

OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

SESSION 1899-1900.

MEETING VII.—28TH MARCH, 1900.

The Vice-President, DR. ROBERT JARDINE, in the Chair.

I.—SPECIMENS.

A. BY DR. JOHN EDGAR.

Dr. Edgar showed the following specimens:—

1. Fallopian tube with blood-clot; most probably due to a tubal gestation. A large corpus luteum is present in the corresponding ovary. No chorionic villi were found in microscopic section.

2. Melanotic sarcoma of right labium. The vagina was also involved, and the inguinal glands were enlarged,

3. Inverted uterus removed by hysterectomy, after all possible methods at replacement had failed.

B. BY DR. FORTUNE.

Dr. Fortune showed microscopic sections of the following:—

1. Epithelioma of cervix.

2. Portion of cervix removed for diagnostic purposes—simple hypertrophy.

3. Fragments removed by curette from interior of uterus—adeno-carcinoma.

II.—TWO CASES BEARING ON MENSTRUATION.

BY DR. E. A. GIBSON.

Dr. Gibson's paper appears as an original article at p. 108.

Dr. Jardine referred to a case where a discharge of blood occurred at each menstrual period from a sinus in the abdominal cicatrix of a woman on whom he had performed Cæsarean section. As regards the occurrence of menstruation after removal of the ovaries, it had always to be remembered that sometimes portions of ovarian tissue were left behind, and that occasionally there was a third ovary.

Dr. Edgar thought that, in a very great number of the

cases of menstruation after removal of the ovaries, it was due to leaving a small part of ovarian tissue behind. Still, he was quite convinced that in many cases that could not be the reason. He did not think that the control of the menstrual cycle resided in the ovaries alone.

Dr. Balfour Marshall gave his personal experience of a case where, after total extirpation of the uterus and ovaries *per vaginam*, a periodic discharge of blood continued from the cicatrix in the vault of the vagina.

Dr. Russell mentioned a case of regular menstrual discharge from an abdominal scar. The patient was a young married woman, whose abdomen he had opened to remove what appeared to be a simple broad ligament cyst, but turned out to be a right ovarian cyst, adherent to the greater part of the bladder. The case had unusual features of some interest, and it will probably be published at a later date. The interesting point, so far as this discussion was concerned, was that the left ovary was flattened over and intimately adherent to the fundus uteri, and as, in attempting to remove it, there was free bleeding, the raw surface was stitched into the abdominal wound, being in effect a ventro-fixation. The wound healed up completely to all appearance, but every month since the operation a slight hæmorrhagic discharge has taken place at the site of the wound simultaneously with the usual menstrual flow. With regard to the case of menstruation persisting after removal of the ovaries, *Dr. Russell* believed that many, if not all, the cases reported were due to the leaving of a small bit of ovarian tissue. He had, while assisting others in ovariectomies, observed occasionally how difficult it was to be quite sure that all the ovarian tissue had been removed. Oöphorectomy itself was, of course, a much easier procedure. In the case mentioned, which was admittedly a difficult one to remove completely owing to its adhesions, it seemed as if the ovarian structure was laid bare in the incision, suggesting the possibility of some being left on the other side of the incision, in the part to which the ovary was adherent.

III.—AN INSTRUMENT DESIGNED TO PREVENT RUPTURE OF THE PERINEUM DURING PARTURITION.

BY DR. ALEX. MACLENNAN.

Any appliance which aids in retaining the integrity of the perineum requires no apology for its existence. That the perineum is often ruptured is proved by gynæcological hospital

statistics. I am not one of the fortunate men who are able to say that they never allow the perineum to tear, so I have looked for means to help me to save my patients future trouble.

The instrument, which has been made for me from a pattern by the Medical Supply Association at a cost of 14s., has the following points:—It is made from a flat piece of steel (plated), the hollow handle being formed by turning round the margins so as to leave a space of half an inch for the purpose of cleaning.



Its dimensions are:—Length, $10\frac{3}{4}$ in.; handle, $4\frac{3}{4}$ in.; blade (circumferential measurement), $6\frac{3}{4}$ in.; the diameter of the arc enclosed by the blade, 6 in.; breadth of the blade (which is also curved from side to side), $1\frac{7}{8}$ in.; breadth of the fenestra, $1\frac{1}{4}$ in. The thickness of the blade is slightly less than that of the ordinary forceps.

Its mode of action is as follows:—The instrument is inserted shortly before the head is about to pass the vulva, so as to lie over the brow and face of the child, the patient being in the usual position. The left hand of the accoucheur grasps the handle of the instrument, while the thumb of the right hand placed in the fenestra

graduates the pressure.

Rupture of the vagina, where not due to mechanical interference, is secondary to, and an extension of, rupture of the perineum. The instrument extends to the perineum the same kind of support as is given to the vagina by the sacrum and coccyx, and, indeed, may be looked upon as a continuation of these structures. The head can be controlled most effectively as regards advance as well as flexion. In some cases where considerable forward pressure has to be exerted on the head, so as to save an otherwise unavoidable rupture, anterior lacerations are produced. Such, apart from the hæmorrhage which often follows, are of very slight importance. They heal, too, very readily. The anterior lacerations, laterally placed as regards the meatus, are a sort of spontaneous natural episiotomy.

In reply to Dr. Kerr, *Dr. MacLennan* said that either the skin or mucous membrane of the perineum might rupture independently, but that the instrument, by keeping the head

away from the perineum, would prevent a tear from starting, or if already begun, from extending. The instrument was not used as a tractor. It was to be recommended in every case of first delivery.

In reply to Dr. Adamson—the instrument was not employed with the forceps, but in forceps cases after their removal, the expulsive force necessary to complete the final act of delivery of the head being applied digitally from behind, or through the rectum when necessary.

IV.—NOTES ON EIGHT LABOURS COMPLICATED BY TUMOURS.

BY DR. ROBERT JARDINE.

Dr. Jardine's paper appears as an original article at p. 97.

Dr. Richmond (Paisley) gave his personal experience of two cases of tumours complicating labour, one a myoma of uterus and the other an osteoma of sacrum.

Dr. Edgar referred to the danger of dragging a child through a pelvis narrowed by a tumour.

Dr. Munro Kerr referred to the injurious effect on the tumour that resulted sometimes from long-continued pressure upon it by the presenting head. So great was the pressure that sometimes the tumour became quite dead. In illustration of this, he mentioned a case that had recently been seen by him.

GLASGOW SOUTHERN MEDICAL SOCIETY.

SESSION 1899-1900.

MEETING XV.—5TH APRIL, 1900.

The President, DR. HUGH KELLY, in the Chair.

REMARKS ON ANÆSTHESICS AND THEIR ADMINISTRATION AT THE VICTORIA INFIRMARY, WITH DEMONSTRATION OF APPARATUS.

BY DR. DAVID LAMB.

In the course of a lengthy address, Dr. Lamb gave an interesting description of the different forms of apparatus at present in use in the Victoria Infirmary. Proceeding, he gave a detailed account of the advantages of the various anæsthetics, including in his review chloroform, ether, and nitrous oxide