Schatz - Notes of cases in private practice, 1884
Thesis

General Notes of Cases in Private Practice with Observations

My practice lies in South Africa. The calling is my home, by birth as well as now, by adoption. The so-called specific disadvantages of colonial life, are not unfounded. My health demanded a climate of such a nature as we enjoy here; consequently I was looking forward to the time when I should be able to leave damp, cold "nude Reekie," to return free from any living sorrows. The colonist for its needs - as well as if not better - than England. Numbers of men have swarmed out here under the delusive idea that they had merely to settle down, start a practice - in three or four years have
have announced "a different site" to start for home, settle down in dignified retirement. This "glorious vision" is not so easily realized. Then coming out here I must be prepared to face competition as keen as - either in England or Scotland. The life here is harder, journeys longer, the work often more - perhaps a great deal more physical than mental. Many hours, often three days together, away from home & family. During that period - perhaps only seeing two or three distant patients. In this way very small opportunities are afforded us, inaccurately, & minutely observing our patients. A great number of the people are of a very migratory nature. Again - with a large proportion, especially - the Dutch element - you are speeded to either kill or cure in the shortest possible time - as if improvement does not set in, when they fancy it, you are frequently told that your services are no longer required and
and they pass on to the next man.

Then again in this far distant offon - the is a most serious, 

Irreparable loss to all of us - as a natural consequence, we are obliged to fall back on our own small, and incomplete study library, for any enlightenment to multitude cases, cropping up constantly in our daily work.

I trust therefore I shall not be considered too bold in praying that the above explanations might be taken into merciful consideration in awarding through the following pages, finding the marked, and evident meagerness of any actual physiological, or other scientific investigations.

However willing therefore the flesh as well as the spirit might have been to enter into any such observation, the difficulties attendant on a rough astral practice, present too many obstacles for a favourable, satisfactory termination. My
Case No. I

My first case which I shall enumerate occurred at sea, on my way to the Colony, shortly after receiving my double diploma of Bachelor of Medicine, & Master in Surgery.

John Rie, aged forty-two, a second class passenger, had been troubled with a very tight structure, & had neglected seeking the surgeon's advice, until one day, the husk being allowed to go unchecked, sudden & complete retention of urine took place. I was asked to see the case at consultation.

Hot baths, opiates, various other remedics, were employed without any success. The patient was now thoroughly under the influence of Chloroform. Every possible means with force were used—such as the silver catheter, for elastic force, &c.,

still no relief was given.

The condition of the patient seemed most severe, & the symptoms most urgent. We calculated well the time since absolute retention had lasted. Finally after due consideration, decided to afford relief by making
Making an artificial opening: unfortunately, the surgeon's stock of instruments seemed rather to belong to the 15th, than to the 19th century. My own set were deep down in the hold. We were at a loss for a curved anal trocar, or anything that would act as a substitute. Don't in vain.

By sheer force of circumstances, we were obliged to puncture above the pubis. The operation, I had always understood, was fraught with more danger than puncture by the rectum. So it was with no very willing spirit I undertook— at the urgent request of the ship's surgeon— with the full consent of the patient— to tap the bladder, by means of a suprapubic puncture. The urine was allowed to escape slowly, gradually; nor did we attempt, to evacuate the entire contents of the organ. Nothing special occurred, during the operation.

Our patient progressed most satisfactorily for over twelve (12) hours after the operation. When— during sleep, unfortunately, managed to pull out.
out the tube & fastening, — which we had so carefully placed in position.

By the time we saw him, there was a tension & trunnation into the arterial but recent tissues. The bladder refilled in a most marvellously rapid time. In order to again relieve the Ditrening retention symptom, & also to allow of the fit of the infirmary, we once more punctured; by first making a long superficial incision, then piercing the bladder.

Shortly after however, signs of inflammation manifest, having set in, showed themselves: pulse & temperature rose higher, higher.

Great depression however now set in: low muttering delirium continued, till the end. When he succumbed to the inevitable. — Although from the history of the case, as represented to us on first seeing the patient, we thought possibly it was less of a spasmodic, or inflammatory obstruction; than an obdurate structure of some standing, yet it cannot be helped.

Driving
coming to the conclusion, on once turning over the case in my mind, and with a little more personal experience to guide me — that we might have shown more patience and perseverance in the use of the hot baths, and catheterism — before resorting to operative measures. No doubt to our youthful minds — my colleague also being a junior in the profession — the symptoms seemed far more urgent, pressing — than they perhaps actually were — Still, as the case stood, had the unfortunate man by accident not withdrawn the tube — the case might have had a different aspect — at any rate. Strict, though I need hardly say if, I have benefitted by the experience gained; although 'gained with such disastrous consequences to a fellow mortal.'
Case II

My best case occurred in one of our small country villages. The carriage making by machinery, was the staple element of industry. I was surgeon to one of these works, employing over 150 men; on an average, I had several minor surgical cases in a month. On one occasion however, I was sent for, I found one of the men had been the victim of a more than usually severe accident. His hand had been caught and dragged into one of the planing machines, of course, mutilated. On examining his hand I found the 1st, 2nd, 3rd, and 4th fingers entirely crushed. The only part that had escaped was the thumb and its corresponding metacarpal bone. The interosseous belonging to the 2nd to the 4th fingers were simply one pulpy mass. In the mean while I had the assistance of a colleague. The patient being placed well under the influence of chloroform, we were able to examine the different parts thoroughly. On cutting away the crushed portion...
I found the injury had implicated
some of the os. phalae as well
namely - portion of the os. magnum
of uniform - My colleague - Dr.
Bacle graduate was in favor
of amputation at the wrist joint.
Taking into consideration the man's
age - five & thirty - this bodily phylype
which was that of a well nourished
adult - the nature of the injury.
last & why means an unimportant
factor - the fact of his being
a working man - with wife & family
dependent on his daily manual labour.
I held out that with due and all possible
precautions the attempt might be
made to save the thumb which
would be of priceless value to
him in after life as compared
to the entire loss of his hand.
I undertook the responsibility
of the case & proceeded as best
I deemed to get a useful limb.
The metacarpal bone of the index
finger was cut away close to its
joint with the trapezoid - the
3rd, 4th & 5th being as above stated are
gone - were entirely removed.
An angular piece was taken off, both from the DS Magnum & theumeiform, by means of the bone-forceps. The parts removed were the following—almost the entire 1st finger—merely leaving a very small portion of the distal corpus adjoining the interdigital— the whole of the 2nd, 3rd & 4th fingers— & portion of the DS Magnum &umeiform.

The debride thus incited, the carpo-metacarpal joints— & yet will using, as far as possible the greatest care in thoroughly cleansing & purifying every part affected. No septic inflammation occurred to mar the progress of my case.

Of course I had no antiseptic—carbolic spray, producer at the Operation—nor subsequently during the dressing— Carbolic dressings were however used— also carbolic lotions. All carbolized catgut stitches were used. These were removed, one after the other, before the 7th day. Up to the 7th day. the hand progressed surprisingly.

On that day, I was obliged to...
reopened a portion of the newly cleansed wound, in order to avoid of the escape of a fair amount of semipermeable matter. By diligently attending to the thorough cleansing of this reopened portion, any possible danger which might have cropped up was fortunately tided over. The cure was an exceedingly tedious, protracted one, causing me many anxious hours yet with the exercise of a fair amount of patience, perseverance, I was eventually rewarded by finding the wound thoroughly healed.

The first few weeks there was great complaint about a constant severe pain at the terminal points of the stump, where the nerves were severed by the crash. The result amply repaid me for all the anxiety and trouble of the treatment. The thumb, my patron, finds the most useful to him. It is marvel to a surprising extent. The temperature, creeping about the 3rd day, did not cause me any worry. Rarely three months after the accident, the poor fellow was visited.
visited by another severe trouble. He had scarcely availed himself of my sanction to leave his room for a little outdoor exercise when he was attacked by a most acute and severe form of Rheumatic fever.

In fact so much so that on more than one occasion I actually feared for his life. Every joint in his body was implicated. The sufferer kept far from the most acute suffering. I was doubly anxious about him—among the symptoms indicative of Sub-cardiac mischief, setting in, I found the pulse irregular—setting suddenly slow and then quicker—intermitting.

On auscultation, I detected at the apex, a murmur septalic in nature of a bellows sound nature.

The case I venture to think presents many interesting & to me as many instructive points. Now doubt the case is a fair example of what may sometimes be achieved by a forced method of conservatice treatment. I used calfus antiseptic as I feared that the sutures might have caused irritation. Was I justified in risking septicemia in order to save one finger? I think so in this case at least. Because had septicemia supervened I shored at once have resorted to amputation.
Case (A)

In order, I shall enumerate four exceedingly interesting cases of polypae of the rectum - occurring in four widely different subjects.

1. The first victim, was an old man, aged 70 years. The next occurred in a young man of twenty, with symptoms of tubercular mischief. The 3rd was a lady, over 60 years, presenting strong suspicions of a cancerous ulcer. The last, was an otherwise perfectly healthy female, of forty-five years.

I shall particularise each, in the order given above.

In the first case, I ascertained had been suffering been by another practitioner, who had declined to use operative interference. The aged man had not the moment's peace from the constant, pain, irritation, & discomfort, at the lowest fare. I found, on careful examination, that he was suffering from a double polypus. The patient was a big, flabby subject, heart's action strongly weak. I quite appreciated my colleague's intention to tackle such a subject, yet his bodily & mental suffering, seemed so great, that I decided to try, believe him.

This
This was my main plea for brethren; my one was dearly such a fine one yet I would with my respected superiors to recollect that I was at young practice, just entering on a new life, thinking I had only to put my shoulder to the wheel, I was sure to succeed; also fancying that one good successful stroke at the wheel of one's practice would lead to have the story, way. & slight up the adfice work considerably—may be pardoned for putting these sentiments when I state that out here—whenever any of our young attorney return to start practice they are constantly told; that the general public are only waiting for a grand stroke of the knife, or the wonder feel sure to immediately open their doors & rush for the new man. He said in this case certain justified the means. A colleague kindly administered the Chloroform, carefully watching the breathing, & heart's action we had decided not to put the patient thoroughly.
thoroughly under the full influence of the
anesthetic. I used in this case
a mixture composed of equal parts
of alcohol & chloroform. I firmly
believe that the stimulation of such
the organs allowed us to push the battle
further than we wanted otherwise have
been justified. The incision of the double
pocket & a thin strip of filed lid
was lightly placed between the edge
of the wound; taking care to prevent
any tearing of, or plugging of, large
veins. The lid was put to confine the
wound for 3 or 4 days. The wound
was only removed my 2nd day, owing
to my patient's home being in a
neighboring village - some hours from
my own. At the termination of the 3rd
week every vestige of the wound;
gaping as it was - had disappeared
except the cicatrix indicating the
line of incision. As a lesson my
old patient felt elate to your
younger - if predisposing came
this case & make out to be the
fact of his having previously passed
many hrs. almost every day in
the saddle, through cold & wet.
Another probable factor likely to have influenced the formation of the fistula tract seems to me to be a coexisting hepatic disturbance of the nature of alcoholic cirrhosis. This chronic inflammation had no doubt had its share in prostrating the vital powers. He had been previously given to indulge too freely in alcoholic stimulants. His strength had reduced. His nervous energy as a consequence was shunted and all these combined paved the way to a lowered state of the system and degenerative changes.

My next case which as stated above occurred in a young man of barely thirty-two years. His case presented some very interesting points in contrast to the former one. He was thin, slender, and very much subject to coughs and colds for which he had previously consulted me. His pulmonary organs showed unmistakable signs of tuberculosis, mischief being present.
There was marked dulness at the apex with slight flattening of the movements on the same site. Worrying me that there was strong evidence of a certain amount of infiltration going on at the apex. My attention was first drawn to any local mischief about the lower border — by quite accidentally feeling a slight hardness about the edge of a mantle about two inches outside the anal orifice. No pain was felt; the swelling increased. He started questioning — unfortunately continued this too long. Given the abscess time, opportunity to burst inwardly. It was said for, immediately caused the swelling—pointing out to him the James. Consequence of delaying to give free vent to the retained matter — was much as the tendency is to burst inwardly with the certain result of leading a fistulous sinus.

So it turned out to have done.

For some months I lost sight of him in the mean while, as afterwards ascertainment, a moderate amount of moisture was constantly exuding from the wound. How he noticed
another swelling on the opposite side to the former one. Following by that advice he instantly sent for me. I allowed him a couple of hours' practice; then seized the swelling deeply. He was under infected, & disappointed at seeing so small an amount of actual matter escaping; but I made him watch the secreta. This turned out most satisfactorily. He collapsed from behind forward; the canal closed thoroughly. The red lining was however acting as a most debilitating drain to him, wearing him down day after day. I feel I had to do something to stop this discharge. The question then before me was: Am I justified in attempting operative interference or not? My patient had also previously suffered from a severe hacking cough and expectoration, certain amount of night sweats. The case decidedly presented an unfavourable prognosis. It seemed to me how ever that if the case was left to itself, the patient would soon succumb. As the outcome of all the pros & cons of the case I decided to operate & see if any relief...
Relief might not be given.

I divided all the structure situated between the intestinal tract & the hymen. Of course it was an extremely anxious time, towards the end of the second week. My constant dread was that the state of the dysentery might be an obstacle to the favourable healing of the wound. Strange to relate however, the wound healed beautifully; only once I thought I detected a slight failing in the mending process. To stimulate the healing action I applied a rather novel treatment: namely:

I lightly touched the wound with a small quantity of Liquor Ispirata in comm. Hasting's fluid. The application however was so stated very carefully, slightly done, sufficient to act as an irritant only, getting the flabby tissues to renewed action. I have applied it several nearly similar conditions & it has always answered well. The case progressed most favourably in less than three weeks, my patient was up & about, resuming his ordinary occupation. Ever
Ever since the operation there has been no return of the cough, & the lung mischief has certainly been temporarily entirely blocked. I do not mean to infer that the operation has had any curative effect on the tubercular process. Still the fact remains, that my patient has never been in better health than now. I also that we are justified to operate in certain cases—though the general condition of our patient might contraindicate any operative interference. Then how are we to decide? What is the line to be drawn, which will indicate to us whether on the one hand we are to hold back our knife, or let the patient take his chance of living on, with such a lesion weakening his body day by day. On the other hand, give him the choice of listening to the greater evil, by undertaking the risk of a smaller damage? We were taught that unless the mischief in the lung was very slight & the local suffering (suffering) very great it would be prudent not to interfere in pulmonary cases. In this case the
the local suffering actually was not so intense, but I considered that the state constantly going on would quickly in fact had already transferred to to a low condition, as to effectually prevent any good being done to the pulmonary organs themselves. Perhaps this will now be a fitting opportunity of bringing before us a few Observations in Connection with the Subject of Pulmonary Consumption in the course of my practice out here; and from what I have gathered from some of our veteran practitioners in this country— with their long experience of colonial practice, they tell me, that Pulmonary complaints are not by any means so rare in our Colony as one might easily imagine judging from our mild dry equable climate. The fact is during any comparatively short tenure out here I have met with a surprising number in regard to the percentage of Pulmonary cases. A most interesting point, in Connection with the symptoms in a large number of cases, was the
utter absence of the development of any catarhal mischief for a considerable time subsequent to the critical manifestations of primary mischief being present. Only too often we are connected for an entirely different ailment - history cough, expectoration and might events seem ever to have disturbed them; yet on physical examination the presence of extensive tubercular infiltration is revealed.

Careful questioning will generally however bring out the fact of previous gradually failing health - diarrhoea or some other complication is often first complained of. The parents of the individuals themselves are generally ignorant of any incipient danger in the region of the lungs.

In conclusion one may be pardoned for inferring from the above that all species of localized apical disease, cedular always be referred applied to the theory that the lesion follows as a result of a gradual 2 sequence of catarhal inflammation from the air passages into the ultimate air cells.
The next case is that of a female aged fifty. The complaint dated back some five or seven years. At that time she complained of constant pain and uneasiness across the bowels. These symptoms gradually passed down toward the lower bowel. However, the pain entirely left her, only a certain amount of irritation remaining. It then turned in toward the rectum. Some twelve (12) months back I violently constant diarrhoeic stools set in, with no great amount of straining. Bloody mucus passed along with the watery mass. My first examination only revealed a small ulcer toward the anterior border of the anus. This was treated by the Soled ointment, which healed through the bloody discharge now stopped. But no treatment had any influence on the diarrhoea. Of course I naturally suspected some far advanced complication.

Now suddenly the stools began to pass through the rectal canal. An examination performed revealed the existence of a hard, indurated, protruding tumour at the position of a piliferous tract.
Communicating with the vaginal canal

Great swelling of the fist set in.

The discharge from Rerema now stopped

entirely; the contents of the bowel passed

through the vagina. It sometimes seem

to fluctuate, show more passing through

the anterior—than more again by

the posterior canal. I did not attempt

the passage of any tampons, &c.

owing to a considerable amount of

ulceration being present at the induction

do to form pessaries seemed for a time to

relieve. The absence of pain since

the case came into my hands—was

a notable feature; consequently

I was not called upon to assuage

pain—generally such a prominent

symptom, as well as a distressing one.

I was naturally anxious after

I had made out a narrowing of the

canal— to ascertain whether the

defect was merely the result of

previous inflammatory action, or

such liable to curative treatment

or whether it was due to cancerous

inflation. All the symptoms pointed

conclusively to the last hypothesis,

which freed her from caputulat.
The general thickening in this case seem to have commenced higher up than usual; so the swelling at first was not within reach of my examining finger, but to have gradually, and with sudden irritating rapidity, extended downward. The patient is speedily declining. Any article of diet taken, instantly brings on a passage of fecal matter, through the rectal canal. Still pain is entirely absent. Any further interference would only tend to shorten their earthly existence; for living she is not — the end to Near; so perhaps, the kindest action would be, to wish her out of her present terrible, suffering, to a world where there is no disease or sorrow.

Our 4th last case, of this nature can be dismissed with few words. It was consulted by Mr. W aged forty-five for a large painful swelling, which had rapidly formed in the region of the left buttock, towards its lower border, approaching the anal orifice. She had been well nourished, previous to my seeing it, felt no distress, fluctuation of
I immediately then and there opened the swelling. A cavity almost large enough to contain a medium-sized orange, filled with matted, infected tissue, presented itself to my view. By careful drainage the gradually decreased in size. At about six weeks time, nothing but a long tunnel of pus remained. Several measures were tried, such as the injection of oil, forcing the canal with fused nitrate of silver, strapping 10. 10. 10. 11. after readily tried.

Finally, I decided to incise. I found the external opening, situated at a considerable distance from the anal orifice, and although I did not think it necessary to force the knife through it, yet the tissue was a very firm, long paping wound. With the usual after treatment, however, the wound healed satisfactorily in about four weeks time. The patient had been complaining for a considerable time previous to the operation, of a rapid severe growing pain at the site of the mass. The site was in other respects a perfectly sound healthy woman. Here complained of a single Puslike fistulas which might be referred to the reproductive organs.
There was no evidence of any haemorrhoids:

She was rather of a sedentary habit,

sitting a great deal – yet no predisposing
cause entered satisfactorily account for
nor was she a person of great flexibility
of body, of her system in any febrile condition.

The above four cases have

however taught me the extreme importance

of getting our patients to grasp the fact – that much valuable time, or great
suffering, may be saved in the one ease – if
be avoided in the other

if they would only act promptly

yet medical advice with no little delay

as possible – what amount of suffering
might not have been prevented in these
cases, if we had been consulted at
the first departure from health, when
the lesion was only in its infancy.

The knowledge of the pathological origin
cause of fistulae is therefore of
the greatest possible consequence.

It is a matter of great practical
interest to us, not merely to the study
of fistula – whether it results in
a morbid condition from local causes, is

27.
in the alimentary Canal itself: or whether
the starting point, was in the sub-
cutaneous cellular tissue, surrounding
the rectum, canal orifice. In respect
to any preventive treatment, it is most
important to decide where the disease
commenced.

---

Remarks & observations on some
Obstetric Cases.

Cases of displacement of the womb,
are indeed very far from uncommon
in our Colony. So doubt the uterine
organs are greatly influenced by the
climate; & the evident relaxing effect
of the heat. I have met a surprising
number of displacements, especially posteriorly,
not only in married women; but
from testimony to its frequent frequency in
unmarried females as well. I have
noticed more particularly, that the angle
of flexion seems to vary in almost
every case. My impression is, that
some authors have attempted, to draw
too great a line of demarcation,
between the flexion & the version,
In the first, the cervical portion of the uteru
uterus remains in position, the fundus only being involved, of falling back; that is, in which the long axis of the cervix is in a parallel line to that of the Pelvic brim - in the 2nd dis-placement is said to take place in the upper portion of the Vaginal canal; the uterus as a whole falling back.

At any rate, practically this minute difference will not be of any great material value to us - the uterine sound has proved to me of immense worth, in readily enabling me to decide the precise angle, which the fundus has to the body of the uterus. Some authors, seem to take a peculiar pleasure, in greatly enlarging, or the smallest change which takes place in using the sound. No wonder young practitioners like myself, find themselves, at first exceedingly reluctant, to turn to have recourse to the sound - in fact this want of courage is often carried to such an extent, that case - in which great & lasting good might have been done, by the proper timely use of the instrument - have been allowed to "hang on" till too late for any benefit the derived - even from our best
men—specialists in Europe when they (the patients) are advised to proceed to as a last resource.

The following is a case in point—

A young lady had been for over twelve months under the care of one of my colleagues. He had diagnosed a posterior displacement—tried without success, all the usual means of getting the fallen organ back to its place.

The case was not of old standing.

There was no sign of any adhesions.

Yet she was advised to proceed to surgery for advice and treatment without ever any attempt having been made to pass the uterine sound. It can hardly be called ignorance on the part of the practitioner; as he had mentioned such an instrument to her, but had enlarged on the dangers of using it, in such an extent that she was only too pleased to continue, that she did not apply it. More—praised him for his prudent caution, carefulness.

Manual replacement—pure & simple.

I have not found in my run of cases answering quite so satisfactorily as I always understand them to do. I don't want to
he found however, as a rule, that by the time we are convinced, the mischief has been allowed to run on so long, and has set so deeply rooted, that the chance are against its being beyond our power to cure.

The tampon of caustic cotton – a recommendation by Homoeo has been of the greatest service to me after a fairly atenue trial. Of course only as a preliminary step previous to applying any remedy.

This brings me to a subject on which I think sufficient stress cannot be laid: as a guide & warning to those just entering practice.

It can be summed up in a few words.

Always aim at finding & pursuing the cause.

The etiology of all diseases – do not fail into the evil habit of treating the symptoms – find the "medios periciti" of the lesion remove them. If the symptoms will as a consequence disappear.

Only too often in the above atermic cases no attempt is made to remove, or lessen the original cause.
Of the displacement. As often almost we find that instead of keeping
in view the fact that the use of a
person is merely to only to prevent
a replacement of the perineum falling
out of its proper position, as it seems
as many practitioners interpret the
move in as much as they suspend
this very instrument for the purpose
of forcibly pushing up the base of the
fundus before leaving it there to retain
the organ in position. And yet one
frequently hears I wonder at the
somewhat indignation expressed by
medical men at the idea. If success
of Greek treatment. So wonder such
possible use of the person when
the fundus of title replaced, only
aggravates the evil. I instead of
straightening the organ. May
actually in some cases double the
fundus in the pelvic cavity of the
uterus. I lately saw a case—
not the first which brought this
point forcibly before my mind.

— I was urgently sent for one
morning, to attend to a lady—Not
Married. I found her in a

M001
Most alarming, faint, and condition. She had been vomiting, almost incessantly since the middle of the day. Her sickness had increased by the day's event. Everything had been rejected, and absolutely nothing would stay on the stomach. When I arrived, she was vomiting, nothing she but white frothy mucus. I tried several remedies, but to no purpose — ice was even rejected. She patient was a comparative stranger to me. A lady patient of mine, however, who was attending her and who had sent for me — gave one to understand that she (the patient) was suffering from uterine displacement, for which she was wearing an instrument. There was then no sign of the Causes. So suspectly some difficulty giving cause to account for the strange and continuous vomiting. I requested permission to examine her. On passing my forefinger well back along the posterior wall of the vaginal canal, I well up to the posterior one. As I came...
came across a singular impediment. I found the uterus not only in a flexed condition, but positively doubled back on itself—so that we have the different parts as follows: first we felt the cervix. Then, going back, we find the posterior wall of the uterus, leading to the posterior outside sac. Now we find the fundus properly fixed into this sac, thus dividing this outer sac into two portions, having another cavity behind the fundus. Now it so happened that it was in this last cavity that the upper bar of the pessary had not implicated, so that instead of supporting the replaced organ, it only forced it more on itself, as stated above, doubled the fundus on to the cervix. In another case I found very much the same condition, except that the fundus had to tightly squeezed between the upper 1/3 of the ascending limits of the pessary. I instantly removed the pessary in the former case, and the result was...
was magpie. Every sign of
sickness disappeared in a wonderfully
short time - and there was no re-
currence of any unpleasant symptoms.

In reference to vaginal examination
in virgins - there has too often occurred
but little for us to examine ordinary
than for rectum - insufficient knowledge
of the condition of the Pelvic viscera
that, nor seems to follow on the latter
examination. Still I firmly hold that
in this the displacement is only
of minor importance - they are best
left alone. No wonder therefore
drawing conclusions from cases
such as the one quoted above - that
a great number of our failures are
due to the fact that we neglect
to remove as far as possible any
inverted conditions that may be the
cause, or contribute to causing the
displacement - before we dent the
uterus in its normal position.

For example in several of my
cases - which have previously been
treated by my colleagues - I have
found the metronome. It is possible.
Refer to such cases where the rectification was associated with decided congestion of the organs.

Although the congestion may be the direct result of the displacement, yet if the congestion was removed, the fixation would be easier to replace. Parturition, with its consequences, being the most general cause of any displacement—should I say the uterine snore, as the yielding fibrous floor—thus resembles the partition. But how in the case of uterine causes, with their no doubt well-defined causes as tight-lacing & constant horse-riding, especially during or too near a menstural period; & then too as in our colony the rectal effect of the heat, & all these combine, are so unlikely in the posterior tissues thinking the uterus to the sacrum, the womb as if it were being now weakened, & predisposed to a slight relaxation, & consequent fulness, may press against the veins, carrying the blood back from the uterus, & thus cause congestion of
of the organ by obstructing the flow of

I find further, in connection with the

parking subject that a large number

of our uterine patients frequently

do not suspect the existence of any

wound mischief in themselves. They

may perhaps complain of having to

suffer with undue frequency, con-
sistipation or dyspeptic symptoms may

crop up. We find through that often

the only sign is the presence of reflex

nerves in the head. Pain that we however

have tried with non-success to allay,
or remove by attacking the head itself,

Having had recourse to various means.

and remedies, we are in the end forced to

suspect that there may be some specific

source of irritation - a sort of sympathetic

motoric sensation, having its origin in the

female reproductive organs, I being

transferred by nerves of some con-

veying power to a weaker, and more

readily impressed part of the system.

The "mode of conveyance" is found

to be traceable to the sympathetic

and pneumogastric nerves. The influence

travelling up to the subcerebral probably

alas
affect the harmony existing there, and affect the parts by their sensibility being altered, and heightened into morbid sensations. Although no doubt to a certain extent these conditions are regulated by irritability, or nervous reversibility of the person—yet in a considerable number of cases occurring under my own observation, I have certainly not found these conditions coexisting, as often with susceptible temperaments, or persons naturally nervous—as I had anticipated. For have I been able to trace any necessarily hereditary history of nervous disease, or insanity? This sympathy between the seat of production of any distant part is further exemplified by pain in the higher from hip joint disease, or pain in the shoulder from hepatic disease, or those under incontinence—a most instructive, and interesting fact. As a consequence of physiological research we have to express our warmest obligations to Dr. Brown Seagard & Professor Bemard, for much valuable information in connection with this subject derived from their physiological investigation.
Case 10

My next was in case of Perforated Salpingitis.

with Plerocercous attack.

Mrs. S., aged five years. One young very tall woman was suddenly attacked one evening with severe "fits" as they were called by the relatives. Her regular medical attendant being out of town I was sent for. I was told she was "sencepe," vowel or at her full time. This was about 5 P.M. I found her breathing vigorously, perfectly insensible. The convulsions were of an epilepsiform nature, foam on her lips, no effort capable of moving her. Her own attendant having come in we decided after due consideration to temporarily await County Surgeon. Having a very serious case in his own family, my colleague requested me to further conduct this case. About 7 P.M. I decided to administer Chloroform carefully, watching the effect. The inhalation was continued in small quantities till 4 A.M. made its influence, the convulsions became less frequent, finally ceased as long as she was under its influence. As the moment she regained complete consciousness the attacks set in.
with renewed power, so much so that I took the husband, another two attendants and myself all our combined efforts to keep her quiet on the bed. Oh, the pain of the distension—disagreement. The pelvis outlet was found to be small, the os firmly closed. Labour now set in—slowly and gradually—dilated—shaving the Bladder wall. With me I further described this dilatation by means of my fingers. The os was being sufficiently open—& making out a vertex presentation. Draped the membranes, applied the forceps. After some trouble succeeded in withdrawing a big female child. The placenta was apparently dead, livid face, perfectly placid. The usual means for wetting such cases were resorted to, but after a considerable time during which I had several times nearly given it up as useless—I was rewarded by finding the child gradually recovering from the temporary asphyxia—breathing become clearly but barely established. In the mean while I had of course directed that one of the attendants should apply gentle pressure over the abdomen.
watched the mother. It was while they again, in examining the mother, hearing the description of the child to an intelligent nurse that I was inspired to find first bag and another bag of membranes present. I gripped another head presenting. The forceps were applied, and another fracture brought down; also in an asphyxiated condition. At this stage I had not yet succeeded in restoring the first child, so here I had to attend to two almost apparently lifeless infants. The task was no easy one. In the latter instance I failed twice in re-establishing the breathing. There were two distinct bags of membrane, and the placenta was enfolded into a single mass, with no individual bifurcating cord. Only slight traces of albumen were detected also a small amount of pus in the urine; but both had disappeared within a week. There were symptoms of "anemia arteriosis" for several days after the delivery. Intense headache has been complained of during the day previous to the onset of the eclampsia. Subsequently she was treated with Chloral.
Chloroform brought about perfect darkness of the room, and a few points to the case. I shall draw attention to the age of the patient as a foreshadowing of the patient's thirty-five years. The period of forced anaesthesia lasted from 9:30 until 4:00 AM, fully 9 hours. This, I believe, considered a fairly long stretch. The patient remained by giving the chloroform was in a decided semi-comatose condition. I had the patient in the immediate effect of the anaesthetic very well and had the method of administering the chloroform in small doses, sufficient to control the violent muscular actions, whilst carefully watching for the recurrence of any paroxysms. The conscious breathing was almost continuous. Further, the presence of pus, which was noted in the urine, might strongly indicate that the pelvis of the kidney had been the subject of some recent inflammation. Its presence being of the pus is understood a rather uncommon complication. The evacuation of the urine was unfortunately delayed.
delayed till the 2nd day after the attack. Daily examinations after that showed a decrease in almost a regular retrograde gradation. I suspected that for some reason or other, her regular attendant had remained he urine about fourteen days previous to the accouchement, I had detected traces of albumen them already. The umbilical area before the birth was not very excrescent. Limited principally to oedema of the lower extremities. I directed my attention to the following points:

The condition of the circulation. More especially to the state of the blood in regard to its watery ingredient. In this point might be of considerable importance in the "rubra manifesta" of the attack. It was worthy of notice that was twice the confinements, my patient presented all the features of an anaemic condition of the blood which lasted for a considerable time, although gradually improved by remedies. To doubt as a result, the nutrition of the nerve centres was not adequately carried out. The cerebral ataxia.
May have been at the same time the result of a weak heart's action from functional cause. No doubt, actual organic paralysis were discovered, or it may been the cause, as stated above viz. due to the condition of the blood corpuscles themselves - maybe an insufficiency in the number of the red ones - This would I take it be a most serious disease as the consequent deficiency of Oxygen would prevent the proper evolution of nerve force from the brain, and doubt so predispose to any convulsive seizure. Now as to the albumen present in the urine - As the fact would point to some structural change having taken place in the kidney - So we might also conclude that not unlikely some change of the following nature must occurred in the kidney. The change which one found within the renal structure - to be associated with the presence of albumen, might be due to a lesion of an inflammatory nature probably at an inflammation of the epithelium of the tubules - also to an obliteration of the lymphatic space by inflammatory products.
products — the nutrition of the epithelium would thus interfered with, or with a natural recess, of the impairment of its functions — having then also a serious nerve disturbance in the brain during the convulsive attack — the tension of the blood in the kidney might be increased — from certain causes, and thus favor the easy escape of the albumen out of the blood. Temporary "an aura" also occurred as another somewhat rare complication — the trio for a time seemed fixed, well dilated. I can only close the above subject by putting the still open question, as to what is the connection between the presence of these morbid agents circulating in the blood, while it is that peculiar, not formidable variety of epileptic convulsion.
And we come to certain observations
made in reference to the subject of
the treatment after treatment, more especially
in connection with the use of ergot
in cases of labour.

When first engaged to be in attendance
along the acquaintance - tried to
labor for some unaccountable reason
a wretched morbid anxiety to get
the expulsion of the placenta effected
with as little delay as possible -
I was never particularly anxious
during previous to the actual birth
of the foetus - I was led, in con-
sequence of the above peculiarly
- to adopt the habit of invariably
unless absolutely contraindicated
administering a good large dose
of ergot immediately on the birth
of the foetal head - I was always
led to believe this to be a safe
- or almost certain preventative against
post-partum haemorrhage - Lately
however, I have given up this method,
owing to my having had on large
number of cases in which I had
the greatest worry and trouble in
gettle the placenta to be expelled.
cause no doubt lies with my mode of conducting the case. Yet I entirely attribute it to the use of the ligatures. I never use more than 3 or 4. The management was done with the utmost good faith in endeavouring to follow out the instructions of my respected teacher. Another factor in the delay of the operation I further ascribe to over treatment. My anxiety to see the completion of the labour, and to have everything conducted in the safest possible way to my patient, led me to err on the side of "doing too much". My anxiety to have the uterus contract made me give the sugar as above. I also resorted to too active attempts in the use of the hand over the abdominal varieties. I give these honest bare facts, as I went along with my cases, feeling confident that nothing but good can come of knowing, and being cognizant of the faults, errors, and which I had fallen and may yet fall. Yet experience is more worthily prized.
opposed by taking note of our own failures, even more than by our repeated successes.

My treatment as given above seemed to produce too rapid, too irregular actions in the contractile tissues of the organ - I lost sight of the fact that it was just only desirable to get a certain amount, and degree of contraction - but also to aim at contractions uniform, and equal in nature. At the same time I wish my experiences to remember that I am practising in a semi-tropical climate - no doubt the same conditions are experienced here as in India - where the warm climate has a decided habituating effect on the organs in women, more especially in the new arrivals. All these prove to inefficient, and irregular contractions - often spoiling the child, but retaining the placenta for a considerable time. As hour-glass contractions - as stated before, my doses are not too large - 3/4 doses of the 30th, 30th, big being generally the most mini dose.
and a fairly long interval between each dose. I have noticed this irregular contraction, as a more frequent cause of haemorrhage than the entire absence of contraction, and yet these must be another factor in operation, as how often do we not find a uterus which appears to be firmly contracted, and almost reduced to its normal size, and yet profuse haemorrhage occurring. Again we frequently find an uncontracted, flabby uterus and yet no dangerous flooding as a consequence. The following case will be of interest as bearing a certain bearing on these points.

Mrs. M., aged 36, had been delivered in 1881 of a stillborn child. Eighteen months after a 2nd dead child was born. At the time I first made her acquaintance, she was expecting again; 8 months about; four months. I was therefore earnestly requested to do my utmost to procure the delivery of a living child.
The general health & condition of
my patient were so excellent
in every respect that I could
hardly do much more in toning
up the system - Sclerotic Hoars
of Chloride of Potash has however
given. - Since three or four weeks
before the expected time I made
constant examinations of the foetal
heart by auscultation - having
made up my mind to bring in
premature labour whenever I
detected any dangerous symptoms
in the heart's action. However
the time passed along - until
it reached the day on which
labour was expected. Toward
it was two and six o'clock in
the morning when I was first sent
for - as a certain amount
of watery discharge had come away
slightly tinged with blood.
But the noteworthy point is that
no pains had as yet been
complained of - I found on Per vag
examination - that the OS was di-
lated to the size of a Shilling piece
- but found the membranes still
intact.
I waited patiently over an hour - still no sign of the smallest pain - I examined again and noticed a slight increase in the size of the bag - I now decided to leave the patient, confidently predicting that labour was due to set in before long; although labour had actually set in already. The general lot of people however only consider actual labour when the pains begin. I directed at the same time that I should be sent for as soon as pains commenced as I judged that delivery would follow very soon after the pains commenced.

Next morning received word to the effect that my patient could not have had a better night - but that there was still not the slightest sign of pain - On my arrival about 8 AM I again examined and found that though the head had had no pain - yet the bag was further dilated to nearly the size of the
Month of a tea cup - At 8:30 am very slightly increased. By 9 o'clock I was able to make an accurate examination of the lower segment of the uterus - The membranes were still unruptured and a vertex presentation was made out - At 9:30 am - judging it to be a suitable case - with the labour fairly well advanced, free from mechanical obstruction - the 05 seeming dilatable and (Mrs being her 3rd baby) also a metapara I administered a full dose (2½) of the Salpury Liquid. I repeated this at 10 am. Still no pain or any visible effect on the uterus - was the result of the said - nor any further progress at the 09 - At 10:30 am Biợ Jenner were given - a similar dose at 11 o'clock - the uterus still felt perfectly flabby & sluggish and entirely failed to act in response to the Stig or - I ascertained that the last labour had progressed much the same way - that the child had been delivered for to.
forceps — but that by that time
life (of the infant) was 4 times
fearing that if I delayed much
longer I should follow in my
predecessors' unfortunate illnesses
determined to apply the forceps
immediately. Being aware that
she was troubled with cardiac mo-
chief of the nature of a central
section I was obliged to ad-
iminate the anaesthetics with great
cautious and attention to her breathing
and pulse. Fortunately however she
turned out to be most susceptible
to the influence of the drug and
was soon sufficiently insensible
for my purpose. I now
proceeded to rupture the membranes,
applied the forceps, and extrac-
ted a fine healthy child
(female). Rather to my surprise
as a result of my applying
gentle pressure over the abdomen
the placenta was soon after ex-
pelled. The uterus also — beyond
my expectations — followed in its
wake and contracted equally and
firmly. There was no sign of any
any serious inconvenience supra
vumq and my patient made
a most complete and gratifying
recovery. It seemed rather interesting
tone that the os showed have
dilated with such regular service
without the medication of a single
paine. The lady testifies that
all through the labors she never
once experienced any unpleasant
feeling about the abdomen or
anything approaching a pain.
When two weeks disappointed at
the entire absence of any im-
pression on the utero — as an
effect of all those large and re-
peated doses of ergot — I cannot
apply the whole cause to the
drug being next. Judging from
the previous history — which points
to somewhat similar symptoms
in her former confinements —
— it rather arises at a certain
peculiarity of temperament in my
patients, system, certainly before
time or vigor of action in the
reproductive organs.

Further
FURTHER - the so-called "meets" or the uterus - the sluggishness - its inability to contract - makes me rather anxious with regard to the probable occurrence of uncontrollable hemorrhages after the fetus and secondarily the placenta. In this "coming trouble" I was not greatly disappointed as nothing of any importance occurred after the infant's birth.

Among our natives, the Pelvic Deformity is unknown, except as a result of accident or injury. We get the opportunity of making observation on the women - for the reason that they are constantly coming to be examined. Their great weakness is to have large families - so that whereas a mother has but a child of a dozen offspring, she forthwith comes to the doctor, despairing. She examined and told the orason of her barrenness!!!

They come off very easily with their compliments - among some of the races they have the habit of leaving the cord intact until the placenta has been expelled. They believe and hold...
The belief that if the child is strong and robust when born it will not suffer from any loss of blood again if the child is weak and dying - then the loss will be the death of the infant. In this way they judge of the power and strength of such child. Wherefore it entirely depends on the length of time the placenta takes to be expelled. Then too, they never use a sharp instrument to cut the cord - but invariably use a really bit of iron - thus through the structure Nature seems amazingly liberal in the primitive people - haemorrhage is almost unknown with them, and certainly not feared. The placenta is separated without by a true Spinal division thus avoiding by the rupture of the arterial coats of the blood vessels - the liability of their bleeding. - Again the uterus by obstructing uniformly, and regularly, minimizes the chance of excessive venous bleeding setting in - by direct compression - no matter how as some of the uterus.
...uterine fibres from the Second Coat of the vein, and also owing to the peculiar well adapted flattened shape of these veins.

Contagious diseases of all forms are unfortunately most common amongst them and refer more especially to venereal disease among the natives. They imagine that if they - each individual that is to say - are able to transmit the infection to a virgin, the general mischief will immediately leave them. The consequence is of course that vast numbers of young girls have in New India contracted the disease. For the cure of these, their own doctors claim an almost sure and certain specific. Now for this is true, I have not been able yet to establish by reliable evidence; as they are most reserved in revealing their nostrums. I neither however, to make a point of trying by every way or otherwise to get at the secret of some of their compositions.
Number of their quack remedies I have seen to act most marvelously. For example in cases where everything had been done to stop local haemorrhage such as ice, gallic acid, worm oil, strong acids &c. &c. &c. &c. &c. Other styptics all in vain. Some of their "healers" were called in & some unknown styptic applied with almost instant success, and so with numerous other cases. I am at present busy with collecting information in respect to the action of their drugs which we are entirely ignorant. It is not such an easy matter as one would suppose, so I have to use a great amount of patience & tact to seize my opportunity and yet not excite their suspicions in regard to your intentions.

[Signature]

W. M. Shockley