II.—FURTHER REPORT OF CASES TREATED IN WARD XXVIII., ROYAL INFIRMARY, FROM MAY TO NOVEMBER 1884.

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RESTORATION OF PERINEUM.

CASE I.—Mrs Y., æt. 35, residing at Elphingstone, was admitted 22nd April 1884, complaining of dragging pain in back, and something coming down. Illness began seven years ago after birth of sixth child. Labour was severe. Since then she has had two children; the last was very large, and after this birth the pain and prolapse became well marked.

Physical Examination.—Perineum absent. Tear extending through sphincter ani. Womb slightly prolapsed.

Treatment.—On 5th May Dr Macdonald stitched up the perineal and rectal tears, using silkworm gut for the former and catgut for the latter. Good union resulted. 28th May.—Uterus replaced and kept in position with ring pessary. T-bandage applied to support perineum. 31st May.—Discharged cured.

CASE II.—Mrs M., æt. 37, residing in Texas, was admitted 2nd May 1884. Patient's perineum was torn eight years ago during labour. Five years ago she began to complain of pain in the back, and menorrhagia, which is her present complaint. Since the time her perineum was torn she has had two full-time children and three abortions.

Physical Examination.—Uterus retroverted, large and very tender. Perineum torn nearly to verge of anus.

Treatment.—After being treated with glycerine plugs and hot water injections on account of the uterine condition, on 26th June the perineum was repaired in the usual way. 2nd July.—Stitches were removed, when perfect union in lower two-thirds of tear was found to be the result. 20th July.—Uterus replaced to normal position, and supported by ring pessary. 24th July.—Discharged.

CASE III.—Mrs C., æt. 34, admitted 3rd June 1884, complaining of incontinence of faeces. Patient had a child on 25th March 1884; the labour was tedious, and instruments were used. Three days after delivery she noticed that her motions came away in the bed and could not be retained.

Physical Examination.—Perineum absent; tear extending into the rectum.

Treatment.—On 17th June Dr Macdonald performed his usual operation. On the seventh day after operation stitches were removed.
removed; perfect union resulted along the whole line of wound. 2nd July.—Discharged.

Case IV.—Mrs S., aged 37, residing at Gogar, recommended by Dr Graham, was admitted 6th October 1884, complaining of incontinence of feces, down-bearing pain, and weakness in the right leg. The patient's illness dates from the birth of her last child, 3½ months ago. Her labour was an instrumental one; the child, a large male; forceps failed to deliver her; craniotomy was resorted to.

Physical Examination.—Perineum torn through its whole extent, the tear extending through the sphincter ani and about half-an-inch of anterior rectal wall. The uterus was retroflexed.

Treatment.—On Monday, 13th October, Dr Macdonald restored the perineum. The rectal tear was first stitched with catgut sutures; then the sides of the perineal tear and a portion of posterior wall of vagina were rawed, and the whole brought together by silkworm gut sutures. 20th Oct.—The stitches were removed, when union was found to have taken place throughout the whole extent of the part operated on, the new perineum being thin, but sufficiently strong. 23rd Oct.—Bowels moved. Patient quite able to retain feces. 31st Oct.—Dismissed.

In presenting the brief record of the above four cases of perineorrhaphy there does not appear to me to be much room for observation, as the cases explain themselves. As three of them represent severe cases, passing up through the anal sphincter, I think we may congratulate ourselves on a considerable measure of success, as they all healed well. I would take this opportunity to urge upon the members of the Society the advantages presented by silkworm gut as compared with silver wire in this operation. The security is equally good—the increased comfort to the patient is very manifest—and the ease and safety with which they can be removed are also remarkable. But the best method of treatment of such cases is their prevention. I do not think I can do better than urge upon the members of the Society the propriety of sewing up the tear at once in every case of rupture, however serious. Success is then nearly certain, and the results are much more satisfactory than those gained by operation after the parts have shrunk out of position, however skilfully it be performed. No advice is worse than that which used to be given as the routine recommendation, viz., in cases where the tear was moderately severe to sew up at once, and leave very bad cases alone until the patient recovered from her confinement, and then operate. The worst cases, involving extensive tear of the vesico-vaginal septum, give usually most satisfactory results when sewed up at once. In dealing with a tear passing through the sphincter ani some special management is needed. I never now practise the method of tying the deep sutures in these cases in the rectum, as it is rather diffi-
cult to cut them out without straining the tender adhesions. I think it is much preferable to follow the method of Bantock, which consists in carefully sewing up the rectal tear in the first place after rawing the surfaces. This part is secured with numerous catgut sutures, care being taken to bring out the needles exactly at the edge of the rectal mucous membrane, and enter it again exactly at the edge of the mucous membrane on the opposite side of the tear. When the sutures are tied, after being passed in this way, the rawed surfaces are accurately brought together without the intervention of any of the rectal mucous membrane, and without admitting a putrescent element in the track of the stitches from the bowel cavity. In this way, also, less rawing of the end of the vagina is needed, as the surfaces brought together after the rectal wound is sewed up form a broad rawed surface posteriorly, which can then be treated as though the sphincter had never been injured. The catgut sutures are cut short and left in the centre of the rawed surfaces.

I never give any medicine either to move the bowels during the time that the stitches are in, or to prevent their moving. One is often astonished to notice in accounts of such cases statements to this effect, that the bowels are kept sealed for a week with opium. If the patient is kept quiet and on fluid food for the week after the operation the bowels almost never give any trouble. I prefer to have the bowels moved by means of a carefully administered enema of castor oil and gruel before the stitches are removed. As to the removal of the stitches much recklessness of statement is frequently made. The stitches undoubtedly give support to the feeble adhesions against undue strain, even when the grip has got relaxed, so that, unless they irritate by their presence, they are better to be left in seven or eight days.

But in some cases they are not well borne, and set up swelling and irritation by the fifth or sixth day, and if left in to the seventh or eighth the entire operation may be spoiled by the adhesions which had formed becoming unhealthy.

Consequently, I watch carefully on and after the fifth day to see whether there is an absence of swelling, of oedema, or of redness. If any such appear I remove the stitches either completely or only such as show irritation. But if those bad symptoms do not appear, I leave the stitches for eight days, or even longer.

**Cancer of Cervix.**

**Case I.—Mrs B., æt. 36, residing at Lasswade, was admitted 9th May 1884, on the recommendation of Dr Allen, complaining of bodily weakness and an offensive discharge from genital passage. Patient’s illness began with the birth of her last child, five months before admission, the discharge commencing then and lasting ever since.**

**Physical Examination.—**On the cervix uteri there is a large
cauliflower-like polypus, which, when touched, causes a pus-like discharge with an offensive odour.

*Treatment.*—The day after admission Dr Macdonald removed the tumour and the vaginal portion of cervix by means of the ecraseur and thermo-cautery. Patient made good recovery, and was dismissed on 5th June relieved.

**Case II.**—Mrs W., æt. 32, residing at North Berwick, was admitted 25th August, 1884, complaining of pain in hypogastric region, and an excessively fetid discharge from vagina. The discharge first appeared four months before admission. Has had three children, the youngest 10 years ago.

*Physical Examination.*—The whole of the cervix uteri is converted into a cauliflower excrescence, and extends to within a quarter of an inch of the vulva. A portion of the upper part of the vagina, near the middle line posteriorly, is in a similar condition.

*Treatment.*—On 6th September Dr Macdonald, with his fingers and curette, tore away the fungoid mass. A large quantity of dirty greenish soft material was dislodged. Patient was douched with warm carbolic lotion. There was no subsequent haemorrhage. Patient made excellent recovery, and was dismissed on 18th September relieved.

**Case III.**—Mrs R., æt. 37, married fourteen years, has had four children, residing at Leith, admitted 17th October 1884, complaining of a badly smelling discharge. Patient noticed that her menstrual discharge increased in May last. About three months before admission she first felt it swelling badly. She suffered little pain.

*Physical Examination.*—Abdomen rather distended; offensive discharge from vagina. *P.V.*—Vagina occupied by an enormous cauliflower mass, depending from the cervix and bleeding readily.

*Treatment.*—18th October. The wire of a galvano-cautery was passed round the root of the mass, which was removed by means of it. A small piece growing from lower lip of cervix escaped the wire and was removed by scissors. For a day or two after the operation there was some little discharge and pain, but these soon disappeared, and the patient was discharged relieved on 1st Nov.

**Case IV.**—Mrs W., æt. 46, readmitted 9th October 1884, complaining of a red discharge from the vagina. This patient had the vaginal portion of the cervix removed for cauliflower excrescence eighteen months ago.

*Physical Examination.*—9th Oct. 1884. Cervix enormously hypertrophied, ulcerated deeply in the centre.

*Treatment.*—11th Oct. Dr Macdonald scraped away the ulcerated mass with a long handled gouge, and then applied the thermo-cautery to the bared surface. Very little discharge
occurred after the operation, and on 23rd Oct. the discharge had ceased entirely, and she was dismissed relieved on 28th Oct.

The above four cases of cancer of the cervix present average specimens of the nature and tendency of the disease in that region. It will be noticed that the first three had had children. It is within our knowledge that the fourth one also had a family, although it is omitted in the record. This bears out the well-known fact that cancer of the cervix is more common in women who have borne children than in those who have not borne children. It also lends support to the opinion that injuries to the cervix arising during parturition are important etiological factors, predisposing to epithelioma of the cervix. It will be noticed that three of the cases recorded above were examples of the malignant papilloma, or what is sometimes called cauliflower excrescence.

Cauliflower excrescence, if seen early, allows of very complete removal, and is doubtless longer in returning than ordinary epithelioma, but I have never been able to meet with a case in which it did not appear in the course of two or three years at longest, and when it does so it is in the cicatrix as above observed. For this kind of tumour the incandescent wire is particularly suitable, because it is painless if properly employed, completely arrests hemorrhage, and destroys a considerable layer of tissue beyond its line of application. It is, however, somewhat difficult to apply and to regulate, especially in regard to the amount of heat and the tension admissible, and I have not been able to see its superiority over other modes of removal in the light that some Continental authorities have placed it. In even the worst cases of cancer considerable good may be accomplished, and the arrest of stinking discharge, as well as the prevention of resorption of putrescent elements effected by removal of as much as possible of the affected tissue.

An element of relief to pain, as well as diminution of resorption, is sometimes brought about by the means employed to remove the clinical cervical tissue allowing of the escape of pent-up putrescent mucus in the uterine body. I have observed the escape of a large quantity of horribly stinking material from the cavity of the uterus on more than one occasion during such an operation. I prefer, however, the use of the knife, the gouge, the scissors, and the thermo-cautery in such cervical operations to the use of chloride of zinc, as advocated by the late Dr Marion Sims. The chloride of zinc I found dangerous and difficult to regulate, both in regard to the extent and intensity of its action on the surrounding tissues. There is seldom much bleeding in the removal of cancer
of the cervix, and when such does occur it is readily arrested by a few touches of the thermo-cautery. The cautery needs to be introduced through a wooden vaginal speculum. All such operations are of course only palliative, but that they frequently give material relief and considerably prolong life is unquestionable.

**Coccygeotomy.**

Case I.—J. S., aged 18, residing in Forres, was admitted on 19th June 1884, complaining of pain at the tip of the coccyx when sitting. Patient nine months ago first felt an uneasy feeling in the region of the coccyx. Two months before admission the pain got very much worse, being especially severe when she sat down, but not while walking or lying. The patient's brother had sometimes playfully caught hold of her by the shoulders, and given her what is popularly known as a "knee-rise." This is the only cause she can assign for her present illness. She has been suffering from debility for the last five years.

**Physical Examination.**—Great pain complained of when the tip of coccyx is pressed on.

**Treatment.**—25th June.—Dr Macdonald, with a tenotomy knife introduced subcutaneously, separated the coccyx from all its attachments. 10th June.—On examination it was found that pressure on the coccyx did not cause pain. 19th July.—Dismissed. 23rd Oct.—The patient returned complaining of the old pain. She states that about a fortnight after dismissal the pain returned. 28th Oct.—Dr Macdonald cut down on the coccyx from behind, and removed it at the sacro-coccygeal joint. There was very little haemorrhage, no vessels requiring to be tied. The wound was stitched with five deep and several superficial catgut sutures, and dressed with iodoform. The patient was kept in bed with her knees tied. 2nd Nov.—Deep stitches removed. Wound healed by first intention. 18th Nov.—Patient has now very little pain on sitting. 21st Nov.—Sent to Convalescent House.

**Backward Projection of Coccyx, with Anchylosis of Sacro-Coccygeal Joint.**

Case II.—Mrs T., aged 21, admitted on 28th Aug. 1884, complaining of pain at the end of the back bone after sitting, and pain while the bowels are being moved. Her illness dates from the birth of her child, fifteen months before admission. The patient is subject to fits. The urine contains no albumen.

**Physical Examination.**—Coccyx bent backwards and pain complained of when the tip is pressed by the examining finger.

**Treatment.**—Rest, hot water injections, and tonics, and blisters applied over the coccygeal region. 9th Sept.—Dismissed improved. 26th Oct.—Patient returned complaining that the pain is no better. 27th Oct.—Dr Macdonald cut down on coccyx, and removed it with bone forceps. The bone was firmly anchylosed and enlarged.
by inflammatory thickening. There was no bleeding. The wound was stitched deeply and superficially with catgut, and dressed with iodoform. 1st Nov.—Deep stitches removed. Union by first intention. 11th Nov.—Patient is now nearly free from pain while sitting. Dismissed to-day.

The above cases are examples of severe distress originating in the coccyx. The first case was exceedingly troublesome, and had resisted all the efforts of the patient's local medical adviser before she was sent to Edinburgh. I accordingly attempted, by cutting the muscular connexions of the bone subcutaneously, to put the sacro-coccygeal joint at rest for some time, in hope that the pain would disappear. Though there was a suspension of the pain, it recurred with equally as great intensity very shortly after this operation so soon as the muscles again began to act upon the bone. Accordingly, when the patient returned a second time I felt constrained to attempt a more active treatment. With this view I entirely removed the coccyx, clipping through the sacro-coccygeal joint.

The operation is a very easy one, the only difficulty experienced is getting behind the tip of the bone with the knife without injuring the important parts lying in front of it. There is hardly any bleeding. The parts are very vascular, and notwithstanding the fact that they are so near the anus, in both of these cases healing by first intention was easily secured; the second case had become decidedly an inconvenient deformity, as from the way in which the coccyx projected backwards, the patient when she sat was in a condition much the same as that of a person sitting on a thorn. While I had doubts whether or not the first case was warranted, I had none whatever respecting the second case. The immediate relief in both cases was great.

Before presenting the cases to the Society, I wrote the medical attendants of both patients, and am glad to be able to record a successful issue in both cases so far as the operation was concerned. Dr Hardie writes as follows:—"Forres, 5th March 1885.—Dear Sir,—Now that nearly three months have passed since J. S. left the Infirmary there can be no doubt she has been much the better of what you did for her. She is free from the old pain in the region of the coccyx, but occasionally has a very sharp shooting pain there, which simply lasts a few moments. Her general health is good; she takes her food well, and is able for a fair amount of exercise every day."

Dr Bentley writes in the following terms:—"Kirkliston, 4th March 1885.—Dear Dr Macdonald,—I must say that the partial removal of her coccyx gave Mrs T. great relief from the pains she suffered in her back, but I do not think it relieved her fits."

As I merely performed the operation in Mrs T.'s case to relieve her from the pain she experienced in sitting, and not with any
expectation that it would materially affect her hystero-epilepsy, which Dr Bentley in the same letter informs me had lasted for ten years, I considered that the beneficial results in both cases fully warranted the operations.

(To be continued.)

III.—CLINICAL CASES OF DISEASES OF THE THROAT AND NOSE.

By G. Hunter Mackenzie, M.D., Surgeon for Throat Diseases to the Eye, Ear, and Throat Infirmary, and to the Western Dispensary, Edinburgh.

Impaction of a Foreign Body in the Sinus Pyriformis.—On 7th November 1884 an elderly woman was sent to me by Dr A. J. Sinclair, on account of a pin which, she stated, had stuck in her throat. On examination with the laryngoscope no trace of it could at first be detected, but on closer inspection it was discovered in the left sinus pyriformis, in close proximity to its outer wall, and apparently firmly impacted. It was removed by laryngeal forceps, a considerable amount of force being necessary to dislodge it from its temporary resting-place.

It is rare for foreign bodies to find their way into the sinus pyriformis. More commonly they are caught in the tonsil (this is very frequently the case with bones of fish), or, should they pass this, they follow the current of air, and are drawn into the larynx, trachea, or bronchi.

Hæmorrhage after Tonsillotomy.—After tonsillotomy hæmorrhage may be either primary or secondary. The former variety is extremely rare, and, after a fair experience of the operation, I have never witnessed a case of it. Secondary hæmorrhage has been ascribed to wounding of the pillars and vessels of the fauces during the operation, and to the subsequent movements of deglutition disturbing the injured vessels, and causing fresh bleeding. Of secondary hæmorrhage I have seen one example. The patient, a medical practitioner, came a considerable distance to have the operation of tonsillotomy performed. This was done by means of the guillotine with complete success and the usual amount of primary bleeding, no injury to the fauces being inflicted. He left soon afterwards to return home by train. In a note received from him afterwards he states, “I had a bad attack of bleeding in the train going to ——. I arrived at —— very faint, and had to keep my bed for a few days. I could not get it stopped in the train. I had nothing of the kind in the first case.”

This gentleman had one tonsil removed by me about a year previously. On that occasion, as he states, there was no hæmorrhage. The only cause which I am able to assign for the bleeding on the second occasion is that soon after the operation, and immediately