CASE OF A FIBRO-CYSTIC SUBPERITONEAL TUMOUR OF THE UTERUS, CURED BY THE ACTUAL CAUTERY.

By A. WYNN WILLIAMS, M.D.,

Physician to the Samaritan Free Hospital for Women and Children.

Miss D., aged 32, consulted me on October 26th, 1877, complaining of severe pain in the back, prolapse of the rectum, costiveness, and great agony during and after defecation. There was also great irritability of the bladder. The catamenia were regular, and not very excessive. On examining *per vaginam*, a hard rounded mass, somewhat larger than a cricket-ball, could be felt, firmly attached to the lower and posterior part of the uterus, filling Douglas's space, and pressing upon the rectum. The os uteri appeared normal, but somewhat patulous. The uterine cavity was half an inch above its normal length. The patient was ordered to take bromide of ammonium and chloride of ammonium three times daily, and Indian hemp every evening. After continuing these remedies for about four weeks without any relief to her sufferings, she entreated me to remove the tumour. I explained to her that no cutting operation would be justifiable. This opinion was based on the position of the tumour, and its close connection with the uterus. I then informed her that I had for some time past contemplated, in a suitable case, when medical treatment had failed to give relief, attempting the removal of such a tumour by another method; one, however, that was by no means without very considerable risk. She replied that she did not care what I did to her; that she would rather die than continue as she was, her sufferings being intolerable. I then explained to her, that what I proposed doing was to pass a red-hot iron into the tumour through the vagina, to which proposal she readily consented. I was fully cognisant of the good results following the treatment adopted by Drs. Greenhalgh, Routh, Meadows, myself, and probably others, by cauterising intra-uterine or submucous fibroids. I was also well aware that pedicles and other portions of the peritoneum in ovarian operations had been frequently severed by the actual cautery, without any injurious results.

On November 22nd, the bowels having been thoroughly cleared, chloroform was administered by my son, Mr. Trevor Wynn Williams of Brixton. The patient being under its influence, I introduced a large-sized speculum; and after ascertaining, by means of the sound used as a probe, the most prominent part of the tumour, I passed a red-hot pointed wire of the thickness of a crow's quill into the tumour; then withdrew it, and passed along the same tract another red-hot wire of the size of a swan's quill. On withdrawing this, about half an ounce of clear transparent yellow fluid followed, which at first sight had much the appearance of urine; but, whilst I was examining the bladder for fear some accident might have occurred, the liquid, cooling immediately, coagulated; which, together with the examination, fully satisfied me that it was the contents of a cyst situated in the centre of the tumour. The speculum was then withdrawn, and a morphia suppository introduced into the rectum.

When I visited her on the following day, little or no constitutional disturbance had manifested itself, and she had passed a very tolerable night. The nurse was ordered to syringe out the vagina three or four times a day with a weak solution of iodine, to prevent any septic poisoning; and to insert another morphia suppository, if required. With the exception of some trouble with the bowels, owing to the prolapse, which was very great, she went on without anything worthy of note occurring until the 29th, seven days after the wires had been introduced; when, on my visiting the patient, the nurse informed me that, after syringing, several large pieces of slough had passed; but, much to my annoyance, she had not preserved them. On making an examination *per vaginam* for the first time since the cauterising, I found the tumour much reduced in size and softened, and was able to pass my finger into the hole where the cautery had been inserted in the upper part of the vagina, adhesion having taken place all round it. The prolapse of the gut was still so large and painful, that I contemplated removing a portion with the cautery; but in the meantime opiate fomentations were kept constantly applied, and confection of senna taken occasionally, until the morning of December 7th, when I received a telegram requesting me to visit the patient immediately, as she was taken suddenly worse. On my arrival, I learned that, on the previous evening, my patient had been frightened by hearing her servant fall down stairs; and that, shortly afterwards, hæmorrhage had set in, and continued till the bedclothes were perfectly saturated. I was glad to find, however, on examination, that the hæmorrhage did not proceed

from the wound, but from the uterus itself. The vagina was at once plugged with pledgets of cotton-wool saturated with one part of the strong solution of perchloride of iron in two parts of water; a scruple of gallic acid, dissolved in warm water, was ordered to be taken every three hours; warm milk, with a little brandy, being administered frequently. After remaining with the patient some time, I was glad to find that the hæmorrhage had ceased; and it did not recur. I removed the plugs on the second day. I was now, owing to the relaxed state of the parts, able to replace the prolapsed bowel, placing a T-bandage with a firm pledget of wool over the anus. The bowel did not again become prolapsed. From this time, nothing untoward occurred. The wound continued to discharge for some time, the vagina being frequently washed out with the iodine lotion. With generous diet and tonic medicines, she soon regained her strength. Some weeks afterwards, on making an examination *per vaginam et rectum*, I could discover nothing more than a small nodule where the tumour had been attached to the uterus, a little above the junction of the body with the cervix; and this in course of time became still smaller, and has continued so ever since. In fact, I do not think a stranger would discover even this slight elevation on examination. She is now in the enjoyment, I may safely say, of perfect health, menstruating regularly, requiring only an occasional mild aperient.

CASES OF LITHOTRITY AFTER BIGELOW'S METHOD.

By REGINALD HARRISON, F.R.C.S.,

Surgeon to the Liverpool Royal Infirmary.

I DESIRE to record four additional cases where I have practised Bigelow's operation for the removal of stone, subject to such modifications as the special features of each instance required. In three, the results were in every respect satisfactory; one was followed by a fatal termination, for which the operation was in no way responsible; it was undertaken to relieve sudden and acute paroxysms of pain, produced by the presence of a stone within the bladder, which nothing in the way of medicine, save the administration of an anæsthetic, served to alleviate. In fact, it was, out of necessity, done during the height of a vesical inflammation, which it was found impossible to assuage. It might be said, 'Would not lithotomy have given the patient a better chance?' I think not. The operation was unattended with difficulty, and, as far as could be judged from what came away in the washings, was effected without any structural damage. The course of events appeared in no way altered by the removal of the stone; and death came, as it probably would have done had no operation been performed. In cases such as these, the inflammatory action is not confined to the walls of the bladder, but extends to the subjacent textures, which are often extensively infiltrated with exudation material. In this patient, as I have said before, I should only have been too glad to postpone the removal of the cause of the inflammation. The unbearable character of the pain left no alternative but an operation. I cannot help expressing regret that a proceeding so well devised as Bigelow's should be saddled with a result for which it was in no way responsible. In order, however, that the profession may be able to form a correct estimate of all proceedings of a new and original kind, it is incumbent that cases terminating unsuccessfully should have equal prominence given to them as those where the results are such as we could always desire.

CASE I.—A. C., a gentleman aged 42, whom I saw in consultation with the late Mr. Long in August 1879, had previously been suffering from the passage of renal calculi; but, more recently, there were signs that one or more had remained in the bladder. I crushed an uric acid stone, half an inch in diameter, and removed the fragments by Bigelow's aspirator. Chloroform was administered by Mr. Long. On the third day after the operation, the patient left for the country. A notice of the case has been delayed, as I thought, from his symptoms, that there might possibly be a recurrence. I saw him on February 17th, 1881, when he reported himself as having remained perfectly well.

CASE II.—W. H., a gentleman aged 69, was seen by me in September 1880, at Seacombe, in consultation with Mr. Byerley and Dr. Craigmile. I found a large phosphatic stone, rather more than two inches in diameter. It was with some difficulty that I could get the stone into the grasp of my lithotrite, so as to allow of the fixing of the screw. I removed the stone at two sittings by Bigelow's method. Considering the age of the patient, and his somewhat feeble powers, and having regard to the nature of the stone, I preferred two shorter sittings rather than a prolonged one. On a third occasion, I introduced the lithotrite for the purpose of removing a small shell of stone

which had remained behind, probably detained in a sacculle of the bladder. The fragments removed weighed 237 grains. The patient made an excellent recovery.

CASE III.—A gentleman aged 77, whom I saw in consultation with Mr. Hakes in December 1880, for some time past had suffered from an irritable bladder, but refused to be examined until his symptoms became suddenly and most acutely painful. I found two calculi. As I have before stated, it was found necessary, in consequence of the extreme urgency of the symptoms, to attempt removal without delay. On December 21st, in the presence of Mr. Hakes and Dr. Lee, without any difficulty, I cleared the bladder of two uric acid calculi; the fragments weighed one hundred and eighty grains. The course of the cystitis appeared in no way altered by the operation, and death took place on December 24th.

CASE IV.—J. O., aged 64, was admitted into the infirmary under my care in December 1880. Under ether, I crushed a phosphatic calculus three-fourths of an inch in diameter, and evacuated the fragments. The patient left the infirmary fourteen days after the operation.

EMPHYEMA: DEATH UNDER THE USE OF ETHIDENE.

By ALBERT MOUILLOT, M.B. Dub.,
Pathologist to the General Hospital, Birmingham.

SAMUEL H., aged 45, was admitted to the General Hospital, Birmingham, on Thursday, February 17th, suffering from effusion in the right pleural cavity. On the 24th, a hypodermic needle was inserted into the thorax for diagnostic purposes, and a syringe of pus withdrawn. Dr. Simon decided on having the empyema opened by two incisions, and a drainage-tube applied. In the evening of the same day, I was asked to give an anæsthetic, which, owing to the man's general condition, I was reluctant to do. However, I decided on giving ethidene, believing its action to be mid-way between that of chloroform, which was too depressing for the case, and ether, which was contraindicated by the trouble of the lung. During the administration, the patient struggled a good deal, but nothing alarming occurred until he was "under", when it became necessary to turn him on the left side to make the incision. He had not been in that position more than two seconds, when I found the pulse and respiration failing; and a glance at the pupils showed them to be widely dilated. The patient was immediately turned on his back; artificial respiration was commenced; and stimulants were applied to the heart—first, by slapping the cardiac region with the hand; and afterwards, by the needle and galvanic current. The only result was to get one long inspiration, which flattered us with hope that he would recover.

At the *post mortem* examination, held on February 26th, I first opened the abdomen, and found the liver pushed down as far as the umbilicus, and crossed by the transverse colon. A trocar with cannula was next inserted in the right side, and seventy-two ounces of pus were withdrawn. The sternum was then removed; and the right lung was seen to be adherent to the ribs, about three inches from the sternum—so that no emphyematous cavity could be seen from the front. The apex of the heart reached the sixth interspace. The right auricle and ventricle contained much dark fluid blood; the tricuspid valve admitted four fingers. The left ventricle was empty. The right lung was adherent to the anterior chest-wall and diaphragm. The pleura was much thickened, and covered with shaggy lymph. The lung was collapsed, or airless. About ten ounces of pus remained in the cavity. The lung was much engorged with blood. A pyramidal abscess was found in the portion of the lung corresponding to the middle of the axillary line, which abscess was surrounded by a patch of pneumonia. A small abscess, connected with the periosteum of the frontal bone, was seen when the scalp was removed. All the other viscera were normal. Microscopic examination of the heart showed no fatty degeneration.

REMARKS.—I do not bring this case forward as any argument against the use of ethidene—an anæsthetic which, since the report of the Glasgow Committee appeared, I have used frequently; but I should like to elicit opinion on the advisability of administering any anæsthetic in these cases. The operation is painful, and sometimes prolonged; but, on the other hand, the danger is great, particularly when, as in this case, the other lung is diseased. My own experience extends only over three other cases. In one, ether was given, but had to be stopped on account of cough. In the second, a young girl of twenty, chloroform answered very well. The third, a middle-aged man, took ethidene, and had respiratory trouble during administration.

COLOBOMA OF THE CHOROID AND IRIS.

By W. C. ROCKLIFFE, M.A., M.D., Ophthalmic Surgeon, Hull.

CONGENITAL deficiency of the choroid being a somewhat uncommon occurrence, any case differing in the slightest from the accepted usual conditions is of interest.

A. B., a male child, aged 4, was brought to me by his mother, who stated "she wished to know whether her fears were correct"—viz., that the child was permanently blind. His family history was good, and I could elicit no case of affected vision (other than presbyopia) in any other member or branch of the family. He had three brothers, and one sister, perfectly healthy, and free from any malformation. According to his mother's statement, "from infancy, the two first years of his life were despaired of, he being almost continually delirious, and apparently blind; suffering from, as his medical attendant described it, 'water on the brain'." Since this time to the present date (two years), the child had enjoyed perfectly good health, and was most intelligent. When I first saw him, he had a well-fell healthy appearance, with somewhat a large head; but no visible signs of disease or defect, except coloboma of the right iris, and nystagmus in both eyes. The cleft in the iris had been noticed since birth. The vision was not easy to test, but seemed somewhat myopic in the left; while there was no perception of light in the right eye, except possibly at the extreme periphery.

Ophthalmoscopically, there was a slightly myopic appearance, with some haziness in the lower half of the fundus in the left eye. In the right eye, there was a large coloboma of the choroid, presenting the usual white surface, glistening from the lower part of the fundus, and extending upwards, embracing the disc and yellow spot; anteriorly reaching nearly to the cleft in the iris. The bulging backwards of the sclerotic appeared uniform throughout, and the retina in apposition, except at two small spots; while the boundary of the coloboma was most distinct, with a dark claret-coloured margin, round which the retinal vessels wound, and beyond which the fundus gradually merged into a healthy appearance, which latter condition was only seen at the extreme periphery. The disc was altogether indefinable; and the vessels twisted in an irregular and disconnected manner all over this white space. Where the coloboma of the choroid approached that of the iris, was a dark narrow band, possibly small rudimentary ciliary processes, as suggested by the late Mr. Soelberg Wells.

The general appearance (although larger) much resembled the engraving in Liebreich's *Atlas of Ophthalmoscopy*, except that the vessels crossing the coloboma appeared shorter, more tortuous and disconnected, and the coloboma whiter.

The coloboma of the iris was situated, as usual, at the lower and inner portion of the iris; pyriform in shape, the base toward the pupil. It was confined to the right eye, and was associated with no other congenital deficiency except that of the choroid.

This case is of interest in that it deviates somewhat from the usual, although by no means certain, conditions. 1. The macula lutea and optic nerve were both implicated and indefinable. 2. The coloboma affected only one, and that the right eye; it having been stated that usually both eyes are affected, or if only one, the left. 3. No deficiency or arrested development presented itself in any other portion of the body; and it was associated with no congenital cataract or defect except nystagmus.

HASTINGS.—The population of Hastings is now estimated at 40,400; and amongst this number of persons, there were 1,097 births and 734 deaths in 1880, equal to rates of 27.15 and 18.16 per 1,000, against rates of 26.97 and 16.84 in 1879. The infant mortality is still very high, those dying under five years of age numbering no fewer than 285, or more than one-third of the total deaths. The reason unquestionably is, in Mr. Ashenden's opinion, the increasing use of artificial foods, which are really little better than common starch. The deaths from zymotic diseases were considerably above the average, no fewer than 60 persons having died in the June and September quarters from diarrhoea alone. "Teething, want of breast-milk, and injudicious feeding, were credited with the specific origin of the disease." In consequence of the prevalence of scarlet fever in the suburbs of London, cases were continually cropping up in different parts of Hastings, chiefly among the middle and upper classes of visitors. Mr. Ashenden, while admitting the usefulness of the existing sanatorium, urges the provision of a building more capacious and better adapted for the treatment of more than one zymotic disease at a time. Constitutional diseases caused 135 deaths, local diseases 362, and developmental diseases 111. A good deal of unpretending sanitary work seems to have been got through,