PART III.

MEDICAL MISCELLANY.

Reports, Transactions, and Scientific Intelligence.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

President—WALTER G. SMITH, M.D., F.R.C.P.I.
General Secretary—J. A. SCOTT, M.D., F.R.C.S.I.

SECTION OF SURGERY.

President—F. CONWAY DWYER, M.D., P.R.C.S.I.
Sectional Secretary—C. A. BALL, M.D., F.R.C.S.I.

Friday, February 26, 1915.

THE PRESIDENT in the Chair.

Living Exhibits.

Case of Double Congenital Dislocation of Hip treated by Lorenz' Method.

MR. W. S. HAUGHTON, in showing the patient, said the treatment had extended a little over two years, which was about double the normal time required. The delay was due in the first instance to gastric attacks, and then to an attack of measles. Double dislocation cases always take longer to treat, as the stages have to be gone through more gradually. Skiagrams before the treatment and during its progress were exhibited, and attention was directed to—the relation of the head of the bone to the acetabulum; the development of the bone; the development of the femur; the development of the acetabulum.

Case of Double Congenital Dislocation of Hip treated by Lorenz' Method.

MR. W. C. STEVENSON showed a child who had been treated for double congenital dislocation by the Lorenz'

method. He said that the left hip was easier to reduce than the right, and it was also found easier to keep it in position. The right hip had only recently been taken out of plaster. Massage treatment was now being carried out in order to develop the strength of the leg.

Case of Arthroplasty of the Knee for Bony Ankylosis.

MR. SETON PRINGLE, in showing this case, said he believed it was the first one of the kind done in Dublin, and it had been a hopeless failure. The man, some two years ago, had accidentally stuck a penknife into his knee-joint. The joint became septic, and nine months afterwards he had bony ankylosis, and his leg was almost at a right angle. He had been reading of Murphy's work, and he decided to try arthroplasty. The technique was carefully followed. The essential points of the operation were to remove the old articular surface and remodel the bones, and then turn in from the tibia and femur flaps to cover the bones. The leg is then put up with an extension of 20 lbs. on it for from three to five weeks, after which time the patient should be allowed to develop active movement. When the patient shown was allowed out of hospital he had a fair amount of movement in the joint. He wore a splint and used crutches for some time, but about four months after operation he gave the joint a wrench. There was now very little movement in the joint, and it was very painful. *X*-ray photographs of the joint before and after operation were shown.

He believed the operation could be done with a successful result. Murphy had not published a long list of results, but stated that a large number of cases did well, and that others did not do well.

THE PRESIDENT remarked that the operation was very new in Dublin, and even the evidence furnished in this case, although the result was not absolutely ideal, was valuable.

The Rôle of the High Pressure Frequency in the Treatment of Tumours of the Bladder (illustrated by intravesical photographs).

MR. ADAMS A. MCCONNELL read a paper on the above subject. He had treated several cases by this method since he learned the technique from Beer in New York three years ago. After relating the histories of four cases, and illustrat-

ing the course of the treatment by intra-vesical photographs and by radiograms he came to the following conclusions:— The high frequency current is the method of choice for the treatment of vesical papillomata which are small in size, apparently benign in nature, and in patients who are not good subjects for an anæsthetic. It relieves the symptoms and checks hæmorrhage from inoperable carcinomata of the bladder. It may be used with advantage as a preliminary to operation in patients anæmic from much bleeding. After operation it should be used to remove recurrent growths as soon as they can be seen with the cystoscope. He advocated the removal of villous tumours by operation and routine cystoscopic examination at intervals of a month for some years afterwards. It was irrational to wait for symptoms before making a diagnosis of recurrent growths, for papillomata may remain in the bladder for long periods without producing hæmorrhage. Mr. McConnell demonstrated the working of the apparatus.

THE PRESIDENT said he believed this to be the first communication on the treatment of the bladder by this method, and if the treatment fulfilled all it was likely to fulfil it would bring about a revolution in bladder cases. The surgical treatment of these cases was not satisfactory, and no matter what method was adopted one was never certain of the complete removal of these tumours. All would, he thought, admit that removal of tumours on the inside of the bladder was not a class of case they liked dealing with. He recollected, some years ago, removing a villous tumour from the bladder, and was very dissatisfied with the operation; but the patient never had a recurrence. In another case, where it was considered that the tumour had been removed with a fair amount of completeness, there was recurrence.

MR. PRINGLE recalled a paper brought forward by him some years ago on the trans-peritoneal method of approaching bladder tumours. At that time it was felt that there was a difficulty about working at these tumours, and it was proposed to open the bladder well in order to see what was being done, and a great advance was made. He had brought forward a case of trans-peritoneal removal of tumour in the bladder, but a year afterwards the patient came back with six tumours. The operation was very nice, and there was perfect control, but still cells seemed to become detached.

He had treated one patient by this method whose tumour occupied practically two fields of the cystoscope, and it was now over a year since the treatment, and there was as yet no recurrence. The treatment did not disturb the patient, and did not cause pain. He would advocate its use in all cases of clinical epithelioma as a curative measure, not as a pre-operative method.

MR. C. A. BALL congratulated Mr. McConnell on the intravesical photographs shown. On one occasion he removed a tumour with the intention of sparking a recurrence if it took place, but no recurrence had taken place, although the case was one in which recurrence was to be expected as the tumour was proved to be malignant. With regard to the question of recurrence of these tumours after operation, he mentioned a valuable suggestion—*i.e.*, washing out the bladder with an antiseptic strong enough to kill any cells that may be left after the removal of the tumour. This, he thought, might diminish the possibility of recurrence. Observation sometimes suggested that these tumours grow rather slowly. He recalled one case in which the bleeding first occurred five years previously. In another of his cases the patient bled two years previously, and again twice at the end of two years, and the tumour in this latter case was scarcely the size of a walnut. He considered that a tumour might be present for a long time before it produced bleeding.

DR. CROFTON asked if radium tubes had been used for treating these tumours, as it struck him that they might be malignant.

MR. BLAYNEY joined issue with Mr. Pringle as to the ease of the trans-peritoneal operation. The ease depended upon the constitutional habit of the patient. If the patient was thin it was easy enough, but in a fat subject it was a difficult procedure, and the suturing was difficult. He considered that the high frequency method should be recognised as the one for dealing with papillomatous tumours.

MR. MCCONNELL, replying, said the method had some disadvantages—the principal one being that one could not assert definitely by cystoscopic examination whether a tumour was malignant or not, and to use the method for malignant tumours would be criminal, except that it was considered that operation was not feasible. In all cases where the diagnosis could not be made sure of the patient

should be operated upon. The method was a slow one, but he hoped to shorten the time in future by following his own method. He thought the right procedure would be to cook the tumour all over, until it was white, at one sitting. This he intended to do in future. He had seen Young operate on many tumours (he used the apparatus before operation), and his procedure was the trans-peritoneal for tumours anywhere in the bladder, except in the vicinity of the ureters or trigone. He considered that the difficulty in the practice of this method was to keep the intestines out of the way. He had not so far used any apparatus to fix the cystoscope and camera in position, but he was making arrangements to do so. The real value of the photographs was to show the position of the tumour and its extent. He thought the amount of bleeding was not in proportion to the rapidity of the growth. It was, he suggested, as important to look for the tumour afterwards as to operate in the first instance. Radium tubes had been used for these tumours. He recalled a case treated by the high frequency current in which the tumour recurred and became malignant. The patient was then treated with radium which eased the symptoms, but a cure was not claimed.

SECTION OF OBSTETRICS.

President—M. J. Gibson, M.D.
Sectional Secretary—Gibbon FitzGibbon, M.D., F.R.C.P.I.

Friday, March 12, 1915.

The President in the Chair.

Exhibit.

An Unusual Degeneration of the Cervix.

Dr. Alfred Smith said that the patient, aged sixty, the mother of sixteen children, consulted him on account of a profuse slimy discharge. The menopause came on ten years ago. She enjoyed good health up to August last, when she noticed a slimy discharge coming from her vagina. There was neither hæmorrhage nor pain nor offensive odour. On

making a bimanual examination, the vaginal portion seemed to have disappeared, the margins being flush with the vaginal vault, the os being so dilated that the index and middle finger could easily be passed in. The impression conveyed was that there was no internal os, that the cavity of the uterus was greatly dilated; the mucous membrane felt like velvet pile. This slight palpation caused hæmorrhage. On curettage, large quantities of brain-like matter came away, as in cancer. The pathologist reported non-malignant. A simple panhysterectomy was performed. The total length of the uterus was 12 c.m., fundus 3.5 c.m., cervix 8.5 c.m., greatest width 6.7 c.m. The fundus of the uterus is normal, but the cervical portion is greatly thickened. On section, this thickening is seen to be due to the transformation of the normal muscle wall into a spongy mass infiltrated with mucoid material; this mucoid material is directly continuous with a large amount of mucus in the cavity of the cervix. This change affects the whole contour of the cervix, though it is more marked in the anterior and left wall. The remains of the true cervical wall are represented by a thin layer of fibro-muscular tissue. No evidence of malignancy. The specimen is in the nature of a channelled mucous polypus, but is remarkable in that it engages more or less uniformly the whole of the cervical wall.

Dr. E. Hastings Tweedy said it seemed to be an adenomatous condition of the mucous membrane, something like a mucous polypus, spreading over the entire surface, and, when one considered it, if the disease that brought the mucous polypus into existence was present, why should it not attack the whole cervix?

Dr. R. J. Rowlette said he had never seen anything like this exhibit. It possessed remarkable similarities to the glandular structure found in mucous polypi. From the little he had seen of it he would be inclined to agree with Dr. Tweedy, but why a tumour should sometimes be so confined and at another time so diffuse as this was a problem.

A Note on the "Dublin Method" of Conducting the Third Stage of Labour.

Dr. T. P. C. Kirkpatrick investigated the claim put forward that the method of conducting the third stage of labour,

known for so long as the "Dublin method," had originated in Dublin. He showed by extracts from the Midwifery of Fielding Ould, published in Dublin in 1742, that this method was not then taught by him. After Ould, the next work on Midwifery by a Dublin writer was that published by Foster in 1781; yet even in this work the "Dublin method" is not clearly described. In 1768, however, John Harvie published in London a short pamphlet, in which he gave a clear and exact description of the method. It seems probable, then, that Harvie was the first to describe the method, and that subsequently it was adopted as the teaching of the Dublin Lying-in Hospital. Though the Dublin School may not be able to claim the honour of having first described the method, yet that School deserves every credit for so early recognising its value and for so consistently teaching it.

Dr. Purefoy said he thought the idea of robbing the Rotunda Hospital of the credit of producing a practice which obstetricians all the world over admitted was a markedly safe practice might have been left to some one else. That Dr. Kirkpatrick had succeeded in the task he for one was very unwilling to admit. He was the happy possessor of Ould's book; he had not studied it with sufficient care to be aware of his views on the management of the third stage, but at any rate the Dublin School has been credited for a very long time with being the originators of this method of management of the third stage. In Spiegelberg's Midwifery that author alludes to it as the Dublin method, and his allusion to it left no doubt on his (Dr. Purefoy's) mind that it was generally recognised as such. The fact that Dr. Harvie described the method did not at all prove (although he must be given full credit for having used it in his own practice) that it originated in England. Whether Dr. Kirkpatrick had tapped all the sources of information on this point he did not know, but he could not help thinking that this practice had been known for a very long time, and in those early days they were not so keen to support their claims as the originators of many excellent practices in midwifery because it was considered that those claims were generally admitted. He hoped that he might obtain evidence that this method of treating the third stage was in general practice in Ireland very shortly after Sir Fielding Ould's book was published. He thought it should be possible to find that this was the practice, although not

specially alluded to, because it was generally recognised. He was still unwilling to give up the practice of speaking of this as the Dublin method, and he considered it a pity that they should be deprived of the credit of what he believed to be the practice of the Dublin School for a very long time. Many of our most cherished and widely received beliefs and opinions are based on tradition, and ecclesiastical writers have often pointed out the danger of depending on *ex silentio* arguments.

Sir William Smyly said they should feel very much indebted to Dr. Kirkpatrick for his careful research into this question, and there was no doubt that the description published by Dr. Harvie was what was now generally known as the Dublin method; but he thought that in most of the discoveries in Medicine the credit was more often given to the person who popularised the method than to the person who first described it. The method appeared to be only mentioned by Dr. Harvie, and he did not even appear to attach much importance to it, as he placed two other methods before it in his book. Whereas in Dublin it was exclusively and systematically taught for generations. He mentioned that when Spiegelberg visited this country he wrote a report in which he said that the two things which impressed him most were—the Dublin method of the delivery of the placenta and the use of chloroform in Edinburgh. He did not think Credé's method was the same as the Dublin method, as his method was much more active and designed to get rid of the placenta as soon as possible; and he advised that it should be expelled with the third pain. Sir William Smyly thought the very best method was the one referred to as being practised by primitive people—*i.e.*, sitting in the crouched position and rubbing the hypogastrium with the hand, and he suggested that the Dublin method was an adaptation of that. He added that after having tried different methods for the management of the third stage, he had come back to the Dublin method as the best.

Dr. Tweedy said that all Dublin obstetricians had been accustomed to look upon Sir Fielding Ould as the founder of the Dublin method of dealing with the third stage of labour. The method is not described in Ould's book. This book was, however, written when the author was only twenty-one years of age, and before he had acquired any practical experience in obstetrics. He did not become Master of the

Rotunda Hospital for sixteen years afterwards. It is, therefore, quite possible that the method described by Harvie originated with Ould, and he (Dr. Tweedy) thought they would be fully justified in believing in the tradition as to the origin of the method.

PROFESSOR SMITH said the late Sir Arthur Macan had asked him some years ago to go through the literature to ascertain the claims of Dublin to this method, but he could get nothing but tradition to support it. Sir Arthur Macan, although very much in favour of German methods and literature, was convinced that this method originated in Dublin. Harvie's book did not come under their notice at the time. He agreed with Dr. Purefoy that the case was not proven. He pointed out that Credé had found that expressing the placenta quickly after birth was followed by hæmorrhage, and in order to prevent this he recommended that at the tenth uterine contraction the placenta should be expressed. At the same time the practice which is known as the Dublin method of managing the third stage was carried on in Dublin by Sir Fielding Ould.

DR. ASHE said he did not think it made very much difference whether the case was proven or not. He considered that when a method was taught in a place and the name of the place was attached to it, that place deserved the credit. This method was known throughout the world as the Dublin method.

DR. KIRKPATRICK, in reply, said it was no pleasure to him to take away any credit from the Dublin School or from the Rotunda Hospital. The record of the Dublin School of Midwifery was one that any country might be proud of, and was, he believed, one of the best records of any department of Irish Medicine. Historical accuracy was, however, a thing greatly to be desired, and the Rotunda Hospital does not need to base its claims to greatness on a suppression of the truth. Many of those who have written on this subject appear never to have seen Harvie's book. M'Clintock mentioned the book, but said he had never seen a copy of it. Jellett makes no mention of it at all. Had this method of conducting the third stage of labour been the teaching of the Rotunda Hospital when Ould was Master, from 1759 to 1766, it would almost certainly have been described by Foster, who was Assistant to Ould's successor in the Mastership—William Collum. Foster, however, does not describe the method.

Alexander-Adams' Operation and its Results.

Dr. D. G. Madill reported the after-results of cases, and described the method of doing the operation with a single incision.

Professor Alfred Smith said it was pleasant to hear good words about an old academic operation. Dr. Madill had brought forward a record of 250 cases done at the Rotunda Hospital in four years, which showed that there was a good number of suitable cases for the operation. His own experience was that the type of case suitable for Alexander's operation hardly required an operation at all. In the type of cases suitable for this procedure it was found necessary to either introduce a pessary or to do an operation Patients who came into St. Vincent's Hospital complaining of backward displacement, menorrhagia and menstrual pain were first examined under an anæsthetic. If the uterus was found to be mobile a simple method of replacement was adopted by applying the weight of the ordinary Rotunda douche, which usually brought the uterus through the Bozeman's catheter into position. The patient was then put back to bed and examined on the third day; the uterus was usually found to remain in position. In that type of case the Alexander operation was usually performed. That Alexander's operation gave good results in a certain limited class of cases he agreed, but he thought it would not do so if the uterus was enlarged. If a case was one for operative interference an operation should be done with which one could be satisfied that he had done the best for the patient, and not one that was doubtful in its results.

Dr. Hastings Tweedy said he considered that few would disagree with Dr. Madill if once his premises were allowed; but neither Dr. Madill nor anybody else could say that he had not been mistaken in bi-manual examinations, and it was the possibility of these mistakes which robbed Alexander's operation of its value. He could not agree with Professor Smith that Alexander's operation was easy. He looked upon it is easy for the expert, but difficult for the novice. Personally, he favoured the operation of ventro-suspension, but his results from vaginal suspension have also been good. Thus he had received replies from nine patients on whom this

operation had been performed. All expressed themselves as having been improved, and four had become pregnant and delivered themselves normally. He thought Dr. Madill had curtailed the application of the operation greatly when he suggested that it should not be done for sterility.

Dr. Gibbon FitzGibbon thought that any operation for the cure of retroversion of the uterus would produce as good results as the statistics brought forward showed. He agreed with Dr. Tweedy that there were no complications after ventral suspension. He had followed up a good many of his own cases, and had never found any trouble arising afterwards in pregnancy or parturition. The number of cases which he had come across suitable for Alexander's operation was exceedingly small, and if sterility was to be excluded they would have been further reduced. Out of seven cases in which he had done vaginal suspension during the child-bearing period, one of them afterwards had twins and two others had single pregnancies, without any complications. He considered that a number of cases of retroverted mobile uterus do not cause any symptoms unless there is trouble in the tubes, in which case ventral suspension enables an attempt to be made to correct the cause of the sterility. It was astonishing the number of times one came across adhesions of the tubes in cases with a mobile retroverted uterus with practically no such thickening of the tubes as would be palpable by bi-manual examination.

Dr. Purefoy said he felt indebted to Dr. Madill for the well-reasoned statement of the case put forward for the Alexander-Adams' operation, and he was certain the paper would be considered an important contribution to the literature of the subject. Dr. Madill had pointed out to them the points of chief importance in the successful performance of the operation. He had pointed out the dangers to avoid and the drawbacks to the procedure. Dr. Madill had stated that it was a safe and justifiable procedure in a very considerable portion of the cases met with, but wisely abstained from comparing it with the results by other methods. He (Dr. Purefoy) recollected that during his Mastership at the Rotunda Hospital this operation had not come into general use there, and he was against it because a woman came into the hospital and said that that was the third miscarriage she had since she had this operation performed by the inventor

in Liverpool. He had on several occasions since seen the operation performed in the Rotunda Hospital, and he was very pleased with the facility with which it was done. He confessed that he had a leaning towards the operation of ventral suspension, but he thought Dr. Madill's statement was a powerful one for the operation in the cases he had indicated.

Dr. Solomons said it seemed to him that there were certain definite cases where the Alexander's operation was very suitable. In cases of prolapse of the uterus, in addition to plastic work by the vagina, he considered the operation very useful. In cases in which the retroversion occurs *post-partum*, and where palliative treatment fails to produce a cure, an Alexander-Adams' operation was most suitable. He suggested if either Alexander's operation or ventral suspension were properly performed there would be very little difference in the results. He considered that one of the prime arguments for an operation for the cure of a simple retroversion consisted in the neurotic symptoms which often followed the insertion of a pessary. He thought that no operation should be attempted if it was necessary for the patient to continue wearing a pessary after the operation. He found that the Alexander-Adams' operation was effective in producing a cure without inserting a pessary afterwards.

The President said that in dealing with mobile retro-displacement three classes of cases generally come under consideration. First, the unmarried woman with uncomplicated retro-displacement. The patients in this class have no symptoms which can be attributed to displacement, and correction of the displacement is not unnecessary. Secondly, the married woman who is bearing children and is suffering—as a considerable number do—from retrodisplacement complicated with descent. The uterine descent in these cases is associated with definite discomfort. Examination under anæsthesia and the absence of history of infection enables adnexal trouble to be excluded, and in these cases vaginal repair with correction of the displacement by the Alexander-Adams' operation give excellent results. Thirdly, the married woman who is sterile. In those cases if an operation is performed for the cure of displacement, it ought to be one which allows of examination of the tubes. If a transverse incision be made the tubes may be examined and treated and the

Alexander-Adams' operation performed without difficulty. He prefers the Alexander-Adams' operation to ventral suspension because relapse is not so liable after parturition, and the position obtained is more normal.

Dr. Madill, replying, said he had seen Sir William Smyly doing a modified Gilliam's operation that morning, and it appeared to have most of the advantages of the Alexander, and in addition there was the extra advantage of seeing the inside of the abdomen. He had no experience of Professor Smith's method of bringing the uterus up, but what was done in the Rotunda Hospital was if the uterus remained forward when brought into position it was taken for granted that there were no adhesions. Two administrations of an anæsthetic were not necessary, as examination could be carried out under an anæsthetic, and the operation decided on could be gone on with. He admitted that a weak point was that one could not be absolutely certain, but he was glad to have the support of the President that one could be fairly certain after examination under an anæsthetic. He admitted that a certain amount of practice was necessary to become expert at the operation, but this could be said of all operations. He had nothing to urge against ventral suspension, except to doubt that the uterus remained in position after confinement. He remembered more than one case in which the uterus retroverted again after suspension. If there was no recurrence he was certain it was a better operation than the Alexander-Adams'. An important point, he considered, was that nearly all his patients expressed themselves as satisfied, but none of them were done for sterility. The results of the Alexander operation were good after confinement, and that was a most important point. There were, he thought, quite a large number of cases apart from sterility in which the operation was suitable. There were, he knew, a number of cases in which there were no symptoms, but all the cases recorded by him had symptoms. The pessary was put in for two or three weeks only, and he thought this might be done with advantage after all operations for retro-displacement.