from operation. I explained to him that the operation was not a difficult, dangerous nor painful one, and that his prospects for a successful extraction of the cataract were good, but that the retina may have lost nearly all of its sensitiveness, and that therefore he should not expect too much from the operative procedure. Under chloroform the lens was extracted through an upward iridectomy. No complications followed upon the operation. By the ninth day the wound had healed and the bandages were permanently removed. When examined the pupil was comparatively clear and the eye exhibited very little injection. There were a few opaque shreds of capsule in the pupil, but not enough to interfere with the functions of the eye, if the retina and optic nerve were in good condition.

He returned to his home one month after the operation, sadly disappointed that he could not see. When asked what difference there was between his present condition and his former state one month ago, he said that light appeared to him very much intensified, and that he could now detect the shadow of any body between him and the light, but that he could not recognize outlines of any object whatever. Sad at heart he went back to his old trade, at which he had become quite skilled, and I heard of him six months afterward as being lead about, in the absence of useful sight to guide himself. I had put his case down as one from which no good was now to be expected, and therefore dismissed him from my mind.

Early in January, 1886, three and a half years after the operation, I was visited by the Bishop, who in the course of conversation asked me whether I had heard of the sight which my patient had finally secured. He told me that he usually spent a part of his summer vacation in the neighborhood where this patient resided, and as he had always taken the deepest interest in his welfare, made it a point to visit him annually and watch his progress. For the first year after the operation the improvement was not great, so that he could not trust himself alone. The definition of large objects seem to dawn upon him very slowly. It took his retina two years to acquire sufficient sensitiveness to detect large objects and to permit him to avoid them in moving about. After two years he could walk alone, and now rides horseback all over the country. On the last visit the Bishop was delighted to note a marked improvement. His vision had become sufficiently acute to detect comparatively small objects, and even the alphabet had been conquered, and the reading of very large type had been acquired. He had secured the aid of interested friends who were instructing him in reading. A book of large print, letters one-fourth of an inch long, had been procured. In this, aided by a two-inch magnifying lens, he could read with some facility. It has taken him nearly four years to attain this degree of useful sight. This progress marks clearly the slow development of retinal sensibility, and from it we may expect that time will still further improve his vision.

I have not seen the patient since he left me for his home, 300 miles away from Baltimore, now nearly four years. The operation, as far as the cataract extraction went, was a success. Before he left me I could detect no abnormal changes in the fundus of the eye with the optical microscope. To what extent the peculiar functions of the retina had undergone development I had no means of determining. As he had no conception whatever of objects beyond what the handling of them would give him, I did not expect him to see or appreciate them immediately after the operation. If the acquisition of sight could be attained I knew that it would be of very slow development. Professional experience had taught us but little in this direction, and surgical reports were not rich enough in such material to give data upon which to build hope. The results of three years' development has put him further on the road to secure good vision than I had imagined possible.

I had previously operated upon a patient 22 years of age who had been brought up in a blind asylum. He could see to get about, but the presence of a zonal cataract in each eye from infancy did not permit him to see small objects. When the cataracts were removed after he had attained his majority his vision was so far improved that he then learned to to read, and eventually became a successful merchant. It took him nearly two years to acquire a facility to see coarse print, and he never exceeded *pica*, which is the largest type that printers use for the body of many books. No magnifying glass permitted him to recognize fine print. There was a great difference, however, in the amount of sight which these two patients started with. One had only light perception, the other already useful vision and the general recognition of all large objects.

Baltimore, February 2, 1886.

INFLAMMATION OF THE LINING MEMBRANE OF THE FALLOPIAN TUBE, WITH EXUDATION OF PUS OR PUROFIBRINOUS FLUIDS.

BY R. STANSBURY SUTTON, M.D., LL.D.,
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This disease is termed salpingitis, and like a bronchitis, it may be acute or chronic. The acute form is not distinguishable from an ordinary peri-uterine inflammation. The chronic form may be recognized. In some cases the diagnosis is limited to certain periods in the history of the case; in other cases the symptoms may be so constant as to render it possible to make the diagnosis with considerable accuracy.

The causes of this disease have frequently been said to be limited to gonorrhœal infection. This is an error. It does arise in strumous women from the constant introduction into the uterus of instruments, whether by reason of the introduction of septic matter, or from mechanical violence, I am not sure. But it is more than probable that it arises from the introduction of septic matter. The entire gynecological practice of some seems to be limited to a single procedure, viz.: the introduction of the uterine sound; and the *rationale* of the treatment is explained to the patient thus: "There are adhesions between your womb and bladder, or womb and rectum, and these must be broken up." Or: "You have got a tumor in your womb,

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and it will be removed by making pressure on it in this way."

I have just now under my care four striking examples of this treatment persisted in to the production of salpingitis, unilateral, in one; chronic cellulitis and fixation in retroversion of the uterus in another; chronic invalidism in a third; and the fourth case was absolutely free from all disease, but had been gouged regularly for a supposed fibroid which never existed. The constant poking at the interior of a uterus with sounds will frequently produce an inflammatory condition of the lining membrane of the uterus and tubes as well as a general pelvic cellulitis. The older I grow, and the more experience I get, the more am I convinced that local treatment directed to the interior of the uterus instead of to the surrounding structures is entirely too much practised. I find scarcely any use of late years for the old Simpson's sound, sponge or laminaria tents; they lie about as relics of the past. Symptoms are no longer treated for diseases, and the uterine cavity is no longer made a chemical laboratory. The condition of the pelvic and abdominal viscera receives more attention, and less local treatment is required. Tonics, massage, rest, hot water, regulation of the bowels, a good diet, and an occasional application of iodine to the vault of the vagina will soon do away with a host of cases formerly treated with text-book punctiliousness. The cases requiring surgical treatment receive it promptly and with the loss only of enough time to prepare the case. I am sure that such a course is productive of less harm and of more good than the other.

An acute salpingitis recognized as a peri-uterine inflammation should be treated on the well established principles laid down by all authors.

The existence of chronic salpingitis is not always easy of recognition. Mr. Lawson Tait said to me in 1882, at his clinic in Birmingham, England, "Please examine that woman." I did so. He said, "What is that?" I replied "a case of chronic cellulitis." "No," said he, "it is a case of salpingitis, pus in the tubes." I now for the first time knew that I had seen the disease before and had not recognized it. I have seen many cases since, some operated upon by Mr. Tait, and I do not yet feel competent to always recognize the condition. When the symptoms are well marked, and the patient is a married woman or a prostitute, it is easier to recognize it than when the patient is unmarried and above all suspicion—because *sexual intercourse in chronic salpingitis is well-nigh unendurable.* Occasionally the muco-pus or pus and serum will escape from the tubes through the uterus and relief follows; if the tube fills again the suffering returns. I have seen this occur. Bimanual palpation will reveal a fulness on one or both sides of the pelvis. This fulness or swelling is not solid and painless, but semi-elastic and painful. The swelling may be well off on the sides or be directly behind the uterus itself. Other structures than the distended tubes are likely to be involved in the swelling, and if adhesions have formed the mass is fixed.

Pain, reflex in character, is usually complained of in one or both groins, in the back, in the bladder or down the legs. Frequent attacks of pelvic peritonitis occur, lasting eight or ten days. During these the patient cannot walk about without much suffering, and there is an acceleration of pulse and temperature. Pressure bimanually produces a feeling of faintness, and occasionally reflex nervous phenomena approaching hysteria are present. The patients lack color, and bear the evidence in their faces of suffering. One patient often complained of being "so stiff as to be scarcely able to walk." In all of my own cases I have observed that the menstrual flow was disturbed, being profuse and lasting beyond the time, and finishing up with a leucorrhœal discharge sufficient to annoy the patients. In one of them the tube was now and then emptied through the uterus. There was no mistake about this, for I finally removed the tube when it was full of pus. The case was a very interesting one. Twice I postponed operating on account of a subsidence of the mass in the pelvis. The patient insisted that she had for several days observed a flow of matter from the vagina. Finally I was called to see her when she was confined to bed with a severe menorrhagia, and I felt the mass unusually large, tense and painful. As soon as I got her cleared up she entered my private hospital and I operated upon her.

Miss ——— has a strumous constitution; pain in right groin and back; stiffness of thighs; is pale, tongue is heavily furred, is slightly hysterical, has menorrhagia. On local examination, a semi-elastic, painful swelling exists in the pelvis to the right of the uterus. It has come and disappeared, to my personal knowledge, several times in the last six months. In a good light, under Sims's speculum, a little pus is found oozing from the external os uteri. On January 9 she was put on the operating table, etherized by my head nurse, and, Dr. Stone assisting me, I opened her abdomen by a two and a half inch incision, and removed her right ovary and Fallopian tube; the latter full of pus. Her temperature never exceeded 99.5° F. after operation, was normal on the fourth day, and remained so; wound healed, as all my abdominal wounds do, by first intention.

It may be interesting to some to know that no carbolic acid or other chemical touched this patient until the wound was closed, when iodoform gauze was placed over it. The sutures were boiled in clear water, boiling water was poured over the instruments, and boiled water was used for sponges.

MEDICAL PROGRESS.

EXPLORATION OF THE UTERINE CAVITY IN CASES OF MENORRHAGIA.—At the meeting of the British Gynæcological Society on December 9, DR. ARTHUR W. EDIS read a paper on this subject. The author desired to draw attention to the urgent necessity of this proceeding, when dealing with cases of severe persistent or recurrent uterine hæmorrhage. The subject was one of great interest, and often one of great anxiety to the practitioner. There was a tendency to treat metrorrhagia as if it were a special

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