Hospital Reports.

BRISTOL GENERAL HOSPITAL.

ANEURISM OF THE THORACIC AORTA.

Reported by JOHN EDWARD ELLERTON, Esq., M.R.C.S. Eng., House-Surgeon.

JOHN A——, aged thirty-eight, was admitted an out-patient of the Bristol General Hospital, in April, 1848, and then first came under my notice. He is a labourer, very often having to lift and carry heavy weights; is married, and has four children; habits and mode of life formerly steady and sober, but recently very irregular; has always had plenty of food and clothes; is a native of Bristol; lives in a confined situation, and the house is damp; moderate stature, stout conformation, sanguine temperament, and florid complexion; habitual state of mind cheerful; sleeps well; parents dead; were both healthy; thinks his father died of consumption; his habitual state of health good; had rheumatism once, from exposure to cold after drinking. His present illness commenced, about two months ago, with a cold in the chest, as he himself described it. Did not leave off work for some time after, but at last was obliged to do so; and finding he got no relief from rest, he applied to the hospital, and was admitted. No treatment previous.

Present state.—Complains of pain and soreness in all parts, lassitude, and great prostration of strength; loss of flesh; feels very cold and chilly, with night-sweats; colour of surface pale; eyes suffused and sunk; great emaciation; no swelling or anasarca; intellect sound; has some pain in the head, but it is not constant—of a throbbing character; feels giddy sometimes, yet never loses his senses; expression of countenance anxious; organs of sense healthy; cutaneous sensibility increased; respiration short and laboured; motion of chest much less than natural; does not complain of pain, except in front of chest, about the second bone of the sternum, on deep inspiration; voice husky; no cough or expectoration. On percussion, the whole of left front was dull; no pulmonary sound elicited; over the middle of sternum the sound was resonant; cardiac region dull, extending over an area of nearly double the normal standard; lower part of left side quite dull; right side resonant in the mammary and infra-mammary regions; clavicles very prominent; above, the percussion-sound was resonant; dull below. On applying the stethoscope to the left side, above the clavicle, a loud, sonorous rhonchus was plainly heard, with coarse, moist gurgling. Below and over the whole extent of left front, no pulmonary sound was heard; but an indistinct rattling, masked by the increased loudness of the heart-sounds; impulse of heart heard over the whole left side. In the right supra-clavicular region the breath-sound was very obscure in ordinary inspiration; but in deep inspiration a wheezing sound was perceptible, which was lost below the clavicle. In the middle and lower parts of right side the natural inspiratory sounds were very much augmented with loud, tubular expiration. Impulse of heart and sounds distinctly heard and felt over the whole extent. The whole of left back dull on percussion, except the supra-scapular region, which was resonant; right side resonant nearly throughout; the scapular region was a little dull; upper part of inter-scapular space loudly resonant; dull in the lower. The stethoscopical examination very nearly corresponded to that of the anterior region, except in the upper part of inter-scapular space. The breath-sound here was tracheal; lost entirely in the lower part; action of the heart distinctly perceptible both to the eye and hand. He did not complain of the least pain or palpitation over the cardiac region, although the tumultuous action of the heart was plainly visible in the heaving of the chest about the fifth and sixth ribs. Impulse of heart very much greater than usual, both as to volume and intensity: first sound abrupt, with a loud, whistling murmur, like the sound of a plane, heard most distinctly about the fourth rib, to the left of the sternum; second sound prolonged, with a murmur at its termination, and followed directly by the first sound.

From the result of this, my only examination, I considered he was labouring under morbus cordis and phthisis, and for this he was treated.

In the course of the following week I was sent for in a hurry. The woman who came, said "that he had been out for a gentle walk, and, on returning, coughed up a gallon of blood." And certainly she was not far wrong; for I found the man propped up in a chair, perfectly dead, with a large pool of blood around him, which was escaping through a grate near the door. My impression at first was, that the diagnosis I had formed was perfectly correct; and that in progress of the disease, one of the larger pulmonary veins had been opened by ulceration, and thus caused his death. I had not the slightest idea of aneurism.

Post-mortem examination, twenty-four hours afterwards.—Weather mild and dry. The chest being the seat of mischief, was first examined, and it was not necessary to go farther. The right lung was first removed. It weighed twelve ounces, had a very healthy appearance; light grey, mottled with black. It was crepitant throughout, except the upper lobe, which was consolidated. At the apex was a cavity about half an inch from the surface, the size of a walnut, surrounded by grey tubercles, occupying nearly the whole of the upper lobe. Middle and lower lobes quite healthy; hypostatic congestion posteriorly. The bronchi and divisions were quite filled with florid blood, and there was also blood in the cavity. I then proceeded to remove the left lung: after breaking down some old adhesions in the upper part, I was going to cut across the root; and then I felt a large tumour, which was elastic to the touch. Having carefully removed the contents of the chest, I thought to dissect off the tumour, and in doing so, cut into it, and found it firmly attached to the third dorsal vertebra; I detached it as close to the bone as possible. The left lung weighed sixteen ounces, and the parenchyma was thoroughly infiltrated with grey tubercle; a slice of it sunk in water. The upper lobe was broken down into a very large cavity, and this was nearer the surface than the one in the right lung. The bronchi, when cleared of blood, were very much dilated, and the secondary ramifications obliterated, several large ones opening into the cavity by truncated extremities; the root of this lung was intimately connected with the concavity in the arch of the aorta. The heart was separated just above the aortic valves; the weight was fourteen ounces; rather larger than natural; concentric hypertrophy was well marked. Walls of left ventricle were one and a half, one and a quarter, and one inch respectively, at the base, centre, and apex; cavity much smaller than natural. Mitral valves thickened with atheromatous deposits. Right ventricle dilated; of natural thickness; tricuspid valves healthy. There was nothing particular in either of the auricles. The semilunar valves of the aorta were very much contracted and thickened, with deposits of atheroma and calcareous matter around them. On making a clear dissection of the aorta and root of the left lung, the aneurism was found to occupy the entire circumference of the vessel corresponding to the third and fourth dorsal vertebræ; the progress of the tumour tending backwards, and to the left. On opening the trachea and bronchi, an aperture, which would admit my little finger, was seen about one inch and a half from the bifurcation of the trachea, and in the left bronchus. The inside of the aneurism was lined with fibrinous deposits, and clots of small size were found in saculi of the tumour. The aorta itself was diseased to a great extent, with calcareous deposits beneath the lining membrane.

THE NEW UTERINE OPERATION.

ON A NEW METHOD OF TREATING STERILITY, BY THE REMOVAL OF OBSTRUCTIONS OF THE FALLOPIAN TUBES.

By W. TYLER SMITH, M.D.,

LECTURER ON OBSTETRICS AND THE DISEASES OF WOMEN IN THE HUNTERIAN SCHOOL OF MEDICINE.

SINCE my former paper on this subject, I have received many communications respecting the new operation, and I beg to make a few further observations upon it. There is scarcely a single author of repute who does not refer to obstructions of the Fallopian tubes as a cause of Sterility, but no one had hitherto suggested any feasible remedy. These facts alone, must be sufficient to demand attention to any means calculated, like that which I have proposed and practised, to remove this impediment to conception. The following quotations will show that I did not, in my former communication, overrate the importance of Fallopian obstruction as a cause of barrenness:—

Dr. Fleetwood Churchill, in his work on Midwifery, gives a prominent place to obstructions of the Fallopian tubes in his account of the causes of sterility. He says,—

"The Fallopian tubes may be congenitally deficient, or im-

perforate, though such cases are extremely rare. Their canal may be obliterated from acute or chronic inflammation, or their fimbriated extremities may become adherent to the ovaries. *Even though not imperforate, yet the canal may be filled with adventitious matter.* In all these cases sterility is the consequence, because the access of the spermatozoa to the ovary is prevented."

Dr. Copland refers sterility to "occlusion of the Fallopian tubes" as one cause. He goes on to observe,—

"*The openings of the Fallopian tubes may be also closed by a membranous production, or by an albuminous exudation from the internal surface of the uterus.* The tubes may be either partially or entirely obliterated, in consequence of the extension of inflammatory action to them from the uterus or adjoining parts. When these alterations extend to both tubes, sterility must necessarily result."

In another passage, Dr. Copland is equally clear upon this point.

"Leucorrhœa is a cause of sterility chiefly when it depends upon inflammatory irritation of the internal surface or neck of the uterus, or when the secretion proceeds from relaxation of the vessels in this situation. When it is a consequence of inflammatory action, sterility may continue after the discharge has ceased, owing to organic changes in the surface of the uterus, or in the Fallopian tubes, especially the formation of a false membrane in the former, *and the production of an albuminous exudation in the canals of the latter, or consequent obliteration of them.*"

Mr. Whitehead, of Manchester, the most recent writer on the subject of Sterility, when speaking of the causes of this defect, and more particularly of inflammation of the lining membrane of the uterus, remarks, that:—

"The diseased condition of the lining membrane of the uterus may be extended to the Fallopian canals, *obliterating for the time their internal orifices,* so as to oppose an insurmountable obstacle to the admission of the spermatic fluid within them, and thus to render the fertilizing effort abortive."

Dr. Hamilton speaks of mechanical obstructions as a cause of sterility in the following terms:—

"In some cases, *inaptitude to conceive depends upon some state of the passages to the womb which act mechanically,* and may be removed by a surgical operation. It is obvious that such cases do admit of a remedy; and accordingly, it is well known to practitioners, that sometimes the efforts of the constitution remove these causes, for instances every now and then occur where married women become pregnant at the distance of several years after marriage."

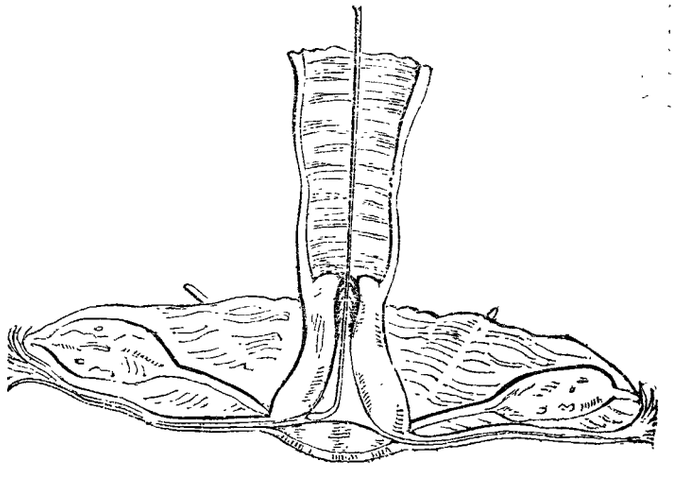
Many other authors might be quoted to the same effect, but it is unnecessary, as the reality of this cause of sterility cannot be disputed for a moment. But I have no wish to attach undue importance to Fallopian obstructions, and to prove this, I give the following very brief sketch of the various causes of sterility. To get a clear and practical notion of sterility, we must consider the generative apparatus in the female, as one tube, extending from the ovarium to the os externum, the perfect permeability of which at every point is absolutely essential to impregnation.

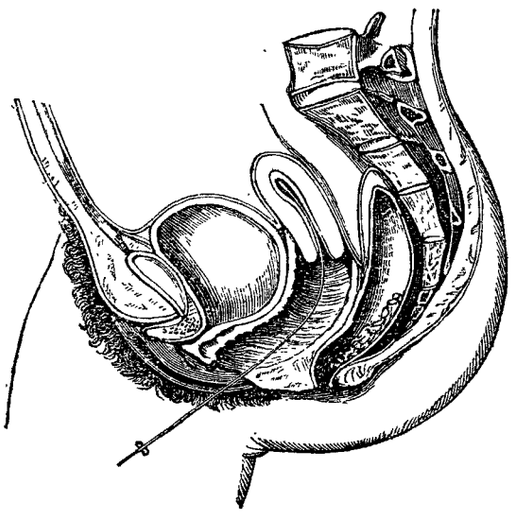
In treating of the causes of sterility, it is also convenient to consider the uterus as a middle point, towards which the spermatic particles of the seminal fluid of the male have to approach from the ostium vaginæ on one side; and to which the ovules matured in the ovaria have to descend through the Fallopian tubes. The absolute conditions of fecundity are, that the male seminal fluid and the ovulum shall be healthy, and that free ingress and egress for the male and female elements of reproduction, through the generative canal, shall be provided for; and further, that the state of the entire generative tube shall be such as not to injure the ovula or the spermatic particles. The uterus, also, must be in a state fitted for the reception and attachment of the impregnated ovule. Infecundity is the necessary and inevitable consequence of failure in any one of these particulars. Into the causes of an infertile state of the spermatic fluid in the male, I do not propose to enter; but when virile, its access to the uterus may be prevented by impediments in the vagina, such as atresia, or imperforation of the hymen; by obliteration, or occlusion of the os uteri; or by occlusion of the canal of the cervix by stricture, or the uterine discharges; or, lastly, the spermatic particles may be destroyed by a morbid condition of the uterine and vaginal discharges. On the other hand, the ovaria may not be in a condition to produce healthy ovules, either from a state of ovarian anæmia or hyperæmia, both of which are revealed by their appropriate symptoms of amenorrhœa or dysmenorrhœa. Or, again, the ovulum being eliminated in a healthy condition, from the ovaria, may be discharged through the Fallopian tubes with such rapidity that it has disappeared altogether from the sexual canal before the completion of the catamenial flow. Or, again, the results of subacute inflammation may have thickened the peritonæal covering of the ovaria, so as to render the extension of ova difficult or impossible: to this form of sterility Dr. Tilt has ably directed the attention of the profession. The ovule also, like the spermatozoids, may be destroyed by the condition of the secretions in the Fallopian canal, before impregnation has taken place.

The uterus, as I have said, may not be in a condition to receive and retain the unimpregnated ovule. The ovarian irritation accompanying the maturation and discharge of the ovule may be so great as to excite the uterus so much that it secretes the membranous exudation found in some cases of dysmenorrhœa, and which is fatal to impregnation. Lastly, there may be mechanical impediments to the passage of the ovule from the ovaria to the uterus through the Fallopian tubes. There may be obliteration and adhesion of the ovarian extremities of tubes to the ovaria; or there may be simple occlusion of the uterine extremity of the tube, so as to prevent both the ascent of the spermatic particles and the descent of the ovule. This part of the generative canal is of especial importance, as it is the narrowest portion, the point where the slightest impediment must necessarily produce sterility. A plug of hardened mucus of the most insignificant character—the merest *débris* of the Fallopian secretion—may cut off an illustrious race, or change a dynasty. It is to this cause of sterility, which I believe to be very common, and easily and safely remedied, that I wish to direct special attention.

Many of the other causes of sterility which I have enumerated, are severe affections, which force themselves on the attention of the practitioner. But we find in practice that in the great majority of cases of sterility, there is a good state of health, the uterine secretion appears regularly, and there is neither appreciable pain nor disease in any of the reproductive organs. The mere absence of childbearing, all the conditions of fertility being apparently present, is the only symptom. This is, in fact, a reason why a vast number of cases never come under medical treatment at all. I submit, that in these cases of good health combined with sterility, the defect can only arise from some mechanical impediment, such as may be remedied by Fallopian catheterism. We sometimes see these cases after years of barrenness, suddenly, and without any apparent cause, give way, and the subjects of them bear children. Such cases are, I have no doubt, cases of Fallopian impediment, relieved, at length, by accident, but which might have been remedied long before by art. In many cases, this form of sterility continues unrelieved, until after the decline of menstruation, when childbearing is impossible. I have no doubt I shall be able, hereafter, to publish numerous cases of success by my method. But sterility is not like blindness or deafness, in which the result of an operation is seen at once. Time is required even after the removal of all impediment. At present, the time which has elapsed since I first performed the Fallopian operation upon sterile subjects, is not sufficient to show the results; but I have already had one case, in which, after several years of sterility, impregnation took place, but which was followed by abortion at the third month.

The following woodcuts give a front and a side view of the vagina, uterus, and Fallopian tube, with the instruments used in the operation, in situ. They convey a better idea of the operation than the former representation of the instruments alone.





I find that different opinions are held respecting the practicability of the operation. Some consider it a very easy and trifling affair; others hold it to be quite impracticable. With reference to the possibility of performing the operation, I may quote the following observations by the editor of the *London Journal of Medicine*, which appeared in the June number:—"We have had, to-day, (26th May,) an opportunity of seeing Dr. Tyler Smith introduce, with ease and rapidity, a fine whalebone bougie into the Fallopian tube of an unopened uterus. By means of a hollow silver tube, suitably curved at the distal end, the point of the whalebone instrument was conveyed to the cornu of the uterus, and was then made to pass into the tube."

Bolton-street, June, 1849.

REPORT OF

A CASE OF PERICARDITIS.—POST-MORTEM EXAMINATION AND REMARKS.

By W. D. EMMETT, M.R.C.S.E., Darlington.

Mrs. A——, the subject of this report, had repeatedly been under my care, suffering from profuse hæmorrhage at each catamenial period. This had been the case, more or less, for about ten years. I prescribed quinine and the acid infusion of roses. This was very successful, the first dose generally making a marked difference in the discharge. The heart was considerably enlarged; the complexion pale and sallow; the the lips bloodless; she was also subject to frequent palpitations. Her relatives were unhealthy and phthisical; her mother supposed to have had some malignant disease of uterus.

June 18th.—I was called to visit her, and was struck by her deathly pallor; she had had severe flooding for two days, but during the preceding night she had been attacked with severe pain in the loins, ankles, and wrists, and informed me, "just in the same way as when she had rheumatic fever some years ago." To take a mixture containing colchicum, laudanum, spirit of nitric ether, and nitrate of potass.

19th.—Has a very anxious expression; a constant short, hacking cough; a tearing pain, referrible to region of the heart, occasionally shooting to the back and to the right side. I at once suspected metastasis, especially as the vital power was so much weakened by repeated hæmorrhages, rendering the patient peculiarly liable to such an event. The stethoscope soon proved my suspicion to be too well founded. In this case, the patient had been so much reduced by loss of blood, and presented such an exsanguined appearance, with weak pulse and pale lips, that I could not venture on depletion by venesection. To take calomel and opium every two hours, and, every four hours, of a mixture containing tartarized antimony, ipecacuan wine, tincture of henbane, spirit of nitric ether, and camphor mixture.—Evening: being in much more pain, in addition to repeated sinapisms to extremities and between the shoulders, eight leeches were applied to the region of the heart. These gave relief.

20th.—Cough much less; pain diminished; sounds of heart very distinctive of the disease; the pleura, on right side, evidently implicated. To take extract of henbane, three grains; opium, one-sixth of a grain; calomel, a grain and a half; every hour.

21st.—Pain much less; considerable incoherence. Omit the pills, and take a mixture of tincture of digitalis, tincture of henbane, tartarized antimony, and solution of acetate of ammonia. Evening: Pain returned. The leeches were applied, sinapisms to the extremities, and to take pills as before. The dry friction-sound has become considerably modified; there is now evident effusion. The leeches were again applied, without my knowledge, hiccough following. The pulse was soft and regular. To take calomel and antimony every two hours, and, the bowels being relaxed, a portion of a mixture of tincture of opium, ammoniated tincture of guaiacum, and camphor mixture after every loose motion.

22nd.—A little more favourable; slept well; pulse regular; cough gone.

23rd.—Sounds of pericardiac lesion clear as before; the patient weaker. To dress the blistered surface with mercurial ointment.

24th.—Had a bad night; slept badly; features collapsed; skin clammy; pulse soft and regular; hydrops pericardii evidently exists. As the vital powers were evidently sinking, I ordered beef-tea and wine, and a powerful general stimulant mixture, with iodide of potassium.—Two P.M.: Says she feels much refreshed, and is free from pain; pulse quite regular, 100, but the countenance has a most ghastly expression.

25th.—Morning: Sinking. Brandy and stimulants; sinapisms. She died in the evening.

Post-mortem examination, twenty-four hours afterwards.—Body perfectly exsanguined; lips very pale, and face wears an expression of much suffering. On dividing the integuments over the sternum, I found a considerable deposition of fat, which increased in thickness towards the umbilicus. The chest was quite filled with its contents. All the viscera seemed hypertrophied, but exceedingly pale. The lungs were healthy though old adhesions existed, more particularly on the right side, where the lung was firmly adherent. The pericardium was very large and distended, containing about seven or eight ounces of clear fluid. The heart was of about twice the natural size, and covered by a deep, rough, granular deposition, over its entire surface; in colour a dirty white, and not unlike the honeycomb appearance of boiled tripe. The pericardium was lined with a similar deposition. There were no adhesive bands. On opening the ventricles, I was struck with the extreme paleness of the same; the valves were perfectly free from the slightest appearance of disease; they were quite free, very pale, their edges clear, sharp, and well defined; there was not the most remote trace of inflammatory action within the heart. The liver was enormously enlarged, encroaching considerably on the opposite side. The intestines presented the same bloodless appearance above noticed of the thoracic viscera.

Remarks.—Several points of much interest were exhibited during the progress of the above case. From the commencement the heart's action continued regular; there was nevertheless a marked want of power, the contractions were deficient in energy, and the pulse was peculiarly soft. The pain was described as most distressing; there was excessive restlessness, and the menorrhagia had returned. I am still of opinion that bleeding was contraindicated, for I attribute the metastasis to the central organs being weakened by such frequent hæmorrhage. The cough was very symptomatic—short, dry, and hacking; there was no concomitant symptomatic inflammatory fever; the dyspnœa was very marked; the respiration thoracic; the dry, friction-sound soon gave way; but though when considerable effusion had taken place, the sound of friction was painfully distinct. I have had many opportunities of witnessing post-mortem examinations after pericarditis, but I never observed the deposition to be so thick and universal, nor yet so rough. The pericardium contained the appearances generally mentioned as the result of common inflammation, as well as the rheumatic. The serum was clear, the effused lymph very firm, and there were no bands of adhesion. The friction-sound was heard very distinctly, even after the effusion of serum. Dr. Drury, who had seen the patient before death, was also present at the inspection afterwards.

Darlington, 1849.

ON A CASE OF DELIRIUM TREMENS SUCCESSFULLY TREATED BY CHLOROFORM.

By GEORGE HYDE, Esq., Surgeon, Maryborough.

Mr. B——, aged forty years; plethoric habit; bloated face; low sized; accustomed to drink two or three glasses of punch daily, after dinner, otherwise I could not discover that he was addicted to spirituous drinking. For a week previous to the