LACERATION OF THE CERVIX UTERI

AS A FREQUENT AND UNRECOGNIZED CAUSE OF DISEASE.

BY

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LACERATION OF THE CERVIX UTERI

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By THOMAS ADDIS EMMET, M.D.,

Surgeon to the Woman's Hospital of the State of New York.

(Read before the Medical Society of the County of New York, September 28, 1874.)

It is now nearly twelve years since I first recognized the importance of this injury from parturition, as a cause of subsequent diseases, and the difficulty of relieving certain effects until the cause had been fully appreciated.

In my clinics at the Woman's Hospital I have for years past demonstrated, by an operation, its practical bearing, and have frequently called the attention of the profession to the necessity for surgical interference under certain conditions; yet the operation is still but little practised or its importance appreciated.

Previous to my own observations, I believe that no one had placed on record his recognition of the lesion as a cause of uterine disease, or had advocated the necessity for repairing the injury after its reception.

Lacerations of the cervix are of frequent occurrence, and are seldom recognized, even at the time of labor. The tissues are then so soft that, without the rent has passed beyond the cervix into the vaginal and connective tissues, it can scarcely be detected by a mere digital examination, and will escape observation unless an unusual amount of hemorrhage should exist as a consequence.

Lacerations in the median line are the most frequent, while through the anterior lip they are of more common occurrence than in the posterior one. When in the median line, and confined to the cervix, these lacerations generally heal rapidly,

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leaving scarcely a cicatricial line to mark their course. This is due to the fact that with the necessary recumbent position of the patient, which is enforced for some time after labor, the raw surfaces are kept in close contact by the pressure of the lateral walls of the vagina, until they have become firmly united. We have, therefore, no serious consequences likely to follow the accident, unless the rent passes beyond the cervix. If through the anterior lip into the vesico-vaginal septum, the tear may extend even to the neck of the bladder, producing at first an extensive fistula. But as no sloughing or loss of tissue has taken place, and the edges lie in contact, the divided septum rapidly unites, from before backward toward the uterus. The laceration through the cervix closes as readily from the vaginal surface toward the bottom of the fissure, and union with the line through the septum may in a short time reunite the entire tract of laceration. This will frequently be the result if attention has been paid to cleanliness, and if a phosphatic deposit from the urine on the raw surfaces has been prevented by the frequent use of injections of tepid water into the vagina. As a rule, however, we will have one of two forms of vesical fistula remaining as a consequence of the injury.

The most frequent result is for the fissure through the cervix to close entirely, with some portion of the laceration in the vaginal septum, leaving a small vesico-vaginal fistula in front and against the anterior lip of the uterus. Occasionally the entire line of laceration through the septum will unite with that through the cervix down to the angle at the bottom of the fissure, but leaving here a sinus along which the urine escapes from the bladder into the uterine canal at or above the internal os. Several cases of this description are detailed in my work on Vesico-Vaginal Fistula,[1] where, to remedy the difficulty, it was necessary to reproduce the original condition through the cervix, and after removing the tract of the sinus, the whole was brought together by interrupted sutures. Lacerations through the anterior lip are found generally in women who have borne a number of children, and with great relaxation of the abdominal parietes there existed anterior obliquity of the uterus.

Lacerations through the posterior lips unite as readily, and the

[1] Vesico-Vaginal Fistula, from Parturition and other Causes, with Cases of Recto-vaginal Fistula. William Wood & Co., N. Y. 1868.

occurrence may not be suspected unless the fissure should have extended sufficiently into the posterior cul-de-sac to set up an unexpected attack of inflammation. When cellulitis occurs at this point and from this cause, we always have a most intractable form of retroversion to deal with afterward. If extensive, the cicatricial band, felt as a cord, will contract, and so shorten the cul-de-sac as to render it impossible to adopt any instrument, for the purpose of restoring the uterus to its natural position, until a surgical procedure has been resorted to for its removal. The history of these cases would indicate that the occurrence of the injury was due to the presentation of the vertex towards the sacrum.

In practice, we have to deal chiefly with the consequences of lateral laceration, and the effects are more marked when the lesion is complete than when confined to either side. Partial lateral laceration of the cervix will sometimes partly fill up by granulations, especially if the injury was confined to one side, but never so perfectly that the line cannot be easily recognized. Whenever the rent has extended to the vaginal junction, or beyond, there will exist a tendency for the tissues to roll out, from within the uterine canal, so soon as the female assumes the upright position. The posterior lip of the cervix naturally catches on the posterior vaginal wall, as the uterus after a recent delivery is still larger than natural and low in the pelvis from its increased weight. So soon as the flaps formed by the laceration are once separated, their direction of divergency becomes increased by the anterior lip being crowded forward in the axis of the vagina, towards its outlet, in the direction presenting the least resistance, while the same force naturally crowds the posterior lip backward into the cul-de-sac. From thus forcing the flaps apart, a source of irritation is at once established, which arrests the involution of the organ, and the angle of laceration soon becomes the seat or starting-point of an erosion which gradually extends over the everted surfaces. With the increased size and additional weight of the uterus from congestion, the tissues gradually roll out to the internal os. The whole organ being in a state of fatty degeneration, and the tissues of the neck soft, these flaps flatten against the posterior wall of the vagina or floor of the pelvis so that all appearance of laceration becomes lost. So perfect is the decep-

tion that it is frequently impossible, for any one not familiar with the condition, to recognize the existence of a laceration by an ocular examination alone. When the laceration has been complete, but confined to one side, the rolling out is not so extensive, nor is the apparent size of the cervix so large, as in the previous condition, but it is as often difficult at first sight to detect the injury. Naturally a partial obliquity of the uterus in the pelvis is produced by crowding the cervix towards the uninjured side, that this surface and the flattened lacerated portion may present a common plane to the posterior wall of the vagina on which it rests. This portion of the uterus presents a reflexion of vaginal tissue over a part of its body, just above the terminating point of the laceration, so that in appearance the length of cervix on that side is equal to the uninjured portion. The apparent os is always more patulous than in health, and this condition is readily accounted for from the evident existence of disease within the uterine canal. Moreover, the deception is still maintained by the passage of the sound as it is introduced within the canal at some distance from the apparent edge of the cervix. In fact, it enters and follows the oblique course of the laceration, from the vaginal junction, but gives no evidence of the true position of the uterus in the pelvis, although the sound passes in the axis of the vagina. So deceptive is the condition that I have been frequently consulted as to the propriety of amputating an enlarged or elongated cervix when I have readily demonstrated the true condition, and proved that, were a small portion only of the apparent enlargement removed, the peritoneal cavity would be necessarily opened. The cervix is never so large as it seems to be, and the line of junction with the vagina is equally deceptive, for as the uterus prolapses from increased weight, it carries with it a reflexion of vaginal tissue. It is a wise procedure, in any doubtful case, to place the patient for examination on her knees and elbows when, on the introduction of the speculum, by atmospheric distention of the vagina, and by the action of gravity on the uterus, the true line of junction with the vagina will be well marked. In a case of laceration on one side, extending to or beyond the vaginal junction, the fissure can be detected generally in this position without difficulty, as by the weight of the uterus its axis in the pelvis will

be brought in line to correspond with that of the vagina. Lateral lacerations of the cervix are more frequently found after instrumental delivery, than as the result of labor which has been terminated by the efforts of nature alone, and yet this may be but a coincidence.

After the reception of this injury, and consequently a "bad getting-up" from her confinement, the female will at length consult her physician in consequence of her inability to stand with comfort, complaining of a continual backache, with pains down her limbs, a profuse cervical leucorrhœa, and, as a rule, hemorrhagic and frequent menstruation. The probabilities are that she will be faithfully treated for both ulceration and prolapsus, in mistaking the effect for the cause. The "ulceration," which will seem to be the most prominent feature in the case, will likely baffle all attempts to heal it, or if any improvement should take place in her condition, after a sufficient rest in the recumbent position, a relapse will follow again and again after attempting to exercise. We find frequently laceration of the perineum in these cases, and as the vagina was unable to regain its natural size after delivery, from the then existing prolapse of the uterus, the canal becomes still more dilated, as the organ, from a want of proper support, continues to advance as a wedge towards the vaginal outlet. The necessity for correcting the position of the uterus is apparent, yet to give adequate support to the organ any instrument used must necessarily be so large as to allow the vaginal walls to prolapse, so as to obstruct the circulation, and by thus increasing the weight of the uterus add to the difficulty. Such a case will pass from one physician to another, until eventually the leucorrhœa will cease, and the profuse menstruation diminish as the surfaces become cicatricial in character from the frequent use of the nitrate of silver or from the application of caustics. But she becomes gradually a confirmed invalid, the hypertrophy remains, and with the impairment of her general health the nervous element becomes most prominent.

When the case has been left more to the reparative powers of nature, the mucous follicles gradually undergo cystic degeneration, and these little bodies can be felt as a number of shot embedded in countless numbers within the tissues of the cervix. These become distended, rupture, and gradually empty them-

selves, by which the follicles are destroyed as the cavities disappear by contraction. At first the cervix is rather hypertrophied from the filling of these cysts, and as the inflammation and enlargement of the follicles extends within the canal, the rolling out of the mucous membrane is increased. The cervix, however, and frequently the uterus itself, gradually become atrophied from the pressure exerted at first by the enlargement of the cysts, and afterward by the contraction following their rupture. Occasionally the atrophy is confined entirely to one flap, and when thus limited it is generally to the anterior one. Eventually the female will frequently cease to menstruate at rather an early period in life, and will then gradually recover her health, or, as the alternative, phthisis will become developed.

November 27, 1862, I first operated for the relief of a double lateral laceration of the cervix by freshening the surfaces, and bringing together the anterior and posterior flaps with interrupted silver sutures. This patient had been an invalid for several years before coming under my care, and had been treated for menorrhagia and hypertrophy of the uterus with an extensive erosion. She was undersize, of a naturally delicate constitution, and after a severe and protracted labor, with difficulty had given birth to a large child. Her general appearance indicated incipient phthisis, but no evidence of a tuberculous deposit could be detected. The uterus was some four inches in depth, and an erosion extended about two inches in diameter, over an enormous cervix. With great care this erosion had been healed several times, by maintaining the recumbent position for a sufficient length of time, but a relapse to the former condition recurred in each instance shortly after beginning to exercise by walking. I had almost despaired of being able to offer her any permanent relief, and attributed my want of success to the condition of her general health. While making a digital examination one day I was puzzled to account for the greater width of the cervix in comparison to that of the body beyond, and a condition I had for the first time appreciated. I placed her on the left side, and with Sims' speculum brought the cervix in view. I drew the posterior lips forward towards me with a tenaculum, but with no special purpose, when I was surprised to observe that it had decreased to nearly

half its previous size. On lifting up the anterior lip with a tenaculum, in the other hand, so as to bring the two portions in approximation, the outline of a cervix presented, of nearly a normal size. The difficulty was at once apparent, for the parts had rolled back within the uterine canal, and a deep lateral fissure became evident, which extended on each side entirely through the cervix and beyond the vaginal junction. On separating the flaps and forcing them back to their former position, I saw the tissues gradually roll out, and the cervix again present its previous appearance. There could then be detected no appearance of laceration, and with the reduplication of vaginal tissue over the sides of the uterus, as I have already described, the cervix presented a normal length above its apparent junction with the vagina. The remedy at once suggested itself; the operation was performed with the aid of my assistant, Dr. G. S. Winston, and I believe Dr. T. G. Thomas was also present. On completing the operation, the uterus was five inches in depth, it rapidly reduced in size, and in time all evidence of local disease subsided, but she never entirely regained her general health. Some seven years after the operation, Dr. F. N. Otis, of this city, her family physician, detected a tuberculous deposit, and she has died of phthisis within a few months, having been ten years under my observation. For two years previous to her death she had resided abroad, but, as a friend, I was kept advised of her condition, and she continued free from uterine disease. I am fully satisfied, at the time of the operation her condition was so critical that it would have been but a question of a few weeks before a tuberculous deposit would have taken place. Although she never recovered fully the loss of vitality to which this injury had reduced her, yet her life was beyond question prolonged many years by the operation.

I have now performed this operation nearly two hundred times in my private and public hospital practice, and it has been witnessed by so many of the profession that I feel it would add but little value to offer in addition a record of cases, where one instance would be but a type of the whole. I can in truth state, with the proper preparatory treatment, and the requisite care after the operation, that it has never been performed without ultimate benefit. Occasionally, secondary hemorrhage has

occurred, necessitating the use of a tampon, by which the integrity of the sutures have been more or less implicated, requiring afterward a portion of the line to be closed by subsequent operation, or left to fill up by granulations. The operation has been singularly free from any subsequent inflammatory complications, and in but one case has pelvic cellulitis occurred. During a portion of the past winter there existed at the Woman's Hospital an unusual tendency to inflammation, which frequently followed any simple exciting cause. After waiting until it was deemed safe, I operated on a patient in the institution for the relief of the injury under consideration. The operation was followed by a very severe attack of pelvic cellulitis, and her condition did not admit of the removal of the sutures for some four or five weeks after their introduction, but she recovered, and the operation was successful.

My first operation enabled me to appreciate the same condition, in a degree, as a result of the lateral division of the neck of the uterus, as practised for the relief of flexure, when the incision has remained patulous beyond the crown of the cervix. Fortunately, however, the ingenuity of man has not yet been able to devise any means by which the divided surfaces could be kept from uniting, so far, that we seldom have after the operation the tissues rolling out to the same extent as when laceration has occurred. Nor are the parts in the same favor able condition, to admit of this gaping, as after child-birth, when the flaps flatten and roll out readily. Yet with the same forces in action as I have already described, they are often quite sufficient, when the operation has been even but partially successful, to separate the flaps far enough to prove a source of irritation. An erosion is thus frequently caused after the operation, which is difficult to heal, and the irritation of itself will bring about hypertrophy of the whole uterus which cannot be reduced until the divided surfaces have been reunited.

Every case of laceration is benefited by some preparatory treatment previous to the operation. The uterus, from its increased weight, and while resting on the floor of the pelvis, will, by traction on the cellular or connective tissue, obstruct sufficiently the circulation, to produce not only increased congestion of the organ itself, but also in the neighboring tissues. To give tone to the vessels and relieve the congestion, it is

necessary to place the patient on her back, with a bed-pan under her, and have administered a vaginal injection, night and morning, of at least a gallon of hot water, at about 100°. The uterus is to be lifted from the floor of the pelvis by means of an india-rubber inflated ring pessary of a proper size. The advantage of the instrument is that if it is introduced with the flaps of the laceration in contact, and the uterus anteverted, they cannot again separate. Any downward pressure has the tendency to crowd the cervix toward the opening in the centre of the ring, while the aperture is not large in diameter to allow any portion to pass far enough to become strangulated. The instrument should be by no means the size of the already over-stretched vagina, for if it were it would but dilate it the more. It is to be used merely as a temporary cushion; and as there will likely be a laceration of the perineum, which will allow of a prolapse of the vaginal walls, the instrument must be kept in place by a T bandage. In addition to the vaginal injections, the local treatment will consist in the application of a solution of tannin in glycerine every other day, and about once a week the subsulphate of iron or Monsel's salt. These applications should be made just after the vaginal injections, and on removing the secretions, with a syringe, as thoroughly as possible; the parts should be well dried by means of small pieces of old linen laid between the flaps, and removed as the application is made. It is advisable to separate thoroughly the flaps before applying the preparation of iron, that the powder may be dusted over the whole denuded surface; but afterwards they must be brought together, with the uterus anteverted, and the patient kept in the horizontal position for some hours. When the circumstances are such that the patient is unable to keep quiet after the application, it is a good plan to place in the posterior cul-de-sac a proper-sized pledget of damp cotton, with another in front of the anterior lip. These cotton pledgets are for a day or two to take the place of the instrument, which would be injured by contact with the iron, while at the same time they will protect the patient's linen. As a rule, I leave the tampon undisturbed for forty-eight hours, and have the vaginal injections omitted for the same length of time. This treatment may be followed for a month at least previous to the

operation, which had best be performed just after the menstrual period.

So long, however, as there can be detected, by pressure from the finger, any tenderness in the neighboring connective-tissue, it is not safe to operate. We may feel satisfied fully that a certain amount of cellulitis has previously existed, and a condition is still remaining which would require but a slight provocation to re-establish the inflammation, were we to disregard this warning.

My mode of operating is to place the patient on the left side, and to use Sims' speculum, or some other perineal retractor to bring the parts in view. The operation can be performed sometimes on the back, as the vaginal outlet is large and the uterus so low that it can be readily drawn outside and returned after the operation. But the left side has the advantage, were there no other, that while in this position there can be less rolling out of the tissues except when the patient is placed on the knees and elbows. The first step is to bring the flaps together in apposition, and while they are lifted up by means of a double tenaculum in the hands of an assistant, the instrument known as the uterine tourniquet is slipped over the cervix below the point of vaginal junction and tightened. The object of this instrument is to control the hemorrhage, during the operation, which is sometimes excessive without its use. Until recently I have used a portion of twisted wire, such as is usually furnished for the écraseur, the two ends of which were passed through a canula. The loop was slipped over the neck of the uterus, while being held up by an assistant, and tightened by sliding the canula down the wires held in the other hand. As soon as the cervix was compressed as much as possible by this means, the ends of the wire were bent back and several times wrapped around the end of the canula so that they could not slip. Within a few years I have had the instrument constructed, which I have referred to, by using, instead of the wire, a portion of watch-spring passed through a canula, with the application of the double ratchet of the écraseur to lighten the loop about the cervix. Just before constricting the neck, I take the precaution to draw up, with a tenaculum, through the loop sufficient vaginal tissue all around the cervix that the flaps may be brought together easily, while

the fold thus formed renders the instrument less likely to slip over the cervix when it has become reduced in size from the escape of blood during the operation. Then, after separating the flaps, the surfaces which have been lacerated are to be freely denuded from one lip to the other, leaving a broad undenuded tract in the centre, from before backward, which is to form the continuation of the uterine canal to the os. The greater the hypertrophy of the organ the more necessity there will be for leaving the canal and outlet large, or both will be too small when the uterus regains its normal size. A difficulty is sometimes experienced in bringing together accurately the vaginal edges of the flaps, in consequence of the great thickening in the central portion, which will be found dense and filled with cysts. It is necessary to remove this tissue freely, and from the opposite side to which it is to be united, so that the two freshened surfaces will correspond in width. Either the scissors or the scalpel may be used to freshen the surfaces, but I prefer the former, from the greater rapidity with which the tissues can be removed. While the tourniquet is being held by an assistant, to steady the uterus, the portion from the flap to be removed is secured by means of a tenaculum in the hand of the operator. At the outer angles of the fissure, just at the vaginal junction, it is necessary when freshening the surface to remove very superficially the tissues at these points. The circular artery is seldom ruptured when the laceration takes place, from its elasticity and position in loose connective tissue, but as the parts contract after cicatrization, it is frequently left just at the termination of the angle of the fissure with the vaginal tissues. The most difficult step in the operation is the introduction of the sutures, from the great density of the diseased uterine tissue and the mobility of the organ. The first suture should be passed through the anterior flap, close along the bottom of the fissure, and withdrawn just at the edge of the undenuded strip left to form the canal, again to enter at a similar point in the opposite lip, so as to make its exit on the vaginal surface of the posterior flap corresponding with the first point of entrance. From three to four sutures are generally needed on each side. The last one, through the crown of the cervix being more superficial, is easier of introduction, but needs be passed with more care than the others, with the view of accurately approximating the edges at

the os and along the vaginal surface from this point. Before securing the sutures already passed, those for the opposite side must also be introduced, or great difficulty will be experienced. Should there, however, be an unusual amount of bleeding, it can be arrested by only twisting the interrupted suture nearest to the bottom of the angle. But it is even better, before doing so, to see if it cannot be controlled by tightening the tourniquet, which may have become loosened in consequence of the shrinkage of the neck from the escape of blood confined within the tissues when the instrument was first applied. The same plan is followed for securing the sutures, as recommended by Dr. Sims for the operation of vesico-vaginal fistula. The needle is armed with a short silk loop, and after its introduction the silver wire is then attached and drawn through to take its place. The ends of the wires are seized by a pair of forceps and twisted over the "shield," but before being freed from the former they should be bent over flat by means of a tenaculum, used as a fulcrum, under the suture at the end of the twist close to the line of union. If bent over properly, so as to lie close to the vaginal surface, and cut off at half an inch in length, the sutures may remain undisturbed for an indefinite time, but they are generally removed on the eighth day. When the sutures are withdrawn the precaution must be taken to cut the nearest portion of the loop so that it will continue to bind the parts in apposition until it has been drawn out. It is best to remove first the suture nearest to the vaginal junction, for if there should be any tendency to gap in the line, the others can be left for several days longer, so that the ununited portion may heal by granulation.

When the laceration has been confined to one side it is necessarily more difficult, in comparison, to denude throughly the angle at the bottom of the fissure, as well as to introduce the sutures with the same accuracy, than would be the case where both sides of the cervix have been laid open. Fortunately, however, it is not so necessary that the sutures should be passed to the edge of the uterine canal, where but one side of the neck is to be united. The main point is to secure on the vaginal surface as perfect a line as possible, for when the two surfaces thus brought together have been freshened to about the same extent, the parts will be kept sufficiently in contact that the line within

the uterine canal will be, in all probability, as perfect as that secured by the sutures.

If the general condition will admit of the confinement, it is better that the patient should remain in bed for some ten days after the sutures have been removed. She will need no local treatment beyond resuming again her hot-water vaginal injections which are generally omitted after the operation, until the sutures have been removed, that she may be kept as quiet as possible so long as there is no vaginal discharge. During this period, however, if a necessity exists for their use, one or two pints of water will be sufficient, to which it is well to add a little castile soap. After the sutures have been removed, the uterus will decrease rapidly in size if there exists no cause of irritation to arrest its progress. To favor this change an early resort to some mechanical support is advisable to lift the uterus from the floor of the pelvis, and to keep the organ anteverted if possible. Some modification of Hodge's open lever pessary I have found to answer for the greater number of cases. The instrument should be made with a curve long enough to go well up into the posterior cul-de-sac, and at least half an inch beyond the uterus, for if too close at this point it will by pressure obstruct sufficiently the circulation about the cervix to increase the hypertrophy of the whole organ. The pessary should be as small a one, both in length and width, as will acomplish the purpose, that the vagina may gradually recover from its overstretched condition resulting from the previous prolapse. So soon as the patient has sufficiently regained her health, and other circumstances will admit of doing so, the lacerated perineum should be closed, and, if necessary, the operation ont he vaginal walls should be performed for restoring the canal to its normal size. On her recovery from the operation, it will then be a question of judgment as to the necessity for some modification in the size and shape of the pessary which had been previously worn, or as to the propriety of discontinuing its use. As a rule there will be no need for any local treatment to the uterine canal, for with the improvement in the patient's general condition all discharge will cease, and the organ will gradually regain its normal size.

NOTE.—With the consent of Dr. Emmet we append the following remarks, which were made by Drs. J. Marion Sims and Horace T. Hanks after the

reading of the above paper at the meeting of the Medical Society of the County of New York, Sept. 28th, 1874, and which were kindly furnished us for publication by their authors:

Dr. J. MARION SIMS said: When I went abroad in 1862, amongst the patients I turned over to the care of Dr. Emmet was the lady whose case forms the basis of the paper he has just read. She belonged to the upper walks of life, and had been under my charge for twelve or eighteen months. I remember the peculiarities of her case, so well described by Dr. Emmet, as vividly as if it were but yesterday. The bilateral laceration of the cervix, and the consequent eversion of the hypertrophied, congested cervical mucous membrane constituted at that time a difficult problem to solve. During the whole time that I observed this case no benefit resulted from local treatment, and I am sure that nothing short of the method so successfully adopted by Dr. Emmet could have been of the least service to her. I now only wonder that this operation had not been worked out sooner. When the perineum is lacerated, the necessity for its reconstitution is self-evident, and it is singular that the necessity for reconstituting the integrity of a lacerated cervix did not sooner force itself upon the surgeon. The operation as devised and practised by Dr. Emmet is as simple, as safe, and as certain in its results, as is the operation for a simple case of vesico-vaginal fistula. The same principles underlie each. The same free denudation of tissue, the same method of suture, the same after-treatment, and the same security from danger, belong to both alike.

I have performed the operation often enough to speak in positive terms of its value. The discussion of the subject must, of necessity, be one-sided. There can be no objection, no opposition to the operation. We must accept it as Dr. Emmet has given it to us. We can't modify the operation; we can't change it; we can't improve it—for it is perfect, perfect in its method, and perfect in its results.

We owe to Dr. Emmet a debt of gratitude for this valuable contribution to uterine surgery. Like all new operations it is likely to be abused, but the time will soon arrive when it will assume its place in the foremost rank of useful improvements.

After the subject had been discussed by other members of the society, Dr. Marion Sims rose again, and said: I am personally so impressed with the importance of Dr. Emmet's paper in a practical point of view, and so pleased with the manner in which he has presented it to our consideration, that I beg leave to move a formal vote of thanks to Dr. Emmet for his most valuable contribution to surgery.

This motion being seconded was carried unanimously.

Dr. H. T. HANKS said: Mr. President, and gentlemen, I took occasion this morning to consult the record-book for diseases of women in Demilt Dispensary, where I am one of the attending physicians, believing it would confirm the conclusions drawn by the author of the paper this evening. I have not been disappointed. Many of us have not realized that this lesion described by Dr. Emmet is a common one. It is only a few winters since that I saw Dr. E., at the Woman's Hospital, point out some of the direct results of lacerations of the cervix uteri, and skilfully perform the operation for its cure. Since then I have been struck by the frequency of the lesion, both in public and private practice. During the five months ending August 31st, 1874, I treated in the department for diseases of women at Demilt Dispensary,

254 cases. Deducting 25 which were not truly uterine, leaves a total of 229 *strictly* uterine. Of these, 19, or over $8\frac{4}{10}$ per cent., were suffering from laceration of the cervix uteri. In 4 of these 19 cases, there was sub-involution of the uterus; in 9, there were granular erosions, more or less severe. In 3 cases, displacements occasioned indirectly by the laceration of the cervix. Thus we see that these statistics emphasize and corroborate the conclusions deduced this evening by Dr. Emmet.—Ed.