catamenia has entirely ceased. For occipital headache, a liniment of aconite or hot salt bag or a stimulating liniment of acetic acid or turpentine applied to the nape of the neck will give ease. If digestion be weak nitro-hydrochloric acid is useful, and above all rest of mind and a complete change of air and scene. As a last resource the hypodermic injection of morphia must be considered; one-sixth of a grain is sufficient to start with. A useful formula is:

- Morph. Acet. ...
- Atropine Sulph. ...
- Acid Carbolic ...
- Glycerine ...
- Aqua ...

6 drops contain half a grain of morphia and one hundred and twentieth of a grain of atropine.—The Provincial Medical Journal.

TREATMENT OF CASES OF SUPPURATING OVARIAN CYST.—The meeting of the Medical Society of London held on February 5th, opened with a paper by Mr. Harrison Cripps on the Treatment of Cases of Suppurating Ovarian Cyst or Pyosalpinx, in which a communication had formed between the cyst and the rectum. He read notes of four cases of the kind which had come under his notice among a hundred other ovariotomies. It is therefore—and fortunately—a rare complication. He tried puncture through the roof of the vagina in the first case in order to allow the opening of the rectum to close, but abdominal section became necessary. In the other three cases he resorted forthwith to this plan, with one death. Mr. Goodsall suggested that it would be possible by inguinal colotomy to divert the passage of faecal matter along the rectum and thus to facilitate the closing of the opening. Dr. Cullingworth related four cases of his own in which he had operated on the lines laid down by Mr. Teale in his 1889 address. Mr. Teale’s plan is to open the abdomen and endeavour to make out the nature of the abscess, then to open it and wash it out, stitching its edges to the parietal wound. This plan Dr. Cullingworth modified by removing the sac wall at the same time, with success. His last case was one in which a communication had been established with the bladder, but in this case, too, he followed his modified procedure with perfect success. He deprecated attacking these cysts from below, a plan which, he said, could never be expected to give satisfactory results.

CRANIOTOMY NOT JUSTIFIABLE.—Dr. Kellock, in his paper for the Southern Surgical and Gynaecological Society, mentions the interesting fact that in regions of Central Africa “some women have been known to perform the Caesarian operation on themselves,” and that “the African laparostomist washes his hands and instruments, and bathes the abdomen of the patient with palm wine, such as was used by embalmers in ancient times,” a very curious fact when we consider the aseptic properties of alcohol, and that in olden times Saxon leeches bathed wounds with red wine.

CONCEPTION DURING THE Puerperal PERIOD.—Dr. Brasseur relates the case of a woman, twenty-two years of age, who was delivered on July 4th, 1892, of her first child. July 8th she practised coitus, and was again delivered, March 10th, 1893, of a healthy child. Calculating from the date of coitus, the second pregnancy lasted two hundred and forty-three days, that is, twenty-seven days less than the normal. This case has caused considerable discussion. Ovulation must have existed in the woman on the fourth day after the delivery, and it was necessarily quite independent of menstruation. Dr. Koenig, who actually observed the case, draws from it the following deductions:—1. A gestation period of two hundred and forty-three days after a fecundating coitus may produce a viable child. 2. The spermatozoa can live in the lochial secretions. 3. The functional activity of the ovaries is not completely suspended during pregnancy. The Graafian follicles so open that they may burst a very short time after delivery. 4. Ovulation and menstruation may occur independently of each other. 5. Among vigorous women, during the period immediately following confinement, the uterine mucous membrane may undergo a rapid regeneration which renders possible the implantation of a fecundate ovule immediately after delivery.—(New York Medical Record.)

Hysterectomy for Cancer of the Cervix by Combined Abdominal and Vaginal Dissection.—Dr. Maurice H. Richardson thus compares the advantages of hysterectomy by abdominal and by vaginal dissection and by the combined method.

The advantages of the vaginal method are:—
1. Less liability to peritoneal contamination.
2. More intelligent and thorough dissection of the local disease; its chief objection is the difficulty in controlling hemorrhage.

The advantages of the abdominal method lie:—
1. In a conclusive investigation of the disease itself, its local extent, and its possible remote metastasis.
2. In the rapidity and safety by which the broad ligaments may be tied and cut.
3. In the case in which the ureters may be isolated and kept on one side.
4. In control of hemorrhage.

Its chief disadvantage is the impossibility of thorough dissection and removal of the cervical portion of the disease.

The superiority of the combined method is seen:—
1. In the intelligent and thorough dissection both of the local disease and of the broad ligaments.
2. In the certainty by which haemorrhage may be prevented.
3. In the protecting of the ureters.
4. In the saving of time.

The combined method is applicable more especially to cases where the disease involves the cervix and a portion of the vaginal mucous membrane, and to cases in which the uterine body is large and fixed. It should also be employed where for any reason it may be difficult to separate the vaginal attachments. The method which he advocates as the safest and most rational procedure for the radical excision of uterine cancer is first to separate by clean incision the diseased cervix from the vaginal mucous membrane by as broad a margin as possible without wounding the rectum, bladder, or ureters. The incision should be carried through the mucous membrane until the areolar tissue is reached; then dissection should be carried on by the finger or by some blunt instrument until we are close to the peritoneum, care being taken not to open the peritoneal cavity. It is, of course, necessary previously to have disinfected as far as possible the cancerous ulcerations. The hands should now be thoroughly sterilized, and the abdominal incision made with a second set of instruments. Having in the manner described, separated the broad ligaments and isolated the ureters, he rapidly connects the vaginal with the abdominal incision, delivered the uterus through the vagina or through the abdominal wound. If the mass is too large easily to be delivered by the vagina, the abdominal route should be chosen; not that it makes any great difference where the exposure is so brief, especially if the intestines, in the Trendelenburg position, are abundantly protected by sterile gauze. After removal of the uterus the folds of the peritoneum may be united by continuous suture, or a gauze drain may be provided through the vagina. In his experience there has been, by the abdominal method alone, a mild sepsis in two cases; by the vaginal method alone there has been a fatal general peritonitis in one case; all other cases have recovered without complications of any sort.

In clean hysterectomies, I think, a continuous suture should be applied; in septic operations a free dependent drainage should be provided by leaving a gauze drain in the vagina.

The prognosis as to recurrence in even the most radical operation upon a cancerous cervix is bad; for, under the most favorable circumstances, the margin of healthy tissues seems utterly inadequate. A small cancerous nodule in the centre of a large breast demands excision of the whole organ, and even then recurrence is the rule. An infiltrating epithelioma of the lip requires in its proper removal the broadest possible margin of healthy tissue; and if that margin is a close one we look upon recurrence as almost certain.

In uterine cancer, therefore, the prognosis is necessarily bad if there is any extra cervical infiltration whatever; and while under these circumstances hysterectomy is justifiable, its performance cannot be strongly urged. If the vaginal disease is extensive, only local palliative operations, performed extra-peritoneally, are justifiable.

Hysterectomy by the Clamp Operation.—Mr. Taylor, Birmingham, in his paper for the British Gynaecological Society, on the above subject, says, that the wire clamp (or serré nœud) operation for hysterectomy appeared to have lost much of its interest during recent years, and that the operators of to-day were chiefly concerned with the intra-peritoneal methods of stump treatment, or total extirpation of the uterus, and seldom or ever clamp operations resorted to. "Most clamp operations were to a certain extent clumsy, but there was a vast difference between the clamp operation for ovariotomy and the one he was discussing." "The secret of its success," he says, "depended very largely on the perfect closure of the peritoneum round the stump;" and he then details the special way of effecting it. The plan of operation is as follows:—

1. The abdome is opened in the middle line, and the bulk of the tumour is disengaged from the peritoneal cavity and drawn outside the incision in the usual way. After attending to adhesions, the position of the appendages of the bladder, and of the rectum, are specially investigated and, if necessary, the uterine attachments of the broad ligaments are separated between double ligatures. Unless this is really necessary, it is much better to leave the peritoneal covering of the uterus intact.

2. Then the transfixion pins are used, being passed through the peritoneum of the right side of incision, then through the base of the pedicle of the tumour, and finally through the peritoneum of the left side of incision. Two or three of these pins are used, according to the size of the stump. The ends rest upon the skin surface, but the pin does not transfix any part of the incision-edge except the peritoneum.

3. The wire clamp is now put on immediately below the pins (and therefore outside the peritoneum). As this is done the opposing edges of the peritoneum immediately above and below the stump are caught together by forceps, and the points of these are included in the loop of wire. By this means it is usually easy to arrange that the parietal peritoneum is caught up by the wire of the clamp all round the pedicle of the tumour. (When the latter rests just above the pubes and the parietal peritoneum has not been divided too low down, the peritoneum being slightly elastic, can be fitted round the pedicle without forming any lower angle, the