tion, and ascertain if it be bent or straight, free or not from tumor. In the case of lateral cellulitis and peritonitis, the finger can commonly feel above the lower margin of the inflammatory swelling projecting into the vagina, and even trace it as a curved ridge across to the sides of the pelvis. Combined with abdominal palpation, the size, position, and relations of the uterus with the surrounding inflammatory swellings can often be defined.

The finger, having reached the level of the os uteri, comes upon the hard peri-uterine tumefaction; it is commonly compelled by the backward projection of this tumefaction to be directed backwards into the hollow of the sacrum, following the globe which carries the anterior wall of the rectum against the posterior wall. In this way we sometimes find the rectum remarkably compressed, and its calibre contracted. Tracing the inflammatory swelling to the sides of the pelvis, we find the pelvic structures, those of the broad ligament especially, fixed to the pelvic wall, perhaps on either side of the rectum, by adhesive effusion forming a collar through which the rectum passes.

Four varieties of peritonitis in many points resemble pelvic peritonitis, and, indeed, frequently are associated with it. One is *perityphlitis;* the second, a *localized adhesive peritonitis, occupying one iliac fossa;* the third, peritonitis of the lower part of the abdomen connected with *cancerous affection* of the pelvic organs and lumbar glands; the fourth is *tubercular peritonitis*, which may have its first and chief origin in the pelvic hypogastric regions.

In the case of *perityphlitis*, the tumor is always on the right side; it is higher, generally, than inflammations springing from the pelvis; it rarely passes beyond the median line, and does not extend into the pelvic cavity; and the greatest bulk or diameter of the tumor is above the pelvis, whereas in pelvic peritonitis, the supra-pubic portion of the tumor can be traced downwards into the pelvic brim, and by combining vaginal touch is felt to be a part of inflammatory masses in the pelvis. The *localized peritonitis of the hypogastrium* is also distinguished by its not penetrating the pelvic cavity. And in both these cases the mobility of the uterus is commonly preserved.

The *cancerous inflammation* in many cases takes its rise in malignant disease of the ovaries; and especially when the lumbar glands are involved. In this case the disease is not so often localized or encysted. Dropsy of the peritoneum not seldom attends. The signs of the cancerous cachexia will rarely be absent. But at certain stages of either disease vaginal examination may lead into error. Before the ulcerative tage of cancer has commenced, and therefore before the malignant cachexia has become marked, the uterine neck may be found set fast in the roof of the vagina by surrounding deposit, hard in some cases to distinguish from the deposit of simple inflammation. There are features of differentiation. In malignant disease of the vaginal-portion, in the first place, the history will generally be different; the disease has come on insidiously; its early stages have probably escaped observation; whilst in perimetric inflammation the starting-point is usually labor, abortion, a chill, accident, surgical operation, or other well-defined antecedent. In malignant disease, the perimetric effusion is usually pretty

uniform, that is, it extends all round the vaginal-portion, catching the bladder and rectum; whilst in inflammation the deposit is often unilateral or anterior or posterior, causing deviation of the os uteri from its central position, and permitting the finger to touch a part of the circumference of the cervix, and ascertain that it is smooth.

When these points are made out, the diagnosis of perimetric effusion is sufficiently decisive. But occasionally cancer is first noticed shortly after a labor; and not seldom inflammatory deposits encircle the vaginal-portion all around. In these ambiguous conditions, we must fall back on individual *tactus eruditus;* and now and then we must suspend our judgment, waiting for the more characteristic changes which time will certainly bring. That there is a difference in the feel of a cancerous os uteri and its *entourage* and that of inflammatory effusion is certain. The first is more nodular, perhaps harder, "stony;" the disease, in short, may be traced to the cervix uteri itself, as its centre of departure, whilst this part is only engorged, abraded perhaps in the second case. But it is difficult to describe the tactile sensations produced by degrees of solidity and shape. Practice alone can teach the finger to recognize them.

A difference worth remembering is, that cancer makes a hard cervix, whilst pelvic cellulitis or peritonitis makes hard masses round about the cervix. Cancer begins in the cervix; inflammation is peri-cervical.

The chief objective characters of perimetric inflammation are described with accuracy and point by Doherty.[1] "On introducing the finger into the vagina we find the hardness, so remarkable in the iliac fossa, has extended to the roof of the vagina, which is tender to the touch, and as firm and inelastic as a deal board—a condition which must immediately arrest our attention. Not the slightest impression can be made on it by our pressure, while we may observe that the uterus is bound down to the affected side, either throughout its whole extent, by which it suffers a lateral displacement, or only partially, so that the fundus is drawn in one direction, while the os tincæ is turned in the opposite."

An observation of Aran is important. He says small perimetric inflammatory swellings may have their seat in the sub-peritoneal cellular tissue; but the voluminous swellings are the result of perimetric peritonitis.

The subject of diagnosis may be appropriately concluded with the caution not to pursue it at the bedside with too much diligence. By instituting repeated and minute explorations it is very easy to do harm—more than enough to counteract any good which the knowledge thus derived may enable us to apply. Nothing in the treatment is so necessary as "rest" of the affected parts; and examinations mean disturbance.

The *treatment*, like that of metritis, must vary according to the types of the disease and its complications. If the result be puerperal metritis associated with septicæmia, the treatment of the perimetric inflammation is simply subsidiary to that of the puerperal fever. In the more purely inflammatory cases, whether post-puerperal or not, leeches, to the num-

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[1] On Chronic Inflammation of the Uterine Appendages occurring after Parturition. 1843.

ber of twelve or twenty, to the groins and hypogastrium, will generally be useful in the early stage. Fomentations or moist warmth applied by a large thick linseed-meal poultice or spongio-piline are of material service. In many cases I have seen leeches, calomel, and opium do good. A pill of one or two grains of calomel with half a grain of opium may be given every four hours for twenty-four hours; and then every six or eight hours for a day or two longer. If there is any disposition to diarrhœa the calomel may be reduced, and the opium increased. Or, in some cases, I have been better pleased with pills or powders consisting of three grains of gray powder and five grains of Dover's powder.

An obstacle to this and other treatment, however, often exists in obstinate nausea, hiccough, or vomiting. To subdue this sympton is the first necessity. Bismuth, hydrocyanic acid, pepsine, creasote, ice, soda-water in various combinations, will be useful. To allay fever, the acetate of ammonia and nitrate of potash with a sedative answer best.

In the more chronic stages, where there is no obvious process of suppuration or pointing, blisters applied to the groins and hypogastrium are often of great service. In the same stage iodide of potassium becomes extremely serviceable, and may be combined with bark in decoction or tincture.

The question as to opening abscesses does not seem to demand much discussion. Not seldom Nature solves it for herself. The abscess bursts into the rectum or roof of the vagina without obvious warning; and generally recovery progresses from that event. It seems to me that these are the easiest routes; that evacuation by them takes place earlier, and often with less disturbance. This may be partly because the walls of Douglas's pouch are thinner and more easily perforated than the abdominal wall. At any rate the pointing and perforation of the abdominal wall is often slow and painful. The progress of an abscess towards the skin generally makes itself visible by the growing prominence and puffiness of the tumor, its reddening, its fluctuation, and finally by the skin becoming blue and palpably thin. It is possible to err by opening an abscess too soon and too late. If an inflammatory tumefaction be punctured before fluctuation is made out, we may fail to find pus; the incision must be carried deeply through tender vascular structures, and cause serious bleeding; and the suppuration-process will not be stopped. On the other hand, if we wait until the abscess is on the verge of bursting we shall have prolonged unnecesarily the patient's suffering; the blue skin may slough in spite of puncture, and will only heal with an ugly scar; and there is the risk of the abscess effecting an opening internally into the peritoneum or in some other direction as well. The proper time for opening an abscess pointing to the skin appears to me to be as soon as fluctuation is clearly ascertained. Incision may be made with a bistoury, or a Syme's knife; and a drainage tube will be useful. The wound should not be allowed to close at once, as pus will continue to flow for two or three days at least. I think it is important to keep the cavity of the sac as small as possible, by adjusting compresses in such a manner as to bring the walls together.

If we find fluctuation in the roof of the vagina or in the rectum the

same rule should be followed. The puncture may be made by a long sharp-pointed hernia knife, or by a long trocar—for the rectum the long curved trocar used for tapping the male urethra is very convenient. Where there is any doubt as to the presence of pus the fine aspirator-trocar is the proper instrument to use. It is sometimes an advantage to insert a drainage-tube in the case of opening an abscess by the vagina. An excellent and convenient drainage-tube will be found in the winged male catheter. It is easily inserted, by help of a stilet. Thus supported it is carried into the sac, where the end is retained by the wings. Sayre's coil drainage-tube answers well.

As a general rule, it is prudent, in the first instance, to tap any pelvic tumor suspected to contain pus or other fluid with the aspirator-trocar. In most cases the fluid, be it pus, serum, fluid blood, or the fluid of an ovarian cyst, can be more completely drawn off by the vacuum process than by an opening by a bistoury. Thus, the aspirator-trocar, whilst superior as a diagnostic means, is often at least equally a therapeutical agent. And beyond this probable benefit of giving vent to discharge, it is a proved clinical fact that puncture of the indurated inflammatory masses hastens their removal.

When an abscess has been opened, and sometimes earlier, quinine generally becomes useful. The diet should be nutritious and supporting. Rest will still be necessary.

At a later period, when suppuration has ceased, quinine may still be useful; but iron now comes into service. The bowels must be kept gently acting. Bed may be changed in the day-time for the sofa; and gradually, but watchfully, gentle exercise may be indulged in. If taken too soon, or exceeding moderation, it is always probable, so long as any marked intumescence or diminished mobility of the uterus remain, that a return of inflammation may occur.

In the advanced, or confirmed chronic cases, warm baths will render great service. The iron-waters are not always safe. I believe many experienced physicians have arrived at this conclusion. The best results I have seen have been derived from the Woodhall Spa. The most valuable medicine in these cases is cod-liver oil.