Clinical Notes on Chronic Eudermatitis

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This paper was compiled from notes on case of chronic Enteritis which occurred in my experience within the last few years, its object being to discuss in connection with these cases, sometimes their pathology, sometimes their etiology, sometimes their diagnosis, and treatment, according as one or other appears of special interest.

Case I. W.M.A., aged 25 yrs., married.

Note that any children, nor abortion; it always enjoyed good health.

On Sept. 8, 1884, an urgent message came to W.M.A. that she was very ill and in great pain. Her husband at once informed me that he was suffering from gonorrhea, a fever which was the cause of his wife's illness. W.M.A. complained of urethral pain, shooting along the urethra, with a frequent desire to micturate. The pain was so great that she dreaded micturition.

There was also a passing burning pain in the external genitals. She felt ill for a day or two, but thought that it was a general cold or rheumatism. Internal examination was made with difficulty. The vagina felt hot to the touch, the vagina was red and swollen on attempting to introduce the finger. The labia were red and there was a copious leucorrhea discharge coming from the vagina. A Sims speculum was introduced, the
Serous-tined discharge was then seen lining the vaginal walls, also a little coming from the os uteri.
It seemed that the process had already invaded the cervical canal although slightly, but that prompt remedial measures might be taken to prevent them from spreading upward and reaching the endometrium. Accordingly, the vagina was washed out with a solution of certain sublimate (1 in 300); the cervix was then lanced from with a needle, & a sound
previously wrapped with cotton wool, & dipped in a particular solution of certain sublimate introduced through the whole length of the cervical canal. Sulphuric acid followed:
a good deal of mucous blood was removed at once & the vagina was again washed with a warm solution of corrosive sublimate.
A similar treatment was repeated, at first three times a day, but after a fortnight, only every morning. The pain & malaise continued for two days, a frequent dose of purgatives were given to prevent slough. The temperature continued at 99.5 till the third day when it fell to normal.
Sept 16th. Patient much better. She can
take food well, feels more cheerful, but
looks ill & complains of great exhaustion
especially in the morning, also of neuralgia.
Pains in her back shooting down to the hips.
There is also a purulent Leucorrhoea discharge, & considerable pain on micturition.

Leucorrhoea discharge much less. Certain lotion has substituted for certain saline stuff, but after several douches has to be discontinued, because of the discomfort it caused through smoking.

Patient now complains of great pain at the entrance of the vagina. Refuses to allow the nurse to introduce the nozzle of the enema apparatus.

On examination I found on the left side of the vagina a large an inflamed Bartholinian gland. Surrounding the duct was an intimately reddish tissue, painful to the touch & micturition with a frequent discharge. A dilute solution of the hydrochloric & dilatation was applied twice used as a douche. This gave great relief & was continued twice daily for a week.

Sept 30th. The Leucorrhoea discharge has ceased.

The patient is able to sit up, but complains of frequent pain in her back.

Oct 3rd. As pain in the back still continued, I made a vaginal examination, found the uterus relaxed & very painful when pressure was put on the fundus. A tampon of lint soaked in glycerine was then introduced. The pain however increased, & had to be removed in the evening. A warm douche
was then given night morning, & medical process introduced at bedtime. She gave relief, but the pain in the back was never entirely
gone.
Oct 12th. Menstruation commenced & continued up to the evening of the 16th. Although there was more pain than usual she felt tolerably well, & in the evening her temperature was 97.8. Early on the following morning (17th) I was sent for, & at 8 A.M. found Mrs. T. with an anxious expression, pulse 116, temperature 103.4, complaining of great pain in her left side with tenderness on pressure in front & behind. She also noticed two or three bright red stains of blood on her linen. On examination I found the left ovary large & tender, & great pain was produced on pressure are round the uterus. There was undoubtedly extension of the original disease causing acute adenitis, ovaritis & pelvic peritonitis. Vomiting was incessant & the temperature continued to rise. Poultices were applied & small doses of antipyrine were given every few hours while the temperature remained high. Alarming symptoms with constipation & pressure in pain & vomiting continued until the evening of
the 19. when the temperature greatly fell to its normal condition - in this case 97.8. Although the temperature kept low, the pain in the back still continued. The patient was unable to sit up until the end of the month. Great care was taken till after the next menstrual period in November.

Examined end of November 1849. Left ovary is still quite sharp. There is a marked whiteness of the uterus which is loose down with fine adhesions also there is a purulent looking discharge coming from the os uteri. The patient herself relates that she had an abundant white discharge for several weeks. The abdomen feels hard on examining bimanually, but free movements could not be made owing to adhesions.

April 1849. Patient has been more or less an invalid all winter. She still complained of pain in her back especially at her menstrual period, also of a mucous purulent discharge which is irregular in character. There is often a burning pain with sensation of weight in her back alone. This pain sometimes becomes so intense that she has to lie down. She has not shown any more hemorrhage except at the menstrual period, yet she has become very anaemic. Fatiguing in the affective, and mentally irritable. Nerves. I have given this case in full and has a good
Opportunity of watching from its commencement a typical case of ovarian with its terrible symptoms to a case for the study of the pathology of one form - by it means uncommon. Of Chronic Salpingitis. We have here a whole train of lesions: acute salpingitis, ovaritis, pelvic peritonitis, retropluritis, lastly chronic salpingitis.

This may add permanent ill health, all depending upon the one exciting cause, viz. sometimes. The patient is a lady in good position; was constantly visited upon by a highly skilled nurse, visited daily by myself for months, so that we may fairly exclude any other cause, such as said at the menstrual period.

Thanks to the researches of Reiss, we know that the hormones is the chief pathological agent in this disease, but the question arises: What is the exact pathological influence of the hormones on the uterine mucosa? How is it to the patient form entering the uterine cavity? It is not enough to say that the hormone simply cause affected by the hormones involving the mucous membrane, producing endometritis. We know that the hormones has a definite pathological action on mucous membranes, but it is for obvious reasons a difficult task to watch its life in the female genitalia. Until this has been done we may regard Dr. S. Bronnim's experiments upon the conjunctiva of the newborn.
as the most reliable information on the life history of the Tèneceus. Dr. Sinclair in his book on "Poisonous Insects in Worn" has given a concise summary of Brunius' conclusions. Speaking of the Tèneceus (p. 73) he says "in union with an animal invasive force it penetrates between the superficial epithelial cells, takes into the soft protoplasmic substance of the same elements, continues to fortify itself between the layers of the epithelium, ultimately reaches the profusely ruptured layer of the mucous membrane. They develop superficially inward, fortifying owing to something in the nature of the soil. The time varies to some extent, but usually in two days the micromonium has penetrated, taken complete possession of the entire epithelial sheath. The way in which it marches forward is always the same — by breaking down the cementing substance between the epithelial elements. Sometimes the penetration is more pressing forward in thin stripes, sometimes spreading out with rounded colonies or thin, scattered groups of young, according to the resistance of the tissue to be penetrated. In every case the reaction on the part of the tissue is at this time very interesting to complete. Great swarms of white filaments protrude from the capillary network which comes close down to the epithelial sheath. Penetrates into the superficial layer of the connective tissue, never find their way through the epithelial layers.
to the surface. When the epithelial sheath is broken
through, the capillary portion of the mucous membrane
also exposed to the sarcog of the microorganisms.
But the invasive force appears to be broken by
penetrating only the most superficial sheath of the
Sub-epithelial connective tissue. While the micro-
organisms are thus invading the superficial layer
of the conjunctival connective tissue, the inflammatory
process appears to have increased in intensity. The
infiltration of round cells reaches finally as much
as two or three layers of the free surface of the mucous
membrane, till the individual cells are eroded
from one another. This process gives direct
origin to the papillary body of the membrane.

The process of repair begins usually within four
days, but it varies according to the severity of
the attack. The new epithelial sheath consists
of a layer of flat, broad or slightly elongated
elements which become rapidly covered with two
or three layers of flat cells. The most super-
ficial of these layers becomes further modified.

The whole sheath forms an impenetrable
barrier to the invading tissue against the
microorganisms. This description sounds
very martial to remind one forcibly of portions of
"Xenophonic Anabasis." But although we cannot
accept the above as an exact history of the
somewhat process in the various portions of the
limited tract, practically there must be many points
of resemblance. It will be seen, for example, that
the epithelial cells in the bladdcr habit of the
persons, and that after the epithelial cells are destroyed
their invasion from this area of the process of repair
begins. That the same mode of repair, viz a re-
placing of columnar by squamous epithelium takes
place in the uterine cavity has been pointed out by
Ellen. In simplified position which he examined,
he found sometimes two or three layers of squamous
epithelium. Shapinskey has in describing the
series of changes which the mucous membrane
undergoes in its attempt to assist approaching disease
mentions some of these Wharton Jopos where the
mucous membrane is lined by squamous epithelium.
And the process is exemplified - at least analogously -
by the study of the four types of the conjunctiva, viz.
the inflammatory process, resulting in hypersecretion
of mucus. In few cells.

Hart & Barlow in the New Edition of their Manual of
Symptoms seem to doubt that the secretion of the
uterine gland is ever increased in chronic inflammatory.
They admit that there is such a condition as adenoma
or gland but maintain that this does not imply
increased secretion. Sometimes it may not but
in most cases I believe it does. That there is a
physiological hypersecretion before during the
menstrual period no one will deny; but it is
hardly feasible to suppose that the excessive uterine
discharge which comes through the os in many

Cases of insufficiency can come from the cervix, understanding the wonderful secreting power which we know that organ possesses in particular in disease. On removing a large and a few months ago, present to using an application of caustic in chronic insufficiency, I perceived quite a rush of fluid from the cervix of the uterus. We have therefore reasons anecdotal or physiological, as well as reasons based on observation for believing that there is a hypersensitivity of the head in some steps of chronic insufficiency. Probably to this hypersensitivity plays an important part not only in resisting the further invasions of microorganisms such as the cocci, but in furthering the process of repair, by breaking out disintegrated epithelium, pus cells, and the debris caused by their seeps.

I propose in the further treatment of this case to administer chloroform to its possible break up the adhesions, replace the uterus; if it insufficiency still continued to irrigate the uterine cavity with some antiseptic solution. Meanwhile we have found great relief from the application of theGran Tampons. A few months afterward she went to London to consult Dr. Matthews, and we advised that any active measure to replace the uterus should be attempted. Since then she has had period of comfort & discomfort, but as far as her sexual organs are concerned she is relieved.
In June 1879 I was consulted by a lady shortly after marriage, whom I found suffering from acute gonorrhea in the early stage. I confirmed my diagnosis by consulting the husband, who admitted that he had a "running" one month before marriage. The symptoms were very similar to those just related, but the treatment adopted in order to prevent the process from attaining the endometrium were not quite so heroic but I believe more successful. After reading some articles to where I shall refer again — regarding the number of microorganisms found in different parts of the genital tract, it occurred to me that the urethra of must be a wonder ful natural barrier against the invasion of these organisms, as they were found in such numbers in the cervical canal, but so seldom in the cavity of the uterus. In this case there was already a greenish-brownish discharge coming from the cervix, but I was determined to find the husband as a chance. Accordingly instead of passing a probe covered with cotton wool soaked in a strong solution of carbolic sublimate as in the previous case, I simply introduced the nozzle of a small syringe slowly to wash out the cervical canal with a saturated solution of common salt. This was repeated many times, the patient passed through a severe attack of fever-burst with any disturbing symptoms, beyond the usual inflammation of the
Uninflamed glands, the pain accompanying menstruation. Certainly no restrictions or occlusions followed. I do not maintain that fully passing a solution of salt into the cervical canal destroys the gonococci embedded in the epithelial thicken, but by destroying those on the free surface it lessens their invasive force without interfering with the internal os which has been found to be an important natural barrier to other microorganisms in multiparas women.

Case II. Mrs C., aged 30, married three years.

Before marriage she was always in good health and menstruated regularly with little or no pain.

In Dec. 1886, six months after marriage she miscarried at about four months pregnancy. The doctor who attended her said that the fœtus had been dead some time before the miscarriage took place. She began to menstruate six weeks afterward, when she had a great deal of pain and more discharge than usual. It was described as a burning pain which commenced three days before menstruation it was accompanied with dysmenorrhea. She continued to menstruate every three weeks, and to have pain more or less severe till Oct. 1887, when she became pregnant again.

In Jan. 1888, she had an abortion at the end of the month. Menstruation commenced about five weeks afterward but this time the pain and discharge had both very much increased. She has been to several
Bacter, but found no benefit.

Case under treatment in June 1841. Patient complains of severe pain in her left side, back right leg. The pain is increased two or three days before each menstrual period, but continues for two or three days afterward, sometimes longer. She never loses any

while discharging, but for six months she menstruated every fortnight. The flow was very profuse.

During the last menstrual period the discharge has been in amount, but for a week afterward she had a burning sensation in her back, her right leg felt as if it were drawn up when she stood on the floor. On examination I found the cervix slightly curved forward, the lips thick, another to the touch. The uterus felt large, there was freely movable, but pain was produced when movement was attempted. There was a well marked introversion which was easily replaced. I introduced a Sims' speculum, looking down the cervix with a veluscope. Whilst an assistant held this in position I explored the uterine cavity with a sound.

The whole uterine muscul was found especially toward the fundus, while for a short while it was touched, the uterine cavity was larger than normal, very attempt to raise the fundus into position with the sound caused intense pain. I noticed that the posterior lip of the ov was congested red in appearance. It is possible

Maintains that uterine fluid cause any
Change in the nutrition of the cervix, but I am
inclined to think that it does, as this telurine
congestion appearance is often present in cases
of intermenstrum. The principal pathological cause
there was the congested state of the mucous membrane
which was probably the cause of the second abortion,
as well as the other prominent symptoms viz
excessive haemorrhage at the menstrnal period,
burning pain. Displacement. The patient had
already become very anemic. I thought it best
therefore to attempt to get at once some
catarsis to the interior of the uterus, or if necessry
on further examination to use the curette.

After being left a few days she felt much
trefixer, the sensation of dragging in the right leg
was not so marked.

June 15. A small forceps tube was introduced into
the cervical canal. There was haemorrhage but
the pain was excessive. Frequent doses of morphia
had to be given in the course of the evening.

June 19. Tube removed replaced by a large one.
The pain for ten or twelve hours was very great
but afterward subsided. The tube was left in
position till the morning of the 15th. The cervix
was now fully dilated, less painful. The vagina
was packed with cotton wool previously dipped in
a paste of bicarbonate of soda in order to protect
the vaginal walls. A strong solution of Chlorid of
Potass (1 in 3) was then applied to the whole of the interior
of the uterus & cervical canal. On the following day, the cotton wool was removed, the vagina freely drenched with a warm solution of corrosive sublimate. The patient remained in bed four days & the thumb was continued until morning. A lump of cotton wool soaked in glycerine was also applied every morning to keep the uterus in position. She improved rapidly, yet her next menstrual period lasted less pain than previously. She menstruated regularly for some months, the menstrual flow only lasted three days & was less in frequency. This patient left the district so that I had not a further opportunity of watching her case.

Case III. M2 M. (Smith) aged 26, married & gave no family. I attended this patient twice she was 19. At that time she had an attack of dysmenorrhea, her mother told me that she was irregular at her period. Sometimes she was three months without menstruating, occasionally observed a white discharge in the intervals. She was an anxious delicate girl, but gradually improved in health, & the while discharge entirely ceased for a year previous to her marriage at 21. Four months after marriage the abdomen at the end of three months pregnancy. She made a good recovery began to menstruate one month afterwards. In the following Sept. she aborted again at the end of three months. After this a pain began to trouble her in her back & increased at the menstrual period. She also observed a return
of the white discharge, but did not seek medical aid. In May 1887, that is a year and eight months after the second abortion, she aborted again at the end of ten weeks pregnancy. She had more pain then on the previous occasions, remained in bed a fortnight. Menstruation did not begin until three months afterward, than it lasted nearly a week.

On August 18th 1887 she consulted me because of a pain in her back, dragging feeling at her left side. The pain increased during the menstrual periods which now lasted from seven to eight days. Formerly they lasted only three days. She had also some white discharge but not much. On examination I found the cervix soft, flabby, inclined to the left side. The uterus was abnormally flexible. Subsequently I replaced the uterus twice with a watchspring instrument. The patient felt more comfortable for some months but still complained of great pain at her menstrual periods. I noticed that the intermenstrual discharge was becoming more abundant, of a yellow color. During the two following years she had lost health. The internal trouble did not improve. I tried various processes but failed to keep the uterus in position, or to give permanent relief.

In Jan. 1889 I removed the processes, kept the patient in the Trendelenburg position as much as possible, inserted tampons of cotton and soaked in glycerin of tannic acid. The uterus now became more
Right, remained in position much better.
After a few weeks I replaced it carefully. The patient still complained of a dragging weight at her side.

The pain in her back, which was intense during the menstrual period, The purulent discharge was greatly increased in quantity, but few occasions the sudden streams of brown reddish mire within. There occurred about seven or ten days after the ceased menstruating. The menstrual periods also became very irregular. Sometimes she was five weeks without menstruating, sometimes only three, or two occasions only a fortnight. Although this patient improved in general health, her local condition seemed to get worse. I decided to try local remedies. Having cleaned the cervix with a warm saline bath, I packed out the uterine cavity with laminin ointment. She stayed in bed for a few days, shortly after being away for a change of air. The following month she returned very much improved in health. The pain in her back had quite gone except at the menstrual period, or when she had extra exercise such as lifting or walking.

As the purulent discharge had not entirely disappeared I began irrigation with a saturated solution of Chloride of Sodium. This greatly improved matters, and after a few weeks there was scarcely any discharge to be seen. The patient has reported herself on several occasions of a
find that the discharge still returns at intervals, but she is entirely free from the intense pain in her back during the Menstrual periods. She has not seen any more inter-menstrual hemorrhages. I believe the discharge is now chiefly cervical. There was doubtless in this case a constitutional tendency to Catarrhs of glandular lesion. After marriage the uterus was unable to perform its natural functions, probably failed to supply the growing ovum with proper nourishment. The result was repeated abortive their consequences. The congested uterus became unable to support its own weight; the badly nourished walls became flabby. Retroflexion followed. I think it was due chiefly to the flabby state of the uterine walls that my repeated attempts to keep the uterus in position with forceps failed. The first step in the right direction was keeping the patient in the Decubitus position, & applying Tompons of fresh urine. I made & considered this an important part of the treatment of uterine cataract when there is a complication or series of complications as in this case. Not only have we the full advantage of local medication but the congested walls of the uterine have a better chance of relieving themselves.

The amount of support for vagina is equal to the Decubitus position. The application of catine was made with a strong gauze wrapped with cotton wool & dipped in the Solution. This
is a much safer and more effectual method of applying strong liquids than injecting them into the uterine cavity with Braid's syringe. I think the mechanical pressure on the mucous membrane in chronic catarrh has a lunging effect.

On the other hand there are stages of the disease when irrigation with a suitable fluid is a safe and effectual mode of treatment.

Case IV. W. 23 years (clergyman) aged 24, married three years, but never had any children. She began to menstruate at the age of 13, continued to do so every three weeks up to the date of her marriage. Since her marriage she menstruated regularly every month. During the last year she complained of pain in her back especially at her menstrual periods, but more or less always. She also noticed a white discharge between her menses for more than a year. Six months ago she noticed that the leukorrhoea. This was thickened with blood, and this has attracted her attention on several occasions since then.

In the beginning of June 1890 I was called to attend her because of an inflamed bursa pubis. The patient complained of a constant pain in her back. Having elicited the above history I made an internal examination on June 20th. I found as follows: the patient felt stools as if in three months pregnancy, only hard nags to the touch, not adherent to the surrounding tissue. I could also feel little irregular nodules the size of lead
within the gaping 15. The surrounding tissues could not be pushed aside sufficiently to make a proper bimanual examination, but as far as I could move out the uterus was normal in position.

In introducing a speculum I could see the uterine cervix, the number of small, irregular red papillae on the vaginal portion of the mucous membrane. The anterior lip was hooked down in order to secure a better view for microscopic examination. In doing so I observed a plug of mucous Coated with pus. Inner examination of the vagina has forced me to introduce a sound. Having come to the conclusion that this was a case of syphilis, I accompanied with comming lesion of the cervix. I called Professor Sinclair of Manchester into consultation.

Dr. Sinclair agreed with my diagnosis, thought that it would be a very favorable case for total subjection of the uterus. Accordingly she was admitted into the Southern Hospital. Early in September, on the 13th, the operation was performed by Dr. Sinclair for vaginam. I was present at the operation. There was no complication beyond a slight adhesion from pelvic peritonitis which made it difficult to reach the fundus of the uterus. On examining the uterus we found that the Carcinoma had advanced further than we suspected. It was still a good way from the internal os, but the whole mucous membrane looked thickened.
sharply tinged with standing inflammation. Towards the fourth postictal half the cervix could be seen a distinct granular patch. About one half of the uterine for microscopic examination.

The patient did well; was discharged from the hospital on the 30th of July, returned to her own home where she was attended by myself for a fortnight. A few weeks after and I met her in town "shopping." She looked healthful and lively, said that she had no pain anywhere, but felt "perfectly well."

The state of the endometrium in cases of Carcinoma of the cervix has been the subject of much controversy amongst pathologists. How there is an inflammation condition of the mucous membrane accompanying Carcinoma of the cervix is admitted by clinicians and pathologists, but the question is what is its forensic pathology? The settling of this question is of immense practical importance in the early recognition and treatment of the disease. If it be true as Abel maintains (Archiv für Gynäk. 1894, p. 2) that the mucous membrane of the body of the uterus is regularly affected with carcinous disease in cases of Carcinoma of the cervix, that such can be made out from microscopic examination, there can be no question as to the superiority of total extermination - the sooner the better. Printed on the other hand (Archiv für
After examining a considerable amount of material describing tumor changes similar in appearance to those described by Abel, but asserts that they are not due to any specific affection of the lining, but are merely the essential phenomena met with in chronic endometritis, varying according as the uterine glands or interstitial tissue become principally involved. England, he says, may be simply enlarged, or increased in number. Allowance must also be made for changes due to purely mechanical causes, 
the state of the patient. He adds, "It is the varying amount of each of these processes in proportion to the other which gives rise to the limitless variations in the microscopic appearances." In a later paper (Archiv. f. Gynäk. Bd. XXXIV. 1873), Landau states that here to the opinion formerly expressed by Abel that the changes in the endometrium are not simply those of chronic endometritis but a new growth in "diffuse Sarcoma." "It is questionable," they say, "whether the forms of sarcomata observed in the endometrium accompanying carcinoma of the cervix belong to the benign series of sarcomata. From our experience we are not of that opinion."

Saurenhans in a paper read before the Berlin Obstetric Society (Zeitschrift für Geburtskunde. Bd. XXXV. 1872) supports the theory that the changes in the mucous membrane are merely inflammatory.
Carl Ruge who took part in the discussion which followed this paper, while giving this credit for showing that pathological changes in the endometrium always accompany carcinoma of the cervix or any part of the genital tract, pointed out that changes similar to those described often occur in the proliferative tissue of the uterine mucosa in submucous glands, so that it is impossible in his opinion to distinguish by the microscopic alone malignant cases from those which are simply inflammatory.

Whether or not there is a transition stage of carcinoma into carcinoma, or whether their relation may be of any, the fact remains that whenever the genital tract is any where seriously affected with carcinoma, the endometrium also undergoes important pathological changes. This has been admitted by Carl Ruge and the supporters of the inflammatory theory of these changes, but has not been pathologically explained.

In connection with this subject, I would like to call to the mind of you, that future researches might well show that protozoa are the pathogenic agents in certain diseases. At present we are in the bacteriological age, but evidence is
not wanting that the dawn of the post-organ age has begun. The observations of Larrey's on the minute spongia found in cases of malaise few have already been confirmed by a report of investigation. Amongst the most recent of these is Canali's of Rome (\textit{fortschritte der medizin} Vol viii) who gives the result of his observations of a thousand material cases in the military hospital. The presence of this minute spongia, not only, Coccidia has been detected by Sfingini (\textit{fortschritte der medizin}) by eye alongside of the spongia within the cell of carcinomatus growth. Some maintain that these supposed Coccidia are merely deposits within vacuoles which have been caused by a type of cellular degeneration characteristic of the disease. \textquoteright{} They support their theory by the fact that as yet it has not been found possible to cultivate these organisms outside the body, \textquoteright{} thus to prove by inoculation their causal connection with the disease in question.

\textit{Fuchs, L.} (\textit{Société de Biologie} Nov. 1890) affirms that he has detected in cases of epitheliomatous of the lip, in the substance of the Mammal a parasite which he classifies amongst the Spongias as a \textit{Coccidium oviforme}. This parasite varies in size from one cell up to the epithelial cells, often in the cell nuclei. It may be either intracellular, when it is small in size, or intercellular, when it is of a large size.
Reproduction is carried on by means of thorac. (which develop in the uterus) and thus the female organism. If it can be shown that such bodies are real parasitic coccidia—and we have no less an authority than Balbiani for regarding them as such—it will go a long way to explain the necessary connection between carcinoma of the uterine tract and the pathological changes in the Endometrium which always accompany it, which may be due to the spread of the coccidia or their fierce attacks along the mucous membrane.

Briefly, we may say on the best authority that the presence there is no definite criterion by which we can distinguish microscopically between chronic Endometritis and the inflammatory changes which are a concomitant of early malignant disease. In such cases so far as diagnosis and treatment are concerned must begin and end with the clinician.

On clinical grounds, therefore, supported by the additional evidence of Langen, Schouts & Slater, that carcinous nodules are to be found in the substance of the uterus in early cases of carcinoma of the cervix, of Dr. Sinclair who told me that he found a similar nodule in the muscular tissue of the uterus in all cases when commencing malignant disease came to work out.
That we shall at some future time attain to a systematic classification of the several processes which take place in Chronic Endometritis is beyond doubt, but at present the lines of such a classification are by no means defined.

On the one hand, the pathologist, after examining microscopically the materials taken with the curette from the inflamed mucous membrane, has taken as his basis the disease structures principally involved. On the other hand, a classification has been attempted on the basis of Clinical symptoms. This latter method, although seemingly very convenient, rests too much on the guesswork of individual experience to be of much permanent value.

The only method, therefore, which can approach to scientific excellency is the pathological one. Appreciating as I do the labors of such physicians as Ashburner, the Senior and Young, who laid the foundation of the pathology of Endometritis, it seems to me that a pathology which attempts to explain such morbid phenomena must rest on a broader basis than the examination of endometrial scrapings taken with the curette from the interior of the uterus, or even an examination of purely local conditions. Instead, therefore of giving numerous examples of such well known types as Cases II and III, to which I can add nothing new pathologically, I shall mention under
the following heads, a few groups of cases, to the investigation of which such a pathology as I have indicated might apply.

1. A consideration of the disturbing elements in the organism generally.

While it is admitted that anemic, senile, and neurotic women are often the subjects of chronic endometritis, the precise relation of these diseases to endometritis is not explained.

In my own experience quite one third of the cases had some past predisposition in addition to what might be termed the local exciting cause. To assume for individuals people this predisposition is easily understood, owing to the inherent low vitality of the tissues, the easy escape of leukocytes from the highly mineralized blood vessels. The neurotic element is still obscure, but clinical evidence favors the presumption that it may be either reflex or trophic in character.

We are familiar with many forms of reflex, trophic neuralgia, and it is not possible that frequent reflex contraction of the uterine nerves might for other reasons cause paralysis, which would lead to distortion of the capillaries, blood stasis, congestion of the mucous membranes? The trophic influence of nerves upon different parts of the body has been proved by section, there is no evidence to show that the life of individual cells is not equally controlled by
The nervous system. Although the cells of the gland, e.g., may recede after nerve connection has been gained, the secretion is not normal secretion. Its muscular or fibrous condition has been altered, its special function destroyed.

The following is a case example of abnormal secretion resulting from functional derangement of the nervous system. It seems to confirm the hypothesis that in some cases chronic symptoms may only its existence to certain nervous lesions.

Case V. Anna Phillips, aged 19, a peasant girl, came to consult me early in April 1890, complaining of pain and numbness in the thumb of her left hand. Three years ago she was bitten by a dog, felt the pain in her thumb more or less since then. She had been to several doctors requesting to have the thumb amputated. This request was repeated some, but as I could see nothing abnormal in its appearance I prescribed small doses of arsenic and ammonia; painted the thumb with iodine; reassured the patient that there could be no serious loss from the bite, that she would soon be quite well.

She continued to come occasionally for five weeks, always complained of pain, although she did her work as usual.

On June 27th she came looking rather feverish, with her hand in a bandage, informing me that as her thumb cannot be too much pain
She was obliged to take it off herself. At first I disbelieved the story, but found it was quite correct. The thumb was really amputated as if by a circular incision, and simply slapped in a bandage. She would not disclose by what means the operation was performed. While a dressing was being applied she had a severe hysterical epileptic attack. This began with a general tonic spasm in which the body became arched so that only the back of the head and heels touched the ground. The attack lasted five minutes, and she afterward walked home a distance of half a mile. At 6 o'clock in the evening I was sent for in a great hurry, to attend my patient in bed exhibiting the symptoms of hyposthenia. She groaned at the mouth; became very violent, clenched her teeth whenever she could get hold of them. She complained of a burning pain in her throat, on attempting to swallow a teaspoonful of water seemed as if she would choke. Following this was a series of deep inspirations, alternating with violent contractions of rigidity of the limbs. Then came a stage in which she was unconscious, without a whisper, rather incoherently. The secret of the operation was that it was done with an ax, chopper.

These attacks of premenstrual dysphoria, which team, a time tended with but little intermission for 4 or 5 hours, continued to return for eight days.
until they were at last effectually checked by
the most sensible application of a wet towel to the
forehead. Examination of the nervous system revealed
that left side hemiplegia, concurrent hemianopsia
of both fields of vision, also two to three hours' pain
over the left muscular region, the stumps of the
left thumb.

In August, the mother came to me in great trouble
to tell me that her daughter had never been
"completely well" since the middle of April - i.e., about
six weeks previous to the self-inflicted operation
and that she had a discharge of "mucus" which
came from her in great quantity at intervals
of from a week to ten days. The discharge was
sometimes preceded by pain in the left groin.

Next time I saw the lesion was held for my
inspection, for it were large patches of pus
mixed with mucus. On inquiry I found
that the girl had menstruated regularly for
three years previous to April. Then she was a
twin. That her twin sister began to menstruate
about the same time, I continued to do so
together regularly. The hysterical attacks
returned at intervals of a fortnight, and
sometimes three weeks, but not with such
severity. The girl herself began to look morbid,
complained of loss of appetite, loss of flesh, and
pain in her head. After the menstrual discharge
was much increased, I made an internal
Examining, at the mother's request, but could find nothing abnormal except that the lips of the orifice was rather flatter and stiff to the touch. The uterine also felt harder on movements, but did not pass a tumour. There was no evidence of any discharge from the vaginal orifices, nor from the uterus.

A simple local treatment was instituted & prescribed verm. tartarica, & the same time advising the mother to take her daughter home to Shropshire for a few months.

In March, 1841, I received a letter from the mother of the girl. Her condition has not yet begun, the mephitiform discharge has increased in quantity & now almost continuous. The girl has also become very anaemic & complains of much pain in her back & legs. It seems possible that these abnormal symptoms of the mucous membrane of the uterus, may be intimately connected with or depending upon some neurasthenia condition of the system generally; but a clear conception than an already, because of the fundamental principles of evolution & development must precede any knowledge of the precise relations of these conditions to the individual cell.

2. The life history of various bacteria & their influence upon all life & consequently upon the mucous membrane in its normal & pathological state.

A fuller knowledge of the bacteriology of the
Genital tract is necessary not only to complete the etiology & pathology of chronic uterine infections but in order to follow the use of antibiotics in gynecology on a rational scientific basis. Perhaps I might say more rational & more scientific. I do not suppose however, that the strongest advocate of antibiotics will deny that their use still leaves a certain unknown quantity of scientific unknown.

The presence of numerous bacilli sterci in different portions of the female tract in the diseased & healthy mucous membrane has been proved by a number of investigations, but their importance as factors in disease has been recognized only in a few instances.

Galler (Centrblatt für Gynäk. 138, p. 1887) made numerous observations chiefly on the cervical canal where he found in healthy pregnant women, a great variety of bacilli sterci, some of which he isolated & cultivated, but none of which proved pathogenic. He therefore came to the conclusion that pathogenic microorganisms do not normally exist in the vagina or cervix, that self-infection is impossible.

Similar results were obtained by Küsters, Leiner & Thacker. A still more extensive series of investigations was carried out by Winter (Zeitschr. für Gynäkol. 51.) who examined the whole genital tract - vagina, cervix, uterus - taking an enormous quantity of material both medical & surgically, by cultivation experiments. In his
Examination of the vagina revealed numerous microorganisms were discovered. The bacteria in the vagina were the same as those in the cervix. In the healthy cervix, lactobacilli seem in nearly equal proportions, usually two or three varieties of each. As pregnancy advances, the increase in number, but this increase is due chiefly to the lactobacilli. After examining thirty with Wits, he found microorganisms in seven, four of the fallopian tubes he found microorganisms in six. Notwithstanding he came to the conclusion that neither in the fallopian tubes, nor Cavity of the healthy uterus are microorganisms to be found, that the dividing line between the parts of the fetus to reach normally containing bacteria, the parts free from bacteria is the internal os.

Of the twenty-seven different varieties of bacteria which Wits discovered the streptococcus pyogenes albus occurred in about half the cases; the streptococcus pyogenes aureus the streptococcus on several occasions; the streptococcus pyogenes fifteen times. In his further experiments in trying to inoculate animals with the cultivations, Wits failed to establish the pathogenic character of these organisms. This explanation of their behavior was that they were in a state of "stimulated vitality."

Hölderlin (Archiv für Synästhenie, Bd. xxvii, No. 3.)
could find no bacteria in the cavity of the healthy uterus, but held that the vagina might contain pathogenic microorganisms; that these might migrate spontaneously into the uterine cavity, thus causing self-infection was possible.

Steffek (Centralblatt für Gynäkologie 1888) unequivocally asserts that the vagina contains pathogenic microorganisms, that they may at any time attack the uterine mucosa if opportunity be afforded them, e.g. after parturition, or gynecologically induced fever. That it behoves every one who attends midwifery cases, or performs a gynecological operation, previously to thoroughly disinfect the vagina. The time at great length describes what he considers complete disinfection. It is needless to say that the elaborate disinfection recommended by Steffek is impossible at least in midwifery practice.

Dr. Schorhoff (St. Petersburg. Frauenklinik. 1889) examined microscopically the cervical uterine discharge from over forty cases of chronic cervicitis of long standing, with the result that fifteen different species of non-pathogenic microorganisms were discovered, in addition to the pathogenic microorganisms described by Wieth. The non-pathogenic microorganisms were of course much more frequent, than the pathogenic.
Clinically, the cases of chronic endometritis where the pathogenic bacteria were present, did not show any difference from those where no microbes of this kind could be found. Scholzky does not agree with Dr. MacLeish that these pathogenic microbes are in a state of "sterile virulence" as by their inoculation in animals he produced the usual infected phenomenon. He maintains that under favorable conditions they would give rise to infection in human subjects. Dr. MacLeish's premise ultimately, not only throws light on the causative pathologies of certain forms of chronic endometritis, but it reestablishes Pasteur's faith in their antiseptic notion of treatment. A belief in the logical conclusions which follow the hypotheses advanced by Wink, Böttcher, Stoffel must tend to make us more cautious in the use of sound or in any manipulation which might introduce bacteria into the uterine cavity.

3rd. A fuller knowledge of the anatomical and physiological relation of the uterus to the organs immediately surrounding it.

Anatomical facts brought out by Bongard that the external muscular layer of the uterus not only extends into the broad ligaments, but into several other structures of the pelvic cavity accounts for some extent for the intimate relation that was known to exist between them in disease. It is possible that during entrapment or dilatation of this
mucosal layer set up in the treatment might extend to the uterus & bring about pathological results of considerable importance.

Just recently Prof Poirier (Le Progès Médical in 1890) has increased our knowledge of the distribution of the uterine lymphatics. The points out their anastomoses, the paths by which infection or disease process is most likely to travel. The fact which they probably take in inflammation, disease. It has treated many arguments there, but I have not much to say on this point for the reason that I do not know much of it & wish to add another to the many theories advanced in explanation of the micturition phenomenon that with uterine pathology.

The physiological relationship of the ovaries to the uterus is exemplified in menstruation. Evidence is not wanting to show that in normal condition of the ovaries, there is also a reflex pathological influence exerted upon the nervous apparatus of the uterus, resulting in a hyperplasia of the mucous membrane. & that the urine in some cases Entomology is this only an expression of symptom of functional disturbance of the ovaries. It is true that in some cases Entomology is thus only an expression or symptom of functional disturbance of the ovaries. It is true that in some cases cysts must be of considerable importance in the treatment of the disease.

Let us examine a case which seems to favour this view.

Case VI. Mrs Walker aged 25; married by year,
She had one child twelve months after marriage. Before marriage she never had any illness, she was quite regular at her menstrual periods which usually lasted three days. In confinement she was attended by a midwife, but a few days afterwards had to call in a doctor because of severe pain in her back down front of her abdomen. The doctor told her that she had inflammation of the womb. She became delirious, she was seriously ill for one month. Convalescence was slow, the feet were excessively swollen. This time menstruation commenced twelve months after her confinement. When she had a profuse discharge which lasted for eight days, was accompanied with a great deal of pain. She continued to menstruate about every three weeks, suffering much pain at her periods for two years. In Nov. 1884 I was sent for. Saw her for the first time. She was rolling about in bed, complaining of a severe burning pain all round the lower back but especially in the lower back of the abdomen. Pain was increased when pressure was applied most marked in the region of the right kidney. The temperature was 99.8, her tongue was dry, her breath hot, there was an anxious expression on her face. Menstruation had just begun. She said she had the cramps and the pain was very severe for several days...
before she went for me, I treated the case as one of pelvic peritonitis, &c. Poultices that fomentations were applied, & local tonics given internally. The first symptoms passed off in three days. She was often attended by my assistant for a fortnight. Her headache was so intense to cause her to dislike to move. She had not menstruated since her illness seven weeks before. She thought she was pregnant. She looked very anaemic and deformed. I prescribed a tonic to aid her to go into the country when she could bear next change of air. Menstruation commenced shortly after she went away. She had a great deal of pain and did not call in a doctor. On returning home, she continued to menstruate irregularly. Sometimes every three weeks, sometimes every fortnight. She also had much pain but I heard no more of her till July 20, 1841, when an urgent message came to go at once to her house, as her husband thought she had inflammation of the bowels. I found her nothing about as on the previous November with pain in the back, lower part of the abdomen. The pain in the right ileum region was particularly liable to the touch. She told me that she ceased menstruating only 14 days ago, but that now she seldom exceeded a fortnight between her periods. Her tongue was dry. Reader, price 130 to 150. Temperature 100. The same
July 27: Menstruation began in the night. Patient is a little scarce, but still has great pain tenderness in the right side. She finds relief by remaining on her back with the right leg drawn up toward the abdomen. A profuse irregular menstruation is continued for 16 days. Several dark clots of blood clots of membrane apparent in the discharge.

August 6: Menstruation now ceased, but patient still complains of pain, also a sensation as if a heavy dragging weight. On attempting to put her foot on the floor she feels a pain lasting from both buttocks. There is some loss of appetite but not so much pain in the back. Patient now without any white discharge.

On examination I found the cervix firm with soft slightly exerted lips. The uterine was heavy, introitus very painful when movement was attempted. It was impossible to replace the uterus as the fundus was bound down with adhesions. The right ovary was enlarged and painful when pressed upon, extending from the level of Douglas on the right side. Behind the uterus on the left was a thickened convoluted mass very sensitive to the touch. Left mass showed heavy fluid within in the uterus.

July 27: Told the bowels will relieve the tension in the uterus.
The cervix then profusely when touched, so I did not attempt to press a sound into the uterine cavity. From the history, examination of the case, I came to the conclusion that the patient after her confinement had a very severe attack of puerperal fever, that on two occasions in which I attended her she suffered from pelvic peritonitis localized in the region of the right ovary. That the contracted bladder was the chief cause of the pelvic irritation set up in the already susceptible uterus. When the bladder mass behind the uterus was I could not determine, but probably there was an infection of the urine from cystic and other bladders. These gave temporary comfort, but my patient did not improve, nor did the hard substance behind the uterus seem any less tender to the touch. A new feature also appeared viz. a periodic discharge of offensive sputa from the 25 uteri.

On Oct 27, 1847 I sent him to Dr. Sinclair to see with some notes of the case.

Dr. Sinclair replied to me at some length, after referring to the history of her case and acute peritonitis he continues: "The uterus is turned back a little, but the most prominent feature is a tubercular ulcer in the front of the female, behind it to the left of the uterus. There are also faeces which require attention. I believe it is an attack of the uterus."
at once you would set up the idea. From
the history of recurrent peritonitis I suspect
some deep lingering about the abdomen or
tuber. Dr. Sinclair advised repeated rest &
infusions, dusting with warm baths. This was
carried on for some time, but the hemmorage
thus obtained, of the patient's sufferings were
very great. About the middle of November she
was admitted into the Southern Hospital Charitable.
Where the same method of treatment was carried
out until

Nov. 27th when both ovaries & tubes were removed
by Prof. Sinclair. At first Dr. Sinclair intended
to remove only the right ovary & tube, but on ex-
amining the tube it was found to be very much
enlarged, to have a considerable cyst attached
to it. I examined the ovaries afterwards. The right
was rather larger than a walnut, the left as if it
were divided into three separate compartments.
The right tube was also thickened & dilated
as if it were several fossils; completely
covering both tubes long was an organized
film indicating recent inflammation.

The patient had one or two alarming rises of
temperature during the course of the following
week, but ultimately made a good recovery,
it was discharged from the hospital on Dec. 24.

Jan. 8th, 1841 Patient able to walk to my house.
She looks very much better, but has a slight
Uncorrected discharge. The pain in her back has almost gone. There is no feeling of drawing in her legs when she walks. She had no haeorrhage since the operation which was shortly after her last menstrual period. The uterus still felt large & heavy & slightly retroflexed but there was no evidence on attempted movement. No cedema. Any substance to feel between the uterus & rectum.

The patient did not present herself again until March 19th. She says that she is now perfectly well. She eats well, works hard, feels no pain anywhere. She has still a little white discharge but no haeorrhage. Her general appearance has very much improved. She looks a great deal better. She affirms that she never had any comfort for five years, except the last three months. Internecin in a cream & slight retroflexion of the uterus. The scar then being of the cervix has subsided. That it has contracted. The womb more round & resembling that of a multiparous more than a primiparous woman.

Removal of the ovaries & tubes has of late become a much almost operation. There is no doubt that it is possible to deal with the tubal tubule of some few British gynaecologists. I do not advocate extirpation of all diseased ovaries & tubes, as the abdominal surgeon has already devised means by which much relief may be given without depriving the patient of these organs, but here there were many indications
for the operation.

(1.) The intolerable pain by which the patient's life was a constant misery to her.

(2.) The disease condition of the ovary itself.

(3.) Intermittic remittent fever, due to reflex vitiation, therefore not amenable to the usual local treatment.

(4.) Anemia of severe degree rapidly improving as a result of the foregoing.

This case points clearly to the strong reflex influence of the ovaries upon the mucous membrane of the uterus explains why sometimes procedures applied to the uterus not only fail to effect a cure but can increase the local mischief. It would be interesting to know what is the precise pathological condition of the ovaries in such cases. The clinical symptoms of any whether subjective or objective by which such a condition might be diagnosed. The clinical history is often very important. In this case the leptomeningeal, nevertheless spread from the uterus in the first place, still up to fibrinosis on the way to the ovary which in turn exerted a reflex influence upon the uterus. Professor Young has made discoveries of the ovary itself but Dr. Sinclair has not been able yet to furnish me with particulars beyond the fact that the muscular layers of the pipe which was enormously thickened. There is at present an unlimited supply of ovaries, which taken along with the history
If the cause were to give ample basis for further,
epidemiological research, Dr. Neirinck (Dr. Petterburg in
August 1801. 19, 1876, to 1876) working in
Professor Stanislawski's clinic has histologically
examined a series of disease ovaries, four of which
were removed for dysmenorrhea. His endeavor was
to show that in these so-called small cystic
ovarian cysts in the chief part of the process,
that this begins by interfering with the umbilic
appendage. The fluid disappears; the walls of the
cyst then come together later, ultimately
the cyst is replaced by fibrous connective
tissue. The author does not offer any suggestion
as to the relation of this pathological process to
the ovaries, but probably it resembles to some
extent the pathological changes which occur in
the menopause.

Although pathology is thus not sufficiently
advanced to give a satisfactory explanation of
all the chronic processes which take place
in chronic submenstrual, it has thrown
much light upon important clinical
phenomena observed during the course of the
disease: given substance aid to the
physicians in his diagnosis; in many cases substituted a rational for
an empirical mode of treatment.
John of God, physician to King Henry III, in his learned treatise on "Boar Anglica," gives the following as a cure for epilepsy—"Boar bladder boiled, distilled, & c. & c."

This principle has an advantage over some of the modern therapeutic agents employed in endometritis. It is, however, the least, not so dangerous as the manipulative injuries which from time to time have been practised upon the uterine lining uteri by way of treatment. Such injuries to the uterus can yelgh as being introduced indiscriminately into the uterine cavity, allowed to remain there; and to the various incisions, incisions performed in medicine to the uterus, some saying regarding the physiology of the uterus, such as that proposed by Dr. Wallis (Extrait des Annales de la Société d'Anatomie du Grand-Hôtel, 1884), where muscular contraction or spasm was accountable not only for endometritis, but for many other pathological conditions. In order to overcome this supposed morbid spasm, plunging about the normal condition, the author in all cases forcibly dilated the cervical canal, cut the bladder of the uterus, thus permitting each part of the cervix with a pair of scissors. Thanks to pathology, such method of treatment is tested more a matter of history than practice. It is impossible to indicate any definite lines of treatment in chronic endometritis.
so much depends upon individual cases. As we have already seen it may be very simple or very complex, but it is always of the first importance to ascertain the cause of the disease, if possible to remove it. Sometimes this may be done in the early stages, before the morbid changes have advanced to any serious extent, and suffering treatment avoided. Occasionally local medicatio is sufficient, but as a rule attention must also be directed to the general state of health. But these points are best discussed clinically.

Case VIII. Mrs West, aged 24, married 2 years, has never had any children.

Came on May 30th, 1890, complaining of severe pain in her back and thighs, commencing a few days before menstruation and continuing during the whole length of her menstrual period. She began to menstruate at the age of 16; till 18 worked in a cotton mill as weaver, where she remained for 3 years.

Afterward she went into service for the likes of her marriage at 22. From 18 to 22 she menstruated every three weeks, it always had a great deal of pain. The discharge was small in amount, tinged with blood, lasted from 4 to 5 days. After marriage the pain at the menstrual period increased, and during the last 12 months she noticed a peculiar looking discharge presuated during the menstrual period. Menstruation now lasts 9 days, although the discharge is
Small in quantity, the pain in the back during the whole of this time is intense. There is also a chill pain on sensation of weight, which remains during the whole of the intra-membrane period. As she was just at "her time" palliative treatment was adopted to gentle specified means.

Examine 9th June. The cervix felt hard introverted.

The uterus was in normal position, freely movable but just large enough, pain was produced when movement was attempted bimanually.

I could not pass a thread of small depth, the canal was introduced with difficulty. On its removal the following day there was found to be a constriction of the internal os. A sound was now introduced, but it caused pain on removal wherever it touched the mucous membrane of the uterus. A larger one was then introduced. Patient felt much pain in lower part during the night. Next morning the bead was removed with great difficulty owing to the tightness of the internal os.

A thin procub was then introduced, the vagina plugged with a tampon of cotton wool soaked in glycerine. At first the tamon caused much discomfort, the patient could not move about on account of the pain starting through to the back limbs. After a few days spent mostly in the recumbent position it did not cause much inconvenience. 5
Reckoned to let it remain in position for some weeks. The history of this case appeared to be considerable delay in the interval, the termination produced by retention of the mucosa, setting up congestion first of the mucous membrane, then of the muscular substance of the uterus. It is surprising when the subject is young and healthy, how quickly the inflammatory mucous membrane returns to its normal condition after the local exciting cause has been removed. I have known a case where displacement of the uterus of long standing, with a history of severe abscess, accompanied with hematothick, was perfectly cured by simply replacing the uterus. In this case I am sorry to say, although the patient was a young healthy woman, her recovery was not satisfactory.

The uterus remained in position for nearly three weeks without causing much discomfort, but the day previous to her menstruating period, the pain was so intense that I had to be removed, and I have not replaced it since. Menstruation has not accompanied with as much pain as formerly, but there was a good deal of discomfort. Since then the patient has been more comfortable, but the menstrual flow still lasts from 6 to 8 days, accompanied with great pain in the back. There is also a considerable quantity of colored and discharge during the intermenstrual periods.
April 17, 1891. Patient does not seem to have improved very much. She has still a great discharge with pain at her menstrual period, a burning dragging feeling during the intervals. As I can find no ovarian or constitutional disease, the application of the curette would I think be the most efficacious treatment, but she is unwilling to present to undergo any further operative interference.

Case VIII. Mrs. Borthay, aged 39, married 20 years, had 7 children. There were six years between the 6th and 7th child. Menstruation was regular & lasted from 4 to 5 days until the winter of 1887 (15. Three years before the birth of her last child) when she began to menstruate irregularly, sometimes at the end of three weeks, sometimes every month. The patient felt much pain at the onset during her menstrual period which gradually increased to 2 days. She also noticed a white bubbling discharge continuing nearly all the time between her periods. This state of matters continued, her general health got worse until June 1889 when she became pregnant. During pregnancy she felt very ill that pain in her lower back. The white discharge continued but not so frequently. Loss of appetite & constipation were unusually pronounced all the time.

In Feb., 1890, she was delivered of a still-born child. Her recovery was very slow, three months after
Confinement. She could scarcely move about, or get out of bed without assistance. For three months she continued to have a constant offensive discharge at all times with a sense of fulness, dragging weight about the loins. Incontinence commenced at the end of three months, lasted 9 days, during which time she had a great quantity of discharge without pain. She has been more regular since her confinement, but the menstruation continues to increase. The leucorrhea is also more abundant.

Nov. 1890. Patient looks pale and anaemic, & complains of great pain in the hypogastric, sacral & abdominal regions. She is restless without pain when she moves about. She feels life a burden to her. She ate little was poorly, & slept little. She is inclined to vomit, expressing when it was the large heavy stools. Movements were easily affected without much pain. The bowel passed beyond the usual time but caused much harmonly, but only slight pain.

As this was a case of Chronic Enterocolitis, probably due in the first instance to Sclerotinuria, I found no important complication existed. I decided that an iron truss first, to be followed by the application of the curate would be the most suitable treatment.

On Nov. 26 a small sinew lump was introduced. The patient stood the operation very well.
Nov. 27. A large clot was introduced.

Nov. 28. Last clot was introduced. Some of the
cause much pain to the patient whilst in the
anæsthetic period, felt tolerably comfortable.
On the following morning—Nov. 29—half a grain
of morphia was administered subcutaneously, the
clot removed, & the interior of the uterus cultured
with a sharp spoon. A large amount of dissected
tissue was removed, & the patient felt very
little pain. At first the uterus felt large &
swollen, but after a few days of tissue was
removed away I could feel it contracting &
grasping the spoon. The vagina was then filled
with a tampon of lint soaked with bicarbonate
of soda, and chloroform (1 in 3) was applied
on a playfair sponge soaked with boric acid, to the
whole of the interior of the uterus. Very little
discomfort was felt, until a few hours after
the operation when a smacking was complained
of.

Nov. 30. Tampon removed. The vagina now felt
only with solution of carbolic sublimate (1 in 100).

Dec. 1. Patient is able to sit up in bed. She has
very little pain but complains of headaches &
sickness.

Dec. 2. She is able to sit out of bed & feels
comfortable. A few days afterwards she went
to Southport where she remained for three weeks.
During the first fortnight after the operation she
Patient had a copious, more frequent discharge of a brownish cast, which was often rather offensive to smell, although she used an enema of liquid with milk & morning. Menstruation returned on Dec. 25th after 7 days. The patient had much distress, at the pain in the back. Lower part of abdomen was very firm.

**Feb 24th 1841**  Menstruation which lasted 7 days has just ceased. There are four weeks since the last menstrual period, and although the patient has still a good deal of pain at her period, she is not so miserable as formerly. She has gained some flesh.

**March 3rd 1841** Patient complains of much pain & sickness. Menstruation commenced yesterday.

**March 8th**  Menstruation has just ceased. Patient is rather protruded. Throat pain in her back & a dragging sensibility in the lower part of the abdomen. I visited her again on April 3rd. I found that the general menstruation on the 5th. Her menstruation lasted about 6 days. The pain was still severe. There is then a gradual change for the better during the last few months. The abdomen has entirely ceased. The anemic condition of the patient has improved; her menstrual period is shorter & less severe. She has not seen so frequently. The uterus is still large but not very painful when movement is attempted. I hope a further application of the Eau de Aut will be even more effectual.
The above is an instance of a group of cases where the application of the curette is invaluable. In cases where there is a large dilatation of the uterus, or a quantity of discharged tissue, the curette not only removes such tissue, but acts as a stimulus to the flabby walls of the uterus, promoting a healthy granulating surface. Good results are also obtained from the use of strong Cantharides alone, such as 0.5% of cantharides acid, but it often becomes a difficult problem to decide when to use the Cantharides when to use the Curette. The amount of discharge tissue; the presence or absence of complications; the age of the patient; the history of the case, are important factors which must be weighed in coming to a decision. In Case II (p. 12) where Cantharides was applied successfully, the uterus was much contracted and the patient was in a fair condition. The curette, when used, did not appear to be sufficiently directed to warrant its further removal, but healthy action was promptly restored by the application of Cantharides. In applying the curette or applying Cantharides to the interior of the uterus, it is impossible to say how much the operation of "dilating the cervix" contributed to the ultimate success of the case. Although I disagree with the doctrine that simple dilatation is of value - I believe that "dilating the cervix" has far the most important action upon the entire uterus than is generally supposed. I know of several instances where simple dilatation of the cervical canal had a
Marked beneficial influence not only upon the cervix itself but upon the whole uterine cavity. But whether it was due to overcoming "inert fluid condition," or to promoting a healthy action of the tissues I know not. After weeks ago I sent Dr. Cripps all that I could gather valuable cases of haemorrhoids and chronic affections, such as catheters of the bladder which had been cured by me alone himself by the use of daily diluting 1/4 of the quinine, to which forcibly reminded me of my own experience in treating the cervix.

These last two cases cannot be regarded as "miraculous cases," but it cannot be forgotten that I am presenting "clinical cases" not "miraculous cases."

Case No. 12. Miss Scott, aged 27, has been married four years, had one child 12 months after marriage. This patient was never robust but enjoyed good health until 6 months from the present date June 1870, when she began to feel a pain in her back, especially at her period. Before marriage she was regular at her period, menstruation usually lasted two days sometimes three. She observed a little white discharge on one or two occasions just after the second menstruation, but nothing of any importance. She made a good recovery from this confinement and menstruation began about 15 months afterward.
In Dec 1867, she began to feel discomfort and pain in her back, especially at the menstruation period. These pains gradually set in, until they became unbearable. The complaint was noted in October 1869.

Patient says she has constant pain in her back, hands, accompanied with dragging sensation as if it were a weight. The white discharge has now increased very much. It began immediately after the menstruation period and continues now or less the recent period. During the last few months it has become yellowish. Each retains her line. The menstrual discharge has not increased or diminished. It usually lasts three days, the only difference is that it occurs at three times or any much increased.

The patient looks very anaemic. In addition to the above, complains of pain in the stomach, palpitation, temporal loss of appetite. Pressure on the epigastrium and abdomen induces pain, pressure on the spine is also excruciatingly tender.

She has often headaches. She feels very exhausted.

She attributes the state of her nerves to the position which she had a great deal of. At the time she noticed the change in her health at the time.

Internally examination shows large uterus. No displacement. Cancer is evident.

As displacement. Cancer is evident. The uterus is not large. The patient has
a constant desire to micturate, but I cannot detect any without irritation or from local injury. Perhaps it is due partly to the heavy uterus pressing upon bladder when she is in the upright position. Partially to the irritable condition of the nervous system.

Thinking this was a favourable case for antispasmodic drugs, I sent the patient to bed for a few days, dilated the cervix, began a systematic treatment with a repeated solution of common salt water. I used a Bouin's syringe, slowly injected from one to two ounces every second or third day. The remaining six liters of the mess for nearly three weeks, by the end of that time the labour had greatly diminished, the pain in her back then had almost ceased.

The labour was not used more than twice a week after the first fortnight. It was discontinued before the end of October.

Rev. Mr. Patrick much better: does not complain of any pain in her back there, has seen no white discharge for 10 days. This was one of my most favourable cases so far as the convulsion & labour and discharge were concerned, but unfortunately she had an attack of delirium tertianum which ended fatally on Dec. 19th 1870. It would be interesting to know whether the labour was permanently ended.

Case 2. Mr. Hutquid, aged 26 & promised 4 sons. I have known this patient for nearly six
Aprias. On May 25th 1886 I attended her in confinement. She was then a strong healthy woman, and was delivered of a female child between eight and nine months after marriage. She made a good recovery, and lived six years. She began to menstruate five weeks after confinement, continued to do so regularly for nearly two years until she became pregnant. I again attended her in confinement on Sept 26th 1888. She had a very hard labour and was delirious for a few days. There was no labour pain

The child was 9 pounds 11 ounces and was retained for some time. There was a good deal of post partum haemorrhage, and I could not obtain the usual contraction of the uterus after labour. Bright red streaks appeared in the bowel discharge for a week but were not accompanied with pain. At the end of 14 days she was able to sit up and feel very weak in the loins. On the 21st day after confinement, while moving about, she was suddenly taken ill with a pain in the region of the left kidney shooting through the back down the limb, that had to be bandaged. Hot fomentations were also applied to the abdomen. The pain gradually subsided. She was able to do about again in a few days. No internal examination was made. Menstruation commenced five weeks after confinement as on the preceding occasion but was
accompanying with severe pain in her back & legs. Shortly after this she notices a purulent looking discharge, sometimes almost green in appearance which continued nearly the whole of her intervals and persisted. She did not seek medical advice till the beginning of the following Sept. (1869) nearly one year after the birth of the second child. At that time she looked very anaemic & weak. She complained of loss of appetite, a feeling of exhaustion, pain in the back, a purulent discharge & a disagreeable odor, & a dragging sensation in the limbs. On examination I found the vaginal walls lax & flabby. The uterus large & soft, lying in a tangle, pressing upon both vasa which were large & tender.

The fundus was pressing upon the rectum & as it was noted not to move with respiration, it was thought that the fundus might be in the rectum. I displaced the uterus at least raised the fundus into position. Instead of pressing, I procured an astringent solution with a tinct. regarding the case as one of urinary tuberculosis with complications. The patient felt much more easier & improved in health for some months, but the purulent discharge continued to increase notwithstanding the constant use of the syrup.
In March 1892, one of the children died from pneumonia consequent upon measles. The patient lost much strength, and constant nursing for three weeks told upon her health. She came to consult me in May, looking very ill indeed.

The pain in her back, tension of dragging in the loins, had increased considerably. The discharge was completed between her menstrual periods, but she described it as "washing the away," as she was particularly clean about her person. This menstrual discharge caused her much annoyance, as yet the bleeding was caused by introducing the hand, but the whole uterine case was incurable.

From the laws of the uterus, the state of the mucous membrane, the history of the case, I was convinced that there was chronic要想 of the cervix and body of the uterus. I introduced a long tube and washing was able without any difficulty to begin a course of systematic irrigation of the cervix uteri with a saturated solution of chlorate of potash.

Owing to the enlargement of the uterus, the constant need for support, the secretion was replaced after each irrigation, the patient allowed to remain in bed for two hours. She showed improvement in a fortnight, the three weeks the improvement was so great that she did not see any discharge for two days towards the beginning of August. The patient felt
Much better, still discharge had almost disappeared. I therefore advised in not any operations for the uterus.

Sept. 21st Patient not so well, is greatly distressed because the discharge is returning. It is not as disagreeable as formerly, but is daily increasing in quantity. The same mode of treatment was again adopted, the improvement although marked was not quite as rapid as before.

Sept. 24th I washed out the uterus as usual, using about two drachms of lukewarm solution of chloride of sodium. I injected the fluid rather quickly, and feared that very little returned through the os. In about an hour afterward the patient began with violent pains in the uterus, & I was sent for. She looked bleached & quite prostrate. The pains were severe. She said they resembled labour pains, only they were shorter & more intense which they lasted. Hot foaming tea were applied to sustain her, but the patient did not find much relief for three hours. This is the only instance where I have observed any alarming symptoms follow the use of intravenous injection. Probably in this case the uterus was induced by a too sudden distension with fluid which I believe was rather cold. Since then I have been careful to use a tepid solution, the inject it slowly. The further progress of this case was very satisfactory.
The injection was discontinued early in January.
Feb. 7th 1841. The patient still wears a pessary, but is seldom troubled with any pain. The menstrual discharge is practically gone. The general health has improved enormously.

April 5th 1841. Patient still improving in general health, menstruates regularly, has very little discomfort. The menstruation sometimes returns for a day or two after menstruation, but it is very slight, is not accompanied with pain in the back.

Much has been said in this country against intravenous injection, experiments made to point out its dangers. Some persons of opinion that with a suitable fluid planned manipulation it will be a valuable adjunct to our local therapeutic agents in certain cases of chronic diverticula. If it be true that many cases take their origin from the action of bacteria or septic processes like the interior of the uterus, the destruction of these bacteria, washing out of their debris must form an important part of treatment. The problem is how is this to be done effectively with least risk to the patient?

Provided that the fluid is a suitable one, provided also that due care and skill are exercised by the operator, I believe the risks of injection are minimized. The number of substances recommended for injection is already large. Constanis Sublinha is amongst the most popular, but I have used...
used it because it has already proved itself to be highly dangerous, notwithstanding the method adopted to prevent its absorption. I am not aware that Chloride of Potash has been used for this purpose, but my reasons for selecting it were: a. Because it is very destructive to lower forms of life, according to recent experiment, it may slightly impair to some life substance.

b. Because there is no danger to the patient from absorption into the System.

c. Because I believe it has a beneficial action upon mucous membranes. It is difficult to explain this action, but experience has taught me that chronic inflammation of mucous membranes taken on a healthy appearance after treatment with Chloride of Potash solution. Probably this is brought about by its destruction of minute organisms and its stimulating effect upon the tissue thereby attracting fresh supply of blood to the part.

In the case of intratracheal applications, its mechanical washing away of the debris from the mucous membrane is an advantage. While irrigation has been the simple application by Cantharides, we want more than the destruction and stimulating action of the Cantharides. We want the surface of the mucus membrane to be kept as clean and aseptic as possible. It is by the application of these principles that the best results are obtained in treating inflammation of mucous membranes.
generally, their application becomes much more necessary in uterine cases where there is a tendency to retain the products of inflammation, not only from the shape and structure of the organ, but from the blocking up of the cervix canal, displacement, or other complications. I do not maintain that vaginal cure will take the place of cauteries or the curettage, although it is safer with advantage for the cure of these. The cases most amenable to vaginal cure with chloroform alone are those where the cataract is in a comparatively early stage, whether of a hemorrhagic or traumatic type, or where the diseased tissue has not become so extensive as to warrant its destruction by cautery, or its removal with the curette.

The extent of the disease must of course be made out by the symptoms, such as hemorrhage, tendency to bleeding when touched by the sound, and a certain amount of hemorrhage. If test of long standing, it is not a contraindication to this mode of treatment. Indeed as the following case will show early treatment in such cases is often most effective.

Case Xi. Mrs Adams (Victim), aged 30, has been married nearly five years. She began to menstruate at the age of 16, menstruated regularly every month up to her marriage at 26. Her menstrual period usually lasted four days, she had very little pain, nor saw any white discharge. I attended her in confinement. Every year for nine months after marriage she had a very hard time, was
delivered by forceps of a child born alive. There was a slight laceration of the cervix but not of the perineum. She made a good recovery, began to menstruate about three months after confinement. Menstruation lasted four days was preceded by a good deal of pain in the back. This pain continued to increase during the latter part of 1889 and early in 1890 she felt a pain in the left side extending to the back, shooting down the left leg.

In May 1890, her menstrual periods were considerably lengthened. The pain in the back increased, and she did not seek medical advice till Aug. 10 1891. Present condition. Patient says that during the last three months the menstruation nearly every fortnight, has caused pain and dragging weight in the loins, especially on the left side. She menstruated twice during the month of July, each time she was lutenized from 7 to 10 days. During this time the pain was intense, but she is more free from pain now. Internal examination of the uterus soft, the lips an intact. The uterus is normal in position but enlarge when movement is attempted. Both ovaries are rather large, but the left is very sensitive to the touch. Pain was produced on pressure externally over the uterus, left side.

There is also laceration of vagina, but no discharge could be seen coming from it. I introduced a speculum of Forman (C) during the following week.
When the left ovary surrounding fluids were less tense she began to irritate the uterine cavity with a saturated solution of chloride of sodium. Menstruation occurred about the 25th August. lasted only four days. The patient had a much more comfortable time. After menstruation had ceased I continued my operations for a fortnight. She was 29 days before menstruation again commenced. It lasted only four days, and she was entirely free from pain after it ceased. Since that time she has menstruated regularly every month and never exceeded four days in duration. The pain has been comparatively slight. Sometimes she has a stiffness in her back for a few days afterward.

April 3rd, 1841 I called to the my patient and found that she has been "just regular" until twice last year. She sometimes has a slight pain in her left groin but only after menstruation.

I offer no explanation of the pathology or etiology of this case but simply give my results. Pathologists have generally described several types of Chronic Endometritis, whose identification clinically is an impossibility. Without discussing the question of classification, for the sake of simplifying my additional observations on diagnosis I shall include all cases in one or other of the two great groups of Haemorrhagic or Inflammatory. Haemorrhagic - This group, depending upon

[...missing text...]

...chiefly of the vascular nature of the
Mucous membrane, as far as my experience goes, is the one which attracts the attention of practising physicians most. Hemorrhages occurring at certain intervals was considered a sure sign of chronic Endometritis. But some exceptions which I shall presently allude to. It may still be considered as the most reliable objective symptom which the process. In some cases the hemorrhage became regular intervals, or only occasionally, in other cases it shows itself in a gradual lengthening of the menstrual period. The following may be considered as typical.

**Case XIII.** Mrs. Strong, aged 35, married 8 years. Her aunt told her of consumption.

She began to menstruate at 19, but was not regular for two or three years. Sometimes she was 4 months, sometimes 5 months without menstruating. At 23 she began to menstruate every month. Menstruation lasted about 12 days, it was accompanied with only slight pain. She never noticed any white discharge, continued regular up to the date of her marriage at 27. She was delivered of her first child which was stillborn, 12 months after marriage. She had a very bad time and a slow recovery. Two months afterward she began to menstruate, continued 6 days regularly until she became pregnant again. Her second child was born two years from marriage. This time she was relieved of a living.
Child. She did not suckle it, began to menstruate three months after confinement. Her period now began to lengthen from 4 to 6 days, there accompanied with pain and tenderness in the back and hips.

In August 1885 she was delivered of her third child, whom she breast-fed for 14 months.

Menstruation commenced the month after the baby was born, lasted 6 days. The pain was now very severe & continued to increase at each menstrual period. This state of matters, by an increase of pain, gradual lengthening of the menstrual period, continued for three years, told very considerably upon her general health.

In May 1889 she began to menstruate once week before her usual time. Menstruation lasted for 7 days. During the whole time she complained of intense pain "shivering down". The pains were described as sharp & cutting, radiating into her back & hips. This was followed by a dull pain in the back which remained after menstruation had ceased. She again began to menstruate at the end of three weeks when the pains & chills were excessive. She was now free from pain in her back & hips, & a remission of weight on attempting to walk.

In August 1889 she became alarmed though medical aid for the first time. The doctor told her that the excessive haemorrhage & pains were due to weakness. She made no internal
Examining, but prescribed medicine, and visited her house. She made no improvement but slowly. On Oct. 3, 1887, her husband met with an accident and she had to nurse him till the middle of December. During all this time, her pain and discomfort were very great, almost unbearable.

On Oct. 14, she began to menstruate, continued without ceasing till the end of December.

January 10, 1890, a doctor was sent for. The patient at first time was so weak that she could scarcely walk. She had pains like the 'cutting of a knife' in her back. These pains were increased when she attempted to walk, or even to put her feet on the floor. The doctor examined her internally and stated her that she was suffering from chronic inflammation of the womb. She was sent to bed for one month. Dr. A. L. Cushing was applied— I could not ascertain from the police the exact nature of this. She did not begin to menstruate till one month after getting out of bed, but after that she menstruated very freely, as nearly as had been formerly. Indeed, she thought it was more severe. The menstruation increased to 10 days, sometimes longer, and during this time she had a constant dragging pain, that would not walk about. She also noticed a white discharge in her intermenstrual period. During all this summer of 1890, the patient could scarcely move about, but recovered

...
from tuberculosis of brain. Her head also began to trouble her. She felt dizzy, and constantly had the feeling of falling. This she attributes to nervousness and loss of blood.

On Feb 20th, 1841, patient came to consult me for the first time. She says that she has been rapidly getting worse for 12 months. The present condition is truly not a happy one. She is lean and anaemic. The heart's palpitation have the typical anemic beats. In addition to the constant pain in her back, sighing, she has neurasthenic pain in her stomach. She complains of nausea on her head like the rocking of water. She is sleepless, irritable — in a word — ushered.

From her appearance, to the clicking in her brain, I thought she was suffering little from a severe middle cerebral insufficiency or possibly from some cerebral disease or incipient smallpox. She had become less to consult me on Feb 12th. I had not yet heard.

I therefore prescribed palliative treatment, I requested her to return for internal examination at some future time.

On March 30th a message came to the hotel.

I found her lying in the bed in a very exhausted condition, complaining of pain all over her heart. She had been unconscious 12 days. I could only after days before the sent for me. She had great pains all round her head.
Scarcely forth. I made an internal examination in April 24th. The uterus was in normal position but felt large and heavy. Great pain was produced when movement was attempted. The cervix felt thick and the life of the os were very much swollen, slightly eroded, and a large flat ulcer, presented through pearly appearance of mucin. The cavity of the uterus was larger than normal, but not so large as I would have expected from the flushing of the uterus being annually. Pain recurred by gout and the slightest touch of the sound, but no reverse could be elicited. The ovaries masses surrounding them were also very tender. Recommended her to remain in bed in order that I might check the cervix cure, explore the uterine cavity, and mediate in the curettage or cautery. On explaining these matters to her husband I found that it was impossible for her to have a reasonable amount of comfort; good nursing at home. Accordingly I suggested her removal to hospital, the following day sent her in a cab, with a note to Professor Sinclair, who after examining admitted her at once into the Southern Hospital. On Sunday April 16th I had a note from the hospital asking me to be present at 12:30 as Mr. S. was to be examined under anaesthetic. Dr. Sinclair agreed with my diagnosis, but on Sunday morning there was a quick rise of temperature from normal
This high temperature kept up all Sunday, I gradually fell on Monday. I administered Chlorophene, P. Dr. Sinclair in Examination came to the conclusion that there was pus forming in the right lung, lymphatic tissue and bronchial interfered with present course of illness.

In addition to the leading symptoms of haemoptysis, the diagnosis of Chronic Endomelitis in this case can be made readily easy by the history. The deep climax as felt bimanually, an introduction of the sound, the differential diagnosis of both cases from lymphadenin or growths of a vascular type, & diffuse sarcena, must of course be borne in mind.

When one is suspicious of the former, the use of the sound, palpation of the cervical node with the antiphlogistic procedures recommended by Schulte are valuable aids to diagnosis. When malignant disease is suspected, a microscopic examination of scrapings taken with the curette must settle the question.

In connection with the subject of diagnosis, Dr. Sinclair showed me an interesting case in Hospital which he cured while I was present. The history resembled in many points that of my own case just related, only the hemoptysis was more frequent, appeared in Character, about 6 months ago. Dr. Sinclair cured it in the interior of the lesions, treated the case as one of haemorrhagic bronchitis. The patient...
Improved for a month or two, but the last four months rapidly got worse; the hemorrhage has been almost continual.

On April 25th, Dr. Sinclair recalled for the second time, while paring away a great deal of comparatively loose tissue detached a laparotomy on the posterior wall of the uterus. Dr. Sinclair was sure in my wish to let me examine it with his luteus, so I could feel two distinct formations about the size of half a walnut. Dr. Sinclair scraped away the so-called fibrous capsule dividing the uterus for diagnosis, and in the further treatment of the case.

Dr. Sinclair said that this was the third case within the last few months. Three small films of my patients' organs were detached by him while submitting it to a chronic endometritis, where the ordinary methods of examination had not revealed them.

Sometimes in endometritis, the hemorrhage is very irregular, or may occur only occasionally. Such cases may either be hemorrhagic from the first (as in 2011), or the hemorrhage may be secondary to an adventitious hemorrhage Cataract.

This latter type where we meet with occasional hemorrhage Patients, rather with a history of prolonged hemorrhage is by no means uncommon. I examined a woman some months ago from a patient who had hemorrhage extending over three years, lately accompanied with fever.
Two or three elongated, but not quite visible to the
naked eye, tubules were doubtless the origin of the
"show" observed during life. The following is an
example of this type:

Case XIII. J.E. present, aged 42, married
22 years and had 6 children. Her first child was
born two years after marriage. She made a good
recovery from all her confinement, but a rule had
very severe attacks.

On March 27, 1886, she consulted me because of pains
in her back, hips and shoulders. These I believed were
of rheumatic origin, treated her accordingly.

The following September she told me that she had a
good deal of pain "internally," and that she had a purulent
discharge, the matter. She also said that three years
previously she had in Feb. 1883, she was delivered of her last
child of 7 months' term. The child lived 19 weeks,
and during that time the patient lost her rest with
nursing. Shortly after birth, in the summer of 1883,
she noticed a white discharge continually increasing
in quantity. She had more pain at her menstrual
periods which lasted from 4 to 5 days — previous
they lasted only 3 days — and she never observed any
hemorrhage except at menstruation.

On examination I found a slight edema of the
labium which was easily replaced without causing
pain, as the labium was firmly movable. The labia
of the vulva were large, elongated. On using a
speculum I could see the posterior lip, a large
When also some inflammatory patches all around the \( \text{os} \), which were inflamed red and covered with epithelium. In addition to these there were numerous enlarged follicles which looked ready to burst; & issuing from the \( \text{os} \) was a thick mucous purulent discharge. I regarded the case as one of Chronic Ceruobal Sinus accompanied with elevation of temperature a lotin of few months of potash to be used night and morning. I applied various laxatives to the ulcerated surface for 12 months with but little effect. The leukorrhea discharge although not offensive was very frequent, changing from time to time. My patient did not improve either in general health or locally. I now became desperate began to dilate the cervical canal with frequent colons with cotton wool saturated in Epsom salt, twice a week at first, but latterly once a week. After three months of this treatment the leukorrhea was not so copious, the ulcerated patches showed signs of improvement. The patient told me not late or reme-
health, the distressed life which was formerly red and swollen had considerably improved.

Towards the end of 1888 I ceased my operations, but the patient still continued her disturbed night and morning. I heard no more of the case till August 1889 when I was called in because she was alarmed at her increasing size and discomfort.

She looked very much like she had, but said she felt much better and had a great distension in her bowels. She had not menstruated since the beginning of February, but being 45 years of age, she thought it was the "Change of Life." On inspecting the abdomen I could feel a large substance. On internal examination found that she was advanced 6 or 6 months in pregnancy. On being questioned the patient said that she experienced a movement occasionally but thought that it was wind in the bowels.

In Oct 1889 she was delivered of a healthy male child. There was considerable postpartum hemorrhage. The sexual discharge lasted about a fortnight. She did not suckle the child. She began to menstruate 5 weeks after confinement. She experienced more pain than usual. The discharge was profuse, lasting for 8 days.

I was not consulted again till Feb 1890. 12. 14 months after confinement. The patient complained that the pain in her back increased. She had been "numb" 3 days during each of her last
Three periods, I had white discharge between them.
The discharge was then sometimes the white discharge was tinged with blood.
She feared lest her former trouble was returning.

Examination - The uterus was slightly retroflexed as formerly; rather painful on movement, and the cervix looked perfectly normal for a multipara's woman. The uterine also felt large. Introitus there was a copious leucorrhea discharge, coming from that.

Explained the uterus introitus accessory.

The patient was more comfortable, but the pain in her back continued. A cataract of hsemorrhage still appeared in the leucorrhea discharge at intervals of sometimes a week, sometimes longer.

The duration of the menstrual period increased to 10 days. Whether the hemorrhages observed in the first instance came from the endometrium, or from the ulceration of the cervix, it is impossible to say; probably the cataractal effusion spread from the cervix into the uterine cavity after the birth of the last child.

Most frequent - Attention was first called to this large important group by the Swiss, but unfortunately it is clinically ill-defined. In typical cases a copious leucorrhea is the chief symptom, but as this is the prominent symptom in cervical as well as in corporal discharges, it is often impossible to distinguish...
between them. In such cases we have to rely chiefly upon the history, such as somnolence, alteration of the shape and hardness of the uterine as best as bimanually, by the touch.

The subjective symptoms such as pain in the back pains, dysmenorrhoea, followed by objective arrangements may be regarded as common to both groups, are valuable only as being suggestive of menstruation in the first place, or confirmation when taken along with some of the more objective symptoms above described.

Of the uncommon type cases 18 & 19 are examples also the following:

Case XIV. Mrs. Hudson, aged 26, has been married 5 years. She had her first child 12 months after marriage; in Oct. 1880. Then for half year after marriage she was delivered of a second child, I attended her on both occasions. She made good recovery, I observed nothing unusual.

Patient says that early in 1883 when she was pregnant about two months, she noticed a white discharge for the first time. She felt very uncomfortable and had more pain in her back than during the previous pregnancy. The white discharge continued to increase until her confinement in October.

The lochia continued very offensive for several weeks, it was succeeded by a discharge of a yellow cast, which lasted until menstruation commenced.
about the middle of December. Patient did not
return to me till the end of December, a few days
after menstruation had ceased. She looked very
anemic, that lost flesh since Summer. She
complained of weakness in her back, I became
alarmed at the return of the mucu-purulent
discharge. There was a history of tenderness.
She of her sisters had further stood in the most
tissue pain & debility, but she was supposed
to be the strongest of the family.
Examination - Cervix felt short and fuller.
The uterus also felt large & lapping but there
was no tenderness in the region of the ovaries.
No displacement, I could find no tenderness
on moving the back of the uterus, but pain was
complaints of when movement was attempted
harmlessly. On passing a Speculum I could
describe an abundant mucu-purulent discharge coming
from the U. As I was not quite sure totally
the catarrh had extended beyond the Cervical
Canal, I recommended a warm bath the night
before, prescribed an ice paraffinment to
viscous my patient to rest from her
household duties as much as possible, to take
after air exercise. She improved very much
in general health, went away into the Country
during the early part of the Summer of 1849.
On her return in July she came again to consult
me. The pain in her back had in creased
especially at her menstrual periods. The menstrual discharge, which was not almost continuously wrong away in any much.

On examination I found the uterine walls soft

and slightly as previously, but not much pain

was produced on movement. There was no

endometritis in the region of the ovaries or parietal

tissue. I was convinced especially from

bimanual examination that there was a focal

lesion probably in the region of the fundus.

July 4th. Passed a very long tenent. The cervix

gave way easily. Every little pain was present.

July 5th. The cervix was sufficiently dilated to allow

me to apply the uterine cavity with calamine

soaked in iodine. A good deal of pain was

experienced in the region of the fundus, a

slight uterus on top occurred. The patient

was kept in the recumbent position a few

days. She complained of thirsting on the

following day, but afterward had not much

inconvenience. I then used an intrauterine

douch of saturated solution of Chloride of Soda,

which a week for a fortnight. The menstrual

discharge gradually subsided. On the return of

her menstrual period at the end of the month,

the patient had not as much pain as previously.

During the whole of August there was a slight

discharge, which the patient regarded

it as slighting. I did not think it necessary
to use the solution again. The vaginal douche was used every night for a few months.

Nov. 27, 1892. Patient has been very comfortable for nearly two months. The pain in her back is much better. She has not had discharge since April 19, 1892. I called upon my patient who says that she is now quite well. The pain in the back is gone. She had no white discharge since the end of October 1892. She has not used the syrup since December.

But beside the well marked cases where menorrhagia is the characteristic symptom, where its development can be traced from a gradual lengthening of the period to an almost continuous flow, the typical menorrhagic subjects, there are many gradations and variations which offer exercise in diagnosis for the most skilled gynecologist.

Post Menstrual Examination of the uterus has shown that chronic Catarrh of the mucous membrane is much more common than was generally supposed. That it existed in Cases where there was neither profuse nor constant discharge, nor irregular haemorrhage, to attract attention, when the usual diagnostic method failed to detect it. For the rest, a review of certain American cases by Dr. S. Schuley in 1882 published an article, "Centrallatt für Trepft: 1882, p. 393" advocating the use of a cotton tampon.
in a 20 to 25 per cent. solution of formalin or glycerin. The vagina must be freely drenched, the tampon then firmly pressed into its vault, so that the upper vaginal portion of the cervix are completely covered. On carefully removing such a tampon through a dilated phenomenon after from 20 to 40 hours in a healthy state of the uterus, there will be found on it only a small quantity of clear glassy looking cervical secretion.

On the other hand, if the mucous membrane of the corpus uteri is affected with catarrh, there is more or less pus mixed with the cervical secretion. This is, of course, not a strict proof that the pus comes from the cavity of the uterus, as in such cases cervical catarrh is more or less always is often present. It is nevertheless a valuable addition to our diagnostic efforts.

There are cases where we can with a fair amount of certainty exclude the presence of cervical catarrh. When by this application a small amount of pus can be detected.

The fact that the menstrual discharge is small or uncertain, irregular or its flow, is the principal reason that makes it diagnosis so difficult. As Shafter points out, the chief value of the tampon is to catch up the 20 or 40 hours secretion coming through the cervix. The smaller the quantity of pus in the mixer,
important to its correctness, as it would have escaped other methods of discovery. Not only so, but the cessation is probably in an early stage, it will afford an opportunity for prompt and systematic treatment.

Dr. Tyler Smith in his description of the arrhythmia of the uterine fibroid noted that some forms of dysmenorrhea were referable to the contractility attacking the myometrium, especially when hysterical accompanied the menstrual state of the uterus.

On the other hand there is an important class of cases, where dysmenorrhea is marked, where there is neither cervical nor vaginal discharge, and when by applying the tampon it may be shown that chronic endometritis is the leading cause. The patient in such cases is usually anemic, complaining of severe nervous pains on or two day's previous to the menorrhea. The usual premenstrual symptoms have ceased to give any relief, eventually preceded her menstrual period, from develops the distressing nervous symptoms such as headaches, lumbar pains, stomach disorders.

The following is an example—

Case XV. Miss M. Age 26. Single.
She consulted me in the beginning of Oct., 1884, complaining of pain in the epigastric region, extending into the back. The pain was increased after meals, sometimes she felt sick but never vomited.
She menstruated regularly, but the pain in her stomas was increased before and during the menstrual period. There was a localized deep-seated pain in the right epigastrium extending upward to the right breast and downward to the right iliac region.

I diagnosed commencing ulceration of the stomach, but once put her on milk diet. After three minutes' treatment, comparative rest she informed felt slightly. The pain in the stomach lessens, but the complaint of pain in her back especially on the right side. She describes it as a dragging toward the right side. On one or two occasions she had an acute pain between her periods, as if she were beginning to menstruate. The periods were regular, but her irritability could be caused by accumulation of mucus. As there was no improvement & I recommended rest, relaying air for the lungs. On returning the patient was as healthy, except the pain had increased in her back pains. She described them as more acute & cutting in character.

On being questioned she stated that she noticed a slight white discharge for a day or so after menstruating, but it was not sufficient to seriously attract her attention. I suggest to her mistress that an internal examination should be made, I found as follows: Cervix in normal position, as slightly
flowing to the touch. Ulcers freely movable but painful when movement was made. No hemorrhage or pernicious discharge was observed, but the posterior lip of the os looked rather red. I applied the best tannin of Schinz, then removing it the following day I could detect nothing beyond the usual plug of mucus. After a few weeks as the pain did not subside, I again used the tannin, and its removal I was satisfied that there was less mucus with the mucus. The patient felt relieved for a day or two after the tannin was removed. I prescribed a mixture of vine, arsenic tannic unica, also a mixture containing muriatic to be taken every hour the pain was severe. She improved in general health during the winter of 1899-1900 but the pain still returned at intervals.

Towards the end of April 1900 the discharge became evident, increased in quantity. The patient also noted that it looked yellow in colour, stained his linen. During the summer months, she went with the family into the country, returned towards the end of July improved in health, but still complaining of pain in her lower part front of the abdomen. The mucus present discharge had also greatly increased in quantity. I then began a systematic intra uterine irrigation with solution of Sodium Chloride.
If fertilization takes place, the ovum attaches itself for a time to the mucous membrane, sooner or later through the impinges of nutrition of the uterine portion of the placenta it becomes detached, infection occurs. It is advisable therefore in cases of delay especially when examining one can find no departure from the normal condition, to apply the tampon before proceeding to a definite course of treatment. It is particularly applicable to the early stage of endometritis. Patients afflicted with endometritis because of the present headache, jaundice, dysuria, or whatever seems to them the most distressing symptom, when in truth the genital malady, if not the sole cause is at least an important factor. Moreover it is of great significance for the entire organism that an early diagnosis should be made in chronic endometritis, because of its influence on the other nerve centers, it because it may be the beginning of a series of grave disorders of the pelvic organs. It is beyond doubt that cases of metritis, parametritis, followed by changes in the region of the uterine, finally in a florid ulcer of the vagina may take their origin from simple uterine catarrh.

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Fairfield
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April 27th 1891