GYNECOLOGY

UNDER THE CHARGE OF

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Anatomical Cure of Cystocele.—White (*Amer. Jour. Obst.*, 1912, lxv, 286) does not believe that any of the commonly accepted theories as to the pathological anatomy of cystocele are correct, and thinks that the unsatisfactory results obtained in its treatment are due in large measure to a faulty conception of the cause. His studies on the cadaver have convinced him that the bladder stays in place because it rests on a firm fibrous shelf, which stretches across between the pubic bones from the symphysis to the spines of the ischium, this shelf being nothing more than the anterior vaginal wall, which is attached by firm adhesions to the pubic bone in front, and laterally to the whole length of the white line of the pelvic fascia. This can be easily demonstrated by running a knife along the white line on either side and severing the attachments to the vagina; a cystocele of marked degree will be produced. Upon suturing the vagina back to the white line, normal conditions are restored, and the cystocele is cured. Acting upon this theory, White has devised the following operation. An incision is made in the anterior lateral fornix of the vagina, extending from the level of the cervix to near that of the internal meatus of the urethra. The finger is then worked by blunt dissection toward the side of the pelvis until it can be placed on the uncovered ischiadic spine. By means of a curved needle three or four sutures are then passed through the lateral edge of the vaginal incision, around back of the white line, and out through the mesial edge of the vaginal incision; when these are tied the lateral fornix of the vagina is drawn up into contact with the white line. The other side is treated in the same manner, so that at the completion of the operation the anterior vaginal wall stretches across from one ischiadic spine to the other, reëstablishing the normal shelf-like condition. The operation sacrifices no tissue, and in the author's experience has given most satisfactory immediate and remote results.

Etiology of Appendicitis.—Excessive eating, especially of red meats, is an important factor in the causation of appendicitis, according to Dickinson (*Amer. Jour. Obst.*, 1912, lxv, 284), who calls attention to the fact that man is the only animal that suffers from this disease, and that he is the only one that makes eating a pleasure, filling his intestinal tract with high proteids, the undigested portions of which undergo fermentation. It is also worthy of note in this connection that physicians working in China, where red meat is very little eaten, report rarely seeing a case of appendicitis among thousands of patients examined. Dickinson believes, therefore, that there is a close connection between gluttony and the disease, but also lays emphasis on the

importance of the condition of drainage in the appendix in determining the type. He distinguishes between the progressive, destructive form, and the chronic hyperplastic, which goes on to fibrosis. In the former the ceco-appendicular junction is tubular, the lymphoid tissue at the junction being so swollen as to choke the aperture, so that the appendix cannot drain itself; this results in tension, leading to gangrene or perforation. In the chronic or hyperplastic type the ceco-appendicular junction is funicular, embryonal in character; drainage is good, and tension does not occur. The sequence of events is therefore probably somewhat as follows: overeating of high proteids, residuum in cecum, decomposition, ceco-appendicitis. The cecum, draining well, recovers; the appendix, if not draining at all, goes on to destruction; if draining poorly, to subacute appendicitis with hyperplasia; if draining well, to chronic appendicitis with fibrosis.

Conservative Surgery of the Ovaries.—Dickinson (*Surg., Gyn., and Obst.*, 1912, xiv, 134) has studied the results in a series of 131 operations performed on intelligent women from private practice. All these were done more than six months ago, this arbitrary time-limit having been chosen because symptoms of the surgical menopause generally develop within this time if at all. In 80 per cent. of the cases in which one or both ovaries were left, no climacteric disturbances of any kind occurred. The failure to prevent these entirely in the remaining fifth of the cases may have been due, Dickinson thinks, to lack of skill or care in preserving the ovarian circulation. He believes that this is better accomplished by leaving the tubes as well, when they are healthy, as important nerves and arteries going to the ovary may be cut in removing them. His doctrine is that all healthy ovaries should be left in place, even if the patient is near the menopause, since no one can say just what is the term of ovarian activity, and especially is this true in fibroid cases, in which the ovary is notoriously long-lived. Dickinson believes that better results are obtained when both ovaries are left than when one is removed, or resections are done. He has found that, as far as can be determined, conservation in married women is followed by persistence of sexual desire in almost all cases. The question of leaving or removing ovaries in operations for advanced inflammatory disease is often a very difficult one to decide, as these ovaries are apt to be very tender, and to give rise to trouble later; Dickinson says that he is, therefore, rather inclined to remove them under such circumstances, unless the patient is fairly young and vigorous, and there seems to be no infection of the ovary.

Post-climateric Metrorrhagia of Non-cancerous Origin.—Dalché (*Gaz. des Hôp.*, 1912, lxxxv, 3) calls attention to the fact that not all uterine hemorrhages occurring after the menopause are due to malignancy, and that although we should never loose sight of the overwhelming importance of this etiology, neither should we overlook the fact that certain of these cases are amenable to medical treatment, or undergo spontaneous cure. Sufferers from an old metritis, following frequent childbirths, and accompanied by a general visceroptosis, are frequently the subjects of severe post-climacteric hemorrhages. These may likewise occur, often associated with a profuse, fetid discharge,