ately the beneficial action of the gland was visible by inducing refreshing sleep and gentle perspiration. On November 19th she expressed herself as feeling better than she had done for years. On November 22nd the swelling of the face was much diminished, and she could now hear the clock strike.

On December 3rd the wrist pulse could be felt. On December 17th she said that she felt quite well and could easily breathe through her nose. On December 28th the swelling of the legs had all but disappeared. On January 20th photograph No. 2 was taken.

I gave her half an underdone thyroid gland the first thing every morning taken with ordinary food, from November 12th to January 12th; no bad symptoms arose during the treatment, except the last week, when there was some feeling of discomfort (tired) about the neck and shoulders.

February 5th. She is now free from pain and feels quite well.

CANCRUM ORIS, FOLLOWED BY EXTENSIVE ULCERATION OF THE CHEEK AND ANKYLOSIS OF THE JAW: RECOVERY.

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N. R., aged 10 years., was sent to me by Dr. B. H. Mumby, the medical officer of the Infectious Diseases Hospital, Portsmouth. The child had been under treatment for a severe and prolonged attack of typhoid fever, which had been followed by destructive ulceration of the right cheek. On admission, on March 15th, 1892, the little patient was much exhausted, and bedsores had formed over the hips and sacrum. The perforation of the cheek was as large as a crown piece, its edges were extremely thin, and several teeth were visible through the opening. (Fig. 1.) The dense cicatrical tissue

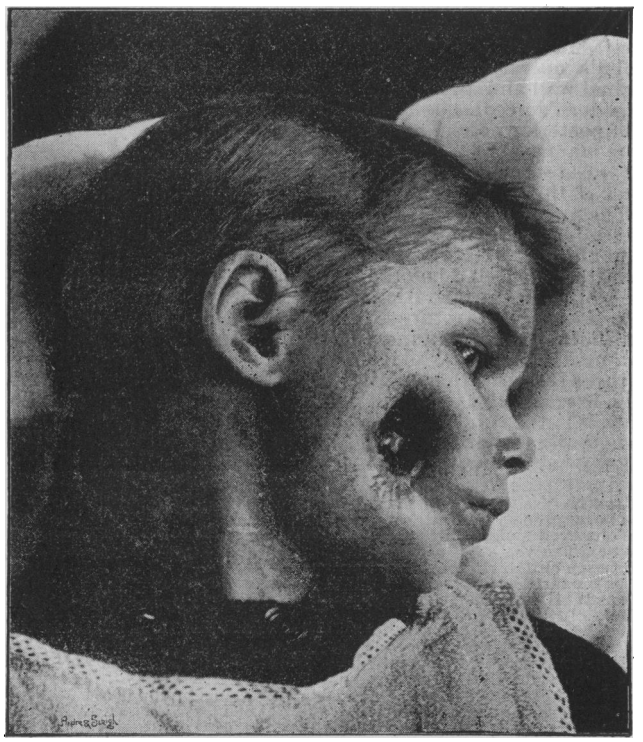

Fig. 1.

bound the maxillæ firmly together, and the buccal cavity was completely obliterated. The jaws were so tightly closed that the child was fed with difficulty through a gap between the teeth. After a few weeks' careful treatment the bedsores began to heal, and the general condition of the patient considerably improved. A false joint was then made in front of

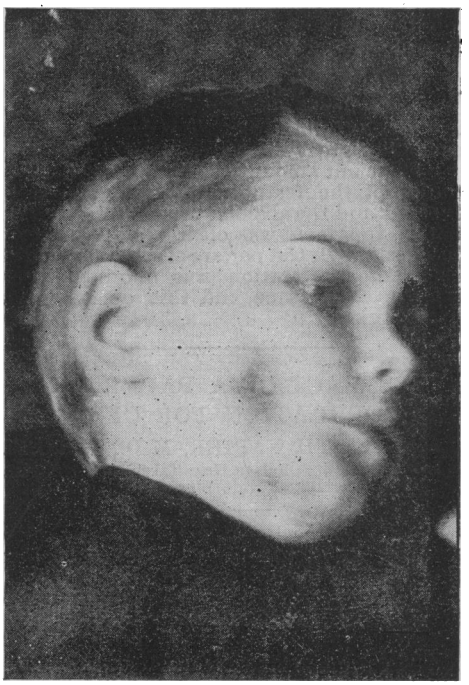

Fig. 2.

the line of adhesion by subcutaneously dividing the lower jaw, and excising a small wedge of bone from the lower border. Three weeks after the operation solid food was taken readily,

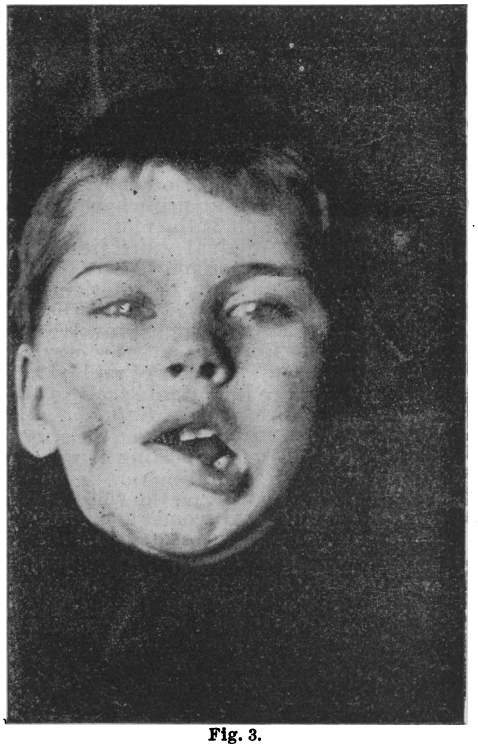

Fig. 3.

and mastication was performed with comfort. The dense cicatricial structures around the opening in the cheek were

freely liberated by several subsequent operations, and contraction steadily progressed. At the time of her discharge from the hospital the perforation had completely closed. (Fig. 2.) The open mouth, showing the action of the false joint, is exhibited in Fig. 3. The child was examined on December 27th, 1892, and in every respect appeared greatly improved.

Remarks.—In this case the cheek had been very extensively destroyed, and the dense scar tissue was firmly adherent to the external surface of the jaws. The desperate condition of the child arose in a great measure from the difficulty in administering a sufficient amount of nourishment. It was quite useless to attempt the restoration of the mucous surface between the cheek and the alveolar processes, as the immediate object of surgical treatment was clearly to overcome the ankylosis, and to re-establish the powers of eating and mastication. The closure of the perforation was obtained by the free separation of the scar tissue, and this operation had to be repeated several times.

ABSTRACT OF A PAPER ON STOLTZ'S OPERATION FOR CYSTOCELE.[1]

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Definition.—Colpocystocele, or, as it is usually called, cystocele, signifies a prolapse of the anterior vaginal wall combined with prolapse of the posterior wall of the bladder. This is very common, but when the prolapse is small and intravaginal it occasions comparatively little discomfort. Vesico-vaginal prolapse is often associated with uterine prolapse; in some cases the former depends on previous downward displacement of the uterus, but in many other cases cystocele precedes uterine descent. The displacement of the bladder is more commonly combined with uterine descent than is rectocele—that is, prolapse of the posterior vaginal and anterior rectal walls. In 108 cases of prolapsus uteri, cystocele was observed 54 times, rectocele but 33. The effects and consequences of bladder prolapse comprise discomfort from feelings of downward pressure, incontinence of urine, dysuria, retention of urine, cystitis, formation of bladder concretions, various reflex symptoms—for example, renal pain, nausea, anorexia. Neglected cases may originate nephritis, hydronephrosis, uræmia.

Causation of Cystocele.—Before entering on the primary object of my paper let me make a brief reference to the pathogenetic factors favouring the production of cystocele. Cystic catarrh and prolonged retention of urine have been regarded as likely causes, but parturition is the most important cause of separation of the vesico-vaginal walls from each other. The vagina is in many cases driven before the advancing occiput, and is thus peeled off from its anterior connections, namely, the anterior cervical lip, the bladder, the pubes, and the triangular ligament. This detachment involves separation of the anterior vaginal wall from the anterior cervical lip and from the base of the bladder. The point of vaginal attachment to the cervix in front is very important, as here the vesico-vaginal connection is very firm. Here rests the *point d'appui* of the uterus, bladder, and vagina. When, as a result of the passage of the fœtal head, vaginal peeling happens, this will usually be arrested at the firm transverse ridge which is formed by the triangular ligament on the vaginal wall. As a consequence the anterior fornix becomes a loose sac, hanging away from the cervix, into which the heavy distended bladder falls; the tissues shortly become relaxed, and then the bladder, full or empty, permanently occupies the vacant space.

Operations Suggested.—Many operations have from time to time been suggested or practised for the relief of cystocele. All of these have been more or less inspired by Marion Sims's original procedure. Emmet's anterior colporrhaphy is only an enlarged Sims's operation. Winckel's method differs in detail, but the principle is similar, and the same may be said of Dieffenbach's and A. T. Reamy's operations. I also have described an operation for the relief of uterine prolapse complicated by anterior vaginal prolapse. Now, with extended experience, and I trust a juster recognition of the proper procedure in treating cystocele, I have abandoned all these methods. I know that for uterine prolapse, incurable except by operation, hysteropexy is vastly superior to any variety of colporrhaphy; and I believe that for anterior vaginal prolapse Stoltz's operation remains as the only reliable method of cure.

Method of Operation.—Having the patient placed in the dorsal position, with the knees well flexed and the labia separated by assistants, I introduce a sound within the bladder, and displace the viscus as far downwards as possible. I then seize the anterior vaginal surface with vulsella or catch forceps, and drag it downwards. A superficial circular incision, varying with the size of the cystocele, is marked out. A large Hagedorn needle, held in a holder, and bearing a stout silk thread, is introduced half an inch below the meatus and slightly to its right side; the needle is carried round outside the marked line of incision, and the suture is kept as much buried as possible; it finally emerges to the left side of the point of entrance. The denudation is then made with a scalpel, commencing usually at the margin near the meatus, and terminating at the line nearest the cervix. When the tissues are non-cicatricial and loose, the handle of the scalpel or finger will easily separate the greater part. Should there be any threatening of hæmorrhage, slight tightening of the ligature, by raising the ends of the thread, not drawing on them, controls it. It is very rarely necessary to apply catch forceps, and inadvisable, unless really requisite, as I think it lessens the chance of accurate adhesion of the denuded surface. After finishing the denudation, the sound is withdrawn from the bladder, and, having thoroughly bathed the raw surface with perchloride of mercury solution, a clean sound presses the denuded part upwards and inwards. The circular ligature is pulled tight and firmly tied. Should there be any puckering at the edges of junction, showing raw surfaces, two or three fine chromicised catgut stitches are introduced. The silk thread is left *in situ* ten or twelve days, when it is removed, or may then be cut short near the knot, and allowed to come away of itself. In some cases of cystocele I have supplemented Stoltz's operation by a plastic operation on the posterior vaginal wall and perineum. For operators unaccustomed to Hagedorn's needles, a handled needle, curved on the flat and with posterior notch for reception of the thread, may be found more manageable.

The Advantages and Results of Stoltz's Method.—The advantages of this modification of Stoltz's original operation are: 1. The amount of tissue to be removed can be more accurately determined. 2. No hæmorrhage obscures the field of operation. 3. No retraction of tissue occurs, as happens when denudation is effected before introduction of the ligature. As to the results of the operation, Mundé says, "In no case have I seen the cystocele return after this operation." Dr. Heywood Smith, in reply to my inquiry, informed me that since publishing his first case, he has only done Stoltz's operation two or three times. He has seen it "fail to heal properly, but then it granulates well and produces some contraction." He adds, "I still think it a good operation, as it takes shorter time than most of the others, and I should try it again."

I append abbreviated notes of three illustrative and very testing cases:

Case I.—Mrs. P., aged 52, married at 25, seven children; her first child was born nine months after marriage. Shortly after her convalescence she observed some "falling down." She had four other children within the next five years; the downward displacement seemed to get worse after each childbirth, but she did not wear any instrument all this time. After the birth of her last child she miscarried at the fourth month. For upwards of fourteen years she wore a pessary, which only gave partial relief. In July, 1891, "the instrument was changed for a rubber ring," which "kept up, but the swelling in front came down below it." On October 7th, 1891, the following note of her condition was made: "Os split bi-transversely, lips everted, blue, and congested; mucous membrane exposed. Uterus retroverted, length of cavity 4 inches. There are cystocele and rectocele. The bladder prolapse has been noticed for over twenty years." She was admitted as an in-patient at St. Pancras Dispensary, and I operated on November 9th, 1891. The cervix was enormously swollen and greatly congested. An Emmet's operation was performed, the sutures used being strong chromicised catgut. The cystocele was then dealt with as described above. Finally the rectocele was attacked, colpoperineorrhaphy being done. One circular suture of silk, five silkworm gut, and seven chromicised catgut sutures were employed, the chromic being used in the vagina, the silkworm for perineum. The patient

[1] Read in the Section of Obstetrics at the Annual Meeting of the British Medical Association held at Nottingham, July, 1892.