THE MEDICAL RECORD

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EDITED BY

GEORGE F. SHRADY, A.M., M.D.

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TWO CASES OF RUDIMENTARY UTERUS.

By SUSAN DIMOCK, M.D.,

RESIDENT PHYSICIAN TO THE NEW ENGLAND HOSPITAL FOR WOMEN AND CHILDREN.

MRS. MARY W——, twenty years old, a tall, well-developed blonde, was sent to me by her family physician in autumn of 1872, to be operated upon, if advisable, for atresia vaginæ. The patient had always been tolerably healthy as a girl, and had developed physically at the usual age; had, however, never menstruated, nor had the slightest molimena ever been felt. At the age of nineteen the patient married, remained well for six months, but was then seized with severe and frequent headaches, dizziness, want of appetite, and feeling of general debility. Under a tonic treatment these symptoms were alleviated, and when the patient consulted me three months later, she seemed well, with the exception of slight anæmia. Upon examination I found the external organs of generation normally developed, and the remains of the hymen existing as four or five carunculæ. The vagina was one inch in length, and large enough to admit the end of the common bivalved speculum. Not the smallest opening was to be found in the vaginal walls. By introducing a catheter in the bladder and a finger in the rectum, the rudiment of the uterus was to be felt about an inch above the blind extremity of the vagina, measuring about one inch in length and one inch and a half in width at the fundus. The thickness at the fundus seemed little more than half an inch. The ovaries were not to be felt. Of course an operation here was out of the question, since, even were the difficulty of making an inch-long passage to the uterus overcome, the functions of menstruation and procreation would be impossible, the uterus being in so undeveloped a condition.

A few weeks after observing the above case, the following came under my care, which, independent of the anomaly in development, presents some points of interest:

Louisa B——, aged eight, a healthy little German Jewess, was brought to the N. E. Hospital for Women and Children, quite unable to stand or walk without screaming with pain. The parents stated that she had always been well until three days before, at which time, while playing with other children, she had tried how far she could stretch her feet apart. The next night she complained of great pain at the vulva, and the parents found a swelling there which they took for a prolapsed uterus. Indeed, upon a cursory examination this seemed to be the case, for protruding between the labia was a small tumor presenting the exact appearance of a congested cervix uteri. Upon etherization, however, this tumor was found to be a hypertrophied ring of mucous membrane around the orifice of the urethra. The hymen was found torn (from the strain at the time of injury?), the vagina of normal length and width, but presenting at its upper extremity a cul-de-sac without trace of uterus. With the catheter in the bladder and finger in the rectum a small thickened strand was to be felt above the vagina, barely larger than the united Fallopian tubes would be.*

The ring around the meatus having been very sensitive to the touch, I removed, drawing it out with dressing forceps, and cutting above with curved scis-

* The uterus is formed *not* from the uro-genital sinus, but by the coalescence of Müller's ducts, the upper ends of which become the Fallopian tubes.—*Weber*, *Waldeyer*, *Frey*, etc.

sors. The bleeding, which was for a moment profuse, was checked immediately by the actual cautery. The little patient felt very slight discomfort after the operation; during ten days she was placed in a warm sitz-bath to urinate, and at the end of two weeks, as she could walk without difficulty, and the wound had entirely healed, she was discharged.

Two cases of supposed occlusion of the vagina from defective development have lately been brought to me. Both proved to be the merely epithelial adhesion which is so frequent, and which gives way upon slight stretching with the probe or finger.

A CASE OF SUCCESSFUL OPERATION FOR RECTO-VAGINAL FISTULA.

By SUSAN DIMOCK, M.D.,

RESIDENT PHYSICIAN TO THE NEW ENGLAND HOSPITAL FOR WOMEN AND CHILDREN.

MRS. ADELA Q., 22 years of age, consulted me, June 11th, as to the possibility of an operation for a recto-vaginal fistula of sixteen months' standing, so large that the fæces passed exclusively through the vagina. On examination, the fistula was found to extend from just above the sphincter ani, two inches upward, the edges being everted and gaping. The vagina was not nearly so capacious as is usual sixteen months after the birth of a child; and, indeed, the sides of the fistula could with difficulty be approximated. The whole vaginal mucous membrane being in an irritated condition, and the patient being thin, pale, and debilitated, I advised her to wait four weeks, during which time she was put upon the most nourishing regimen of meat, wine, etc. The tartrate of iron and potassa was administered in 2 gr. doses three times daily, and a daily sitz bath given at 99°, as also a vaginal injection of a pint of water at 99°, to which a drachm of alum had been added. During the month the irritation of the vagina disappeared, and the general health of the patient was much improved.

She was accordingly admitted to the New England Hospital for Women and Children on July 13th, on which day I operated, it being seven days after the cessation of the menstrual flow. The bowels were thoroughly moved by castor-oil before the operation, and the vagina and rectum cleansed by injections. The patient being etherized, the sphincter ani was paralyzed by stretching, and the patient placed in the position for lithotomy. I then removed with the scissors all the cicatricial tissue formed at the junction of the rectal and vaginal mucous membranes; but this giving too narrow a surface for union, I separated the rectal and vaginal mucous membranes with the scalpel, thus obtaining a surface three-quarters of an inch in width, without encroaching upon the already scant vaginal walls.* The patient was then turned on the left side and, the posterior rectal wall being held backward by Sims' speculum, the rectal mucous membrane around the fistula was united by five stitches of fine silk, which were tied very tightly, in order that they might slough away. The patient being again placed on the back the vaginal mucous membrane was united by silver sutures, and the wires, which were doubled, fastened upon "quills" three inches in length, made of a flexible French bougie. Seven deep stitches were thus inserted, and afterwards, the edges at the lower end of the fistula gaping, two superficial stitches of single wire were used.

During the six days succeeding the operation, a camphor and opium pill was given each night, and the diet limited to tea, toast, and beef-juice. The vagina was syringed three times daily, and the urine drawn. On the 4th day the vaginal stitches were removed, as the mucous membrane was beginning to ulcerate under the pressure of the quills. On the 7th day, the last rectal suture having been drawn away, castor-oil was given, followed by a large enema of milk. The fistula had completely healed, and the bowels moved freely without any pain or passage of fæces into the vagina. The patient's general condition has been uniformly improving since the operation, and three weeks after, she was discharged well.

The case is interesting as an illustration of a new method of operating, namely, by splitting and turning outward both rectal and vaginal layers of mucous membrane. This method is invaluable where material is scanty, as nothing is cut away except cicatrix.

* The fistula measured after the removal of the cicatricial edge about three inches in length.

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DR. SUSAN DIMOCK.

Dr. Dimock was born in Washington, North Carolina, April 24, 1847, and was lost in the wreck of the steamer Schiller, May 7, 1875. In her short life of twenty-eight years she acquired, in the face of many serious obstacles, an amount of medical knowledge and of surgical skill such as but few possess; and to these qualities she added a maturity of judgment and power of reasoning which are quite as rare. Her father, Henry Dimock, was born in Limington, Maine, and having obtained a collegiate education by his own exertions, was in 1831 head-master of the Roxbury High School. He afterwards taught school in North Carolina, where he studied law and married a Southern lady.

Until the age of twelve, Dr. Dimock was educated entirely by her parents, and her classical studies had advanced so far at this time that her father spoke of her as understanding Latin verse better than he did when he left college. In 1861, when she was fourteen years old, her school studies were interrupted by the war of the Rebellion, and by the death of her father. These trials, however, only served to ripen her judgment and to develop her character as no school-work could have done. Her interest in the study of medicine had already shown itself, and at this early period she determined to make it the occupation of her life, and firmly held to this resolution until she was able to carry it out some years later. Her Southern friends and some of the officers of the Southern army remember well her deep absorption in reading any medical book, however dry, which she could obtain. In the autumn of 1864, Dr. Dimock and her mother, who had suffered much and lost most of their property in the war, came North. For the next six months Miss Dimock was at school at Sterling, Mass., beginning at this time a course of systematic reading of medical books, which were supplied her by a friend in this city. The following autumn she taught school in Hopkinton, continuing her reading under the direction of Dr. Pratt of that place. After she had taught for one term her mother at last gave her full consent to her studying medicine, and at once she devoted herself wholly to her chosen work.

From her entrance into the New England Hospital for women and children, January 10, 1866, until her return from Europe, in 1872, all her time and energy were given to her professional studies. She lived in the hospital for two years and a half, making the most of every advantage offered her in the wards and dispensary. During this time she was admitted to attend the clinical visits at the Massachusetts General Hospital, and the clinics at the Eye and Ear Infirmary for a brief period. After her application for admission to the Harvard Medical School had been refused, she went to Zürich to avail herself of the advantages of the best instruction which was open to her. There, in spite of her previous unfamiliarity with the language, she soon stood among the first of her class, and in 1871 she was graduated with high honors.

The following year she spent in clinical studies at Vienna and Paris, returning to America in the summer of 1872, and at once, on the 20th of August, entered upon her duties as Resident Physician to the New England

Hospital for Women and Children. No sooner had she taken this position than she moved the hospital into its new building, and began at once to systematize the work of both nurses and students in such a way that their services extended to a much larger number of patients than was ever before the case. She also took charge of the dispensary for two days in the week, for the first two years of her hospital life, relinquishing it only when obliged to do so by the requirements of her hospital duties. The training-school for nurses, connected with the hospital, was completely reorganized by her; it was under her charge until just before her departure for Europe.

Her medical skill is attested by the hospital records, with their evidence of favorable results. Her success as a surgeon is also proved in these records by the numerous cases of important surgical operations followed by success. Her skill and self-command in operating no one can appreciate who has not witnessed it.

Few are aware of the loss the public and the medical profession have met with, in her untimely death. Those, however, who have worked with her, have learned fully to respect and admire her rare abilities; and to them, her loss can never be made up. Her brief and highly honorable career points surely to the high position she would have attained had her life been spared.

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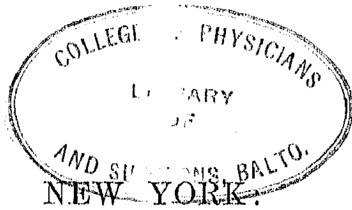

COLLEGE . PHYSICIANS
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A CASE OF CONGENITAL ANAL OCCLUSION OF AN UNUSUAL KIND.

By SUSAN DIMOCK, M.D.,

RESIDENT PHYSICIAN TO THE N. E. HOSPITAL FOR WOMEN AND CHILDREN.

WITH AN OBITUARY OF THE AUTHOR,

By MARY PUTNAM-JACOBI, M.D.,

NEW YORK.

NORA N——, a mulatto child of 11 years, was brought to me in summer for examination, with a view to an operation for incontinence of fæces. From the rather imperfect history given by the aunt of the little patient it appeared that at birth the anus was imperforate, with, however, a fistulous opening in the perineum. Within the first week after birth, she was operated upon at the Massachusetts General Hospital by Dr. S. Cabot, with whose kind permission I insert the record of the case. While there "a diagnosis was made of congenital constriction of anus, the passage being pervious, admitting a full-sized probe. A small sponge tent was introduced and retained in place by adhesive strips. Next day a No. XII. bougie was introduced. The opening was then considered large enough, and the patient was discharged. Was readmitted to the Hospital a short time after, on account of the opening being insufficient for the demands of nature, and an operation was now deemed necessary. Upon further examination the case was decided to be one of congenital occlusion of the anus. The place where the true anus should be was marked by a depression and discoloration of the skin, but no opening existed there. One inch in front was the fistulous opening enlarged by Dr. Cabot, through which the fæces were discharged. A large silver probe was introduced into the false anus, and carried back as far as the centre of the depression in the direction of the true anus. With the probe for a guide a + incision was made through the skin. The mucous membrane exposed by the incision was then united to the edge of the wound by means of three sutures. A small roll of cloth, well oiled, was introduced into the anus and left for a short time. Fæces continued to pass through both openings, when the patient was discharged."

The passage of fæces has always been involuntary, and the action of the bowels very irregular, there being sometimes no movement for a week, and at other times as many as twenty-four discharges in a day, while, whether constipated or otherwise, there is no voluntary control over the passage.

Upon examination I found two openings into the rectum, one (the artificial opening) where the anus is normally found, large enough to admit a goosequill, the other opening through the perineum about three-quarters of an inch in front of the first, and large enough to admit the fourth finger. The child being very nervous, very sensitive, poorly nourished, and slightly feverish (the temperature ranged from 99° F. to 100° during several evenings when it was observed), all operation was deferred, and nourishing diet and out-of-door play recommended during the summer.

In September the patient entered the New England Hospital for Women and Children, and upon the 13th was etherized for thorough examination and such operation as should show itself advisable. I had hoped that the contraction of the artificial anus might be owing to the sphincter, and might be overcome under the influence of ether, in which case a closure of the congenital fistulous opening would remedy the evil, but I found that the anus remained impervious to the finger, a tense cicatricial ring preventing the least dilatation, while water injected flowed constantly from both openings, showing the entire absence of any sphincter action.

Under these circumstances, the best thing seemed to be the division of the bridge between the two apertures, and I hoped that the one large opening thus formed might become small through cicatrization of the cut surfaces, and that even perhaps later a tolerable sphincter might develop itself through use, as is often the case. I therefore divided the bridge of the perineum without much bleeding, the tissue cutting like cicatrix, and the cut surfaces, which were half an inch in diameter, retracting immediately to a line. The opening thus formed was large enough to admit with ease four fingers, but to my surprise and great pleasure began to contract visibly and take on the folded appearance of a normal anus, so that after the lapse of ten minutes a quart of water being injected was *retained* perfectly, and only ejected with the use of a Sims' speculum. The after history of the case confirmed the most favorable anticipations; the wounded surfaces healed rapidly, there was no fever again, and not the least involuntary defecation. During the first week the bowels were moved by enemata, but afterwards naturally, and by the 21st of September the child was discharged well.

The question naturally arises as to the exact nature of the malformation. It seems to me that we can exclude here the usual atresias of the rectum caused by deficient development of the anal end, which, as embryonic investigations show, starts from the skin and stretches upward toward the rectum. For in such case the sphincter, which shares to some extent in the deficient development, could not have attained so perfect an action in so short a time. Neither can the anterior opening have been of the fistulous nature which is usual in many cases of aproctia, for even after opening the true anus the fæces continue to discharge involuntarily through the fistula, which is of course without sphincter. But in our case the anterior opening, the artificial anus, and the divided surfaces all contracted regularly and alike into one round aperture with sphincter action everywhere. Are we not, then, justified in considering this case one of embryonic ulceration and adhesion of the nates near the anal opening, an adhesion complete posteriorly, but leaving anteriorly a canal between the bridge thus formed and the perineum, which canal passed backward into the anus? With this view of the case, the mechanism by which the sphincter was kept powerless for so many years is easily explained. Draw together as illustration the commissures of the mouth, and the action of the orbicularis oris will be so far prevented that at least no liquid can be retained in the mouth. The adherence of the skin at the margin of the anus drew together the sphincter laterally, and rendered its circular action impossible. When this strain was taken off by the division of the bridge, the sphincter naturally assumed its normal action.

THE OBITUARY OF THE AUTHOR.

TO THE EDITOR OF THE MEDICAL RECORD.

SIR:—The accompanying article was entrusted to me for publication by Dr. Susan Dimock, just before her departure for Europe in the ill-fated *Schiller*. I had not yet fulfilled her commission when the news of her death reached us. This news is terrible, not only to Dr. Dimock's personal friends, but to that still wider circle who had recognized her fine talents, and

her great value therefore in the difficult enterprise of hewing out for woman an equal place in the medical profession. Dr. Dimock graduated with honors at Zurich after the prescribed four years' term of study. Her thesis was written on the cases of puerperal fever she had had an opportunity of observing in the wards of the hospital. She has been practising medicine in Boston a little over two years, but in this short time has already won for herself a deserved reputation among some of the best surgeons in the city. As resident physician at the New England Hospital, she has already performed many important surgical operations. A case of vesico-vaginal fistula was published in your columns some months ago. The brief note that I have again the honor of sending to you relates a successful operation on a child, on whom so distinguished a surgeon as Dr. Cabot had already operated in vain. Last fall, while on a visit to Boston, Dr. Dimock showed me the photographs of another hospital patient, from whose neck she had removed a large sarcomatous tumor. The operation had been performed in the presence of the students of the hospital and of Dr. Cabot, consulting surgeon. After reading the record of the case, I mentioned a precisely similar operation that I had seen performed by Richet in the Clinique at Paris, and the lecture, in which he described the great difficulties of removing a tumor deeply imbedded in so dangerous a locality. The Professor had seemed not a little proud of his own success in coping with these difficulties, and had taken care that a numerous auditorium should witness *his* triumph. At this Dr. Dimock laughed, and said, "I was asked why I had issued no invitations, but I had forgotten all about them." She added, "Indeed I have too little personal ambition to care who sees, when I am once assured my work is well done." The remark was characteristic of the modesty and simplicity that distinguished the young surgeon. She was as fresh and girlish as if such qualities had never been pronounced by competent authorities to be incompatible with medical attainments. She had indeed a certain flower-like beauty, a softness and elegance of appearance and manner such as is abundantly lacking in the women most eager to denounce surgical accomplishments as outrageously unfeminine. I have wondered whether she did not resemble Angelica Kaufman. Underneath this softness, however, lay a decision of purpose, a Puritan austerity of character, that made itself felt, though unseen. "She ruled her hospital like a little Napoleon," said a lady who had been there under her care. The ideal steadfastness, which is only possible in characters of this kind, was shown to me at my first interview with her, when she came—a girl scarcely out of her teens—to Paris, on her way to Zurich. We urged her to spend a few days in the capital, for the sake of the recreation to which American students usually consider themselves entitled before they settle down to their studies. Miss Dimock alone refused, for the reason, which she gave with the utmost frankness, that she had been obliged to borrow money in order to prosecute her studies, and should not feel justified in spending a cent of it for amusement or sight-seeing. She put forward all amusements into the future, until she should have won her university degree, and should have fulfilled a pledge of hospital service in Boston. Towards this horrible voyage of April, 1875, converged the pleasurable anticipations of nearly seven years. Among all the bright lives that have been engulfed in this dreadful shipwreck, none is more valuable than hers. Perhaps no woman's life of equal social value has met this tragic fate since the body of Margaret Fuller was washed ashore on the western coast of the Atlantic. For the success of the social enterprise of securing for women a place in the medical profession finally depends upon but one condition, the demonstration, namely, by repeated indubitable practical evidence, of their real fitness for each branch of its work. None are fitted for all, and both the surgical talents and surgical training of Dr. Dimock are certainly, at the present date, exceptional among women. It is on this account that her loss is literally irreparable, for at this moment there seems to be no one to take her place. Many battles have been lost from such a cause. But although ours be ultimately won, we would not, if we could, grieve less loyally for this girl, so brilliant and so gentle, so single of purpose, and so wide of aim, whose life has been thus ruthlessly uprooted and thrown upon the waves at the very moment it touched upon fruition.

MARY PUTNAM-JACOBI.