NORTHEASTERN LANCET.

A SEMI-MONTHLY MEDICAL JOURNAL.

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VOLUME XIX.

ST. PAUL:
W. L. KLEIN, PUBLISHER.
1899.
inflammation of the tubes, as the migration of the cocci from the uterus into the tubes is quite rapid. At this juncture the process may again be arrested and the latent form of gonorrhoea brought to a standstill, as was the case with the acute attack at the internal os. The discharge is now more abundant and purulent. If the inflammatory process does not extend into the peritoneum, but remains localized to the tube owing to an agglutination of its fimbriated end or of the isthmus, the result will be a closed, dilated sack containing pus, a pyosalpinx, which invariably produces sterility, both tubes usually being affected.

The peritoneum may be infected in one of two ways, either through the wall of the tube, that is, through the lymph channels, or by means of its abdominal opening, thus causing very painful, circumscribed forms of peritonitis in and around Douglas' cul de sac. There is usually moderate fever and a formation of sero-fibrinous exudation in Douglas' pouch. This exudation later is reabsorbed and forms adhesions between the serous surfaces of the various pelvic organs, causing the many different displacements of the uterus and its adnexa.

The diagnosis of gonorrhoea is as a rule not difficult. We have burning on micturition, possibly cystitis and Bartholinitis, the former being evident by the turbid, alkaline urine, ammoniacal odor, triple phosphates, micrococci, nucius, pus and blood corpuscles; the latter by the extreme tenderness, redness, swelling and eventually fluctuation at the lower half of the labium major; discharge of pus from the vagina and the fact that this pus has its origin in the cervix; purulent discharge from the urethra; tenderness of the uterus and its adnexa; irregularities in menstruation, sterility, and last, the finding of micrococci in the discharge by one of the methods mentioned above.

The treatment of acute gonorrhoea is very simple, and the first requisite is thorough cleanliness of the parts. In vulvitis they are bathed and perfectly dried and some dusting powder applied. A little medicated cotton is insinuated between the parts to prevent contact with the adjoining skin. If the symptoms are very severe, the patient is kept in bed for several days, during which time applications of lead water and landanum are made, until the acute inflammatory symptoms subside. Urethritis in women is much easier to treat than in men owing to the short urethra. In hospital practice it is advisable to use injections or the swab. For this purpose, a solution of corrosive sublimate 1-5000 can be used, also permanganate of potash 1-2000. The best results are obtained, however, from the silver preparations in the following strengths, several times daily: Nitrate of silver in one or two per cent. solutions; agonic in five to ten per cent. solutions, and protargol in one-half to one per cent. solutions. In private practice where the patient is unable to report once or twice daily, and the irrigations cannot be used, we must content ourselves with local baths and cooling applications, and it will be found that fortunately the mucous membrane returns to its normal state in the majority of cases. If cystitis develops, the bladder must be irrigated with salicylic acid, 1-300 to 1-200, permanganate of potash, 1-5000 to 1-1000, or nitrate of silver, 1-300.

Acute Bartholinitis requires poultices, and as soon as fluctuation is apparent an incision should be made, the wound being irrigated and packed with iodoform gauze. In chronic Bartholinitis local treatment is often of no avail and relief can only be found by splitting the gland duct and applying a caustic or by excision of the entire gland.

Condylomata are cut away with the knife or scissors, or cauterized with a twenty-five per cent solution of chromic acid.

After vaginal injections have been used for several weeks, we begin to look after the treatment of the uterus, which differs in no way from that of endometritis and metritis as given in our text books on gynecology. We must, however, remember always to make a bimanual examination in order to exclude disease of the adnexa, as every attempt at intrauterine treatment is answered by an exacerbation on the part of these organs. In case they are affected, we must direct our attention to them before treating the uterus.

Noeggerath's prediction, that time would prove the truth of his statement concerning the destructive influence of this disease upon the reproductive power, has been practically verified. The relation of gonorrhoea to sterility was one of the important features in his original article. Sterility is the result in all cases where the disease extends into the Fallopian tubes, excites an inflammatory action in them and seals their abdominal ends. In such cases it is irremediable: a more or less complete cure of the inflammatory process is possible, but a restoration of the tube and integrum is impossible.

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**OBSERVATIONS IN ANÆSTHESIA.**

**By Alice Magaw,**

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During the past six years I have acted as anæsthetist in the service of Drs. Mayo, at St. Mary's Hospital. In a general way the anaesthesia has been conducted under the direction of Dr. A. W. Stinchfield, or, in his absence, by Dr.

*Read before the Olmsted County Medical Society, May 2, 1892.*
Christopher Graham, and our results in over three thousand cases have been so favorable that it encourages me to write this paper.

In presenting it I do not expect to bring out many new or important theories, as I do not feel that we have yet advanced sufficiently in anesthetics to do so; still at the same time we are willing to show the changes in our ideas concerning various and improved methods in anesthetizing agents.

Having been educated only as a nurse I am not expected to make the choice of an anesthetic. The Drs. Mayo prefer ether, as the anesthetic of choice; they, as well as many other surgeons, believe ether to be safer. Chloroform is given as a rule to old people and children, also when there is pulmonary trouble and in most cases where there is kidney disease. Whenever there is high arterial tension from any cause chloroform is selected. Ether should be given as an anesthetic pure and simple and not combined with asphyxia, as has been recommended and is now practiced in many hospitals, the so-called "chokeing or smothering method." If given with plenty of air there will not be the cyanosis and stertorous breathing which too often characterizes its use.

We find that women pass more readily into the stage of anesthetic sleep than do men, and think the sleep is more profound. The emotions of patients should be observed, as excitement and fear often overpower the heart to such a degree as to make a great difference between safety and danger. A few words of encouragement will often be of great service in quieting the heart and improving the circulation. Even with children there should always be a certain amount of explanation, so that they will not think the means to get them asleep are violent.

The day before the operation the patient is examined thoroughly, first by the surgeon, then by one of the physicians, when all the conditions are noted as regards heart, lungs and kidneys.

Operations are almost always in the morning, and no food is allowed, excepting in feeble cases a small cup of coffee at least six hours before the operation. One or two ounces of castor oil are given the day previous and a warm bath the same night.

During the six years in the work I do not suppose I have anesthetized a half dozen patients outside the operating room. In some way or other, the surgeon, nurses and anesthetizer gain the confidence of the patients and they soon take a notion to walk into the room, or if unable, are wheeled in and mount the table. They are allowed to look around, see all they can and questions are answered as well as possible. Seeing for themselves seems to do away with a great deal of fear.

The face is anointed with vaseline, a thick pad of moistened cotton placed over the eyes, and the anesthetic preferred by the surgeon commenced.

The inhaler we use at present and have for some time is the Esmarch mask with two thicknesses of stockinette. We sent to the mills and had a bolt of stockinette woven loosely for this purpose; it has more body than the regular surgeon's gauze. We usually put two thicknesses of the gauze over the mask and get both ether and chloroform ready, and give whichever is best for the conditions observed.

If we start out to give ether we commence with the drop method as carefully and with as much air as though it were chloroform, until the patient's face is flushed, when we have a large piece of surgeon's gauze of several thicknesses and about the size of a towel convenient, and keep adding a few more layers of the gauze and giving the ether a trifle faster until the patient is asleep, then remove the gauze and continue with the same covering as at the start and the drop method. I find that I can get alcoholics or any other class of patients under in this manner as a rule.

If when giving ether it should produce difficult breathing, profuse secretion of mucus, or cough, change to chloroform and your mask is ready, except that it is saturated with ether and one should wait until the ether is evaporated or the patient is coming out from ether anesthesia and then proceed with the chloroform, by the drop method, very slowly and carefully. We find that in making this change from ether to chloroform or the reverse is where the greatest of precaution should be used. On a visit to St. Mary's Hospital, Dr. Archibald MacLaren called our attention to the fact that if a patient could not take one anesthetic well he could most always take the other, and observation on my part has verified this fact.

We think the method we now use in giving ether the best we have ever tried. Ether was given for several years with Wyeth's modification of the Ormsby inhaler, but we noticed in the use of this cone that it was not clean, neither did the patients get the proper amount of air, and a number of cases of bronchitis of varying severity followed the use of it, until we finally fell into the use of the Esmarch mask and drop method introduced in the Augustana Hospital by Dr. L. H. Prince in the service of Dr. Ochsner. We tried it thoroughly, that is, using the chloroform in all cases unless there was some contraindication, until the patient was unconscious and then the two together, not mixed but dropped from separate bottles until anesthesia was produced; but objections arose as it seemed that the danger from chloroform came just with the beginning of
the anesthesia, and ether is the anesthetic of choice in the hospital and is used for the majority of the cases.

Ether should never be given carelessly; lift the mask from the face occasionally when the patient is fully under, and allow several breaths of fresh air, and in returning the mask with a fresh dose replace it slowly and gradually to prevent choking, change in respiration, etc. A commendable improvement in giving ether with a great deal of air is that we do not find the extreme nausea we used to have following anesthesia, neither do we have the bronchitis to contend with. One should change the gauze in the Esmarch after each patient, or put in fresh gauze any time very quickly should vomiting occur.

While the general effects of chloroform are very much like those of ether there are some marked differences. Chloroform should be given with more air, in less quantity, and with the regular drop, as advocated by Dr. J. E. Moore. It should be given slowly and carefully, and as it acts very quickly the greatest of caution should be used. The pulse should be watched very carefully in either anesthetic, but too much care in every detail can not be taken in chloroform. It does not produce nausea as a rule as does ether, and it is not so unpleasant, but when we do get chloroform nausea it will often last for days and it is almost impossible to give any relief. Too much cannot be said for the drop method in giving chloroform, it seems to be the safest way that has ever been introduced.

The great secret of giving an anesthetic of any kind is not to feel hurried and to have the operator say occasionally, "there is no hurry, lots of time." There is such a difference in patients; some will be as calm and fall asleep as easily and quickly as babies, while others are nervous and can not give up and when you try to crowd the anesthetic you are lost. Nothing is ever made by crowding the anesthetic; I have tried it; rather than crowd ether it is best to give a few drops of chloroform. The surgeon should not hurry the anesthetist, neither should he begin the operation until the patient and anesthetizer are ready. While it is not necessary for the anesthetist to watch the operation, he should know how the operation is progressing so as to be able to stop the anesthetic.

It is a rule of ours not to keep a patient under an anesthetic a minute longer than is absolutely necessary to do work well, and this is one reason why the patients are not anesthetized outside the operating room.

The surgeon can never tell just what complications may arise; he means to be through at a certain time, but should he fail, the succeeding patient will be inhaling the anesthetic much longer than is necessary. We find that we lose little time in giving the anesthetic in the operating room, for as a rule, when the patient is fully ready the anesthetic has taken its effect.

Oftentimes the patient is out from under the anesthetic when the dressings are put on, and can help himself a good deal and is allowed to do so.

In our alcoholic cases and in operations on the stomach, we find that from one-eighth to one-fourth of a grain of morphia one-half hour before the operation carries them through better and with less anesthetic. In some operations of this character, after giving the morphine and a little ether until the incision is made the patient has been wide awake and talking to those about him and almost free from any pain, more ether being given to close the abdominal incision.

When dangerous symptoms arise, either during the administration of an anesthetic or after, a good many factors are often responsible; the anesthetic, the work of the surgeon and the condition of the patient. Often when the patient is nearly under the anesthetic he will stop breathing or seem to have a sort of spasm; instead of crowding the anesthetic remove the mask and give several breaths of air and then proceed, and the patient will usually be all right.

I have rarely had occasion to use a gag or tongue forceps since giving ether with more air, in fact, I think we have not had to resort to either once in three hundred cases. As a rule, if the anesthetist is careful and slow, all that is needed is to raise the lower jaw up and forward and the patient's respiration will be as regular as when asleep, and instead of using the tongue forceps catch the tongue with a towel or a clean piece of gauze and draw it up toward the nose and a little to one side and you have the desired effect.

The eyes give very early warning of danger. Some insist that the state of the pupils, the pulse, or change in respiration are sure indications of danger, but to rely upon any one of these signs would be folly; carefully watch all of these symptoms, not relying on any one of them. Usually the surgeon will give warning of the color of the blood, which is also very important.

Often when the heart is acting badly under ether it may behave beautifully under chloroform. I think the eyes and respiration are the things I notice more particularly, then the color of the skin. I often remove the mask and note the general symptoms, and if I am not satisfied with the general appearance of the patient give more air and less anesthetic and improvement is noticeable at once. In children we almost always give chloroform, as they usually take it easily, but I never feel safe when a child is profoundly under chloroform and try to avoid it. I try to keep them as near as possible in moderate anesthesia.

Sometimes the pulse may mislead an inex-
WHAT ARE THE RESPECTIVE INDICATIONS FOR THE ANTERIOR ABDOMINAL AND VAGINAL INCISIONS FOR PELVIC DISEASE.*

BY A. W. ABBOTT, M. D.,
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The reasons that a surgeon can give for not fully adhering to opinions previously held, are entitled to some consideration, because they represent the unbiased expression of his added experience. The recent enthusiasm over vaginal operations has not been altogether sterile. While we have learned that a few things can be best done by the vagina, we have also learned, what is of greater importance, that most operations upon and about the pelvic organs can be better done by a generous exposure of the pelvic contents, through a free anterior abdominal incision.

Certain conditions naturally place themselves outside of this discussion. We refer (1st) to all tumors of pelvic origin, of whatsoever kind, that have grown so large as to extend above a line uniting the two anterior superior spines of the ilium.

(2d) Abscesses of pelvic origin that show a distinct inclination to point toward the anterior abdominal wall, and which are not accessible by the vagina.

(3d) All tubercular pelvic diseases, because of the greater probability of a high peritoneal infection.

(4th) Cases complicated by appendicitis, intestinal obstruction, or any other condition which of itself would demand the anterior abdominal incision.

(5th) Extrauterine pregnancy after the third month.

These conditions for well known and appreciated reasons should always be operated upon through an anterior abdominal incision.

This still leaves us quite a list of pelvic diseases, cases of which have been operated upon with fair success by each method:

1. Pus tubes and tubo-ovarian abscess.
2. Abscess of the true pelvis, and recent exudates.
3. Malignant disease of the uterus or ovaries.
4. Small tumors of the ovaries or uterus.
5. Extrauterine pregnancy.
6. Retro-displacement of the uterus, with adhesions.
7. Uterine prolapse.
8. Abscess within the broad ligament.
9. Hematocele not due to ectopic gestation.

*Read before the Minnesota Academy of Medicine, May 3, 1888.