along bled profusely from its whole surface, and by this time the patient had lost at least a pint of blood. A sponge was packed into the perineal wound, the suprapubic incision made, and the bladder opened above the pubes on the stone; a matter of little difficulty, as the stone was pushing forwards the anterior bladder-wall. The incision in the skin was extended upwards for about four inches from the pubic bone, the bladder-wall being opened for about two inches up to the reflection of the peritoneum. The lithotomy-forceps was again introduced, but had no power, and slipped. There was the same difficulty as before. The midwifery-forceps of a neighbouring practitioner was now sent for, and, on its arrival, one blade was introduced at a time, as in an ordinary instrumental delivery. The entrance of the first blade was followed by a gush of putrid urine, which escaped over the abdominal wound, and must inevitably have run into the peritoneal cavity had it been opened. This urine, about two ounces, was lying in the base of the bladder under the stone, and at a lower level than the urethral opening. The forceps being locked, the stone was easily removed by slow and gentle traction, the wound in the bladder expanding without laceration, and no further obstruction being encountered because of the long incision through the superficial soft parts. The bladder-wall was very much thickened, and so vascular that it bled freely. Lying at the lowest part of the bladder was another small flat stone, which was now removed.

The operation was completed by the introduction of two deep and three superficial sutures of catgut into the abdominal wound, leaving only the lower half open; by stitching a full sized drainage-tube reaching the bladder into the perineal wound; by flushing out the bladder and wounds with boracic lotion; and, finally, by the introduction of a large sponge, with Péan's forceps attached, into the bladder to stop the oozing from its interior still going on. The operation occupied three quarters of an hour, including the delay occasioned by having to send for forceps.

An hour afterwards, the sponge in the bladder was removed by means of the Péan's forceps, which was left attached, and all the bleeding had ceased. The patient had a fair pulse, but had not yet rallied from the cold, chloroform, and shock.

August 16th, evening. Fair pulse, 110; temperature 97°. He had not yet recovered from the shock, and was inclined to be cold. A hypodermic injection of one-sixth of a grain of morphine was made, and some hot milk and water given.

August 17th, morning. Temperature 97°. The hands were still cool, but the body warm and perspiring. He had had a good night; he had slept three or four hours, and had taken milk freely without sickness. 1 P.M., temperature 97.6, pulse 112; 3.40 P.M., temperature 99°, pulse 120; 10 P.M., temperature 102.6°, pulse 160. Ten grains of quinine, and ten grains of compound ipecacuanha powder, were ordered.

August 18th, 1 A.M. Temperature 100.2°, pulse 140; 8.20 A.M., temperature 97.4°; 3.20 P.M., temperature 98.8°; 8 P.M., temperature 99°, pulse 117. After this, his temperature only once reached 100°. For several nights he required morphine to make him sleep, not because of pain, but of restlessness.

August 19th. Most of the urine escaped by the abdominal incision, in spite of the fact that the perineal tube was large and patent. The tube was removed in consequence. The secretion of urine was very free, and had been ever since the operation. To-day he took a quantity of egg-flip; he looked much better, but his tongue was dry, and he was disposed to hiccough. One grain of calomel was ordered to be taken every four hours.

August 21st. His pulse occasionally intermitted, and had kept up to about 120 since the operation. He was ordered 10 minims of tincture of digitalis every four hours. The tongue was much cleaner. He asked for and relished some tea and toast.

August 22nd. Most of the urine escaped through the abdominal wound; and a tendency, apparently, for it to find its way into the urethra had caused some pain. I passed a full sized drainage-tube through from the perineal to the abdominal opening, and ordered the bladder and tube to be syringed out from above every four hours with warm boracic lotion. The patient seemed very well and strong; pulse 100, temperature normal. He could not, however, sleep well at nights; the urinary secretion was very free.

August 27th. He was very well and strong. The upper part of the abdominal wound was healed; the lower part was granulating, and both it and the perineal wound had closed in so as to embrace the drainage-tubes. His diet had been gradually improving; to-day he was allowed to have for dinner chicken with vegetables, pudding, and a glass of beer. After dinner he enjoyed a smoke, and was anxious to know if he soon could get up a little. He was in excellent spirits about himself.

August 28th, morning. He looked rather depressed, and said he did not feel in such good spirits. He had had hiccough occasionally; but, as his pulse was good, and temperature normal, the wounds looked well, and the secretion of urine was free, no importance was attached to it, as, even when fairly well for some months, he had sometimes had it. In the evening the hiccough was much worse; it never let him rest. The tongue was dry; pulse 120, temperature 98.4°. He was very thirsty, drowsy-looking, and low-spirited. He said he was going to die. Hypodermic injection of morphine, and a variety of other things, were tried.

August 29th. The hiccough never ceased. He had been delirious all night, wanting to get out of bed, etc. He died early in the morning. *No post mortem* examination could be obtained, though there could be little doubt from the history and his condition that the ureters were dilated, and the kidneys diseased.

ENDOMETRITIS.

Read before the Glasgow Obstetrical and Gynaecological Society.

By ROBERT BELL, M.D., F.F.P.S.G., ETC.,
Physician to the Glasgow Institution for Diseases of Women.

Two reasons have influenced me in my selection of endometritis as the subject of this paper: 1, because this morbid condition is so frequently met with; and 2, because its existence is so frequently overlooked by the general practitioner. I do not, of course, wish it to be inferred, when I speak of endometritis, that I believe that the endometrium, in any great number of cases, is affected alone—that is, without the parenchyma of the uterus being likewise involved; but, as it is principally through the lining membrane of the organ that we are able to reach its more remote structure when treatment is being employed, and as the indications of restored health are reflected through the canal, the health of this membrane must always be viewed as indicative of the health of the uterus as a whole. I have just observed that this diseased condition of the uterine canal is often overlooked; but I go farther, and would point out that not only is it passed by unrecognised, but one of the manifestations of the disorder, and one which of itself is of little account, is accepted as the disease, and, even when this is detected, it is misnamed. I refer to the so-called ulceration of the womb, which, so far from being an ulcer, on the contrary, is a hypertrophic condition of the cervix. This partakes no more of the nature of an ulcer than an ectropion of the eyelid does. Papillary and follicular ulceration of the cervix are terms in our nomenclature which never should have existed. Certainly the strawberry appearance of the cervix, which frequently, but by no means constantly, is a part of endometritis, is a most prominent symptom; and to observe its gradual disappearance is a most welcome sight; but to treat it *per se* by local applications, in the expectation that the patient will thus have her health restored, will surely end in disappointment. What we have been long in the habit of calling an ulcer of the womb, in common parlance, is, we now know, an ectropion of the cervical membrane due to hyperplasia, which results in the mucous membrane being crowded outwards; and this hyperplasia is due to endocervicitis. Let us now, however, consider endometritis, not in part, but as a whole; and it will be my endeavour not only to demonstrate what I consider the safest and surest means of arriving at a correct diagnosis, but also to detail my experience in its treatment.

First, then, its etiology must have careful attention, as this is very varied. The causes of endometritis are frequently at the onset apparently very trivial, so much so, that it is not a matter of surprise that they are often overlooked; and yet these may advance so insidiously, that quite unexpectedly they come to be mighty factors in the production of this most painful and trying disorder. We cannot be surprised, however, that a woman should suffer intensely and long before applying for relief, when the uterus is the seat of disease. It must always be a great effort on her part to submit to examination, and to a course of treatment. Symptoms are thus apt to be pretty well advanced, and, therefore, more difficult to remove than otherwise they would be, before they come under observation. As each menstrual period is accompanied by a physiological hyperæmia of the uterus, which in the healthy woman passes off with the emptying of the surcharged vessels, it will not be difficult to comprehend how, if any inflammatory condition be present as well, though it may not be sufficiently marked to indicate itself by any decided symptoms during the intermenstrual repose, this will be so aggravated at the period of

menstrual activity as to make its presence distinctly evident. The tendency, then, will be for the hyperæmic condition to persist beyond the normal number of days, and possibly induce menorrhagia, which will, in its turn, give relief to the symptoms so far; but in all probability this will again be succeeded by a catarrhal discharge, which will, in a minor degree, act as a depleting agent, though it will, by its very presence, perpetuate the disease. It behoves us, therefore, to employ means at once with a view of checking this incipient form of the disorder, such as rest and general tonic treatment, with, perhaps, a moderate amount of shampooing. At the same time, special attention must be directed to the bowels, a duty which is too often neglected, much to the hurt of the patient; otherwise, if the disease be permitted to advance, it will soon manifest its presence by unmistakable symptoms. I have frequently met with cases similar to that which I have just depicted, in girls who have either been indiscreet during the menstrual flow, going into baths, for instance, or getting their feet wet, or who have suffered some mental shock, by which means the discharge has been checked; and I feel sure many here must have had similar experiences. Then we must not overlook the fact, that an atonic condition of the general system is a potent predisposing cause to endometritis, which condition, we know, may arise from a number of circumstances, but which would be beyond the scope of this paper to detail. If we view the anatomical relation of the uterus to the neighbouring parts, its dependent position in the pelvis, its blood-supply, etc., it is not difficult to realise how readily a passive congestion can obtain within its structure, and how this, being aggravated at each menses, will sooner or later assume a chronic condition.

Constipation is another predisposing cause, and, I must insist, a much more frequent and energetic factor in inducing endometritis, than one is fain to imagine. It acts in two ways: first, by interfering with the circulation in the pelvis; and we must remember that it is always the circulation in the veins that suffers first when pressure exerts an effect on the vascular system, the elastic walls of the arteries rendering them, to a large extent, free from much risk of compression. The venous capillaries, therefore, become engorged, and œdema results. Now, an accumulation in the rectum and lower reaches of the colon interferes very considerably with the vascular health of the pelvic viscera. In the second place, we cannot have a sluggish action of the colon, and, therefore, a loaded colon, without some portion of the liquid fecal matter being reabsorbed into the blood, in this way developing within the vital fluid a poison, modified certainly, but still a blood-poison, which exerts upon the red corpuscles a most pernicious effect; and, in my opinion, actually reduces their vitality so far as to destroy large numbers of them, and thus to tend very much to bring about anæmia. Nay, I will go further, if I may be pardoned a slight digression, and I would suggest that, in a large majority of cases, constipation is the starting-point of anæmia. Moreover, I have detected, in not a few instances, an accumulation of hardened scybala in the rectum, actually crowding the uterus out of position; and, in more than one instance, have demonstrated that this was carried to such an extent as to produce a temporary retroflexion.

Vaginal leucorrhœa may produce so much irritation of the mucous membrane of this canal, as to give rise to not a little vaginitis, which may spread by continuity of tissue, and involve the cervix, and afterwards spread to the endometrium. On the day I am writing this, I have had an unmistakable example of this brought before me.

Displacements, but more especially flexions, are pregnant sources of endometritis, and generally of a most acute type. This is more especially the fact in traumatic cases. The reason is obvious; for here we have the relation of the venous to the arterial flow suddenly altered. Some gynecologists affirm that a bend in the uterus does not and cannot interfere with the uninterrupted circulation in the uterine tissue; and, therefore, cannot prove a factor in the production of endometritis. Two cases, however, at this moment are present to my mind, which, I think, demonstrate beyond a doubt the distinct effects of sudden retroflexion. The accident in both cases happened to unmarried ladies, who, previously to the event, were entirely free from any uterine symptoms, so that the evidence is as distinct as it possibly can be, and, to my mind, most valuable. The first, Miss L., while walking on the footpath after dark, slipped and fell with a thud on her sacrum. The next morning, she called in her medical man, on account of a severe flooding which had come on. He plugged the vagina, and gave gallic acid, without producing the slightest effect on the hæmorrhage. A day or two afterwards, I forget exactly how long, he asked me to see her with him. The patient was very anæmic, and in great alarm, as also were her friends. On making a vaginal examination, the uterus was found to be acutely retroflexed, and very flabby, but not in the least degree tender to the touch. I therefore concluded that the flexion

had been produced by the fall, and that the sudden venous congestion which resulted had terminated in the rupture of the walls of the vessels; and hence the hæmorrhage and absence of inflammatory symptoms. I therefore replaced the uterus, and kept it in position by means of a Hodge's pessary, with the almost immediate effect of arresting the hæmorrhage; and in a short time, with the exception of the weakness resulting from the loss of blood, the patient was in her usual health, and free from all inconvenience. She wore the pessary for some months, and has had no recurrence of the metrorrhagia since, nor has she had any uterine symptoms. The second case was that of a young lady (Miss R.), who fell from a height of several feet, and came down on her haunches. She was carried into the house, and suffered intense pain, which continued for several weeks, the discharge being excessive at each menstrual period for some time afterwards. It was fully a year after the accident when she came under my observation, and then she was very nervous and depressed. Vaginal examination disclosed retroflexion, with considerable hyperplasia, and acute sensitiveness of the fundus. I did not attempt at first to reduce the flexion, but took measures to support the fundus with tampons, and thus allay the inflammation as well. I thereafter replaced the fundus, and supported it by means of a pessary, with the result that all local symptoms disappeared. I should have mentioned that, during the whole of the time this patient was under treatment, endometritis existed, and this was accompanied by a muco-purulent discharge. This was treated *pari passu* by the method which I will afterwards describe.

I now come to speak of the most frequent cause of endometritis in the virgin. I was going to say, in the nullipara, but, for special reasons, I will not speak of married women at present. I refer to stenosis of the internal os. This stenosis is generally spasmodic, and in consequence of this, considerable dysmenorrhœa accompanies each menses. (I concluded that it is spasmodic, from the fact that the painful character of the period usually disappears when once the flow has been thoroughly established. Were it due to a distinct narrowing of the cervical canal, or of either orifice of it, the pain would necessarily be prolonged during the whole period.) The physiological hyperæmia becomes, in process of time, prolonged beyond the continuation of the flow, in consequence of the irritation produced by the violent contractions which have accompanied the expulsion of the discharge through the constricted orifice. The inflamed condition of the canal is indicated, first, by the clotted character of the menstrual discharge, and, secondly, during the intermenstrual period, by a copious mucous, or, in more advanced cases, muco-purulent exudation; by backache, pain on a slight amount of fatigue, weight in the abdomen, ovarian neuræsthesia, lowness of spirits, etc.; and the uterus is exquisitely sensitive to touch. It may be remarked that I am not warranted in classing stenosis amongst the causes of endometritis, that this is purely an assumption on my part; but that, on the contrary, it is more likely to be a result than a cause. I think, however, gentlemen, if you inquire into the history of dysmenorrhœa, you will find that it rarely exists during the early life of a menstruating girl, and that it will not occur at all if the girl lead a natural, and not the artificial, life into which our young ladies are thrust. We hear of these young creatures going out night after night to dances, and drawing upon the powers of nature to such an extent as to render them totally unfit for the ordinary and rational duties of life. They make no difference whether their catamenia be present or not, but pursue their wild career after pleasure, passing through an amount of physical fatigue in a heated atmosphere, and then exposing their heated bodies to draughts of cold air, in a way which would try the strongest frame, not to speak of the delicate organism of a woman. Along with this, they neglect the function of the bowels, and, as a rule, set every hygienic law at defiance. Is it to be wondered at, then, that this routine of foolhardiness, as I have observed over and over again, results in stenosis? Whether this be concomitant with a persistent hyperæmic condition of the organ as well, I am not prepared to insist; but that it is followed by this condition, and, to say the least of it, aggravated by it, I have not the slightest doubt.

Overstraining the nervous energies at school is another predisposing cause of stenosis, and thus of endometritis, by the neglect of hygienic precautions which it engenders, and also by the actual wear and tear resulting therefrom. Irritability is the natural outcome of reduced tone, and a highly delicate organ like the uterus is sure to suffer. A woman, to be healthy, must lead a natural, useful, and moderately active life. She must not overstrain her natural powers, or indulge in a too luxurious mode of living. If we analyse the various classes of society, we will find that symptoms which point to endometritis are by far more prevalent in those women who lead the artificial existence in which the upper classes indulge.

A conical cervix is another potent cause of endometritis, and for the same reason that stenosis of the internal os induces it, namely, an obstruction to the menstrual flow. It is a well known fact that fluid will pass much less readily through an elongated narrow canal than it will do through a shorter tube of the same calibre. Now, the smallest amount of irritation in the cervix—which irritation is most prone to exist when this portion of the canal is hypertrophied—will produce coagulation of the discharge, thus making the resistance still greater, and necessitating uterine contractions to accomplish expulsion. This repeated and continued effort of the uterus, in due time, produces congestion, and an inflammatory condition results.

Now, with reference to the married woman, we will not unfrequently observe that this disease is induced by excess of sexual excitement and over-indulgence. How often are we compelled to attribute endometritis to this cause, on learning that it dates from the commencement of married life, and from the history of the patient, which she reluctantly gives.

But perhaps the most prolific cause of this affection is subinvolution of the uterus, following the delivery of either a premature or a full-grown foetus. This, however, most frequently occurs after a miscarriage, from the fact that much less care, as a rule, is exercised in these circumstances in securing a complete convalescence, before the woman is permitted to rise and resume her ordinary duties. On inquiry, in a large majority of cases, it will be ascertained that the patient dates the commencement of her illness from a miscarriage or a confinement. It therefore behoves us to be most exact with our instructions, and to ascertain for ourselves that these are carried out, so that complete convalescence may be ensured before the patient is permitted to resume the ordinary duties of life.

Attention has of late been, and very justly so, called to another most potent factor in the production of endometritis; moreover, it is one which renders the disease most persistent. I refer to laceration of the cervix. Now, if we inquire into these cases carefully, we will ascertain that, when a laceration occurs in the middle line, either anteriorly or posteriorly, it does not act so detrimentally as when the lesion is situated in the lateral aspect of the cervix. This leads me to conclude that it is not so much the fact of a laceration existing that is so baneful in its effects, as the position of the tear. Why should the effects of the injury be influenced by its location? it may be asked. And this seems not an unnatural query. Yet, if we look at the anatomy of the circulation in the cervix, it will not be difficult to account for the difference in the results. It has been accepted as an explanation of laceration producing endometritis, that the cicatrix formed in the fissure compresses the nerve-filaments involved therein, thus producing and propagating a continuous nerve-irritation. Now, if this be correct, why does a laceration outside of the middle line exert a greater effect than that in the middle line itself? I, therefore, have excluded this view of the *casus morbi*, and attribute the consequences entirely to the effects of the lesion upon the circulation. The vessels are divided in their course, and this does not occur if the middle line be the seat of injury. The nutrition of the pendulous and semi-detached portion is interfered with in consequence of the incomplete vascular supply that results, and therefore its vitality becomes diminished, which renders it an irritant to the neighbouring structure; and its continued presence gives rise to congestion, which persists till the injury is repaired or the weakened portion removed. I have repaired such cases with most complete and satisfactory results; but, in a small number of instances, I must confess, no relief followed the operation. But where trachelorrhaphy has failed, success has most surely followed amputation of the cervix in a line with the apex of the laceration; thus proving, I think, that it is the presence of the devitalised portions of the cervix which has produced and kept up the diseased condition of the uterus. This is still further placed beyond doubt by the fact that, the greater number of segments into which the cervix is divided, the greater amount of irritation is then produced.

So far, then, I have gone briefly over the etiology of the disease under discussion; I naturally, therefore, come now to speak of its semeiology. What are the symptoms which would indicate the uterus as being the seat of disease, and that the disorder is endometritis? If a woman complain of depression of spirits, amounting in many instances to despair, and in not a few cases to suicidal mania, we naturally inquire as to the uterine functions; when it will be ascertained, if the disease be not far advanced, that there is excessive menstrual discharge, often clotted, preceded by a dull, heavy pain in the pelvis, which passes downwards into the limbs; backache, polyuria, etc. The nature of the woman is changed; from being an active, cheerful and energetic member of society, she has become lethargic and careless of her duties; she is fretful, and ill-natured; her sleep is fitful and unre-

freshing; there is copious catarrh, either muco-purulent or entirely composed of pus. The physiognomy is completely altered, a dejected and an anxious look having taken the place of the once lively and sprightly countenance; and she seems to have lost all interest in life. A common complaint is, that her back aches so much that it makes her feel as if she would fall to pieces. Vaginal examination by the finger discovers that the cervix is enlarged and spongy, and that the uterus also is hyperplastic and sensitive to touch. When the speculum is introduced, the vaginal portion is found to be eroded, and to present the usual characteristic strawberry appearance, and from the os exudes a purulent discharge. Bimanual examination makes it evident that the whole organ is considerably enlarged. If the sound be passed, it will produce exquisite pain, and its withdrawal will be accompanied and followed by more or less hæmorrhage. The ovaries will also be very sensitive to touch; and, if the disease be of long standing, the Fallopian tubes will be found to be thickened. Indeed, I am convinced that disease of the tubes in every instance is simply an outcome of endometritis, they having become involved through continuity of tissue. This, however, is beyond the scope of my paper, and therefore I will not dwell more on this subject at present. If we examine carefully the eroded surface, which presents itself to view through the speculum, it will be seen that it is composed for the most part of the ectropic and denuded surface of the cervical mucous membrane; and the discharge which exudes from the os, and from this raw surface may, and frequently does, attain such acidity as to give rise, not only to vaginitis and condylomata, but to erosion of the vaginal mucous membrane also. If this have occurred, it will not be difficult to infer how much pain an examination must give to the patient. Reflex irritability of the bladder is almost invariably a concomitant of this disorder; and this fact must not be overlooked, as frequently the bladder-symptoms are laid great stress upon by the patient, thus often leading the practitioner to treat them as the disease, while the cause is overlooked. An irritable condition of the bowel is also frequently connected with endometritis, but it is superfluous to remark that this is only sympathetic.

Another most important symptom yet remains to be mentioned, and one which it is only natural to expect when the uterus is so sensitive, and that is dyspareunia. This is frequently of such prominence, as to be the incentive which impels the poor woman to seek advice and relief.

Having thus briefly passed in review the causation and symptoms of this distressing disease, I will now, in a few words, give my views as to treatment; and first, I would insist that, although general tonic and hygienic measures are essential to promote recovery, they as a rule are useless if employed alone. Local treatment must also be had recourse to, and may be accomplished either by the medical man or by the patient herself. If the case be not far advanced, then rest, with periodic douches of water, at a temperature as hot as the patient can bear them, and continued each time for at least ten minutes, will prove most effective in restoring the health of the parts. These will, if properly conducted, always have a most beneficial effect. At the same time, the patient must be dieted, have her digestive organs attended to, and the bowels carefully regulated.

It would be superfluous, not to say presumptuous, in me to hint at what would constitute constitutional treatment in such cases. I will, therefore, in as few words as possible, detail the local treatment I usually adopt. If there be much hypertrophy and excessive sensitiveness, I content myself with the introduction, twice a week, of a tampon, saturated with glycerine of alum and boracic acid, which I make sufficiently large to act as a support as well as a depleting agent. In a short time, varying from a week to a fortnight, it is generally practicable to commence intra-uterine medication; but sometimes this requires to be done for the first few times while the patient is under chloroform. This consists of an application to the whole endometrium of a saturated solution of iodine in carbolic acid; after which a tampon is introduced, and allowed to remain *in situ* for three days, when it is removed, and another applied for a like period. If there be much depression of spirits and nervous irritability, I find a pill, containing 2½ grains of valerianate of zinc, and two grains of the extract of conium, administered forenoon and afternoon, of great service. Of course, if a laceration of the cervix exist, this must be at once repaired, or the pendulous portion amputated, after the hypertrophy has been reduced by the local measures indicated. It not unfrequently follows that the presence of a mucous polypus is recognised, when most of the symptoms of endometritis have disappeared. This is, doubtless, a result of the prolonged irritation of the Nabothian follicles or mucous membrane. If such be present, it will prevent a complete restoration of the parts to health, and it frequently accounts for a satisfactory result being difficult to attain. With the removal of the polypus, however,

the difficulty will end. It will be necessary to warn the patient against overexertion of any kind for some time to come, and also to insist that the vaginal douche be employed for some considerable time after she passes from under your care. If rupture of the perinæum exist, it is most desirable that this be repaired, so that due support to the uterus may be given by the vaginal walls. This will not only add to the comfort of your patient, but remove a grave risk of a recurrence of the uterine mischief. Lastly, I come to speak of the treatment when elongation of the cervix exists. Doubtless, local treatment generally is successful in giving relief, but it may be looked upon as almost a certainty, if impregnation do not immediately ensue, that the endometritis will recur. I, therefore, of late years, have always insisted on removing the redundant tissue, an operation which has hitherto invariably been followed by the most satisfactory results.

ON THE DIFFERENTIAL DIAGNOSIS BETWEEN DISTENSION OF THE FALLOPIAN TUBES AND FIBROMYOMATA OF THE UTERUS.

By P. HORROCKS, M.D., B.Sc., M.R.C.P.,

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IN the JOURNAL for March 27th, I pointed out the differential diagnosis between my case of "Pelvic Tumour" (*vide* JOURNAL, March 6th) and distension of the Fallopian tube. In that paper, I confined myself rigidly to the clinical account of the case, and showed that, in all probability, the case was one of fibromyoma.

The diagnosis of distension of the Fallopian tube, in the present state of our knowledge, is very difficult; indeed, those who have had the largest experience in operating for this disease, admit that they are never sure that the tube is diseased or distended until they have got it outside, through the abdominal wound. But this difficulty of diagnosis is due to the similarity between distension of the Fallopian tube and many other conditions, more especially pelvic cellulitis, pelvic peritonitis, and ovarian disease. It is, as a rule, not difficult to distinguish between fibromyoma of the uterus and distended Fallopian tube. The broad distinctions between these two conditions are as follows.

1. Fibromyomata are usually accompanied by menorrhagia, and distensions of the tube are not.

2. Fibromyomata, especially when intermural, cause uterine enlargement; whilst, in distension of the Fallopian tube, the uterus is not enlarged, or only slightly, unless complicated by some other condition.

3. Fibromyomata are usually painless, except that there is often dysmenorrhœa (as in my case, published March 6th), and, if large, a bearing-down pain, or sense of weight; whilst, in distension of the tube, the pain is constant throughout the intermenstrual period, aching in character, and aggravated by the menstrual period.

4. Nutrition is not much affected in fibromyomata, whilst it is in distension of the tube, especially when the distension is caused by pus; hence, wasting or loss of flesh is a valuable distinction.

5. The temperature is normal in fibromyomata, raised more or less according to nature and amount, in distensions of the tube.

6. Fibromyomata, when intermural, move much more rigidly with the uterus than distensions of the Fallopian tube.

7. Fibromyomata are much less painful, on pressure, than distensions of the tube.

8. Fibromyomata are usually much firmer in consistence than distensions of the tube.

9. Intermenstrual discharges, usually yellow, are much commoner in distension of the Fallopian tube than in fibromyomata.

10. The position and direction of the uterine cavity is much more affected by fibromyomata than by distension of the tube.

11. Fibromyomata are usually more or less spherical, distensions of the Fallopian tube cylindrical.

12. Aspiration yields serum or pus in hydrosalpinx or pyosalpinx; and blood in fibromyomata and hematosalpinx.

13. Distensions of the Fallopian tube are accompanied by pelvic inflammation much more frequently than fibromyomata.

These are, in my experience, the broad distinctions between these two diseases. Exceptional cases occur where the diagnosis is not so easy; but distension of the Fallopian tube is much more likely to be mistaken for some disease of the ovary or broad ligament, rather than for fibromyoma of the uterus. My experience does not agree altogether with the statements of Mr. John W. Taylor in the JOURNAL for April 17th, but I agree with him that the discussion may be profitable.

A CASE OF LAPARO-NEPHROTOMY.

By H. LANGLEY BROWNE, F.R.C.S.E.

E. C., aged 46, was admitted into West Bromwich Hospital in December last. She had an abdominal tumour, occupying the right half of the abdomen, and extending across the median line towards the left iliac region. It was dull on percussion, except in two places, where there was adherent intestine. Obscure fluctuation was observed. There was a history of renal colic extending over twenty years. Many calculi had been passed *per urethram*, but none during the last five years, although there had been very frequent attacks of pain. For five months only had the enlargement of the abdomen been noticed, and the pain been constant and severe. There was no pus in the urine. On January 21st, ether was given, and an incision, about four inches long, was made in the median line, below the umbilicus, exposing: 1, adherent intestine; 2, stretched out mesentery; 3, a tumour with a dark blue thick wall, evidently containing fluid. The intestine and mesentery were detached and drawn up, and a small puncture made into the cyst, through which

a small ovariectomy trocar was pushed, and about three pints of pus escaped. The finger, introduced into the incision, came into contact with a small calculus lying loose; and, when this was removed, a large mass was felt deep down on the right side, firmly imbedded in soft friable tissue, which bled very freely. Partly by cutting, and partly by tearing, this mass was removed in two portions, and, by a thorough exploration of the tumour, five other smaller calculous masses were detected and removed. (See diagram.) The tumour was so adherent