should be removed surgically. If this is not possible, they should be encouraged to break down by poulticing or by other means of inducing active hyperæmia, which will produce a protective inflammatory zone around them. The abscesses are then opened, scraped, and packed with wick or gauze.

OBSTETRICS AND GYNECOLOGY.

UNDER THE CHARGE OF

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INTERMITTENT HYDROSALPINX.

UNDER the term intermittent hydrosalpinx or *hydrops tubæ profluens* there lies concealed a somewhat elusive morbid entity, an entity to which Dr. Paul Wanner (*Rev. méd. de la Suisse Romande*, 20th October 1914, xxxiv. 608) tries to give clearer definition. For this purpose he narrates a case. His patient, a married woman of 36 years of age, had an uneventful infancy and childhood, and menstruated for the first time when 16. From her eighteenth year she noticed that she was often wet; at first she attributed the discomfort thus produced to passing urine, but was struck by the fact that the liquid did not stain her linen. Her general health was not interfered with, but she noted a slight distension of the abdomen from time to time. When twenty-five years old she married, but no pregnancies occurred. Until 1911 she continued to have small losses of fluid, and the abdomen was slightly swollen from time to time; after that year the discharge became greater in amount and more troublesome; it also became irregularly intermittent, and a small dose of purgative medicine would bring it on. More recently the losses had been still greater, and were brought on by slight movements, as in laughing, running, and the like; she had to wear a diaper. Menstruation remained normal and had no apparent effect upon the discharges. Still more recently the losses had become regular, occurring every three weeks; the abdomen had also become more distended, and the patient thought there was a sort of reservoir for the fluid on the right side. The physical examination revealed a fatty abdominal wall and a swelling above Poupart's ligament on the right side. This swelling was slightly tender on pressure; it gave to the fingers the sensation of a resistant, slightly elastic, fluctuating, but ill-defined mass. The uterus was small and exhibited distinct sinistro-version; the sound, when introduced, passed distinctly to the left side. Immediately after the uterine sound had been withdrawn a clear fluid began to pass from the patient; it amounted to nearly half a litre, was free from albumin, had a specific gravity which was less than that of water, and left no deposit when allowed to stand. Thereafter the bimanual examination showed that

the uterus was in its normal position and was freely movable in all directions. There could be no reasonable doubt that the patient was the subject of hydrosalpinx.

Dr. Wanner regards complete closure of the ostium abdominale as a necessary precedent to the development of hydrosalpinx, and he points out that when the uterine orifice of the tube is also closed the salpingeal sac may attain a large size and be mistaken for an ovarian tumour. In cases of *hydrops tubæ profluens*, however, the swelling is never so large, for its contents are periodically or constantly escaping. It is a rare morbid state, Martin having met with no more than four instances of it in five hundred diseased tubes. Its diagnosis is not always easy, although it was so in Wanner's patient; and it is liable to be confused with ordinary hydrosalpinx, with hæmatosalpinx, pyosalpinx, subperitoneal fibroids, hæmatometra or hydrometra in a separate uterine cornu, tubal pregnancy, various tumours of the ovaries and tubes, and with inflammatory exudates. The absence of fever and the intermittency of the phenomena are useful diagnostic indications of hydrops profluens. The morbid state rarely undergoes spontaneous cure, and even when there is a tendency in that direction it is hindered by the existence of adhesions between the tube and the surrounding organs. The present-day treatment is operation by the abdominal route.

Dr. Wanner confirmed the diagnosis and brought about a cure by abdominal section. He found the salpingeal sac markedly adherent to the floor of the pelvis, and was only able to remove four-fifths of it. Indeed the attempt to remove the whole was followed by tearing of the parts and alarming hæmorrhage; it was necessary to suture the tear and to stitch the peritoneum over the part of the sac which had to be left behind. The patient made a good recovery. The only matter of interest which the specimen exhibited was hypertrophy of the tubal musculature; in ordinary hydrosalpinx the opposite condition of thinning, with atrophy of the muscular coat, is produced.

Intra-Uterine Stem Pessaries.

Dr. W. R. Nicholson (*Amer. Journ. Obstet.*, 1914, lxx. 608) begins an article on dangers in the use of the intra-uterine stem with the following somewhat surprising sentence:—"The frequency with which this little instrument is used at the present day and the steady increase in the number of its advocates renders the above question (its dangers) one of much importance." Now, if there is one matter about which gynecologists, in Great Britain at least, would be likely to agree, it is that the use of pessaries, and especially of intra-uterine pessaries, has been steadily decreasing for several years, and that the whole-hearted advocates of these little instruments are few and far between. Dr.

Nicholson of Philadelphia, however, is of an opposite opinion, and thinks it necessary to record as a warning certain dangers which may follow the use of the stem. A patient who had been suffering for some years from dysmenorrhœa and sterility applied to Dr. Nicholson for advice. He first had her husband examined, and after getting a clean bill of health regarding him, he agreed to operate upon the wife. She was first examined under ether, and an acutely anteflexed, mobile, and well-developed uterus was discovered; the ovaries were a little smaller than usual, and there were no signs whatever of any infection, recent or of old standing. Cervical dilatation and a gentle curettage were performed; a stem pessary was inserted; and a Smith-Hodge pessary was also put into the vagina in order to retain the stem. No evil effects followed, and the patient left the hospital in which the operation had been performed at the end of a fortnight. A week later Dr. Nicholson was sent for, and found her suffering from intense pain in the right lower quadrant of the abdomen; her temperature was 103°, her pulse 120, and her respirations were quickened; some pains in the limbs and back were complained of. At first Dr. Nicholson hoped that the symptoms might be explained by influenza, but a pelvic examination soon convinced him that an infection had occurred about the uterus. There was acute tenderness in the right vaginal fornix, and, as the appendix had been removed previously, no suspicion of appendicitis could be entertained. It was discovered that the patient since she left the hospital had been douching herself, and that intercourse with her husband had taken place on one occasion. The intra-uterine stem was at once removed, but symptoms pointing to pelvic peritonitis continued, and in the end the abdomen had to be opened and the uterine appendages removed. Dr. Nicholson was able to save the major part of the left ovary and about two inches of the corresponding tube, but the right ovary was much enlarged and the seat of cystic degeneration. The patient made an uneventful recovery, but, as the author says, the case was a most unfortunate one, and the treatment resulted in a young healthy woman, with normal organs and suffering only from slight dysmenorrhœa, but being very desirous of having children, being left in a mutilated state with no hope of a pregnancy. Dr. Nicholson considers all the possibilities, and believes that he is able to exclude infection before and at the operation; he thinks that the infection followed the return of the patient to her home, and was due to the stem pessary, the actual infecting poison coming either from the sexual act or more probably from the employment of non-sterile douches. Most gynecologists are doubtless well aware of the risks accompanying the insertion of stem pessaries, especially when they are introduced at the time of or immediately after curettage, and more particularly when they are accompanied by the use of a vaginal pessary; but the reporting of such a case as Dr. Nicholson's may serve a valuable purpose in

keeping alive a wholesome dread of these instruments, particularly in the case of patients not under professional observation.

Rupture of a Bicornute Pregnant Uterus.

It is interesting to be able to refer to an interesting report of the rupture of a malformed uterus occurring in far-off Saskatchewan. Dr. G. A. Wright of Saskatoon (*Western Medical News*, 1914, vi. 213) not only records the case, but he was also able to operate successfully upon it. The patient was a married primipara of 18 years of age. When about four and a half months pregnant she was seized with violent pain in the abdomen while walking across the floor. When Dr. Wright reached her she was complaining of pain in the hypogastrium, with marked distension of that region. Her pulse was a hundred, and she was semi-conscious. The temperature was normal. A very tender mass, resembling the gravid uterus, was felt in the pelvis. The woman was removed to the hospital, and as she was no better on the evening of the following day Dr. Wright, assisted by Dr. H. E. Munroe, opened the abdomen. The cavity was found to contain blood-clots and a fœtus of about five months, with placenta and membranes. These were removed, the abdomen was flushed out, and then it was discovered that the uterus was bicornute, and that the left cornu (the one which had been pregnant) was ruptured. There was only one cervix, and the ruptured cornu was clamped just above it and removed with the tube and ovary. The abdomen was flushed with saline; its cavity was also filled with saline and closed, a tube being left in for drainage. On the third day after the operation the patient expelled a cast from the right uterine horn; she made a good recovery, and was able to be moved to her home on the twenty-second day. Ten and a half months later she became pregnant, and she was delivered comparatively easily under Dr. Wright's care at the full time; the only anomaly was the presentation of the infant by the breech. The labour lasted six hours, and, although Dr. Wright was prepared to dilate the cervix and deliver early for fear of rupture, the progress made was so satisfactory that he determined to leave the expulsion of the child to the natural efforts. Previous to the opening of the abdomen the operator was in doubt whether he had to do with a ruptured tubal pregnancy, a perforated gastric ulcer, or an acute appendicitis; abdominal section enabled him to clear up the diagnosis, and doubtless saved the patient's life.

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