, or

the gut has been pushed before the end of the tube.*

If there is no escape of flatus, a seidlitz powder should be administered ; if in four hours there is no action a second may be given, and in four hours a third. I lay great stress on this simple method of endeavoring to restore peristalsis and prevent constipation, which in the peculiar condition of the intestines after abdominal section is a dangerous complication. The immediate good results which follow the administration of a simple saline purge are so palpable to the surgeon of any experience, that it has come to be one of the simplest and most useful adjuncts in the treatment of peritonitis.

Of all the internal medicines used, aconite is by far the best. It is the only remedy, in my experience, that will arrest the disease in its early stages. It is beginning to be used in the old school now with good effect and approbation, but the doses recommended are all too large. It is taking the place of opium, given always to arrest peristalsis, which in the majority of cases hastens the death of the patient. It has been shown that immediately after a laparotomy there is a tendency to paralysis of the intestines, there is a stasis in the vessels, there is increased

* While these pages were passing through the press I had occasion—in an aggravated case of sarcoma of the descending colon—to employ the metallic rectal tube devised by Dr. E. V. Cole. The instrument acted admirably and I was assured that I had actually entered the flexine.

reflex contraction of the larger arteries—to administer opium at such a time is to complicate this condition. The effort should be to gently equalize the blood pressure, to restore a healthy peristalsis, to relieve the bowel of gas and its accumulations, and aconite does this, aided, as before stated, by a seidlitz powder—or a teaspoonful of Tarrant's Aperient. A word here about the dose to be employed. Five drops of the tincture of the root of aconite should be mixed in ten tablespoonfuls of water, and a tablespoonful given every hour for four hours, and thereafter two hours. It is remarkable in some cases to see how this medicine in these doses will subdue a commencing peritonitis, and it is my experience that if the disease is not overcome in the early stages it will overcome the patient in the later ones.

The pathogenesis of turpentine shows many symptoms identical with peritonitis, and where the meteorism is great, and the pain rather severe, I have had good results from its internal administration. An injection of turpentine and a hot—but not strong—turpentine stoup as adjuvants gives great relief to the patient. A good formula is:

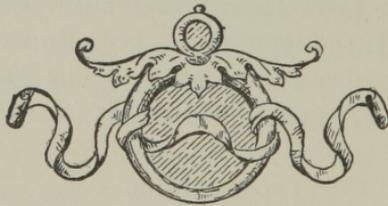
℞

Olei terebinthinæ
 Lactis asafœtidæ āā fl ʒ ij
 Aquæ ferventis fl ʒ iv
 ℥. et. sig. Use as injective.

Opium is inadmissible. After all laparotomies in Helmuth House, although I cannot say I do not use it at all, in the majority of cases it is tabooed. When morphine is used, it is only when the patients are in a hopeless condition, or if there be great pain immediately after operations.

The patient ought to be fed by the rectum with beef peptonoids, mixed with a little brandy and milk, and food by the mouth given cautiously and in small quantities after the first week.

Irrigation of the abdominal cavity with hot water has only been used once in non-tubercular peritonitis. The patient died, but she was almost *in articulo* when the abdomen was opened, but was much relieved. In tubercular peritonitis I have opened the abdomen several times, and on every occasion with great amelioration of all the symptoms.





XI.—STATISTICS OF SUPRA-VAGINAL HYS- TERECTOMY FOR MYO-FIBROMA OF THE UTERUS.

I N the tables will be found twenty-two cases of supra-vaginal hysterectomy. These with twenty-one cases operated upon in the Flower Hospital, the Woman's Hospital, and in private practice, and twenty-two cases already recorded,* give me sixty-five cases of this operation with fifteen deaths, rendering a mortality of 23.1 per cent. This death rate is high compared to many published statistics. It is recorded because it is so, and to state a fact of which all operators must be aware, who carefully scrutinize their surgical work, that a series of successful operations is often followed by a number of unsuccessful ones, although the same care may have been taken in all. I have not been as fortunate in the last twenty-five as in my first twenty-five cases, which is a contradiction to the experience of most abdominal surgeons—and indeed of surgeons in general. It marks a point, and that

* *North American Journal of Homæopathy*, Nov. 1890.

is: how important it is to allow our experience to extend over a number of years before reporting it for the benefit of others. I have had as many as nine consecutive cases of hysterectomy following one another in rapid succession, without a single death, and *per contra*, have had four deaths, one after the other, with no successful case between, to break the dismal and discouraging, but palpable record. I have always been in favor of the extra-peritoneal method of treating the pedicle, and use even now the pins and ligature, of which more will be said hereafter. I am in favor of leaving the cervix—of course if healthy—within the vagina to support the contents of the abdomen. I cannot see that anything is gained by its removal, nor the advantage of prolonging the operation merely to remove a healthy mass of tissue doing good service. The only objection that can be used against this method is the suppuration of the stump. There is no denying the fact, that sometimes profuse suppuration ensues, but two other facts may be also considered, viz.: that often these very badly suppurating cases recover, and *that septicæmia is not the cause of the majority of deaths after supra-vaginal hysterectomy by the extra-peritoneal method.* The deaths in my hands have been mostly set down to shock, peritonitis, and heart failure, and I cannot remember but one or two cases that have succumbed to septicæmia. If a patient, after an abdominal

hysterectomy, survives the fifth day and has passed flatus she generally recovers. As has been mentioned in the preceding section, deaths which are often attributed to peritonitis and heart-failure are caused by what is now known as *pseudo ileus*.

It will be interesting to all gynecologists to give here the latest comparative mortality from removal of the uterus by the different methods. This operation has occupied a good deal of the attention of the surgical world for the past twenty years, and has been the subject of grave discussion among the gynecologists of both hemispheres. The question of methods and technique are still under discussion, and from the rapidly decreasing mortality, the operation for removal of myo-fibroma from the abdominal cavity (if there be such a thing as an abdominal *cavity*), either with or without the uterus, or with portions of it, is daily undertaken without much misgiving on the part of the surgeon. The trouble will be, that the operation will be attempted far too often. Had I operated upon every case of "*fibroid*" of the uterus that has come under my observation, in the past twenty-five years my cases would have been numbered by many hundreds. I have not made any special record of these, but my experience fully accords with that of Boldt who states that in 321 cases (aged 18-66 years) coming under his observation, only 57* were opera-

* *American Journal of Obstetrics*, vol. xxvii., 1893.

tive. I am not sure whether it was Burnham or Kimball who made the first successful abdominal hysterectomy, but I know it was in 1853, the year of my graduation. Storer, of Boston, afterwards performed the same operation. In 1861 Mr. Wells made his first abdominal hysterectomy, and in 1874 Keith, of Edinburgh, also made one. My first attempt at the removal of a fibroid (interstitial) was thirty years ago in Danville, Ill. I could not dislodge the growth, but the patient recovered, although there was no antisepsis and no drainage. The operation was done in a dark little room; the incision was made from the ensiform cartilage to the symphysis, and from the umbilicus to the anterior superior spine. The bleeding was profuse, the intestines were long exposed, and yet—the patient made a good, yea, rather rapid recovery, and the tumor diminished in size.

The first complete hysterectomy I performed was in Brooklyn about 1872. The patient was one of the late Dr. Henry Minton's. The operation was ovariectomy for one of those immense tumors which, since the recent improvements in abdominal surgery, are never encountered in these days. The pedicle was very flat and broad, and in raising it outside the cavity (?) the entire body of the uterus came with it. I clamped the cervix with silver wire, turned in the ends and removed the whole mass. This patient was very poor and had no nurse but her



MYO-FIBROMA AND MYOMA UTERI.

husband, who was obliged to leave her, frequently for a long time. On the night of the tenth day she took cold from a draught of icy air blowing directly upon her, and died of tetanus on the thirteenth day thereafter. This case might be called "an accidental hysterectomy" as the removal of the uterus was not contemplated when the operation was begun, and although having read Kimball's pamphlet, I considered such a performance as scarcely justifiable.

Tempora mutantur.

The discussions regarding supra-vaginal hysterectomy have centred, until recently, upon the best methods of treating the pedicle. At present the question of total ablation is added, which includes the technique of "abdominal-vaginal," "vagino-abdominal," and "complete" hysterectomy—each method having its ardent supporters. In all my cases, save two, the pedicle has been treated externally; in those two (both of which recovered) it was ligated in sections with strong ovariotomy silk. For all the other *recent* cases, the elastic ligature and pins were employed. A clamp or serre-nœud has not been applied, although Kœberle, Bantock, Keith, Price, Tait, and other experienced operators highly recommend this form of metallic constriction. I have, in former years, used Tait's, Kœberle's, and Thomas's large clamp and discarded them for the use of the simple elastic cord. If the latter is properly applied, it is safe and sure. Its removal to substitute the serre-

nœud, requires still more manipulation, opens the mouths of vessels, which have just begun to be occluded, and disturbs the parts that have been put to rest and—*takes time*, which in all abdominal operations should be carefully minimized. The elasticity of the ligature keeps it securely in its place, and requires but little further attention during the progress of the cure. The non-elastic substances used to compress the pedicle require constant watching, for as the tissue shrinks, the wire or the jaws of the clamp must be tightened ; if this is not carefully supervised, the stump is liable to slip into the abdominal cavity, an undesirable result, often followed by the gravest consequences. Things are easily gotten into the abdomen, but, ah! how difficult to find and remove them. It has been argued that the *serre-nœud* leaves a more cleanly cut surface ; of this I cannot speak, not having seen it employed, but the beautiful resulting stumps from a well applied elastic ligature, antiseptically treated, are difficult to improve.

I know well while writing this, that the “complete” removal is now fashionable, and also that a good many of the more conservative men still apply the ligature and *serre-nœud* ; and though holding myself open to conviction as to the best method of conducting these operations, shall avail myself of that method which is followed by the best results, when a sufficient time has elapsed to show the “survival of the fittest,” still it is hard to teach

“old dogs new tricks.” I have seen within a few weeks a total extirpation skilfully performed, and the patient die in a few days. A short time after I removed a larger tumor, tightly locked in the sacrum, by the old method, the woman never having a temperature of 100°. I am therefore loth to take on the new love before I am off with the old.

My mortality, as already stated in the beginning of this section, is 23.1. It may, however, be explained by the facts that I have never picked my cases, and wherever I thought there was an opportunity of relieving a patient, even if the symptoms were most unfavorable, the operation has been unhesitatingly performed. It is a consolation, however, to find myself in company with distinguished and reliable men, thus—Ascher has a mortality of 40%, Hegar 32.2%, Schroeder 20.5%, Bantock 33.9%, Spencer Wells 50%, Thornton 37%, Boldt 33%, Irish 26.3%, Munde 33.3%, Terrier 39%. These are all for the extra-peritoneal method. By the intra-peritoneal method Schroeder has a mortality of 29.2%, Martin 34%, Fritsch 40.7%, Spencer Wells 37.1%, and Byford 23.5%. At the end of this section the comparative mortality of the methods is fully given, and therefore it would be anticipating to make further remarks here.

At present there are four methods of performing abdominal hysterectomy:

First, by the extra-peritoneal management of the

stump; second, the intra-peritoneal; third, vagino-abdominal; fourth, complete removal. Each of these procedures must receive a trial by competent operators, and fair statistics must decide the question. All statistics are more or less unreliable. To enable the student earnest in his desire to improve operations done for the prolongation of human life, or the prevention of human suffering (not for the sake of proving the efficacy of a special method of operating):

1st.—*A standard must be fixed* as to what constitutes a *successful operation*.

2d.—*Consecutive* operations must be recorded.

3d.—An absolutely "straight" account of the case must be given.

4th.—The cause of death must be plainly stated.

5th.—The collector of comparative statistics should have a particularly unbiased mind regarding the methods he reviews. Again it would seem manifestly improper to compare the statistics of one who has operated upon two cases, side by side with the surgeon who has operated upon a hundred. On this point, however, more will be said.

The figures which follow are taken from the recent work of M. E. Gentilhomme published in 1894. I have arranged his latest records into tables for easy reference and comparison, and designated them as follows: Table I. Supra-vaginal hysterectomy. A. Giving the names of the operators and the cases

treated by the extra-peritoneal method. B. The cases treated by the intra-peritoneal method. Table II. Combined and complete operations. C. Vagino-abdominal. D. Abdomino-vaginal. E. Total ablation.



XII.—STATISTICS AND PERCENTAGES.

TABLE I.—SUPRA-VAGINAL HYSTERECTOMY.

A.			B.		
Extra-Peritoneal Method.			Intra-Peritoneal Method.		
Operator.	Cases.	Deaths.	Operator.	Cases.	Deaths.
Ascher	5	2	Zweifel	50	6
Leopold	34	7	Ascher	10	4
Price	96	3	Kaltenbach	8	3
Doyen	29	3	Léopold	22	5
Elliot	1	1	Schroeder	164	49
Fehling	30	3	A. Martin	135	46
Chrobach	55	5	Dick	11	2
Kaltenbach	22	1	Fritsch	27	11
Hégar	31	10	Terrilon	32	3
Albert	50	3	Lauwers	3	2
Schroeder	34	7	Sp. Wells	26	10
Fritsch	33	6	Cushing	3	3
Lauwers	13	6	Boldt	3	3
Terrilon	26	3	Traub	42	4
Keith	38	2	Bear	9	0
Tait	88	10	Leonte	26	0
Bantock	56	19	Brennecke	22	4
Sp. Wells	20	10	Martin (U. S.)	6	1
Thornton	54	20	Delettrez	18	0
Cushing	25	5	Byford	17	4
Boldt	6	2	Chaput	8	6
Irish	19	5	Meyer	21	4
Maun	12	1	Hofmeier	11	5
Munde	12	4	Terrier	8	4
Hamilton	10	4	Doyen	1	1
Polk	11	2	Carl	52	5
Byford	4	0	Richelot	20	1
Terriei	38	15	Chrobach	17	0
Segond	20	9			
Meyer	30	7	Total	772	183
Richelot	16	3			
Pozzi	16	2	Average mortality, 23.70 per cent.		
Carl	11	1			
Total	945	171			
Average mortality, 18.09 per cent.					

COMPLETE HYSTERECTOMY. TABLE II.—COMBINED AND COMPLETE OPERATIONS. SINGLE OPERATION.

C. Vagino-Abdominal.		D. Abdomino-Vaginal.		E. Total Ablation.	
Operator.	Cases.	Deaths.	Operator.	Cases.	Deaths.
Leopold.....	17	3	Péan.....	27	1
Bardenheuer.....	7	1	Boldt.....	7	2
Bouffart.....	6	0	Beckel.....	4	1
Jacobs.....	5	1	Le Bec.....	7	3
Boldt.....	3	0	Gouilloud.....	3	1
Chaput.....	3	0	Bouilly.....	1	0
Calderini.....	1	0	Schwartz.....	1	0
			Jacobs.....	4	1
Total.....	42	6	Regnier.....	1	1
Average mortality, 14.29 per cent.			Pichevin.....	1	1
			Total....	56	10
			Average mortality, 17.85 per cent.		
			Baldy.....	5	1
			Boldt.....	10	3
			Crofford.....	1	0
			Craigin.....	1	0
			Eastman.....	79	8
			Edebohls.....	6	0
			Dixon Jones.....	1	0
			Keith.....	2	0
			R. Hall.....	10	1
			Lanphear.....	5	1
			Polk.....	18	2
			Price.....	2	0
			Ross.....	1	1
			Stimson.....	7	2
			Chrobach.....	20	0
			Mackenrod.....	8	1
			A. Martin.....	97	8
			Schultze.....	1	0
			Tredelenbourg.....	2	0
			Lennander.....	16	0
			Bossi.....	1	1
			Chenieux.....	1	0
			Doyen.....	28	4
			Fochier.....	1	0
			Guernonprez.....	3	2
			Hue.....	2	0
			Lannelongue.....	1	0
			Pozzi.....	4	2
			A. Rervardin.....	2	0
			Terrillon.....	2	1
			Carl.....	20	0
			Calderini.....	4	2
			Meyer.....	5	1
			Total....	376	52
			Average mortality, 13.8 per cent.		

To further facilitate a better comparison between the extra-peritoneal and intra-peritoneal methods, Gentilhomme states that he has selected the operators who have published the results of a sufficient number of cases (twenty at least), and that he has eliminated all those who have included in their total "too old cases."* He then gives the following figures which have been arranged for comparison, *Vide* Table III. Comparison of methods. F. Extra-peritoneal. G. Intra-peritoneal. H. Total removal. While fully agreeing with the author regarding his exclusion (for a better comparison) of those operators whose record does not reach twenty cases—and I have already expressed my ideas on this subject,—I do not at all coincide with his second proposition, that is, to eliminate all those who "have included in their total 'too old cases.'" First, because it is the very experience of these men who are able to report the "too old cases," which we desire,—and to exclude their statistics from either side would lead to unfair deductions. Every man—nay and woman too—is entitled to consideration no matter what his or her ideas may be concerning the technique of an operation which has been successfully performed.

His earlier experiences with his methods are by no

* " Nous avons choisi les opérateurs qui ont publié des résultats assez considérables (20 cas ou moins) ; de plus nous avons éliminé tous ceux qui comprennent dans leur total des cas trop anciens."

III.—COMPARATIVE TABLE.

F. Extra-Peritoneal.			G. Intra-Peritoneal.			H. Total Removal.		
Operator.	Cases.	Deaths.	Operator.	Cases.	Deaths.	Operator.	Cases.	Deaths.
Leopold	34	7	Zweifel	20	6	Léopold	17	3
Price	96	3	Léopold	22	5	Péan	27	1
Fehling	30	3	Terrilon	32	3	Boldt	10	3
Chrobach	55	5	Treub	42	4	Eastman	79	8
Kaltenbach	22	1	Brennecke	22	4	Polk	18	2
Fritsch	33	6	Meyer	21	4	Chrobach	20	0
Terrilon	26	6	Chrobach	17	0	A. Martin	97	8
Keith	38	2	Richelot	20	1	Lennander	16	0
Cushing	25	5	Leonte	26	0	Delagenière	10	1
Meyer	30	7	Total	222	27	Doyen	28	4
Terrier	38	15	Average mortality, 12.16 per cent.			Carl	20	0
Segond	20	9				Total	342	30
Doyen	29	3				Average mortality, 8.77 per cent.		
Total	475	72						

means to be overlooked ; besides it leaves the matter as to what constitutes the old and the new entirely in the hands of the compiler. By far the fairer method would be to expunge from the tables the work of all operators who have not performed twenty operations, and to give the figures of all from twenty cases upwards. In these third tables, said to be drawn for more careful comparison of the methods, the author, unwittingly perhaps, has been very partial to the intra-peritoneal method, and has excluded from the extra-peritoneal the magnificent work of Hegar, Albert, Schroeder, Tait, Bantock, Spencer Wells, Thornton, and others. Nor can the upholders of the intra-peritoneal method omit the 164 cases of Schroeder, the 135 cases of Martin, as well as those of Delettrez, Carl (of Turin), Byford, and others. There are several other rather curious inaccuracies in these data. In Table III., in which the author gives the names of the operators who have made twenty and upwards, in section G (intra-peritoneal) the name of Chrobach appears, who has a record of only seventeen operations but with no deaths, which materially diminishes the mortality on that side. Again in table "A" (extra-peritoneal), Terrilon is accredited with 26 cases and 3 deaths, while in Table III., F (extra-peritoneal), 6 deaths (twice the number) are set down to him. If we now exclude from the classifications all surgeons who have not performed twenty operations and give

to Terrilon the three deaths accredited to him, the following will be the result: Extra-peritoneal method, 809 operations and 148 deaths, giving a mortality of 18.29 per cent. Intra-peritoneal method, 639 operations and 148 deaths, giving a mortality of 23.15 per cent. If the same method is employed in rendering the statistics of the total ablation of the uterus, either by the combined or single method, we have 271 cases with 21 deaths, reducing the mortality to 7.76 per cent., which in the rather paradoxical nomenclature of to-day might be called "an ideal mortality."

OPINIONS OF HOMŒOPATHIC SURGEONS.

Before closing this important subject it will be interesting, especially to our own school, to compare the opinions of our surgeons in regard to the varied questions which we have been considering, namely, the mortality and technique of hysterectomies made above the pubis. With this object, I wrote to the leading Homœopathic surgeons and gynecologists throughout the country, asking their ideas and figures. The answers received express the same diversity of opinion which prevails in the old school and are highly interesting as exhibiting the methods of each. I have therefore given them in full. I regret that some to whom letters were addressed have failed to reply, as therefore a complete list of OUR operations is impossible.

LETTER FROM DR. SIDNEY F. WILCOX.

Mount Washington, Berkshire Co., Mass.,
Sept. 7, 1895.

Dear Doctor HELMUTH:

Yours from Paris was received yesterday. From the record of the hospital books, I find that I have made six (6) supra-vaginal hysterectomies with one death. I think this is the right number. All of these were done with pins and the rubber ligature. So far as I am able to judge I consider that the total removal of the uterus by the double method is rather unfavorable so far as my own experience is concerned.

Yours sincerely,

SIDNEY F. WILCOX.

LETTER FROM DR. HORACE PACKARD.

Boston, October 18, 1895.

Dear Doctor HELMUTH:

I find that up to Jan. 1, 1895, I made thirty-five supra-pubic operations for *myo-fibroma uteri*. None were made by the combined vagino-abdominal method.

Nearly all these cases were large tumors, of long duration, and with urgent symptoms calling for operative measures. I have not operated on small and medium-sized tumors to any extent.

The first group of cases, twelve in number, were

those in which a tumor was removed without accompanying mutilation of the pelvic organs, *i. e.*, where the tumor was pedunculated, or had escaped into the broad ligament. There were in the above, three deaths, or 25% mortality. Among the recoveries was one case of extreme interest, where an eight-pound pedunculated tumor was removed from the pregnant uterus without interruption of the gestation. In this case the stump was treated extra-peritoneally. There was also one other case in this class where the pedicle was similarly treated.

In the next group of cases, eighteen in number, supra-vaginal hysterectomy was performed for fibroids with extra-peritoneal treatment of the pedicle or stump. There were ten deaths.

In the remaining five cases total ablation was performed with one death.

The fourteen deaths occurred as follows :

Cases <i>in extremis</i> when operated upon	3
Case of extreme chorea, died of meningitis	1
Deaths from peritonitis	6
“ “ shock	2
Deaths from secondary hemorrhage, in one of which there existed marked varicocele of one broad ligament	2
	—
	14

Very sincerely,
HORACE PACKARD.

LETTER FROM DR. O. S. RUNNELS.

Indianapolis, Ind., Nov. 8, 1895.

My Dear Doctor HELMUTH :

I have had four cases of myo-fibroma of the uterus (consecutive), which I have treated by cœliotomy and the intra-peritoneal pedicle. Or rather two in which I made entire removal of the uterus and appendages together with the growth, and two in which I left a small portion of the cervix (about an inch) as a stump. In the cases of entire removal the vaginal opening was closed by suturés while the edges of the peritoneum were approximated by another line of sutures. Where the cervix was left as a pedicle the cervical canal was closed by sutures, and the peritoneum made to close it in flap. All of the cases recovered uneventfully, and with as little embarrassment as any of my most favorable abdominal operations.

I should say too, that in the last case I did not even tie an artery or vessel as formerly, employing the whip-stitch advocated by Dr. Pratt, with the utmost satisfaction. I think the extra-peritoneal or clamp-method for the stump is a thing of the past, except perhaps in certain rare instances difficult to define beforehand.

Sincerely your friend,

O. S. RUNNELS.

LETTER FROM DR. H. I. OSTROM.

New York, 42 West 48th St.,
Oct. 28, 1895.

Dear Doctor HELMUTH :

About four years ago I decided to give up the use of the clamp in abdominal hysterectomy and to treat all cases by the intra-abdominal method. I, at first, left the cervix intact, covering it with peritoneum, and draining the stump through the vagina. One such case in which the cervix was thought to be perfectly healthy, in less than two years after the operation developed fibroids, necessitating a second operation. My mortality with this method was 16%. In the fall of '93, I began to remove the entire uterus, leaving the peritoneum intact by sewing together the peritoneum, covering up the broad ligament, and draining when necessary through the opening made in the vagina. With this method in a series of fifty-nine cases I have had two deaths. The ultimate results have, in my hands, been better than when I have left the cervix. Recovery has been more rapid, there has been less suffering covering a shorter period of time.

Yours truly,

HOMER I. OSTROM.

LETTER FROM DR. ALONZO BOOTHBY.

1061 Beacon Street, Brookline,

Sept. 24, 1895.

WM. TOD HELMUTH, M.D.

299 Madison Ave.

My dear Doctor:

Your favor of Aug. 24, from Paris, was duly received.

I think the enclosed list will give you the number of cases operated upon with the results, of myofibroma as well as other hysterectomies.

I must say, however, that I have not an exact list of all my operations where the pedicle was treated externally, but the number of deaths is certainly correct.

I always treat the pedicle externally when it is possible to do so. Yet I own that such treatment is called unscientific, and various criticisms of that kind have been made, but in cases where the operation is possible I can assure my patients there is no danger (almost). The one death out of seventy operations was an old colored woman, who was brought to me on a stretcher, and had septic peritonitis when she entered the hospital.

I feel the danger of hernia is of little account as compared with the safety of having the stump outside the peritoneal cavity.

For perhaps the first half of the cases an elastic ligature was used. Then a change was made to the

wire *écraseur* simply because it is easier to keep it clean and to remove it.

The point on which I lay most stress is stitching the stump below the wire to the external abdominal peritoneum, so as to shut out completely the decaying stump from the peritoneal cavity.

It is true that it requires care to manage the stump in this way, but the greater safety is well worth the extra trouble.

In regard to the cases of complete abdominal hysterectomy I should say that they were invariably bad cases, still, I feel sure that one of the cases could have been saved by the complete operation. The most of them would not allow of any other method.

I congratulate myself that I made over thirty supra-vaginal hysterectomies, and just thirty vaginal hysterectomies before a death.

Yours truly,

ALONZO BOOTHBY.

HYSTERECTOMIES BY ALONZO BOOTHBY.

Incomplete Abdominal (Supra-Vaginal):

Pedicle treated externally,	No. of cases	68 (about)
	Recoveries	67 (about)
	Deaths	1 (exact)
Pedicle treated internally,	No. of cases	1
	Recoveries	0
	Deaths	1

Complete Abdominal (Opening into Vagina):	
No. of cases	8
Recoveries	5
Deaths	3

LETTER FROM DR. E. H. PRATT.

Chicago, Sept. 15, 1895.

My Dear Dr. HELMUTH:

I write to acknowledge your kind letter of the 24th of Aug. I will ask my secretary to look up my record of cases and prepare the statistics which you desire. I do not know how many fibroids I have removed, but it has been quite a number, some by the abdominal route, and three where I have begun the work in the vagina and completed it by way of the abdomen. I have had no deaths from the vaginal route, one death by the abdominal route, and three cases in which I employed both routes were lost, which prejudiced me, of course, against operating both ways at the same time, although I am aware that other operators have succeeded admirably when they employed both methods at the same time. The case which I lost by the abdominal route was not from my fault, but from an unclean person putting his finger into the abdominal region without my invitation or consent. The woman died from blood poisoning four days later, abscesses forming in the abdominal walls, and also in the peritoneal

cavity. The case would have been successful, I am satisfied, as all the others have been, if it were not for this unfortunate circumstance.

Yours very truly,
E. H. PRATT.

LETTER FROM DR. JAMES C. WOOD.

Cleveland, November 15, 1895.

Dear Doctor HELMUTH:

Please pardon my delay in complying with your request. When your first letter came to me I was away on my vacation and did not have access to any record. I have arranged the enclosed schedule so that you can see at a glance just what my record in hysterectomy for fibroids is. I never did like the extra-peritoneal method of treating the stump, which accounts for the larger number of vaginal hysterectomies. Up to a year ago everything that I could remove through the vagina I did, and in at least three of the oörophorectomies I should, were I to do them again, remove the uterus with the appendages over through the vagina. I am working more and through that route. My last four hysterectomies for large tumors were total vagino-abdominal hysterectomies, the patients being in the Trendelenburg posture; while the number is too small to warrant dogmatism, I am delighted with the results. I believe that it is the ideal method.

Most sincerely yours,
JAMES C. WOOD.

DR. WOOD'S CASES.

Number of cases.	Method.	Deaths.	Remarks.
8	Extra-peritoneal	1	Large fibroid complicated by pregnancy.
4	Total extirpation, vagino-abdominal	0	All over ten pounds in weight; convalescence shortened at least two weeks.

LETTER FROM DR. WM. D. FOSTER.

Kansas City,
420 West 11th St., Nov. 6, 1895.

Dear Doctor HELMUTH:

In reply to your favor of the 3d inst., I beg to advise that I have been making hysterectomies by abdominal incision for myo-fibroma, for ten or twelve years; just how many altogether I cannot now state. Of late I make them pretty often. Some are done in hospitals and others in the patient's home, in the city and country, under the most diverse environment. With one exception I have treated the pedicle extra-peritoneally; in one case I did the complete operation. This patient died so promptly that further attempts have not been tried. So far as it is possible to learn here all the complete operations have been fatal.

Respectfully yours,

WM. DAVIS FOSTER.



HYDRO-NEPHROSIS—NEPHROTOMY.

I regret to say that the statistics of Dr. Lee of Rochester, Dr. Ward of San Francisco, and Dr. McLelland of Pittsburgh, have not as yet been received.





XIII.—HERNIA.

IN no disease has the ingenuity of the surgeon been more taxed than in the operations devised for the radical cure of hernia. The operations of Würtzer, Clark, Berard, and Wood are almost unknown to the surgeons of to-day. The Heatonian method, though practiced somewhat, is not preferred by operating surgeons, while the procedures of McBurney, Bryant, Banks, Barker, Macewen, Ball, and others are now those chiefly relied upon. I doubt if any of these are always successful. In very many cases (after a period of time from nine months to two years) the gut again descends, and even in those deemed most successful, the patient is obliged to wear a truss. When the elder Gross or Parker first suggested the closure of the pillars of the external ring, after returning the gut, great results were expected, but like many operators their anticipations have been disappointed.

I have tried all these older methods: Würtzer's with wooden plug and needle; Wood's by denudation and invagination of the scrotum; the leaden

bullet of Clark; the Heatonian method, the approximation of the rings with silver wire, with about the usual results. I do not think that any of the patients were cured permanently, although in some instances for months I have been very much encouraged, but unfortunately have been afterwards disappointed. McBurney's or the open method seems to be the most practical, and in my hands has been more successful than any other. The free division of the roof of the canal and full exposure of the internal ring, the ligation of the sac flush with the internal surface of the abdominal wall, preventing the pouching of the peritoneum (which is the beginning of future trouble). Sewing the tissues together leaves a long open wound to be filled with inodular formation, thus making a firm and contracted cicatrix. These are the advantages that this operation possess. Of the other procedures Macewen's presents the best record; he states that he had 81 cases, with no death, but 48 (over half the cases) were obliged to wear a support of some kind.



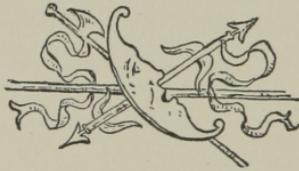


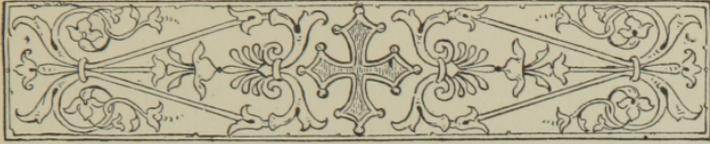
XIV.—THE NEW OPERATION FOR PROLAPSUS UTERI.

I HAVE operated a number of times for both anterior and posterior colporrhaphy and have made vaginal hysterectomies for prolapsus with varying success. I think, however, that Westermarck's arguments regarding the rationale of his operation are reasonable and deserve attention. In the one case in which I resorted to this method it was followed by complete success. Westermarck (a Swedish surgeon) devised and practises this operation for the following reasons. First, he contends that the loose connective tissue between the bladder and the vagina in front, and the rectum and the vagina behind is very lax and allows the vagina to pouch either anteriorly or posteriorly, as the case may be, without causing any decided prolapsus of the womb. With these conditions, viz: cystocele and rectocele, we are all familiar. He argues that therefore it must be the firmer connective tissue in the broad ligament which gives strength to the vaginal column and supports the womb. The relation between the

uterus and vagina he compares "to a funnel hanging down the neck of a bottle," and contends that the uterine ligaments *i. e.*, the upper part of the broad ligament, the round ligaments, and the sacro-uterine ligaments, being too feeble to keep the uterus in position, it is the lower part of the broad ligaments and their strong connective tissue which keep it *in situ*. The operation may be described as follows: The patient is placed on the back and the ordinary antiseptic precautions taken. The next step is to carefully remove any cicatricial tissue in the cervix. If the bleeding should be troublesome deep silk sutures are employed and their ends left long for subsequent traction. There is not, as a general rule, much hemorrhage, but it is necessary that strong silk ligatures with long ends should be placed on each side of the cervix. By lateral traction on one of these ends, the neck and body of the uterus is drawn to one side and the thread given to an assistant to hold. By this manœuvre the para-cervical and para-vaginal tissue is made tense and can be readily recognized. An incision is then made from the side of the cervix to within one half or three-quarters of an inch (three centimetres) of the *ostium vaginæ*. A second incision is then made in the same manner about half an inch posterior and parallel to the first, and terminating at the end of the latter in a somewhat sharp angle; thus an oval bit of mucous membrane and connective

tissue can be removed. The same process is carried out on the other side; the tissue being made tense by drawing upon the ligature of that side. Sutures are inserted, the womb pushed up, and *then* the sutures are securely tied. If there be cystocele, it should be remedied, or if the perineum be lacerated it should be repaired. This operation its originator has named "*lateral colporrhaphy*," and I think it should receive a fair trial as in principle it appears to be thoroughly correct, and though no opinion as to its efficacy may yet be offered, in the case in which it was resorted to the results were so good that I shall certainly give it a further trial when opportunity offers.





XV.—CURETTING THE UTERUS.

I HAVE on several occasions been called upon to examine uteri of both married and single women, who had previously suffered from uterine disease, had gone through the fashionable process of curetting, and who had at first been somewhat relieved, but afterwards began to experience intense spasms of the uterus, especially before the establishment of the menstrual period. Upon examination I have found that in every case stenosis of the internal os was palpable, and the introduction of the sound impossible or only accomplished with difficulty and pain. I can recall at least six cases of this kind. That curetting the uterus is a valuable operation in certain forms of uterine disease there can be no question; neither can there be doubt that it is done too often, and too carelessly. There is no reason why the mucous surfaces of the cervix if rendered raw will not obey the law holding good in other mucous surfaces of the body and adhere and become the seat of cicatricial tissue if brought into contact. Indeed, cases are upon record in which atresia of the

entire uterus have occurred after severe curetting. Such instances must be rare, because the uterine walls in a normal condition are not in contact. Neither may it be said are the surfaces of the *os internum*, but this portion of the cervix is much narrower than any other part of the uterus, and though in a normal condition it may readily admit the probe, after being subjected to sharp curetting, the œdema of the parts (occasioned by the rapidly exuded leucocytes) may bring the raw surfaces in such close approximation that atresia results, giving rise to those formidable local and reflex symptoms which characterize stenosis. With this fact before me, while I am curetting a uterus, I pass the blade well into the cavity and am careful to endeavor to preserve the mucous surface around the internal os from any contact with the sharp edge of the curette. This is a point which has not been sufficiently dwelt upon by writers upon this subject, but any observant gynecologist will bear me out in this assertion that, unless the mucous surface immediately around the *os internum* is materially diseased, it had better remain untouched. There are other serious accidents which have been occasioned by the indiscriminate and careless use of this instrument. I have been called to treat a lady, lately in the hands of a distinguished gynecologist who had pushed the curette entirely through the uterus, and though this accident is said to occur quite often without serious effects, this patient was

suffering certainly from infective localized peritonitis. It is said, however, that a gynecologist in Vienna, in order to prove how insignificant is this accident, will deliberately thrust the sound through the uterine wall. Of course the introduction and use of the curette into a pregnant uterus would be likely to produce abortion, or it might open an abscess in the vicinity, but the most frequently occurring accident, at least so far as my experience has gone, is atresia of the internal os and the consequent suffering especially at the menstrual epoch. This unpleasant result is easily avoided by a morsel of care at the time of operation.

Again the curette must be carefully employed in abortion as, indeed, must the dilators, if they are used as a preliminary measure. At such times the uterine wall is thinned, the tissues are softened, the cavity is deeper, and it has occurred in the practice of more than one gynecologist that loops of intestines have passed down through the rent made in the uterus into the vagina. In one case several feet of gut were actually drawn down by an operator, who supposed he was disembowelling a fœtus. This was a singular mistake, considering the relative size of the intestines in an adult woman and a six-months' fœtus. But when one comes to think the matter over and remembers what strange things have happened to the most experienced operators, and how much environment has to do with conditions of both

mind and body, all such accidents should be leniently regarded, instead of being heartily condemned. Muscles have been mistaken for blood-vessels, tendons for nerves, abscesses for aneurisms, and vice-versa, and if the mistakes made in the diagnosis of abdominal tumors "should be written, every one, I suppose that even the world itself could not contain the books that should be written."

I know of a case where one of the most distinguished surgeons in the world after careful examination failed to recognize an ununited fracture of the tibia; of another where a gall bladder was opened for a kidney. I have mistaken an encysted dropsy of the peritoneum for an ovarian cyst, have diagnosed a cyst of the pancreas, when the kidney was cystic; and failed to recognize a pregnancy at the third month, complicated with a large sub-peritoneal fibro-myoma of the uterus. And I could detail many such cases from the practice of other surgeons. I desire to impress on the mind of every surgeon how much care and thought are necessary before condemnatory judgment is passed on the work of a brother surgeon, for in the first place it is always hard to thoroughly understand the environment of time, place, and circumstance; and second, because one never knows how soon one may suffer from such unfortunate occurrences.



XVI.—LYMPHADENOMA.

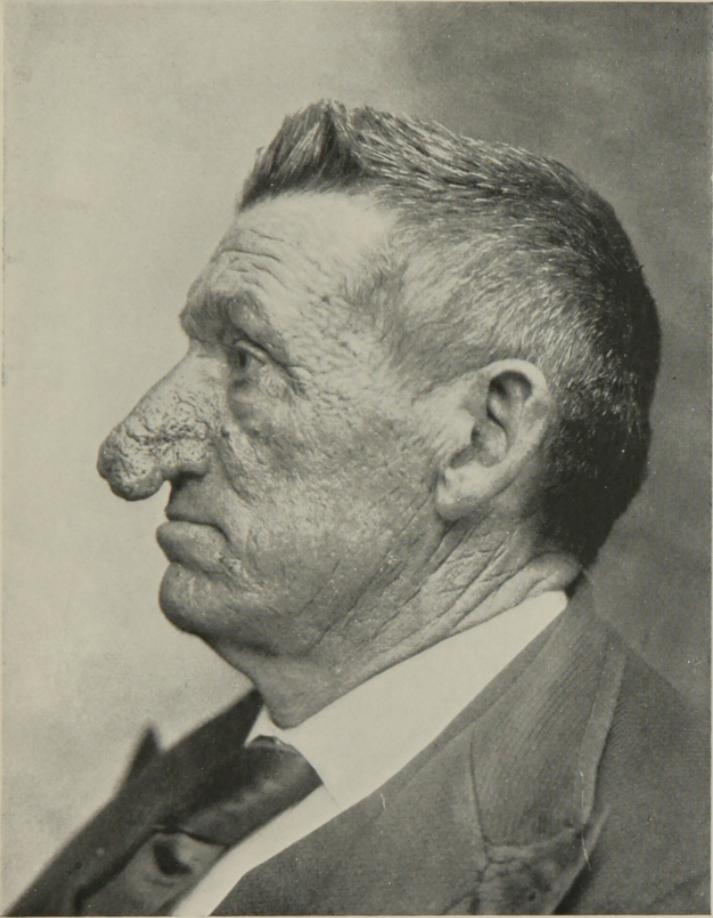
I N addition to the cases of lymphadenoma treated at Helmuth House, opportunity has been given in private practice of observing quite a number of others, and as the affection is usually very intractable and operations are not followed by ultimate good results it is desirable to place upon record a method of treatment which has done more for me than any other. It is my opinion from close observation that the distinction drawn between lymphadenoma and Hodgkin's disease is rather indefinite. It is said that the latter is a malignant form of the former, or a variety of lympho-sarcoma, accompanied with leucæmia. If lymphadenoma continue for any length of time the vitality of the lymph corpuscles is more or less affected, the hæmoglobin in the blood becomes much diminished in quantity, and pallor, exhaustion, and death often supervene. That the entire glandular system becomes affected cannot be denied; that the extirpation of the glands with the knife is followed *in loco eadem*, or in other portions of the body by recurrence, is also a fact; and that, as a rule, medical

treatment is of little avail, there can be no question. The success in the treatment of simple adenoma by homœopathic medicines however, is often remarkable. Bronchocele in its earlier stages, buboes, axillary and submaxillary enlargements are often cured by the internal exhibition of the proper remedial agents. Not so with lymphadenoma. I have tried faithfully for many months such medicines as seemed applicable. The preparations of lime, sulphur, potash, baryta, silica, the clay treatment, the myo-petroleum applications, blistering, Schussler's remedies, have been exhibited without any permanent effect. I have extirpated one gland after another, indeed have begun an operation expecting to remove but one or two affected glands, and have found, lying beneath the larger, many smaller ones giving distinct evidence of incipient disease. The experience of most operating surgeons is similar.

I desire, therefore, to allude to an internal treatment which to my knowledge has not been introduced before. It is the internal administration of the thyroid extract. There came under my care a bad case of lymphadenoma of both sides of the neck, in the person of a Scotch gardener, who had been under treatment of several physicians for a number of years. Originally of a robust constitution, he had gradually failed in health and strength. His complexion, originally florid, had become yellow, his nervous system was materially affected, his digestion impaired,

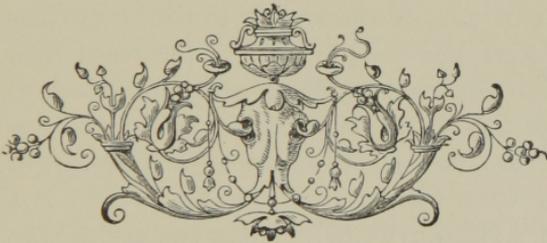
and he began to suffer from constant chilliness incident to the loss of red corpuscles. It may be mentioned here, that in addition to other treatment he had tried the hot-water and raw-meat system without benefit. He was given ferrum calc. phosph., calc. carb., various preparations of mercury, the varieties of potash, and an application nightly of potter's clay made into a thick paste with warm water and spread about half an inch thick on a stout cloth. There was no especial precedent in this, excepting that (after reading Hewson's earth treatment of wounds and tumors of the abdomen,) this application in the ordinary cases of cervical enlargement, had been used with considerable success. For over a year this method was pursued with no improvement excepting perhaps that the enlargement did not advance. The animal extract craze was then affecting the mental faculties of the profession. Myxœdema, was being better understood, and brilliant cures had been effected by the thyroid extract. At a venture I resolved to try this preparation upon my case. Half an ounce of the extract as prepared with great care by Dr. G. W. Crary of New York, was procured and administered internally. (I have never given any of these extracts hypodermically, which is the usual method of exhibition.) It was administered at first five drops in a teaspoonful of water once a day. It produced upon this patient, as it did in the cases of myxœdema in which it was given, very unpleas-

ant symptoms: sharp pains in the head, humming in the ears, some dyspnœa, and a general feeling of malaise. The dose was therefore diminished to one drop three times a day in a tablespoonful of water, and improvement immediately resulted. This method, with the intermission of one week, after three weeks taking the extract, was continued for several months. The enlargement gradually decreased on both sides of the neck, the color began to appear on the surface, the patient gained in weight, and when I saw him last (about the 1st of June) he appeared as well as ever. Careful examination could, however, detect some induration at the seat of the old enlargements, but the entire aspect of the case was so much improved that I look for complete recovery. I have also had opportunity of using the thyroid extract in two other cases during the time that the first patient was under observation, and in both great improvement is manifest. When we consider the peculiar condition of the system which results some months after the extirpation of the thyroid gland or even of its "starvation," a great similarity exists between it and that presented by these patients. The general homœopathicity of the remedy to the disease may be claimed. I have used the thyroid extract in capsules and in powder as prepared by Parke Davis, but have found both the taste and smell so disagreeable that many patients were unable to take



LIPOMA NASI.—HYPERTROPHY OF BOTH NASAL SEPTI.

it without nausea. The preparation first named as made by Dr. Crary and procured from Caswell & Massey has acted better than any other, and next to that the tablets made by Burroughs & Wellcome of London. In my opinion, five grains is much too large a dose. One grain, or a trituration made 1 to 10, given twice or thrice a day will be amply sufficient.





XVII.—HEMORRHOIDS.

OF late years diseases of the rectum have received more study than formerly. Necessarily among these, hemorrhoids have secured a large share of attention. In my opinion operative measures in the treatment of piles are too often employed. In many cases hemorrhoids need no attention whatsoever, and give but slight inconvenience. Oftentimes the periodical hemorrhages resulting from them are salutary, and if suddenly prevented or arrested are prejudicial. Medicinal treatment will often suffice to make a permanent cure, and in the majority of cases the clamp and cautery and the ligature are better operations for the purposes of removal than either Whitehead's or the American method. Hemorrhoids in most instances are venous tumors, or simply enlarged veins of the lower end of the alimentary canal, occasioned by general constitutional disturbance,—in the majority of cases the cause is stasis in the portal circulation, occasioned by irregularities in diet, want of exercise, indigestion, the gouty diathesis, pregnancy, tumors, etc. The

veins, not being supplied with valves, are not able to uphold the superimposed column of blood; they become distended, the hemorrhoidal plexus enlarges; the connective tissue, which is very loose surrounding the anus, becomes indurated, hypertrophied and redundant. Sometimes the arterial capillaries are involved, and we then have a sessile tumor within the rectum, covered with mucous membrane, which when ruptured pours out a prolonged and exhausting stream of blood, which may become serious in its results. Varicocele is not a dangerous affection, and often exists for years without causing much inconvenience. Varix of the extremities is a frequent condition, which, even though occasionally producing ulceration, does not incapacitate the patient, and can be palliated by simple means. So it is with many cases of piles. I have cured hemorrhoids both internal and external by internal medication, and have been often led away from my older experience to adopt surgical measures, because by them the patient feels himself immediately relieved of an annoying and painful trouble, and most persons are not willing to persevere in the medical treatment for a sufficient length of time to make a permanent cure. In the earlier days of my practice I have made, and have seen others of the older homœopathists make, wonderful cures of this troublesome affection. In the days of my pupilage, when through my uncle and preceptor,

Dr. Wm. S. Helmuth [who was at that time (1851) Professor of the Institutes and Practice of Homœopathy in the Homœopathic Medical College of Pennsylvania], I was brought in personal relations with Dr. Con. Hering, Dr. Walter Williamson, Dr. Caleb B. Matthews, Dr. Jacob Jeans, Dr. James Kitchen, Dr. Alvan Small, and Dr. Chas. Needhard, I used to hear of and see aggravated cases of piles, blind and bleeding, internal and external, treated by internal medication and cleanliness, with magnificent results. I have heard one of these sages remark that he thought "that nux vomica and sulphur properly given and persevered in, with diet, cleanliness, fresh air, and proper hygienic surroundings, would cure almost every case of hemorrhoids." My own *penchant* for surgical therapeutics has led me often away, but as I advance in years and am able to cast a retrospective glance over the past, in these latter operative days I do not see the successful results of homœopathic treatment, either in my own practice or in that of my brothers. I had a regular routine for the treatment of hemorrhoids, which I abandoned later for operative measures, which was successful. I do not vouch for its purity as a homœopathic method, unless the good results which followed it proved it to be so, but was led to its adoption by the fact that many cases came from the surrounding country, and knowing the treatment required some time, I was obliged to supply the patients with suffi-

cient medicine. The treatment consisted of nuxvomica 3X trit., a powder three times a day for ten days; an interval of three days was allowed to elapse, and collinsonia in tincture was given, three or four drops in a tablespoonful of water three times a day for ten days; again an interval of three or four days was passed without medicine, and then sulphur 3X trituration, a powder every night and morning, was administered for a fortnight. If hemorrhage occurred, the medicines were omitted and thirty drops of hamamelis were mixed with half a glassful of water and a tablespoonful given every hour until the bleeding ceased, when again the routine was begun. During the time, the parts were to be kept scrupulously clean. I may mention here *en passant*, that one of the worst cases of internal profusely bleeding piles, for the removal of which I proposed an immediate operation, was cured by the patient taking on her own responsibility, thirty drops of Pond's Extract night and morning, and injecting and allowing to remain in the rectum a teaspoonful of the same liquid every night. That there are cases demanding surgical treatment cannot be denied; that the newer methods of operating are often not only successful, but brilliant in their results, must also be conceded. The immediate relief given to an external and congested hemorrhoid on the margin of the anus, by incision or excision, is often most surprising; but I am not quite sure that the more

prolonged and bloody operations are not performed too often, and that proper medication has not been given to the patient before resorting to the knife.

After considerable experience with the varied methods more or less enthusiastically recommended for the cure of hemorrhoids, my later experience, represented it is true by a few cases, gives preference to the clamp and cautery. I arrive at this conclusion first, because of the facility with which the operation is performed; second, from the rapidity with which the patients recover; third, the avoidance of hemorrhage; fourth, the absence of further surgical dressings; fifth, the short space of time occupied; and sixth, the absence of those disastrous sequelæ which I have known follow the more serious and bloody procedures. I do not deny that immediately after the performance of the American or Whiteheads operations the appearance presented is not highly satisfactory, but I am sorry to say that I have seen patients upon whom these methods have been resorted to rendered miserable for life. Incontinence of fæces, or preternatural contraction of the rectum, is likely to follow even the most carefully performed operations. The first results are no doubt very satisfactory, but ah! what often follows? The great debt the profession owes Dr. Pratt for directing attention to the numberless reflex phenomena arising from artificial contraction has never been sufficiently realized or repaid, but it will so be,

and the philosophy of orificial surgery, as applied to diseases of the rectum, will receive in time the appreciation it deserves. From my own experience the proper dilatation of the sphincter, with the application of the clamp and cautery, will be more successful in the hands of the majority of surgeons, and less likely to be followed by serious sequelæ, than the removal of the pile-bearing inch. I am now speaking only of hemorrhoids. The argument that the latter operation is the *more surgical*, I regard as of no value whatsoever. It often happens that these excessively "surgical" operations have the surgeon and not the patient at the end of them. They are carried out in all their minutia not so much for the welfare of the individual, as to show forth a new method. The actual time often taken to make operations "surgical" seriously endangers life, and this is true of all operations, especially those of the abdomen. The *most surgical* operations are those that are the simplest, the quickest, the most effectual, and followed by the least pain and the least shock. Extraordinary stitching, or extraordinary cutting, or extraordinary paraphernalia adopted by a single surgeon to carry out a particular method of his own devising is *not* surgical, if the patient can be cured by a simpler and shorter method. Time is the stern arbiter in all these matters, and time will efface any procedure, no matter how brilliant it may be, and will set in its proper place in the domain of surgery every operation and every instrument.

I see by the last statistical report that in St. Thomas's Hospital, London, in the past ten years there were 140 cases of hemorrhoids treated with the clamp, and with the ligature, and sometimes with both. In 85 the clamp was employed, and in 55 the ligature. Of these three died, and to quote, "in one the case was severe anæmia; a few piles were ligated, but she died in eight days from profound anæmia; in the second case the woman was eighty-one years of age, and died of erysipelas; the third died of broncho-pneumonia."





XVIII.—PROLAPSUS RECTI.

IN this connection it appears appropriate to speak of a new operation for prolapsus of the rectum (that is, if there be anything new under the sun), which was suggested by the operations usually performed for cystocele. The case in which it was first practised was one in which the ordinary operation by nitric acid and the actual cautery had been performed with only temporary benefit, although I had thoroughly used the Pacquelin cautery several times. The rectum protruded nearly five inches, and was surrounded by a mass of hypertrophied cellular tissue. The patient was obliged to remain on the commode from two to three hours each day; the tenesmus was intolerable and there had been a complete laceration of the perineum, which had been restored at the same time that I made the first operation for prolapse. On several occasions I have met with cases of prolapsus so severe excision of the lower portion of the bowel was necessary. In every instance the operations were followed by constriction of the anal orifices, and the patients consid-

ered that they were better off with a rectum that came down too much, than with one that could not come down at all. The operation performed was as follows: after the usual antiseptic precautions, the bowel was gotten out of the body as far as possible. It was held by four T forceps placed equidistant. it was washed first with green soap and water and then irrigated thoroughly with a bichloride solution 1: 2500. Making the anterior surface tense, I marked out upon it with the knife, cutting merely through the mucous coat (which was thickened), an oval—large enough to reach from the margin of the anus to the end of the protrusion, and wide enough to reach from one side of it to the other. With a pair of blunt-pointed scissors, curved on the flat, I cut out the mucous surface outlined. There was some bleeding, but nothing of magnitude. Around the rim of this oval through the mucous membrane, a stout needle armed with sterilized ovariotomy silk was passed in the same manner as a thread is introduced around the mouth of a bag, in other words “a drawing string.” I began the introduction of the needle at the end of the oval raw surface *nearest the anus*, and carried it around to the point of introduction. Then drawing the two ends together, the rectum, puckered like a bag, was pushed back into the abdomen, leaving the two ends hanging from the anus; these were turned over on the buttock and secured with a bit of plaster. It will be seen that by this

method of introduction, the removal of the thread is easily accomplished by pressing open the margin of the anus and snipping the thread on one side the knot, then by making traction on the other end the ligature comes away. An important feature in the after treatment is the absolute quiet of the bowels for *two* weeks, and the rest in bed for the entire time. The patient must not get up at all, the urine must be passed in a urinal, or be drawn with the catheter. *The patient must be fed* with the most nourishing food in the smallest volume. After two weeks, a little more liberty of posture may be allowed, the meals taken in a sitting posture. At the end of four weeks the patient may be allowed to go about a little and gradually resume his or her ordinary avocations, but must be cautioned against straining at stool, lifting weights, or using undue bodily exertion for some time.





XIX.—TUMORS.

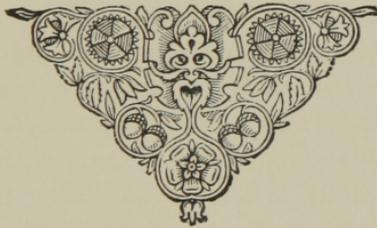
I N attempting to arrange a proper classification of tumors in these tables, I am impressed with the difficulties which surround the microscopic arrangement of all neoplasms, more especially the so-called malignant growths. From the time of Abernethy up to the first scientific arrangement proposed by Virchow, the "simple" tumors formed one class, and "cancers" another, the latter embracing all the malignant. But since the introduction of the microscope such variations and so many changes in nomenclature have been introduced that it is impossible, even with a tolerably fair knowledge of the surgical literature of the day, to begin to definitely classify them. The origin of new growths from the different layers of the blastodermic membrane has given rise to much discussion, and now almost every tumor of the malignant order receives a name in accordance with the character of the cells which compose it. There are giant cells, spindle cells, round cells, mixed cells. There are angeio-, gelatini-form, plexiform, adeno-, and lympho-sarcomas.

There are endothelial, squamous, columnar, cinousa, and a hundred other varieties of carcinoma, the one overlapping and eventually passing into the other in endless variety, to perplex the practitioner, to mystify the student, and confound the general surgeon. I have always taught, and the more I observe the ever-varying changes in tumor-nomenclature, I am convinced that the clinical classification is the best for the operating surgeon, because it is necessary for him to give to his patient a prognosis and a diagnosis *before* he removes the growth. After the operation, and sections have been properly hardened, examined, and stained, it may be well to understand the more precise classification. What the patient desires to know when he consults the surgeon is: Is this a simple tumor or is it a cancer? Will it return after its removal? What are my chances and what will be my condition if I allow this growth to remain untouched? The grave import of these questions is self-evident. The answer affects, perhaps, the life of a human being and the reputation of the surgeon.

It must be remembered that the microscopist is by no means infallible; that appearances are deceitful and delusive; that one portion of a tumor may present a normal type of constitution, and another be a highly malignant structure. The discharges often present very different histological formation from the growth itself. There are some tissues which are benign and so closely resemble malignant

formations (granulation tissue) that the microscope cannot determine the difference between them, and grave errors have been made on account of this difficulty. In a report of this kind it would be out of place to go into the differences between the numberless classifications. I would merely say that to the experienced surgeon there are certain conditions that can be seen and appreciated during his physical examination that will give a tolerably fair estimate of the condition of the parts and the sequelæ to be expected. Rapidity of growth, infiltration and cachexia, secondary glandular enlargements, emaciation, are all symptoms of value. The naked-eye appearance of the growth or the ulcerations (save the exception of granulation tissue), the character of the pain, are all to be considered. In certain forms of carcinoma it must be recollected there is no defined tumor, properly so-called, but jagged, irregular ulcerations. The worst cases of so-called squamous-celled carcinoma, or what used to be designated epithelioma, that I have seen, arose from fissures, irritations from teeth, or some local cause, and a so-called new growth never developed. There was merely a breaking down of the normal-cell element and the indiscriminate and irregular conglomeration of embryonic cells presenting all the varied appearance of retrograde metamorphosis. Certain sarcomas of the breast and the hard variety of columnar-celled carcinoma (scirrhus) are always well defined,—but

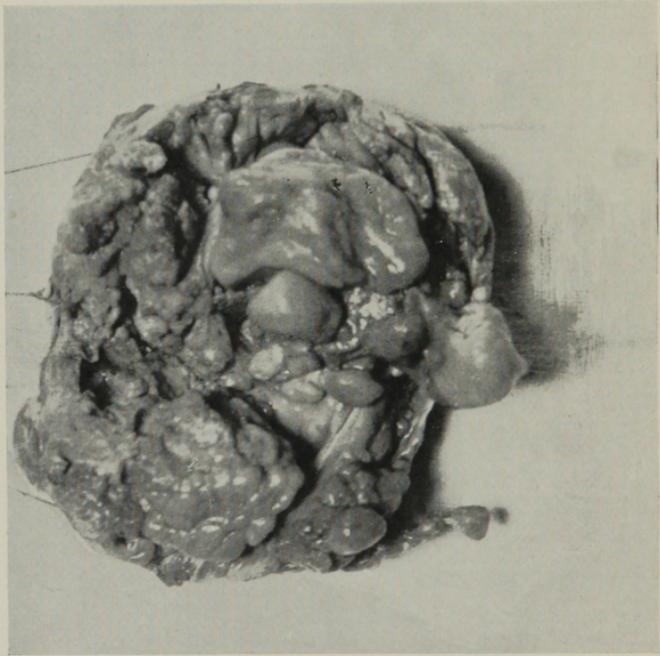
there are forms of fibroid tumors of the mammæ and even some cysts in very large breasts that I could not diagnosis until after removal, and had to be guided in my prognosis more by general than by special indications. Let me say here that the old motto, *Cave quid dicis, quando et cui*, applies very pointedly to the diagnosis of certain tumors, especially irregular abdominal neoplasms.





XX.—EXCISION OF THE MAMMA.

IN regard to the removal of malignant tumors of the breast, the method of Halstead of the Johns Hopkins University deserves consideration. His statistics are remarkable, though the method is rather severe. The removal of the mammary gland is among the simplest of all operations. As soon as one learns to get behind the gland by a single deep incision, it is easy to separate it from the connective tissue lying immediately upon the pectoralis major and it can often be removed with great rapidity. It is more in the closing of the wound and the dressings afterwards that the success of the operation depends. With Halstead's method and those detailed by others, a simple and rapidly performed operation is transformed into a tedious and much more dangerous procedure, and whether life has actually been prolonged for a greater number of years by these extensive cuttings is a point yet to be determined. I think Halstead has kept a record of his cases for five years, and that in no instance has there been a return of the disease, which of course



COLLOID CARCINOMA OF THE BREAST.
OVER 300 CYSTS.

is a great improvement on the old-time figures, in which we used to reckon nine to twelve months for the return of "encephaloid," and eighteen to twenty-four for the return of "scirrhus." In my own practice I have known patients operated upon with strict antiseptic precautions (the tumor being thoroughly removed) live over five years. It is, I believe, an unwritten understanding in surgery, that if a patient survive an operation for cancer, either three or four years, that a cure of the disease is said to have resulted. This is the opinion of both Volkman and Butlin. I have had several cases that have lived over five years, one over six, and one about seven and a half years after the operation. Objection will be made to this statement that the primary diagnosis was wrong. I do not think this possible, in view of the microscopic examination of the tumors immediately after removal (which were spindle-celled sarcomas), and the "manner of death," when the end came.

In every case of amputation of the breast the axilla should be examined through the wound, and *not* externally. Any surgeon of experience knows that sometimes clusters of glands can be found enlarged after opening the axilla, that by the ordinary skin examination gave no evidence of their existence. If after such an examination no enlarged glands can be discovered it is my opinion that it is not good surgery to "clear out the axilla," as it is

called. Statistics will bear out my assertion. Distinguished operators who have adopted in every case the wholesale "clearing out method" have abandoned it, or at least have only employed it when there was evidence sufficient to warrant the operation. In more than half the cases, however, the glands of the axilla will be found enlarged. As a rule, after a carefully conducted and dressed amputation of the breast, no interference of the wound will be necessary until the healing is complete. It is a triumph of modern surgery to witness the removal of a dressing from the breast in fourteen to twenty days after an operation, and find the entire wound united, the ligatures absorbed, and a firm cicatrix extending from one end of the wound to the other. It is interesting to study the statistics of removal of malignant tumors of the breast. Mr. Treves quotes from the Williams analysis of cancer cases treated at the Middlesex Hospital: "The average duration of life, dating from the time when the disease was first noticed, is 60.8 months for those who undergo operation, and 44.8 months for those in whom the disease runs its natural course. The average duration of life subsequent to amputation of the breast is 40.3 months. The average interval between the first operation and the first recurrence is 26 months; the maximum 130 months, the minimum 25 months."

It is stated by Mr. Platt who gives a carefully

prepared table of all the cases of cancer of the breast operated upon in the Manchester Royal Infirmary from 1883 to 1892 inclusive, that if absence from recurrence of the disease for three years constitutes a cure, then of the 55 cases reported 12.5 per cent. were cured by operation. Recurrence took place in 42 cases, of which 34 have died (since 1892) and 8 are still living (1895). The average length of life in these 34 cases was $19\frac{1}{2}$ months; in 5 it was under 6 months; from 6 to 12 months in 10; from 1 to 2 years in 9; from 2 to 3 years in 2; from 3 to 4 years in 6; and from 4 to 5 years in 2; of the 8 cases still surviving, the average time is 4 years, and the longest period 11, the shortest being 2 years.

London Lancet, August 31, 1895.





XXI.—REGULATIONS AND CHARGES.

ROOMS on the fourth floor \$25.00 per week.
All other rooms from \$6.00 to \$8.00 per day.
These charges include the daily morning and evening visits of the resident surgeons; regular day and night nursing; dressing of wounds; douches and ordinary medicines.

Patients desiring the exclusive services of a nurse are charged extra.

The fees of Dr. Helmuth, Sr., are regulated by the character of the operation performed. Ordinary day visits, \$3.00 each.

All meals are served to patients in their apartments, which, though involving increased labor and expense, insures greater privacy.

Meals served to visitors are charged extra.

In order to properly maintain the discipline of the House, no nurses, excepting those engaged by Dr. Helmuth, are allowed to care for a patient.

Open fires are charged \$1.00 per day extra.

Wines, liquors, tonics, mineral waters, extra meals, surgical dressings, and use of telephone are charged extra.



A BED-ROOM.

All accounts of indebtedness to Helmuth House are payable weekly.

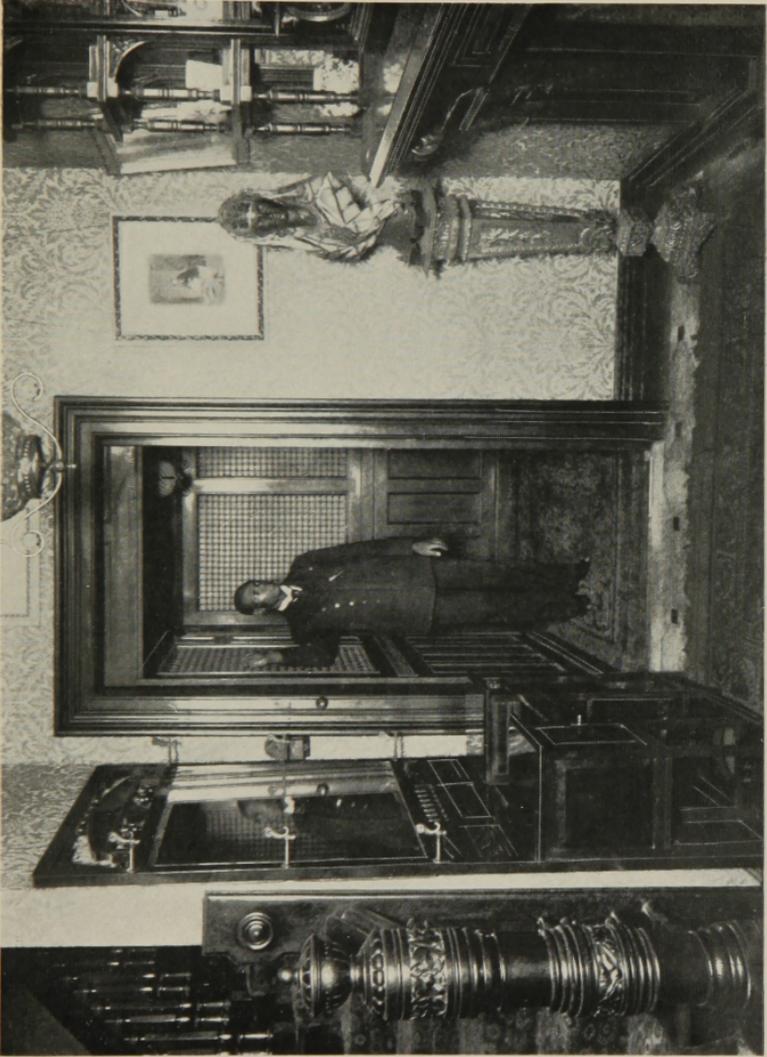
Fees for operation are due on the day of their performance. All accounts are expected to be settled before the patient leaves the house.

Visitors are allowed from 10 A.M. until 6 P.M., provided such visiting is approved by the resident surgeon.

Laundry lists, carriage and coupe, call cards, or messengers furnished upon request.

Money, jewels, and other valuables must be placed in the safe at the office, otherwise the proprietor will not be responsible for any loss.





THE ELEVATOR.

