GYNECOLOGICAL EXPERIENCES

THESIS

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Gynaecological Experiences.

Of much operative work as has fallen to my lot as a General Practitioner although I have had, and can look back on, experiences in General Surgery with peculiar interest and genuine pleasure—if not always unmixed—experiences which I would not have missed passing for anything—yet, I think, I may safely say, that the gynaecological has largely overshadowed the other. Of course, in such a position as mine this has been no matter of choice, but has resulted quite simply from having to face things as they came, and conscientiously utilise the best of what did turn up, both for patient and self, so that we might learn something for the benefit of future cases.

Looking back, as I now do, over some twelve years here one has to deplore the comparatively few opportunities of seeing the men who have done most in this special Department at their work. In this country it is much more usual for the General Practitioners to become a sort of handy-man than in the Old Land, though even here the
The patients who can afford it naturally gravitate to the cities and centres where there are those devoting themselves to expert work in the different branches.

Recalling to mind my student days in Edinburgh (1884-9) I must confess that through a diligent attendant on clinics and ward duties, as a laboratory fellow in the University Entomological School, where we had the opportunity of making various examinations under chloroform or ether, and of operating freely on the animal condition of the patients, discussing the diagnosis, causation and treatment, I never saw any surgical operation actually performed except one, and that was during my earlier student days probably in 1884, when (as I believe, the only occasion of his operating in the large surgical theatre, which I need scarcely add was that day packed) I saw the late Dr. Thomas Keith, assisted by his son Dr. Ewing Keith, without his own larynx as a laryngologist, remove a large multilocular bronchial abscess, the pedicle of which he severed. I remember the emotion of that day for though aware, from pamphlets distributed to us in his class in obstetrics, that Sir Heiliday then Dr. Lorson was
was doing similar work, I here saw another gynaecologist operate, whose name is famous even to this day, and that of Dr. Thomas Neil and I doubt not, will long remain open and memorable, in the Edinburgh Annals of abdominal surgery. That day I particularly recall, together with one in which I first saw Professor Annandale amputate a thigh by transfusion, and one in which I saw Dr. Joseph Bell operate when I first was a dresser in the Royal Edinburgh Infirmary. The surgeons were then using the spray for operations and dressings, with the exception of the two I have mentioned, who were both using the irrigator with solution of hydrochloric acid, but I cannot be certain at this distance of time, whether the quantity I have mentioned, was due to the spray or not, probably not. The other fact I remember well for the man who was in my "pact" was a case of the late Dr. Wilson of Hindeford, I mind, and at that time patient of Joseph Bell's who as a special mark of favour made Dr. Bell take his irrigator charts, thus enabling him to be always to the fore.

A few years later in going down to Gloucestershire as an assistant to a man
Now as I was doing a practice of some £1500 per annum the only operation I
had really, were one of Peritonitis Th ready, and one in a boy who had sustained a
very severe depressed fracture of the vault,
due to a kick from a horse causing much
laceration and necessitating the digging out
various detached fragments out of the cerebral
substance; though he had many convulsive
attacks for days which gradually diminished
in number, he ultimately did well, making a
good recovery. This was all the surgery in
the twelve months until, by way of
contrast, I may mention that I did during
1905, seventeen cases of Radical Cure of Ulcer,
in adults and infants (counting double cases
as two), then having decided to see and in
at least two different practices I went to
a very good man with a fine practice—
Dr. John Stowe, who was one of the honorary
surgeons to the Huddersfield Infirmary, where
in 12 months I saw a good deal of surgery,
but no pathological work, though a little
was being attempted there, by Dr. Lillicr who
had done several Abdominal Sections. In the
private practice a very large and good me
ues we had not been a meeting in 15
minutes, and this are managed to do without.
I cannot now think, though I can recall
patrons yet, who right I have been done,
and many I feel certain suffered much,
from being deprived of that slight attention.
Such neglect would not be long tolerated
in this country where there is little, if any,
remnants of the prejudice against change of diet,
as little indeed, so there is reverence for a
family attendant. Practitioners have naturally
accommodate themselves to local ways, and in
spite of more frequent changes in the clientele,
we get as well among ourselves as they
do in the old country. For such usage necessarily
cuts both ways, and I think, we feel that if
why we have been paid for where we have done,
the patient is welcome to bring his next advice
where he will.

Coming to this land for a sea-bird
as health reasons accenuated avoiding a lime build
and London area for twelve months, and finding
climate suitable, then got settled by practice in
my own little corner here and fortunately does
not grow less, though responsibilities grow greater.
With increasing confidence however, he does mak
A more frequent call on sick energies and powers, and can better afford favour with 
appreciation the leading weight of responsibility which 
 accompanies it. For there is no doubt that the 
 tendency with the general practitioner to evade this is 
greatly fostered by the knowledge that he is so near 
those of more experience, on whom he may not so 
frequently call, feels both to protect himself, as 
less than to benefit his patients, but away from 
those centres where he is absolutely than in 
his own resources, self-reliance has to be cultivated 
and depended on more early—when it becomes 
possible to get a practical and through grip of 
things not otherwise attainable. Then, once in 
the rails proper is more speedily made, necessary 
improvements observed and defects remedied. If not 
this, then next time, while all the time steadily 
and manipulative skill are being acquired, 
with the requisite strength and confidence to enable 
us successfully to tolerate larger and longer 
procedures. But, though I am inclined to believe 
these notes more particularly to the latter method 
of operating on the pelvic contents by means of 
the vaginal incision, still it may perhaps be permitted 
to allude to other means of procedure which have 
had reason to adopt and to point out how,
now they are now accomplished as compared
with earlier efforts. Any reference to the books
by others to those I have added are the
methods recommended by different men and
loops confusing the study is, the student that
are reading. We two operations that
ever think it more difficult to grasp, or more
fulfilling, to study the different details and
diagrams of them, those of medical etymology and
perineurology. Now, though here so far back,
the inducements to literary effort are not great
and there are two pretensions to which I desire
to make no claims, and which I shall make in
later, the task has come to me to write down,
and I will do it plainly as it is, and am
actually carrying out, step by step, the procedure
I have found most successful, and the
methods of performing these and other operations
which have yielded in my hands the best
results. In as wise wishing to communicate to
any who have had as much or more experience
than myself, and granting that many can
give some points—still, with so much undeveloped
literary ability, and being never especially
scientifically inclined, having only eyes and
ears for a factual & useful point, I am
am endeavoring to put into a thesis, the facts learned during the ordinary exigencies of my daily round.

I apologize that I have no historical, digest, or literary compendium to present, though it be possible to dispense with one & I am very thankful the necessary accessories are not available in any case.

Moreover, I am painfully aware that the penman of this volume will reach no fresh scientific fact still the opinion of some of the medical world is scientifically adverse - even in what I feel & I can rejoice for some of us, an atmosphere other than that where so many can usefully walk is necessary, they working under circumstances so different, and yet no perfectly be directed in prepare with us an e. i.e. in laboratory research.

Something has often to be wanted & sometimes deliberately, sometimes without deliberation according as the circumstances demand. But for perhaps in the middle of the night one finds a woman pallid, restless and gasping for breath and presses hurriedly inresponse the result of atomic while remaining fragments why help up a toy
For being dead in me also has for some reason no other suffered in it may be, in several days mutual assistance; in such a case there must be no delay — there is immediate necessity to clear all the debris and peevish of the paper baggage, and such cases are all meet from time to time. As an instance I found a poor young wife had a baby so terribly and studiously treated, that I could only believe it to be due to illegal interference with criminal intent, in another after having to go a good long journey in the night inquiring for help the only available female presented herself only to beg to be excused, tendering any and in the plea that she was herself pregnant. Here was nothing for it had to get the husband in and he held the sheeling and the candle, while I made a thorough clearance with a good sized corkette after doing her suit right and sheeling having previously removed the chemicals etc. and finally getting her warm with the foot of the bed clapped. In such cases I have found a salutary saline transformation to be immediately helpful (Sake 10 in a pint of boiled water, e.g. lumps 100 ft.).
and I keep the required apparatus—glass funnel, rubber tube and needle (the two for aspirating case) handy for such purpose. Both these patients did well—indeed, it is surprising how quickly such cases improve. No preparation need be made in these unforeseen emergencies. I at once, with sterilised gloves on, wipe the vagina sufficiently & pains & strain of the cervix, while the antiseptic cells are laid hold on by a straight obturator, then changing the speculum for a short, needled retentor, wash it more thoroughly, effectively removing all clots & debris; then after passing the sound to ascertain depth and direction if the large curette will not go in & insert any time's three- or four-bladed dilator and gently stretch after which it enters probably with a slight give, when & withdraw it emitting me out of the internal os, and re-introducing repeat this several times going all round, after which it enters easily and also freely permits exit. In this manner the need for thoroughness was quickly imparted as some years ago by a case which & emitted, removing a large amount of debris. Next day I was informed the patient had suffered
suffered considerably from pains in the right of the abdomen. The
woman stated that she had had relief, since passing something which on
inspection proved to be a foetus, the length of an inch and a half.

The same lady, after the operation, was again engaged, and also as a nurse, when however the 8th month arrived, her husband called
on me, and requested me to see her, as he judged things were not quite right. Examination showed that she was not pregnant at all,
although she was confident she was, and quite sure she was having false movements in search of birth.

After clearing the cervical region, I then ran the curette right to the fundus, and
found that the curette seems to pass through or
engage in another contraction, but probably this is caused by the retained masses
being placed high up near the cervix,
and the upper spout of the uterus making some irregular contractions to try and expel
the same, or again it may be due to some fleshy associated with the very
very considerable elongation of the cervical region. This makes it necessary to go very cautiously in such cases, since owing to the great depth the curette may be its whole length in the cavity. Nevertheless, this work must be carried out skillfully, and the required time and effort put in—i.e., securing perfect evacuation—and as this is secured, the uterus often expands down and the curette can not be got in so far this always giving one confidence that have proceeded in my task. In this manipulation, careful insertion of the curette, which is held in the palm of the hand loosely but under the perfect control of the thumb and fingers, and the slight antero-posterior motion as the downward sweeps are made, or it may be lateral motion downward from the cervix and these combined persistently till the well human impression, but to touch and sound, given only dry retia, wall is recognized. Should there be a retroversion it is sometimes well to find an extra bend in the flexible curette, especially if the implantation seems to have been in the lower segment of the uterus.
and to practice even more freely the external palpation movements. Before finishing I have got into the habit of always using a small curette that has a slight curve in it, which I gently apply to each of the colons, as into these the large we might and have quite sufficiently entered. I gently emulsifying any tendency to drain of the layer, any slight colic, or attending to any indolence hypertrophy in that region, then I give in such a case a warm friction about the general generally with forceps, using as Ramon'sca's saltwater, emulsifying with a good wash out of the vagina. It is then only necessary to see to the patient's comfort and general condition for having made a clean and thorough evacuation of the uterine, everything is now in her favour.

The cases of such haemorrhagic cases have all recovered, but two exceptions to the rule of delivery I cannot just notice. The young cousin of this lady, who has been living enamored to his bed by Euthenia's death for me, having been bad for four days, I found she was running a high
High temperature with delirium, and evident signs of pneumonia. She had nursed two months, had services herself induced a miscarriage, and had been doing very poorly for days, though dragging along to attend to her husband, self, and family. I examined her attempt anesthetize removing a good deal, but was unfortunately too late—she died from septicaemia. The site was the case of dangerous condition, of the inflammation that I have mentioned. The lady in question was employed in a neighboring city, but subsequently removed here, and some weeks later passed what I was assured by her nurse was a placenta, so hurriedly examined that it was not kept. High temperature and delirium indicated the ankle and examination revealed large gangrenous chills with an indescribable smell, hanging through the cavity and entering its interior. No amount of the fullest cries could completely remove this coating—it was evident that much remained in a large fleshy internus, the walls of which were felt were very fragile and made me especially careful lest I should perforate. She lasted also for a few days in a
a very quiet delirium evidently from the septic absorption, and finally succumbed without a sign of Pneumonia.

Then we may operate on an arranged day, with preliminary preparation as I have, say for Deposition, perhaps associated with antacidion or Pethidine. In the case, where there was considerable Pelvis in getting in a small emcelte it went right through the fundus, and could be felt under the abdominal wall, yet very little of touch did not advise me of any uterine wall, when I passed through. As far as I can remember I went and myself in this case, with cutting the cervix in order to give free drainage, but at any rate there were no untoward effects, from the accidental penetration of the uterine substance by the instrument, though the patient was not relieved of her original symptoms. Again it may be had recourse to, on account of Polyphid affliction, possibly of long standing, in spite of the troublesome symptoms. Frequent irregular haemorrhage, slight but liable to occur at any time, especially should there appeare any excitement of congestion, and accompaned by varying expectoration, backache and bearing down.

In at least five such cases I have operated, removing the polypi or polypi as high as possible.
after deixing it then thoroughly curdling. For me
least the polips were two in number, one of which
extended higher to the womb as the other half way
both were pretty fibrous in character. The paient
had been married about two years, and was
pregnant about three months for the first time.
I found she had been much annoyed by
constant backache and bearing down for
considerable time before her marriage. At this time
lately, she had been subject to pains which with
some discharge kept her bed up for three days,
with little sign of puton development, and as she
had no sleep was running a temperature
much affected by nervous prostration, after examing
with a neighbor, I interfered, fearing the danger
of infection too great, and cleared all n.t. This
was some twelve months ago. I saw the paient
quite recently—just returned from a trip to
bomipa, but not apparently pregnant again yet.
Measures may be called for in Retention or
sensation with Indometritis, just to speak of it as
a preliminary to every operation on the lining, lacerated
vagina or even below leg before doing a Farinesherapy,
I should always take the opportunity to curet, it were
there any learned instruction to do an Nme.
Truthfulness in this question involves the question of flatulence, and I may say, that for the last three or four years I have used nothing but extract. I first used silver nitrate with a lead and hitched into a small loop, passed into paper and mixed with my thumb's needle and thus drawn through the use of a funnel's needle, with little drawing through all the values required. Later, this was superseded by the use of a red-wool glycer, which in this particular situation appears to be in little advantage over the others, and is equally difficult to remove.

Lately, I have bought new extract and prepare it in two methods, I have found as reliable as any I have had. A formolin me and the formolin certainly the simplest of methods. I keep it in lengths in tubs with 5% formalized spirit.

A bought preparation - Red cross ligatures put up in sterile envelopes by Johnston & Johnston, I have found reliable, and always keep by me and have used for all sorts, also, be it lowered, made them. These ligatures I use for all purposes unless it be, say, for abdominal section wounds, where silver has its place as also in
in the immediate repair of ruptured Bladder. In ordinary abdominal surgery, Lordship and I have employed in ligaturine an empty tube in both in the tying of all vessels in a nephrectomy and ureterectomy alone. Even in operating in Urethral fistulas by a method I have illustrated in the British Medical Journal, a couple of years ago, namely by scarring each in the long axis with a medium long forceps after tying & cutting down with ordinary hemostatic forceps, forming me stitch with needlei daily deep just above the base of the forceps. I tying, so securing the cutting jaws cutting off the edges and continuing over and over the forceps till the junction of mucous membrane and skin is reached. Then, after clipping off the forceps and tightening the ligature, it is tied, thus leaving a straight vertical incision line and no hemostasis, thus, even in the rectum, where we were taught that rectal wound must stand it is found to answer excellently.

In this operation (Annel’s) it seems to me there is no more important instrument than the bulldog, and I like me which is straight in the handle, with two teeth, half and half, reasonably sized and separated so
so as to try on the principles; then it
must be capable of applying me in both
kinds of the cases at once, without obtaining
the joint. As to needles I used Hume's
ordinarily, then Hume's straight but now have
had some specially made, particularly strong
and with full round curve.

Humes I always6 use at the time,
and as a prerequisite to trephining,
it also dispenses with the necessity for two
operations with preparation and anaesthetic.
It saves time and is equally satisfactory in
every way, while it has one decided advantage
of which I proceed to shall refer. As a
preparation measure the patient is advised to
use a douche with Lysol for a week beforehand
while this is done for the last two days twice
daily by the nurse who also makes the set
ablations, prepares antiseptic emulsions, does
necessary chaining, gives aspirin, followed by
an enema, the night preceding and another the
morning of operation and should thus be
prepared in a private room, sees to the
preparation of the room. All being ready
with patient duly under the anaesthetic &
placed in lithostomy position, by the aid of
Of labour's bruit (unless on the operating table of our little hospital) I insert a short needle-shaped, broad as is convenient, retractor and draw down the perineum, then seizing the anterior leaf of the cervix with vulsellum, give the retractor to the assistant who is seated on my right & pass the sound to ascertain depth and position, insert the dilator and dilate, then introduce the curet, carefully and thoughtfully goring over the whole endometrium. Next, freely swinging away with sterilised gauze all debris and blood, and getting the cervix with its gaping lips clean and dry, I take a pair of straight blunt-pointed scissors and by a straight in line enlarge the deeper laceration say on the left side, then exactly opposite on the right side make a corresponding cut. As the anterior leaf is being held up forwards by the vulsellum, this separates the lips still further, and reveals the new angles at each side one in either lip—angles with their concavity towards the operator and which may be represented as,

though for convenience the view is a side one.
Now, holding at times long scissors, curved on the flat, and with the left first finger supporting the posterior lip near me side, I lay these scissors on it, with their point so disposed to the bottom of the new concave angle of the laceration, as at the edge (times permitting) to remove the new concave angle, which was created by my preliminary straight cut; then reversing the scissors, and presently taking the scissors with the left first finger — if necessary — supporting from above the anterior lip, I remove the corresponding upper concave angle. Thus we should have the old angle of laceration quite cut out, and this has been facilitated and made more certain by the initial straight cut.

If next proceed to break in like Joshua in the other side, making sure that the whole angle is cleared out — i.e. no anterior membrane left from the cervical canal to the new junction of normal cervical anterior membrane, and of the integra cervical amnion, which latter it is, that in its entirety, must be removed. Having made sure of the two angles, the removal of this same membrane is proceeded with to across the whole face of
Of the excised posterior lip, which is aided by counter-pressure from underneath by the left forefinger. An occasional wipe with gauze will also have perfectly this is being done, the uterine cavity and all round, it is well to reach just slightly in the vaginal mucous membrane, leaving a clean cut margin of it for approximation with the corresponding portion of the anterior lip. This satisfactorily carried out, it is next to transfer the vulseillum—me or only being used—to the posterior lip gripping it centrally and proceed to meet the anterior, as was done in the anterior lip, which finished it off, and freely cleansing, make sure that all requisite demulcent is applied. The surfaces being now clear of all clot and debris, a broad shield of the vulseillum or posterior lip—be kept its posterior points acting. Vulsellum-wise, elevate the anterior finally, evert the anterior lip, and being of the same line, so bringing support, has demulcent surfaces into approximation—will the new os protected, which hidden by the vulseillum. Slight regulation of the gauze may perfect this approximation e.g. if the lips are very thick and fibroid, by arriving not quite so
For few weeks—let is with less bile, or try
shaping one lip slightly to right or left,
much may be accomplished, and here
comes in the utility of our trusty friend
the colostomy. Having now absorbed
and cleanse all clear, so that the secretions can
be estimated, it may be noted that
have made special provision for the
lower portion of the cervical canal. I have
not done so for some years past, finding it
unnecessary and not detrimental to the
junction of the canal, while tending to more
perfect union of the cervical body. The feel
of drawing first united with the consequent
slight discharge for some days, and the future
placing of the sutures with a anti, too
close proximity of the two placed relatively to
the vs. I find serves all purposes. Some
years ago I used to insert a chip of rubber
tissue up into the uterine cavity with one
end protruding into the vagina, as a piece
rolled like a joint and sealed by gluton,
but have abandoned all such devices,
finding that the uterine discharge joining
the cervical and the secretion due between
the periods, the discharge attendant an
In menstruation keep the passage open. All the vesicles cease membrane has grown down. The prevention of false, being an inspection between the vesicular periods, with passage of the round - an inspection which, for exer-

ion satisfaction as to the ultimate result, is in any case advisable.

Now with the whole cervix held in the vesellum the next stage is the introduction of the arteries. I threaded four needles before starting and here we at a suitable angle engaged in the needle holder, then grasping the vesellum which is comfortably but not too tightly closed, one by the handle that close up to the cervix with the left hand, the handle lying in the tips of the palm, the has a capital control over the cervix and drawing it a little to one's left, with slight rotation so as to show the under surface in the patient's left, the needle is inserted from below upwards, the cervix being turned down on to the point of the needle through both lips at corresponding points - if not at first easily - then after being half way withdrawn, guided by the left forefingers which can be laid in the joints at which it is
is driven the needle should emerge. This
and all succeeding sutures are so placed as
to pass deeply through the cervical body,
imbired of both lips—such as the obliteration
points hold the whole. The first suture
clings the upper angle, and the second
placed probably midway between No. 1 and
the orbiculum is likely all that will be
required on that side, and if so, I then
proceed to the No. 1 (corrugts is No. 3) so
that it shall lie where tied with a suture's
thread and an extra thread tie, say 1/4 inch
from the angle. I next similarly tie Nos. 2
followed by the insertion and tying. If
the No. 2 is the other side No. 3 near the
right upper angle, and finally No. 4,
which will probably suffice, though
occasionally three are needed on the side
and must be inserted if required. Then
holding all ligatures long I release the
orbiculum and pass the sound into the
wound, to see that the passage is free,
which will likewise be confirmed by some
escape of blood which has been ducted in
temporarily by the orbiculum, while inserting
the sutures and coming from the cicatrise
enraged inflammation, and thus judge the state of the oesophagus. If satisfactory, I cut ligatures to say a rich and right
way. This description, of course, applies to an ordinary case with the application in the most usual site,
and any variation in this situation will require corresponding change in the application of the operative steps. Lead down and allow
cases of this kind have come under my notice. The I recall with special interest in that I had previously assisted the
patient for Placenta Perinix. Some haemorrhage
at seven months with much lassiness on
determination was checked by rest etc. and
followed by a week's rest. The beph
remained, but on her attempting to get
up, soon recurred. Called me midnight
and having knowledge of the case, I put
a band. The in gauge in my bag.
Finding haemorrhage had been twice free
with the slight pains, I little sign of lead,
I placed the ligature between the whole
of any gauge and detained in eight
lines with it. Then I removed the
gaunt, and being prepared got past the
The presenting portion of the placenta and finding dilatation easy, accomplished podalic version, thereby securing an easy delivery and a good recovery. At maturity under an examination showed the cause of the trouble. This was her second child, which, by the way, in spite of easy and rapid delivery was stillborn, so much placenta having been separated, owing to its low implantation. The former child had been born in another state, she had been in labour for full three days and made a very slow recovery. This child a boy, then one three years old was certainly a very big fellow, with a particularly large head. I found the cervical lacerated apparently right up to the uterine body, but it was repaired entirely to the one side—the right.

When delivered we must see which is the deepest, and if we ride corresponds with the other, while found there be two or five quite close to each other—have found it well to excise one small island, with a wedge incision rendering the two adjoining incisions me. The finds
finds great differences in the ease with which
the cutting is done in different tissues—
one cuts easily and very few mishaps occur,
others are tough and almost cartilaginous
in consistence, while some elude the knife,
which must be applied so if too deep
leave the deeper part which is left well
scrapped out with a Vollermann. Occasionally,
I have found it so difficult to make
the scissors work well in a really tough
lip that I have had to resort to an
extractor which in such cases generally
works well, as indeed I think it
served in any case.

Suppose now that there
has been some pelvic trouble than the
operation accounted for, and it has been
determined to explore further to see the
condition of the adnexa, we may proceed
to vaginal exploration and by either the
anterior or the posterior route i.e. the
anterior or posterior approach, which latter term—
approach is perhaps better for general use,
in that while it may seem a less invasive
it does not necessarily involve one, as
for instance in the next case I shall mention.
If these two, I have performed the latter much more frequently, only indeed preferring the former as a step in a hysterectomy or when some large tumor—probably an abscess—seemed to be more directly accessible in that position. The latter case had been operated on in the Melbourne Hospital for appendicitis, and the report was that the appendix was inaccessible and consequently not removed. On being sent for, I learned that the girl had suffered considerable pain and constant discomfort for some nine months, with much urinary trouble—in fact, ever since leaving the hospital. I found a large tumor in the hypogastric region right side region, with much tenderness, and on examining per vaginam the uterus was firm back and to the left—while anterally especially to the right was a very tense and tender gallbladder, evidently a gas accumulation. She was not ready and an anterior incision across, and extended upward, with the finger I try working a little to the right, any fingers pressed into a large cystic tumor just above the rectum, flushed profusely. The opening was gently stretched and
and evacuation encouraged as completely as possible, the irrigated and finally a large gauge drain inserted which was removed after 48 hours. With careful attention and after treatment for some weeks, a complete delivery as far as the second and thirteenth was expected to have been attained.

Seven minutes later the mother miscarried into my surgery and informed me that her daughter had never been well since she had experienced continual trouble with her sick, but that the previous evening she had passed with the same something which she had brought up for my inspection and, which I at once saw was a joint which completely encircled the head just being visible, the joint above on. Unfortunately it had at least become engaged in the right axis of the mother and I was able to say that she had been really well for the past twelve months. This patient is a dressmaker, and my opinion is that she complained the pain that it set up some appendicitis possibly with much adhesion, that it perforated elsewhere in the region of the ileum, whether appendicular abscess,
Access was found or not, or else there must. Probably erosion took place to the right.
Proper treatment, into which the pin-paned,
and all up the closed, which I suspected
for several, but unfortunately its career
was continued through the cervical wall
causing much dysuria which, not
having been invited to investigate—
resultantly terminated happily as selected.

This brings me to

Vaginal hysterectomy

of which I have done three cases. The
first was that of a stout lady who had
to work hard for her living, and suffered
much from a slightly uterine which caused
just above in spite of an anterior photobehavior
and Perineorrhaphy, which she had had
performed in Melbourne. With these
operations, access was not difficult,
and being made by an elliptical incision
round the top of the cervix with series
curved in the flat, and keeping their base
well in the cervical body, then defining
the plane of more time between the bladder
and cervix, with closed points of series, get finger
lip inserted and swiping a few bands was
was able to make it up, easily lifting the bladder
right up off the uterus, and finally perforate
the peritoneum; then clearing the uterus well
naturally, got in few perfusions completing this,
and introducing once the vessels were no displaced
fowards. I then got the patient out the
nce opened, and well stretched and feeling
for the pulsation of the uterine artery I passed
a well curved American needle through the broad
ligament above it, held an inch from the
uterine wall, and holding the ligature down
through the opening into Drayls' pouch, got it
bied down as snugly as possible, then
divided and passed, looping closely the uterine wall.
The same thing accomplished in the other side
I was able to draw down as well, that I could
from the fundus right up with a perfusion and
perilune, allowing the cervix to pass backwards.
then getting a ligature passed through the top
of the broad ligament, so as to occlude the
uterine artery, tightened up, went repeated the
fundus from the remainder of broad ligament
from the tube down, keeping close to the fundus,
and reining the cut stumps when dvided,
with artery forceps, so as to steady and
eased it in case of hemorrhage & tightened
by
Up to the ligature, and having treated the other side similarly, and still more loosely owing to the uterus being only attached in that one side – the sidetrack was completed.

All ligatures were left long, and in fact some haemorrhage necessitated the passing of me and again through the broad ligament and another tie, after which in repeated withdrawing of the sponge-held by amsuch dressing both clearing out all clots and washing down to be dry and clean, the vagina and whence ligatures were tied together in each side, and all cut so as to project for about an inch into the vagina.

Since then and during the past twelve months, I have done other two cases one for maligran disease of the cervix, and one for haemorrhage which resisted all other treatment.

In the former a lady of 64 years of age, slight irregular haemorrhage had been going on for some time on small provocation or exertion, and as it was sitting another member of the household, she mentioned the matter upon which I arranged for an examination which disclosed to touch a slightly fungating mass which felt indurated and to
to sight a mass in the centre of the lip extending up into the cervix, but serene, and much inclined to bleed. In a week later I removed it, but not having so much room, as in the previous case, found it more difficult. As in the first case I took both lips of the cervix in the forceps, and used this through for traction and compression, so to draw to one side as required.

Before applying the artery ligatures I cut a little through the base of the Brach ligament, till I was near the arterial arteries, but some haemorrhage from this region before finishing obliged me to take heart and if the arterial ligatures (this I did) that day broke with me, and put me 4 p. midday ligature; and passing it with the mosquito needle through the parts of Brach ligament I had incannily divided the anteriorly and the posteriorly and no through the cut edge of vaginal mucous membrane, then seizing the veined Brach ligament with hooker dexter it into the blade before tying down. This veins and being so large was more easily burned and led again I had tumble with me of the ovarian arteries - no way of
I removed, and tried to pass a ligature through the fascial ligament once before getting a tie that entailed the haemorrhage completely. The third case was that of a lady aged 79, who complained of much postmenopausal pain in bladder, and her general condition was much affected thereby, forcing her to come for advice. Examination showed a large H/U in deep retroverted uterus with an open os, and a protruding mass from which the fundus and round caused very free bleeding. It was much preferred to think it malignant, and advised complete preliminary rest &c. but in spite of dynamis and estroterine hydrochloride in a week she had had much gained, for the haemorrhage seemed quite uncontrolled as I determined to live no more time, her condition being already bad. Here I used clamps from the stack, but having the utures clamped and division made &c. I could not draw the uterus down to get through the perineum anteriorly, so was forced to ligature this at times before proceeding further—the removal of the prepa giving me more room to work, and I got through. Then came my chief difficulty the
The uterus was so large and in trying to get
it down, I felt like it if it hit the
cervix, however by pushing the cervix well
back & perseverance, I at last got the
funds engaged, but it seemed like delivering
a head, and was only managed by obtaining
successive grips with forceps, one over the
other.
My difficulties with hemorrhage
were much the same as in the preceding
case, both wombs being large and very
crude were removed. Finally getting
everything dry, I was able to get
her off the table and back to bed, where
she got a large sub-mammary saline
transfusion and ethyl alcohol hypodermically.

All had saline rectal injections,
very few hours and an apparent return
36 hrs. after operation followed by me with
traps. if it did not act, and then
sanaetate regularly every day. The whole
three made good recoveries though the last
gave me a very anxious 24 hrs. but
the transfusion seemed to do a great deal for
her. She was fortunately a woman of
particularly even temperament, and of a
consideration we seldom need, for I afterwards found
found that she had distinctly told her friends
that if the case terminated fatally or was not
to be blamed, she was one too, and when
I first mentioned operation warned that all
her life she had declared she would never
submit herself to be operated on.

The above, if the case has had any
trouble since, suggests the menopause, though
how she is and how she is well this point in
her's weight—the suffers severely from fluctuating
vessels, and all these had
the vagina just hourly packed with gauges,
which, when removed in 14 to 26 hours, and
not re-applied. In the third second day gentle
expressing with a bell syringe was employed,
and later, twice daily and more freely—and
through some days later the slight discharge
had become somewhat odorous in spite of
pressing dressing, this ceased—as the lifethines
came gradually away. The areas in the
least of these three cases was very large and
uniformly thickened in its walls, which were from
one to one and a half inches in thickness and quite fibroid in
nature, while on its interior were several open-
combed veins from which, and from a polypus the
haemorrhage seemed to have occurred.
Posterior Colpotomy

This is an operation I have frequently practiced, and for very varied conditions. It seems to me to have an elastic range of utility, and to possess several advantages over other operations done for a like purpose, which entitle it to greater prominence than I have as yet claimed for it.

Ten years ago a specialist from Melbourne operated on me in a case of Dyspsilpinia, by the abdominal route and unfortunately in separating the adhesions, the tube ruptured and very offensive smelling pus escaped out to the sponge. The lady died two or three days later from Peritonitis. Having felt that mass from vagina, it could not help thinking afterwards, had it I had attempted to keep it from the vagina, it might have survived. Today I would undeniably open the peritoneum and the sac, and though I would probably not get it out without rupture, and I knew I could get it up and he did, I even if it did rupture, during my manipulation, I believe the patient would not have had the risks to run with the free drainage, which I could so secure and
and keep up with the aid of gauge. One
five or six years ago, I first attempted this,
and was chanced there be evidence of any
abnormal condition of the uterine arm at
once expel. I always feel as if retiring,
perhaps an hour, may be necessary, and
if so after having got all the stitches in
and had, I remove the speculum and holding
the ligatures as a stay I thrust in the patient's
right, the assistant holding these in her left
arm the sound to judge of the os and
new canal, then recapitulating the speculum
cut off ligatures. I hold the speculum
well forward and swabbing into the patient's
private, I suddenly slip the cervix back over
the speculum, by gently jerking the speculum backwards,
when a transverse fold in the vaginal mucous
membrane is revealed, which indicates the
reflection of the preputium. In Dayton's book,
no just above that, say 1 inch. Now the
meridian be made. This is done with
scissors, after ceasing to bear on the fist,
and holding the cervix well down. Manoeuvr
steadily in the mid line, make a bold cut
through the mucous membrane, parallel is and
slightly higher than where the fist appeared, keeping

Reaching the nose of the retractor directed right forward against the body of the worm, then use a few little feeling ridges - not such as would injure the anterior time, but used and incised time to peritoneum, and a slight stroke with the closed points when probably they slip through it and some of the fingers, which will reveal just where the peritoneum is, and enable us to go through with another rinse in it and managed as able feeling quick it with. Notice directing fingers and cringle through.

Ewing, through these generally produces a similar reflex effect to stretching the fingers and very a long deep audible inspiration. Three through with the retractor open them widely and withdraw, on stretching the opening then inside the finger and if sufficiently free insert his fingers and stretch. As soon as ever the finger has gained entrance the assistant clamped at once withdraw the retractor. Which will quickly will be again required: this period f free digital exploration. Perhaps, there is a large prolated way which is at once encountered and if free jam adheres it
It is persuaded that the fingers should be used. The wound should be dried gently, and the opening should be touched by the index finger, stretching it gently if necessary. Then finger the wound around the pelvic wall until we come to the mesentery. With a slender pair of forceps slightly curved we lay a straight sponge and touch the opening, then stretch it and grasp. With this tool it is brought right into the wound, and the fingers behind it do the rest, bringing it into full view. Now, screw the finger round behind the way, and the ball will be recognized, and easily brought into the opening, it may be, except for some small cysts pedunculated. These may be detached after dividing the pedicle; if not, the pedicle may be recepted through a fine needle used as a stitch or this settles it, and attention may be turned to the wound. Possibly it is getting it into something as noticed to give away, and inspection reveals a ruptured cyst, the opening into which may be enlarged (readjustment of
Of the Jenner, but getting them fixed on to the
anterior part of the eye, is often advisable
at this stage) with scissors, and then the
cavity cleared out with a Hollmann's spoon.
Palpebra will probably bleed more expeditiously
which perhaps the incision may be continued.
Sometimes, if there be much epithelial deflection,
the margin is best laid right open along its
length, and gently, but firmly, all epithelial
remains removed. Should there be much
scars to remove or shorn, the edges be large
after reaping out, the edges of the wound
are frequently ragged and evidently devoid of
mechanism, so I usually trim these with
the sound object is to reduce the way
so that any apparently healthy elements
remain.

These causes any bleeding, and the margin
is clipped back, and the other we sought
and dealt with likewise according to its
requirements which, unless, it be sufficiently
disorganized -- and the age of the patient is
here of course an important point -- many
will for removal. In first meeting
the Jingle adhesions may be encountered,
and these vary much from light and实力
Fairly separated - simply inflammatory lymphatics, varying degree of organization, and will tend to less holding in up the waves and lakes. Sometimes there are found as a laminar mass, the component parts of which are chiefly indistinguishable till a little luincting begins an incrustation, and gives some indication of the direction where further effort may be most advantageously applied. Certainly I have found that mere mere experience of such cases has greatly augmented the manipulative force, and ability to instill inflammatory fluid into the waves and lakes and may be exposed for examination. During such manipulation cysts or lakes may ensue and their contents be disclosed. If, for instance, has appeared and effort made at once the surface, to keep the see with its fluid in as close proximity to the bottom as possible, and to wash away immediately, thereby limiting the likelihood of infection being carried upward. Sometimes if the replaced cyst or lake be fairly large, its rupture practically solves the problem. As soon as the contents are evacuated, it is easily
sensibly goes down sufficiently to be laid which by some few steps, and in probably nearest
or not if only the muscle made
it thus brings the remaining adherens
within reach of the finger, and enables me
to separate same; so that the whole see
may be extended with ease and lighted.

One, or if only, if such a manner is found
or require this, it may be possible to introduce

Another class is one with which I
have had at least twice presents much
bothering of the bladder, it is difficult in finding
place to get a start but when once obtained
the relief of lute and many pains adhering
of a cheesy and almost brittle nature become
easy so much so that I have had both
actually come away in the meep when
was more force than was necessary to Delta
them as scarce and strange to tell in
better case as they are easily from
hemorrhage. The spigot got and
with it enterius that if have felt, but the
The knee. The left fallopian tube seemed to be shortened and felt like a string. It took no further heads. A black fibrous membrane, whether its cause there was in this ease at least, as initial sign to indicate either tuberculosis or pseudocystic tumour, though in another ease of such cut, all the organs within reach were felt to be studded with tuberculous nodules and the patient could breathe away some grains of quite sandy-like material. Still another ease of tuberculous affections is expected in, but any diagnosis as Murrin kept receiving as high as the thorax itself in doing an abdominal section I found free fluid, and every portion of resemble peritonitis, bowel, mesentry and pelvic organs, was studded with minute tubercles. To much adhesion had fallen place that the cavity into which I opened seemed wide limited in extent, and this adhesion it was that giving the signs of circumcised fluid, had existed one in any diagnosis. I gave all the parts I could reach a good sear, with a gauge each to see up some little irritation, and closed up them placing the patient in its best fitting position, I opened the matrix cut to see any...
and just in a grave clain. The learning
was a good one and fully three years have
passed, and she has suffered no further
obstruction in health but is fit for
ordinary household duties and quite as stilt
as she was before.

I have seen cases of tubal obstruction.

I believe there is certainly the others
unfortunately died. The only one I have had
following a coeloscopy. This lady presented
herself with a very large pelvis tumour, behind
the uterus, evident fluid and very tender,
resembling the uterus itself on the pubis.
She was running a high temperature and severely
in a bad way. So I opened her and cut free
the largest collection of dead blood, apparently just
beginning to pass that I have ever seen. There
was no fresh bleeding on the cavity was
washed out, and drain inserted, but the
patient rapidly came from septice mischief.
I felt that I aided at least way, that she
died in spite of the operation.

A more recent case was that of a
woman who complained of pain and bleeding
continuing for six weeks. She had two
children, the younger 12 yrs. old and
and she had been regular from the second month after the birth of her baby till her last period which lasted one day; for two days after which she was clear, for 20 days during which she had much pain in her right side, then haemorrhage set in, and continued without intermission for five weeks, at times quite free, at other times very painful. The pain was extremely severe with tramontizing cramptness pains, both being aggravated by effort. A correct diagnosis was made from the history and the feeling of which was taken to be a distended tube in the right ovary. On entering Douglas' pouch blood at once escaped, and on palpation the swelling was recognised as the swollen tube and found to be adherent, but not difficult to separate, which being done, it was easily delivered and showed a swelling the size of a small walnut. The ovum which seemed to be threaded had all the fibrinous clot drawn on to it, but with the slightest of any adhesion. The humour was evenly in both sides with sheets of inflammatory lymph, which showed the adhesions that had been broken down, while at one spot there was a
A small area about the one indicated on the peritoneum, and with a base like granulation tissue having a clean cut edge and resembling a liquid glue more than anything I can suggest. This I took to be clinodactyly which had been absorbed the peritoneum, but of this I am quite certain. The advice was calmly given, by means of a Staffordshire knife, when cut open the tumor was distinctly within the tube, and was apparently solid blood clot. I believe the hemorrhage had taken place through the tube - so seeming for which was found in the cul de sac.

In the case which occurred in the practice of my friend Dr. Pahl, when I was assisting with the operation, it became necessary to do an abdominal section on account of hemorrhage which followed upon the breaking down of much adhesion and the freeing of a quantity of pus. Here going to further adhesion situated higher up, he was unable to get the tube down, and the hemorrhage was altogether too free and continuous. Abdominal section then was disposed of the difficulty, permitting of the further
Phys. definite separation and the necessary ligatures. Lieutenant was then introduced from above, through the vagina, with its ends left in the cul de sac, and the abdominal wound closed. The occurrence of such a possibility must consequently always be kept in mind, and the necessary to cope with it at hand.

Cysts may be eminently to the uterus, which is found to have a cystic implantation or may be found in the Fallopian tube, ligament — a long pedicle. It is being common — the so-called myelocele of Morgagni. These are usually small, except in the broad ligament, where parasitic cysts may attain a large size. But are generally easily resected.

The tubes may be distended with serous fluid, blood or pus. The blood and pus tubes are better examined, while to have saved the Jones suturing up putting in a few stitches to unite the cervix to amnion membrane.

Again the way may be found like small and rounded, in thick bladder, probably, with resection and removed boldly.
I have also seen a distinctly watery or papillomatous fluid in an every that drained at times described as "dilatation" in the areas during appendicitis. Three or have met with the Appendix in one of the most cases of adhering, I have had to deal with. I proceeded in breaking these down and getting into the much disorganized field, and tube both which I disregarded it. In proceeding to explore the left side, I found a time when I could not make the decision of the Appendix. I had distinguish also the left tube, and the right I had removed. After considerable manipulation it looked as if we had, and I did. We had been simply buried in an inflammatory mass. The patient did as well as if she had had an elaborate appendectomy; with some I think I have referred to the chief conditions. I have met with in doing anterior abdominal section I find I have done some severe (40) lines preceding it by a booking, in fact of these cases lobotomy was preceded by booking and [in legible text, likely "hepatectomy." If the legible text is "hepatectomy," in one it was preceded,]
selected by lumbar and followed by anterior colpotomy. It was followed by anterior colpotomy alone, and then by anterior colpotomy and perineorrhaphy, and then by perineorrhaphy alone. In the anterior colpotomy followed, in one operation. In other words, in two Radical cases of lumbar, while in one, I did lumpectomy, lumbar colpotomy, anterior colpotomy and perineorrhaphy.

In spite of this tissue, the tissue was extensive, but in many cases they were considerable. In 239 cases, the size was more or less cystic and were treated, in one a single every was removed, and in one instance the appendix was also taken, while in the double baricotomy was required.

Whenever possible, vesicles were closed and subjected only to excision and removal of diseased structure, and it may be that in the instance of a young woman of 33 married for one year without family, whose ovaries it found much decreased. My notes say, they were almost entirely removed, by the necessary excising they received, she was recently under my care again, and that for sickness of pregnancy.
The operation of suitable cases seems to me to be most immediate, and I have distinct advantages over the abdominal rate, any small operation of which should be excluded as a rule. It can be done, and it has been done in almost painsless manner and then the convalescence and cure are short and not recommended this course. It certainly seems to produce much less shock and disturbance to the patient while there is no risk of renewal of the delirium. If blood or empyema collects or is drained down during operation, these are readily replaced, and have I seen them brought down afterwards, both by the surgeon's skill and sickness. The free drainage afforded by the wound appears to be a very important factor in its favour, and the which tendon together with the remarkable healing nature of the fluid of tissues. If presenting the proper passage of infection ensures a safety. I think this otherwise formidable. Then as the patient always have the benefit of the simplest possible procedure and in the vast majority of cases there is the possibility of determining its applicability - if thought suitable it
It should be tried— if found unanswerable, no
reason will have been more probably good, in
the formation of drainage, while the abdominal
route is always in reserve, and may be
proceeded with, if thought advisable.

The temporary drainage so established is
likely to prove beneficial in any, whether acute
or chronic, inflammatory process which may
be found, and this route is more calculated
to contribute to the conservative treatment of the
organs than the abdominal one.

I really find it necessary to
put every stitch in the surgical incisions.
In the event of any bleeding, it is generally
from one angle of the wound, and if so a
curved needle in a twiddle should be run
through the peritoneum, peritoneum and
through the peritoneum
and anterior peritoneum, membrane, near the angle,
and in tying the wound is checked
and the bleeding is a rule stopped.

It is, however, most important to
keep, with gauze packs in "dressing free areas,
the pelvic cavity, making sure to clear
away any fluid, etc., and this effected,
The drain is pushed back, as the abdominal


is removed, and the vagina gently sucked, for it will be due to the uterine discharge released by the withdrawal of the catheter.

No gauze is left in. Should, however, there have been any pus evacuated, or suspicious tubes removed, or much adhesion between it, it is well to insert 2-4 small gauge through the wound, leaving the best loosely packing the vagina for 30 hours after which it should be gently loosened, and removed then or next day after which gentle touching may be practised.

I like to have the hysters moved each day by enema for several days at least. If a rise of temperature shewed excessive, and continue for some days, it may end in the discharge of pus and if retained it is occasionally necessary to reopen the wound with the forceps, and drained pus be released well and good if not I am led again introduce a bladder which will probably soon bring it.

The patient is taken up and back made quickly than after abdominal section.
have seen pyogenic ganglions form in the
rect of the intestine, in the intesine
appendices, and have stripped them
off, or backed with bile. If bile which
quickly has done all that was necessary
to perfect healing. 

Abdominal Section I

have done for self clinics, hydrodips, cancer
appendectomy, and intravenous injection,
half-thirty only for pathological purposes, in
which cases I have already alluded to my
first tuberculous peritonitis case. One of the
other two I regret to say was a fatal case
and it showed also have been. It was for
the removal of a large ovarian cystoma joining
the abdomen, and if rapid death in a young
child of 20. The operation was accomplished
comfortably, but she developed a bas septie
peritonitis. The incision was infected, and
the bowel became adhered and fistulous, so
very patient ends. I felt one that
was able to bear the onset of infection,
though that was due from extravasation.
She was saved from happy, to

woman of 50 sends for me, and I found
her as large as tall form with epilomas, but
but she absolutely declined operation. Shortly after her mistress, whom I had attended for years, sent for me and informed me that she herself had had an internal fever for two or three days in much pain and running a temperature. The abdomen was enlarged and palpation revealed large nodules. Her condition and much kindness from peritonitis. I also found a pale, acrid discharge and that the original walls had become invaded and infiltrated making it quite impossible. I operated her as best I could till she died a few months later. Soon afterwards the friend sent for me, and wished to have her removed.
She had meantime been under a much advertised American quack remedy, named bromo, in which she had spent some 
She was very much distressed and helpless at the time. I relievating it with which had no suction and got it up through the sound, the pedicle tied by a heavily-lathered ligature (in three divisions) and the pedunculated base tied with silk from the umbilicus by my needle and fine caliphs with Lambert stitches I found the left way as large as any finger and
And so removed it too, then a fibroid like a clump closed up with a well marked pedicle coming from the fundus uteri, so I removed it clipped down the pedicle of the pedicle and got it shelled it, and then we try to discover another embedded in the posterior wall of the fundus which I incised and shelled and closing up with has deep sutures. This last ones why the time of a large bean.

She made an excellent recovery, only retarded by a slight attack of Pyelitis due to her walking back from her nurses to her bed on the first occasion of HER lying up. In five minutes later she resumed her duties was one and a half ago.

My task is finished, and the works is just a simple read if that I have personally come in contact with and learned in any non plain words to form this thesis which I have admitted to the tender mercies of the medical faculty of my alma mater.

John Alexander Scott
Arnhem Red.

Victoria, Australia

6/3/86