**Observations on occlusion of the vagina and uterus, with its means of prevention, and the operation necessary for its removal / by Evory Kennedy.**

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ART. VIII. *Observations on Occlusion of the Vagina and Uterus, with its Means of Prevention, and the Operation necessary for its Removal.* By EVORY KENNEDY, M. D., Master of the Lying-in Hospital Dublin.

[Read before the Dublin Obstetrical Society.]

THE subject of occlusion of the vagina and uterus demands our attention; first because a close investigation of its cause will shew us, that this very distressing affection may, in most

cases, by proper management, be prevented, and again, because from the difficulties and danger attending its cure, it is often either mismanaged, or totally neglected; the patient from a conviction that the case was beyond the assistance of art, being consigned to a life of misery and suffering.

It may be considered under the heads of partial and complete occlusion of the vagina; occlusion of the uterus; occlusion complicated with openings into the bladder and rectum.

It is not at present intended to treat of congenital occlusion, but of that form which is the result of inflammation occurring as consequent upon delivery or otherwise.

Partial occlusion of the vagina is to be met with, the product of ulcerative inflammation at certain parts of this canal, occupying more or less of its circumference, and which has terminated either by cicatrization, with an absolute deposit of new structure, constituting those bands which afford obstruction in labour, or by an adhesion of the opposite walls, and consequent cicatrization and contraction of the passage, throughout a greater or lesser extent of its course, causing a narrowing or diminution of calibre in the vaginal passage generally. The former is by no means an unfrequent occurrence, and one with which most practical men are conversant.

The principal inconveniences resulting from partial occlusion, are the interference with the vaginal functions, but more especially its obstructing the descent of the child in labour.

There is, in my museum, a preparation strongly illustrative of the necessity of dividing these bands when they offer any obstacle to the progress of the child's head; a plan of practice questioned by some of our midwifery authorities. In this case a falciform band spread round the posterior and lateral part of the vagina. The woman had been in violent labour, and the head resting upon the band for some time without advance: satisfied of its nature, and the necessity that existed for dividing it, I delayed operating for a moment, to afford my assistant an opportunity of examining. In this interval, the pains continuing

with great violence, the uterus became suddenly lacerated, and a triangular* flap of the os and neck of this body was thrown down into the vagina.

In a case in which two such bands had formed, seen with Dr. Labatt and Dr. J. Labatt, some years since, one band was divided, and whilst awaiting in expectation of the other yielding to the uterine efforts, the whole recto-vaginal septum gave way, and the rectum and vagina were thrown into one cavity, the rectal sphincter, however, remaining uninjured. The other form of partial occlusion, or that in which the canal becomes generally contracted, is more rare in its occurrence. In some the vagina is only slightly diminished in calibre and its functions consequently little interfered with, a subsequent labour inducing relaxation and development of the canal. In others, however, the passage is scarcely pervious to an ordinary sized catheter, and even the introduction of this is attended with pain and difficulty; in two cases of this kind which we met with, the external orifice was of its natural size, but about eight or ten lines within it the canal became suddenly narrowed, in both instances being pervious towards the recto-vaginal wall. In fact had it not been for the regular discharge of the menses, the contraction was so great in both, that they might have been mistaken for cases of complete occlusion.

I lately had charge, along with Dr. Johnson, of a patient in her first labour, who had a contraction of the vagina similar to the last described, but which was congenital; coition was attended with great suffering, and she had been treated by the introduction of sponges to admit of this: the first stage of labour lasted for forty-eight hours; at first the finger could with much difficulty be introduced, but the vagina gradually dilated to the fullest extent, when ergot of rye was administered, and the child expelled without further difficulty, by the uterine efforts.

In complete occlusion of the vagina, the adhesion may exist

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* Dr. Kennedy exhibited this preparation to the Society.

between the opposite walls of the vagina, only at a certain part leaving an upper and lower chamber, separated by the adherent part.

A case of this kind I saw lately with Dr. O'Reilly, the effect of inflammation, after the removal of a uterine polypus, to which I shall afterwards allude, and a similar case, some time since with Mr. Mansfield of Camden-street, the effect of inflammation consequent upon difficult labour; but in the latter, although the os uteri was perfectly locked up, yet, as the symptoms were not sufficiently urgent to require an operation, nothing was done. The age of this individual may explain the absence of suffering, as she was rather advanced in life, and possibly, as the period approached at which the menses were about to cease spontaneously, their suppression might not be attended with the same extent of constitutional or local disturbance. Many cases of this kind have been sent up from different parts of the country, for treatment in our diseases of female ward, the result of difficult or instrumental delivery.

The walls may be adherent throughout their whole extent, obliterating entirely the vaginal canal; the bladder and the rectum being separated merely by the now common or coherent walling of the vagina; of course the latter is a case much more serious and difficult to be managed than the former.

In the great majority of cases, this disease might, with very little attention and management, be prevented; the midwifery practitioner should anticipate its occurrence in every case in which there has been tedious or difficult labour, laceration of the perineum, vagina, or uterus, or where instruments have been had recourse to, and symptoms of inflammation or sloughing of the vagina evince themselves after delivery, and even in cases of operation in the vagina, unconnected with labour, as polypus, &c. The result of the case of the latter kind already alluded to shews that it should be guarded against. The duty of attending to the state of the vagina after delivery, and under the circumstance alluded to, is but too frequently entrusted to the attending,

perhaps ignorant, nursetender, and hence arises the train of miseries alluded to. The practitioners in all such cases, after the immediate irritation has subsided, and the slough separated, should direct, in addition to frequent injections, the daily introduction into the vagina of some resisting cylindrical substance; a mould tallow or wax candle rounded at the point, and immersed for a moment in tepid water, answers the purpose very well; and when the parts are inclined to cicatrize and contract, this should be cut to fit the vagina, and left constantly within it, even this however, the practitioner should not entrust entirely to the nursetender, but occasionally explore the vagina to satisfy himself it is pervious, and that the os uteri can be distinctly felt. If bands or contractions form, he should divide them early with a bistoury, before they encroach much upon the canal, and retain the dilating plug constantly within the vagina; by this simple process he will prevent the occurrence of these adhesions.

When, however, either by neglect upon our own part or that of others, occlusion is allowed to occur, how is it to be remedied? and in the first place, what necessity exists for interference? In those cases in which the obstruction occurs merely at a point, the adherent portion of the walls may be separated without any great degree of difficulty, by careful division with a scalpel; more especially if the menstruous fluid have accumulated above the obstructed part, it serving as a wedge to separate the walls, indicate the part to cut towards; the fluid sometimes distending the uterus upwards to a very considerable size, at the same time that it protrudes the obstructed floor downwards, and this accumulation is usually accompanied with much suffering, principally periodic. The directions of practical authorities is to await the accumulation of this fluid, in any operation we undertake, as it facilitates the operation and renders it more safe. This is to a certain extent a useful hint, as far as it deters practitioners from rash and unnecessary interference, but it is *wrong* to allow this consideration to influence us by inducing us to *withhold relief from all patients, in whom no*

*accumulation occurs,* no matter to what extent they may suffer in consequence of obstructed vagina. It is a mistaken idea, but one in general acceptation, that the inconveniences resulting from obstruction in the vaginal passage, are productive of suffering to the patient *merely* by the *menstruous secretion accumulating* above the point of obstruction, and that hence arise the lumbar and pelvic pains, abdominal spasms, nausea, vomiting, &c. *Whereas the fact is, that this train of symptoms will occur at the return of the menstrual period, without the slightest accumulation or secretion taking place.* It is a curious law of nature, which I have observed in this, as in some other cases, that the functions of an organ should be suspended, as it were by an intelligence possessed by the organ of the futility of their performance; thus in some cases no secretion is formed by the uterus, because from the obstruction to its passage in the vagina, it cannot escape, and again remove the obstruction by rendering the vagina pervious, and the uterus immediately re-commences its functions. Now, whilst I would anxiously caution the junior practitioner againt unnecessarily having recourse to so dangerous and serious an operation as that of rendering pervious the completely occluded vagina, yet I should wish him not to be led astray by the dictum of writers on this subject, in expecting to find an accumulation of the menstruous fluid beyond the point of obstruction, where the symptoms alluded to occur, or in withholding the necessary operation awaiting the proofs of this accumulation having occurred; else, he will often be disappointed, and his patient obliged to support, year after year, a life of misery and suffering, eventually sinking under it, or undergoing an operation, in addition to what she has already suffered, when ill able to bear it; and this, although the effect of a well-timed operation would have been to restore the functions of the uterus, relieve the patient from her excruciating torment, and re-establish her general health.

Let it not be supposed however, that this operation is not one of a very serious nature to the patient, from the risk in-

volved, as well as the pain attending it; or that it is not a very difficult one to the operator. The thinness of the texture to be divided, the danger of wounding the bladder on one side, and the rectum upon the other, or getting into the peritoneal cavity, above, the depth of parts in which the operation is to be performed, and the confined space afforded to the operator, renders it as difficult and hazardous as any operation that can by possibility be undertaken. When the operation has been determined upon, I would advise the operator to be provided with several spatulæ of differenth breadth and thickness, either of wood or ivory, as well as with knives of different forms, at least two well rounded scalpels, with handles seven or eight inches long, a double edged scalpel, a blunt-point bistoury, muffled to within half an inch of its point, two or three brass tractors to separate the vulva, and a sponge, fastened to a stick about seven inches long. The patient is now to be placed in the usual position for lithotomy on the edge of a bed or table; the bladder and rectum having been emptied, the forefinger of the left hand is to be introduced into the rectum, and a careful dissection made from side to side, in the line of the vagina, through the coherent walling; the finger in the rectum indicating the correctness of the line in which we cut; and if a doubt exist in our minds, as to the course we should pursue, always directing the knife more towards the rectum than the bladder, as a wound in it is productive of less inconvenience. Having cut in this manner as far in as is safe, carefully withdrawing the knife, and inserting one finger to ascertain the situation between each incision, when the incision becomes deeper, we introduce a narrow spatula and cut carefully upon it, with the knife parallel to the blade, widening it from side to side as we proceed. Much may also be done by separating the cellular tissue connecting the walls, by the finger or spatula as a dilator, gaining a central separation, and afterwards cutting it larger from side to side with the scalpel. Where the textures are too dense for this, then the double edged scalpel may be used for the same

purpose, and the sides enlarged with the ordinary scalpel or bistoury; we shall find the latter instrument particularly useful where bands of the cellular tissue, more resisting in their nature, remain laterally, and which ought to be carefully divided by it. By persisting in this manner, cautiously and carefully dissecting the structures, we at length get up to the uterus, the lips of which we now detect bounding the cavity above; if menstruous fluid be accumulated above, we are satisfied of the operation being completed by its escape, which in its dark and grumous character contrasts with the blood escaping from the vessels; where this is not the case, we must carefully pass a round or metallic catheter into the os uteri, if this be pervious, and if not we must either proceed to render it so, or await for some days the further dilatation of the vagina, before taking this step. I have been induced to be thus explicit in describing the method of operation, because I esteem our success in these cases to depend entirely upon the manner of operation; nor can I avoid alluding to an operation on occluded vagina, recently reported in the Medical Gazette, in which the plan ordinarily recommended, that of operating by forcing up the trochar at random, was adopted by one of the most eminent and distinguished operators in the sister kingdom. The trochar may with propriety be used for giving escape to menstruous accumulation, by perforating a hymen or slight vaginal band, but it appears to me to be quite unfitted in case of extensive adhesion, where the nicest and most careful dissection is necessary to separate the coherent membranous wall, with such risk of opening into the adjoining cavities.

I shall now briefly state in detail, some of the cases in which the above operation was had recourse to.

1st February. Ellen Hughes, æt. 27, was delivered eight months ago, of a dead child (her first) by instruments, probably the perforator, after a labour of thirty hours. She was confined to bed for a month after delivery, with pain of abdomen and vagina, after which time the vagina became closed,

and since that she has not menstruated. At every menstrual period, she has pains in her back, accompanied, she says, with the formation of two lumps in the lower part of abdomen, which usually remain for two or three days, and then gradually disappear. Has no headach or other symptom at these times. Bowels generally costive. It is now about three weeks since the last menstrual period. Some purgative medicine was administered, and on the 8th February, the operation was performed of opening the vagina, from a short distance from the vulva up to the os uteri, at least three inches and a-half; throughout the whole of which extent, adhesion existed. This was successfully done by cautious touches of the knife, whilst the finger of the left hand was for the most part in the rectum, to shew how far they might be directed towards the gut. The os uteri itself, which was also found occluded, was then pierced. Some difficulty was experienced in detecting its situation, and the incisions into the vagina were in consequence carried rather higher towards the cul de sac, than was necessary. After the operation she was ordered Cal. gr. ss. cret. gr. ii. 3tia qq. h.

9th February. Slept well last night; pulse 120; no tenderness on pressure over the abdomen. Bowels have not acted since the operation. Passed water freely; on examination, a fluid covers the finger, similar to retained menstruous secretion. A catheter was passed into the os uteri: took nine powders.

Ordered to be syringed with tepid water twice a day. Oil draught; continue powders.

10th February. Says she is quite well; pulse 120; gums slightly touched; no tenderness or pain in abdomen; slept well during the night; respiration rather hurried; headaches. Syringing caused some smarting, and brought away copious discharge.

Continue powders.

11th February. Pulse 112; no tenderness in abdomen; passes water freely; bowels moved without pain.

Omit powders. Oil draught.

12th February. Constitutional symptoms have subsided.

From this period the treatment consisted in passing the finger at first, afterwards leaving a candle, (No. 6,) in the vagina, and great attention to cleanliness. The cathether was occasionally passed into the os uteri.

23rd. February. A tent was introduced into the os uteri, and on examination, a very minute ulcerated opening was found just within the sphincter of the vagina leading into the rectum. Tenderness of the vagina on pressing the candle has almost gone.

1st March. Complained last night of pain in back; some red discharge appears on the end of the candle, when withdrawn from the vagina; os uteri admits a catheter to a considerable depth.

In consequence of the attempt at menstruation, she was given a hip bath each night, and iron was administered, first in the form of the sulphate, and afterwards in Griffith's mixture. The slight red discharge continued three days and then disappeared; some irregularity of the upper part of the vagina continuing, in which, apparently, the passage into the uterus is obstructed. The caustic pencil was freely applied, the irregular surface destroyed, and the uterine aperture rendered free and pervious, by the frequent introduction of the catheter.

In this case the vagina shews but little tendency to contract again. The passage easily admits a mould six. Patient returned to the country quite well, but rather sooner than we could have wished, as these cases require watching for some time, to prevent the recontraction of the vagina.

Here then we have menstruation setting in within three weeks after the operation, and although the vagina had been occluded for eight months, yet no appearance of accumulation was per-

ceptible. The mercury was administered here, as shall be seen in others, as a precaution against peritoneal inflammation, an occurrence so much to be dreaded in these cases; and which, when it sets in, there is scarcely time to combat by producing mercurialization; therefore in these operations, as well as in operations in labour, when I have reason to anticipate the occurrence of peritonitis, I generally adopt the precaution of administering small and repeated doses of mercury, before the symptoms I dread shew themselves; a practice to which, particularly when a peritoneal tendency has been prevalent, and operations have been necessary, I feel convinced I owe the safety of many valuable lives. In some of these cases after operation there is an obstinate disposition to recontract, requiring our protracted and assiduous care to prevent this. The case of Bridget Fitzsimmons was one of this nature.

Bridget Fitzsimmons, æt. 28, married four years, delivered of her first child, a boy, by instruments, after a labour of five days, subsequently she suffered much from vaginal pain and tenderness, and was confined for two months; did not notice closing of vagina till about three months ago, when her husband directed her attention to to it; never menstruated since, but has suffered from head symptoms; vagina completely closed, excepting a small canal anteriorly admitting a small quill.

On the 28th May, the vagina was opened, as above described, and the os uteri punctured. She was then put on the use of calomel till all danger of peritonitis had passed away. A candle was thenceforth constantly employed to dilate the vagina; and a very remarkable feature in the case was, the rapidity with which the canal closed when she allowed it to slip out, or when a fresh one was not introduced before the former had melted down. From these causes the vagina frequently diminished so much in size, in thirty-six or forty-eight hours, as instead of admitting a mould six, to require even a dipt to be paired, before it could be passed. When the vagina was so far dilated, as to receive

with ease, a mould four, she was permitted to go about July 27th, at the same time being cautioned to continue its use.

Nature occasionally makes an effort to relieve herself, in these cases of obstruction by the discharge of the menstruous secretion, by a curious process; a case of this kind we had in a woman named Bowles, which, although it proved but temporary, was interesting, as proving the resources occasionally available in diseased states.

Anne Bowles, admitted January, 1837, with occluded vagina; was delivered September, 1835, of her first child, followed by peritonitic symptoms. The vagina continued sore for some weeks; had subsequently an attack of continued fever. States that about six months ago, on the 3rd of the month, she was seized with pains resembling labour pains, which continued for three days and nights, and then ceased; (had always menstruated at the beginning of the month, but not at all since delivery.) These pains have continued to recur regularly every month; vagina was completely obliterated; there is a fungous growth about the meatus urinarius, which is very painful; the uterus can be distinctly felt distended midway between pubis and umbilicus. In this state she continued (the fungus having been destroyed by caustic) until March, the paroxysms of pain becoming more frequent and severe, requiring opium pretty freely for relief. She now complained of an uneasy forcing sensation in the rectum, and on passing the finger into the gut, a tumour not unlike the lower part of the uterus could be felt; this sensation became more distressing, and eventually, powerfully expulsive pains set in, during each of which the right labium was protruded in a conical form, the apex of which shortly assumed a bluish colour. She now suffered so much, and as on examination of the protruded tumour it was found to contain fluid, supposed to be menstruous, a bistoury was passed into it, and exit given to a large quantity of menstruous fluid, which continued to flow for two days, after which it became seemingly mixed with pus, which continued

discharging up to April 4th. She subsequently suffered from peritonitis; was treated by leeches and mercury, and left the Hospital April 22nd, the communication existing between the vagina and tumour: readmitted September 30, the opening in the labium having become obliterated; suffered again as before, until after a severe paroxysm, menstrual fluid escaped *per rectum*. November 25th, the vagina was opened up to the os uteri, by the operation already described, treated with dossils of lint, and eventually the introduction of candles gradually increasing the size.

The os uteri is occasionally occluded, the result of adhesive inflammation without the vagina participating in it. This is to be ascertained by speculum examination, and the impossibility of passing a catheter of any size into the os. In two cases of this kind which occurred to me, the menses were suppressed, and no accumulation took place, although several months had passed over. The opening in one case was made with a trochar, passed in the course of the uterine cavity; in the other with a double-edged knife, and no inconvenience resulted in either. From the operation, the menses were speedily secreted and discharged, in one within a fortnight after the operation; in both, however, a strong tendency existed to re-occlusion, which was only prevented by keeping a tent for some weeks in the opening and by introducing gradually increasing-sized catheters for some time afterwards. We have already seen the difficulty attending the keeping the os and vagina *open* after operation. Since writing the above, I detected occlusion of the uterus in its commencing stage, in the case of Curtis, one of the women from whom the os uteri separated and was thrown off before the head of the child in labour, and which I reported at a former meeting of this society; in her the lymphy deposit was not completely organized, therefore the adhesions were easily broken through by the finger, and on doing this a considerable quantity of pus escaped, which had evidently been secreted and accumulating within the uterus, above the point of adhesion in its neck; sub-

sequently a band of adhesion in the vagina near the os was divided, and she recovered perfectly.

After these operations, as well in the os uteri as vagina, although the divided surface will cicatrize healthily, an inclination is sometimes taken on to ulcerative inflammation at certain points, leaving communications with the adjoining cavities. We have seen, in the case of Hughes, that this took place to a small extent in the recto-vaginal septum, leaving an opening into the rectum. This however is a matter of little moment or inconvenience, and if treatment be necessary, can be easily remedied by diminishing the aperture by the application of the cautery or caustic.

It is of much more serious moment, however, if it extend to the vesico-vaginal septum, and attended with still greater danger, if it occur after puncturing the uterus; as here, the ulcer may open into the pelvic cavity through the peritoneum. This occurred in the case which follows:

Fitzsimmons, whose case is above referred to, returned to hospital in September, having through neglect allowed the passage to become again contracted to very small dimensions; the os was again quite imperforate; candles of successive sizes were used to dilate the vagina, which succeeded without any operation; and on the 28th the os was again pierced, and opened to about its natural size, and a dossil of lint left in the opening.

30th. Some menstrual secretion adheres to the catheter when introduced into the artificial os uteri.

October 1st. In passing up the catheter cautiously this morning, it went up so far as to leave no doubt that it must have got into the cavity of the peritoneum through an ulcerated opening; she immediately complained of pain of abdomen and loins, similar to what she usually experienced during the menstrual period; she was immediately placed under the most active mercurial treatment.

About 5 o'clock she was reported to be very ill; pulse was then 112, and small and hard; she had had rigor during the day; skin was hot; tongue foul; excessive tenderness on pressure existed over the uterus, and in the right iliac region; she was

bled in the upright posture to ℥xx., when her pulse failed; twenty-seven leeches were then applied to the abdomen; at 9 o'clock a warm bath was given; after which mercurial inunction was employed every two hours. One grain of calomel and one grain Dover's powder given every hour.

11 P. M. Pulse down to 80, and is much fuller. Found relief from the bath, but still intense tenderness exists all over the abdomen.

Contr. remedia. Two and a-half dozen of leeches to abdomen. Hs. anodynus.

October 2nd. Tenderness a good deal relieved, but in the left iliac is still considerable. Mercury and depletion were pushed rapidly, and she was salivated on the morning of the 3rd, after which she gradually improved.

On the 11th. Vagina is now found to have contracted at one part as if encircled by a cord.

A small candle was passed, and gradually a larger one, until a mould four was easily introduced.

November 18th. Complains of pain in the loins and head, and symptoms of the approach of the catamenia. On withdrawing the candle, a small quantity of menstrual fluid is found on its end. The candle has been constantly used since last report, but still the same difficulty on keeping the vagina permanently dilated has been experienced, as formerly remarked. Even when fully dilated, so as to admit a mould two, if neglected for twenty-four hours, contracts so as to refuse admittance to the point of the second finger, and it requires seventy-two hours to enlarge it to the same size.

For the catamenial symptoms, she was ordered a hip bath each night, which increases the flow of the menses.

December 8th. Vagina admits easily a large wax candle, which seems to agree well with her, and does not prevent her going about.

Allowed to go out on condition that she use the candle constantly, and return occasionally.

Here then ulceration had evidently set in on the neck of the uterus, consequent on its perforation, and induced such a diseased state of the parts, as caused the catheter to pass into the cavity of the peritoneum, and that without the slightest force being used in its introduction, it having been passed in the same way, day after day, from the period of the second opening of the os, up to the sixth day afterwards, when this occurred.

The woman no doubt owed her recovery to the nature of the disease being so instantly discovered, and actively treated. This case is further illustrative of the necessity of extreme caution as well in our after treatment, in retaining the os uteri pervious by the introduction of catheters, as during the moment of the operation for opening the occluded os.

Fitzsimmons' case is further illustrative of the difficulty attending the keeping the newly formed vagina dilated.

The following case shews the necessity of attending to retaining the vagina pervious after operation unconnected with labour, and in diseased states of this canal, or of the uterus generally. It occurred after the operation for the extraction of a uterine polypus, in which I assisted my friend Doctor O'Reilly.

"Dear Sir,

"The subject of the case you require was a widow, æt. 48, who at the commencement of the present year observed an exceedingly offensive and copious vaginal discharge.

"On examination I found a polypus of the magnitude of an infantile head, impeding the functions of the rectum, and exciting irritation of the neck of the bladder. It presented itself between the labiæ externæ, and had a very thick stem attaching it to the inside of the body of the uterus, there was occasional hæmorrhage, and as she was declining much in health, from the irritation and discharge, a ligature was applied, by means of the double canula, which was tightened every day, until the fourth day, when the ligature gave way, and the removal was effected by

your curved uterine scissors; she speedily recovered her health and strength. From a feeling of delicacy on her part, my attendance was dispensed with, and she committed herself wholly to the care of a nurse-tender. Three months subsequently I was sent for, when she complained of a bearing down pain, similar to what she felt on a former occasion, at the same time observing, that she attributed those pains to an interruption to the menstrual discharge; not having seen any appearance since the removal of polypus, this circumstance, together with my hearing the night previously a part of your paper on the subject of occlusion of vagina the result of various causes, distinct from congenital obstruction, led me to anticipate occlusion, and finding on examination that the vagina was occluded, I sought for your assistance, when the operation was performed, by cautiously cutting through, and separating about one inch and a-half of the cohering walls; exit was given to nearly one pint of retained menses, which possessed all the characters peculiar to that fluid. Although I have had to make an incision through an exceedingly dense imperforate hymen, still the danger or difficulty attending such will bear no comparison with the operation for occlusion, the result of adhesion of the vaginal walls, the puckered cicatrices and consolidated vagina bringing into contiguity the urethra and rectum, and every movement of your scalpel endangering both. The candle plug was subsequently introduced, and the parts kept pervious until cicatrization was completed.

"Yours,

"C. O'Reilly."

The last form of occlusion of the vagina is that in which it is combined with lesion of the vaginal walls, leaving openings into the rectum or bladder; this is a very complicated and unfortunate case, generally allowing little to be done in the way of operation, at least with a view to cure, although it may, by management, be much relieved.

In the first case, where the communication exists with the

rectum, there is little comparative inconvenience. As has been explained by Dr. O'Beirne, the bowel is possessed of a power of retaining the fæces in many cases, although the sphincter ani or recto-vaginal septum be injured. This I have constantly observed, and although during the effort of emptying the lower bowels or otherwise, a portion of fæces may make its way into the vagina, little attention is paid to it. I have always noticed, however, in these cases, that when the patient took aperient medicine, more especially when the sphincter was injured, she lost the power of retaining the fæces, for the time the medicine was in operation, and in injury of the septum it made its way more freely into the vagina. The state of constitutional health will also influence these cases, in their power of retaining the fæces; and tonic regimen, with the shower bath, sea bathing, or dashing cold water on the loins, will prove favourable to them; operations, or mechanical contrivances, are therefore seldom necessary: pad and bandage sometimes afford relief, particularly if combined with uterine displacement.

The case in which fistula of the bladder is combined with occlusion of the vagina, is, however, very distressing, and generally attended with excoriation of the vulva and thighs, and all the miserable circumstances attendant on vesico-vaginal fistula, in addition to those of occlusion.

The irritation of the parts must be removed before any plan of treatment is adopted; this is to be done by attending to the position in which the urine escapes least, which is generally, but not always, the recumbent. The introduction of a catheter, and retaining it in the bladder, if the urine pass through it; rendering the urethra pervious, if this be occluded; and the strictest attention to cleanliness, by frequent ablution and soothing vaginal injections, the constant application of a poultice made of goulard and bread crumb, and smearing the parts with an ointment consisting of equal parts of the ointment of the oxyd of zinc, and that of the acetate of lead well blended; an ointment that I have found of great benefit as well in these exco-

riations, as in those of infants, the result of neglect or otherwise.

When the irritation is removed or lessened, then if the fistulous aperture be large, or not easily commanded, it may be reduced by touching the edges of it with the actual cautery, so as to enable the bladder to retain the urine longer, and after this has been attended to, a mould of softened wax* should be introduced into the vagina, so as to take accurately its form, a cast of this is to be taken in plaster of Paris, and in this is to be moulded a plug of caoutchouc, with or without an adapting stalk, such as we see in stalk pessaries, with a ball and socket joint, connecting it to a plate fitting to a vulva pad, all of which are to be kept *in situ* by a T bandage. [Doctor Kennedy here exhibited to the Society several of these instruments and plaster moulds of different forms.]

The following case was one so treated.

B. M., æt. 34, sent up in 1836 from County Meath, after her sixth pregnancy; all the children born alive but labours tedious; last followed by sloughing vagina, and with inability to retain urine. The vagina was found nearly occluded by the adhesion of its walls at one point, by which it was divided into two chambers, the adhesion occupying two-thirds of the circumference posteriorly, and on each side. The upper chamber engaged about one-fifth of the whole cavity, and had communication with the os uteri and bladder by a fistulous opening into its neck, about the size of a silver penny; the upper and lower chamber communicated by an aperture somewhat larger than a pea, through which the urine constantly escaped, as also the menses. Various methods were tried to relieve her, and she left hospital wearing a plug of plaster of Paris made to

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* Dentists' wax should be obtained, and softened by exposing it to the heat of the fire, not by immersing in hot water; it should be rolled as nearly as possible into the shape of the vagina, and a strong tape, so placed within it as to catch the wax, and answer as a handle to assist in its extraction.

fit the vagina accurately, by first taking a cast of the part; this afforded her much comfort. she subsequently managed to be impregnated through this fistulous aperture, and returned to hospital to be delivered of her seventh child, in May 1838. Sloughing and peritoneal inflammation, however, succeeded upon her delivery, it having been necessary to divide the adhesions, and she sunk under them. [Dr. Kennedy, here exhibited the preparation of the parts and the vagina mould and plug to the society.]

Another case was that of Catherine Magrath, admitted to our diseases of female ward after her first labour. There is an opening into the bladder nearly the size of a halfpenny, the mucous coat protrudes on taking exercise or forcing down; vagina contracted superiorly; os uteri in situ seemingly fixed and patulous, about one inch of urethra anteriorly remaining pervious. The plug, contrived as before mentioned, was the only means found to afford relief.

Anne Home, æt. 24, fistula after first labour three years ago, vagina contracted by cicatrices, especially at upper part, os uteri cannot be satisfactorily ascertained. It seems as though the bladder and uterus opened into a common cavity of small extent, communicating inferiorly with the vagina, urethra permeable. A cast was taken and a gum elastic stopper made, which is supported by a bandage and pad, and thus she is enabled to retain her urine, which she passes at pleasure through the urethra without removing the plug.

The occlusion of the uterus may be complete, when the menses will of course be entirely retained; or it may be partially occluded and constricted, when the menses shall escape; in those cases where the contents of the bladder and menstruous secretion escape through a common opening, the greater part of the vagina being at the same time occluded, the menses would sometimes appear to pass through the bladder by a communication had with the upper chamber of the vagina; or the bladder and upper chamber of the vagina may have one common fistulous communication with the lower chamber, through which both urine and menses

pass out. In these cases, which are not unfrequent, we are precluded undertaking any means of completely closing the common aperture; as by preventing the escape of the urine we should do the same by the menses, and might cause them to accumulate in the bladder. We may however diminish the size of the fistulous aperture, so as to enable the patient to retain her urine a little longer; thus we did in the following case.

October 10th, 1838.—Anne Allen, æt. 26, married seven years, had five children, the last born in June of this year. The first three children were born by the natural efforts, but did not survive, the last two were extracted by instruments, according to her description, the crotchet. The day after the latter operation, which was performed, she says, after a labour of about forty-eight hours, she had frequent desire to make water, with pain in its expulsion ; these symptoms continued for two months, when she lost the power of retaining it, unless when she lay quietly on her back. She menstruates regularly ; on examination was found, adhesion of the walls of the vagina at its upper part, with a large opening which admits the finger into the neck of the bladder, and through it the os uteri can be felt projecting toward that viscus, and contained in a separate chamber. The fistula was touched with the actual cautery and diminished in size, but as she menstruated through it, it was not thought advisable to attempt to close it more completely.

In some of these cases of occlusion with fistulous communication with the bladder, the patients are able to retain their water for some hours; in such a case, the less we meddle with them the better, as their retaining power would appear to depend upon the excessive degree of constriction induced by cicatrization at the lower or occluded portion of the vagina, for instance.

Hanna Halpen, æt. 26, was delivered in the country, two years since, of her fourth child by the crotchet, after a tedious labour; on examination of vagina it is found firmly contracted, and at the distance of an inch from the external parts, the canal is stopped by a thick hard ring of the vagina, bounding an

opening into the bladder, and through which the menses pass. The urethra is impervious from an inch within the orifice; she suffers, however, but little inconvenience from the state of parts, as she can retain her urine for two or three hours at a time, and menstruates freely. The urethra was merely rendered pervious and she was discharged.

Now it will be seen in the above cases, that the extent of the treatment adopted was, removing existing irritation and excoriation; diminishing the aperture in some by the actual cautery; rendering the urethra pervious when obstructed, and adapting a mould* to accurately fit the parts and press upon the aperture through which the urine escaped; the minor inconvenience of the impervious state of the vagina, was put up with, when communication existed, admitting of the escape of the menses, as any attempt to remove it would only have added to the major evil, by rendering the patients less able to retain their urine. I wish this to be distinctly understood, as sometimes attempts are made to benefit these cases by operations, which by rendering the vagina more pervious, only add to the sufferings of the patient, leaving her totally unable to retain her urine; of course any operation directed towards the closing up the common menstruous and urinary aperture (even should it prove successful, which is very unlikely) would only create more serious mischief, by locking up the escape for the lochial discharge, which would, in all likelihood, accumulate in the bladder, and eventually a fresh aperture for its escape would become necessary.

* This may be constructed of any fit material. Dr. Churchill lately suggested to me in conversation, the trial of a simple method of making one of these plugs, by fastening a piece of sponge cut to fit the vagina, and covered with bladder or oil silk upon a stalk; it might also be used without the stalk.

## Art. IX.—*Letter from* Doctor Murphy to Doctor Stokes, *on the Exhibition of Opium in Peritonitis.*

12, Upper Temple-street,
July 30th, 1839.

My dear Sir,

At your kind suggestion, I have again perused your paper in the Dublin Journal, (vol. i.) on the Use of Opium in Peritonitis, and gladly take this opportunity of correcting the error I had fallen into, of attributing to you a priority in recommending it; I find you to state that "nine years ago (1823) Dr. Graves treated successfully two cases of peritonitis, after tapping, and occurring in patients of bad habits, *by opium*, without withdrawing a drop of blood, and more lately employed the same remedy in a case of peritonitis, from effusion of purulent matter into the serous sac."

The error I had committed arose, from the length of time which elapsed since I had read your interesting paper rendering my recollection of its contents a little inaccurate; I would be obliged, therefore, if you would have inserted in the Dublin Journal this correction of my mistake.

I remain yours truly,
Edward W. Murphy.