I have had two cases where I declined to attempt the removal of tumours diagnosed as ovarian, and where *post mortem* examinations have justified my refusals and the grounds for them.

The first occurred in the case of a young woman of 24 years of age, in whom there existed a multilocular tumour, lying chiefly to the left side of the abdomen and fixed there. She gave a history which showed that, on three or four occasions, cysts had ruptured into the peritoneum, and that the rupture had been followed by some peritonitis on each occasion. She entreated that an operation should be attempted to relieve the sufferings she had to undergo on defecation. I declined to attempt an ovariectomy, being quite certain that the tumour was so adherent as to render its removal an impossibility, and the contents of the cysts were found to be too viscid to be removed by tapping. She died during an attack of peritonitis due to the rupture of a cyst, which, on *post mortem* examination, was found to be adherent to the bladder. The tumour was found to be so intimately attached to the sigmoid flexure of the colon, some coils of small intestine, to the brim of the pelvis and to the bladder, that its removal would have been impossible.

In October 1869, I saw Mrs. C. in consultation with Dr. Hollings of Wakefield. She had a large oval tumour, solid, hard, and smooth, moving freely in the abdomen, centrally situated, with a similar smaller one to the right side. The larger tumour reached about two inches above the umbilicus, could be felt high in the pelvis, and had no attachment to the uterus. I diagnosed it as a case of solid cancer of the ovary, and declined to operate. The abdomen was free from ascites or other complication. I saw her a second time in a few weeks, and found that the tumours had both increased in size, and then, having made myself more familiar with the subject, I gave it as my opinion that it was an instance of the rarest of all forms of cancer—the fibroid. On December 5th, I found her with symptoms of peritonitis, and a considerable effusion of ascetic fluid. I tapped her, to relieve the breathing, and found a large soft semi-fluctuating mass extending from near the xiphoid cartilage to within three inches of the pubis, masking the outlines of the tumours. This I recognised as possibly a fungoid growth of the omentum. I tapped her again on the 9th, and she died next day. Twenty-four hours after death, I examined the body, and, on opening the abdomen, I found adhesions everywhere to the large deep-coloured fungous mass which I had correctly regarded as growing from the omentum. It was adherent behind to the intestines and to the tumours. The larger of these latter was found to be perfectly loose, save from the omental mass and the right corner of the uterus, to which it was attached by a short thick pedicle; in fact, it was the right ovary, as no other trace of the gland could be found. The smaller tumour was similarly the left ovary, and a still smaller tumour seemed to grow from the same pedicle. Scattered over the surface of the peritoneum were patches very similar to those previously described in a case of cancer of the peritoneum. These patches were also found on the surfaces of the tumours, and were stripped easily off with their investing epithelial coverings. In the right or largest tumour were a few cavities containing fluid, and also some curious cruetification at the base and in the pedicle. It weighed probably twelve or thirteen pounds, so that I could not remove it conveniently for preservation. I removed and carefully examined the smaller tumours, some peritoneum, with specimens of the patches and a piece of the omental fungus.

In the piece of omentum, nothing but blood-detritus, a few scant fibres, and some irregular cells were found. The nodules on the peritoneum showed all the characters of cancerous tissue, being composed of large irregularly shaped and irregularly sized cells, containing variously shaped nuclei in varying numbers. There seemed to be no fibrous tissue in them at all, and their elements readily separated by gentle pressure between the cover and the glass slide. A careful section showed the epithelium of the free surface of the peritoneal layer to be undergoing interesting changes. The cells of the upper layer were normal; but, at two or three layers' depth, they were seen to be larger, more irregular, and the number of nuclei increased, the latter fact being most clearly displayed on the addition of acetic acid.

The ovarian tumours removed were ovoid, smooth, and glistening, and here and there the surface marked with the peculiar patches above described. Together, they weighed nearly three pounds. When cut into, no juice exuded from them, and the scant moisture scraped from the cut surface showed no cells. The tissue was pearly white and very tough. Teasing with needles did not give any satisfactory results, and a great many sections had to be made before one thin enough for examination was obtained. I then found that the texture was purely fibrous, there being nowhere, under the epithelial layers, any cells discoverable. The fibres were extremely fine, closely and regularly packed, without any appearance of undulation or interweaving, but seemed to lie parallel with only faint curvings in their general direction. They

were readily stained by carmine. Acetic acid showed no nuclei, and did not influence the fibres beyond a slight clearing of the section.

It will be found that this description differs in some important particulars from that given by Sir James Paget of similar structures, especially in the absence of nuclei; but the rarity of opportunities for the examination of such peculiar growths stands much in the way of their proper investigation.*

[To be continued.]

THE GAINS DERIVED FROM THE USE OF THE LARYNGOSCOPE.

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MR. ARTHUR NORTON, in the last number of the JOURNAL, referring to my paper on the above subject, doubts the possibility of *bilateral* palsy of the laryngeal muscles resulting from pressure on *one* recurrent nerve; and he suggests that in such a case the paralysis on the opposite side "is only apparent, and not real". If Mr. Norton will refer to the history of Dr. Bäumlér's case of aneurism of the innominata (*Pathological Transactions*, vol. xxiii, p. 66), and my case of aneurism of the aorta (*Pathological Transactions*, vol. xxiv, p. 42) he will find that in both cases there was conclusive evidence of paralysis affecting both sides of the larynx. There was almost complete immobility of both vocal cords, with such close approximation of the cords during inspiration as to cause stridor and urgent dyspnoea, for which, in my own case, tracheotomy was performed with great relief. The immobility of the vocal cords was almost as complete as in a case which I saw where both arytenoid cartilages had been destroyed by necrosis. This closing of the glottis, and consequent impediment to respiration, is the result which Mr. Norton says he would expect to occur from bilateral palsy of the laryngeal muscles. After death, in both cases, there was found atrophy of the laryngeal muscles on both sides, though to a greater degree, in my own case, on the side on which the recurrent nerve was compressed. In one case, the nerve on the right side only was compressed; and in the other, that on the left side. I cannot accept as satisfactory Mr. Norton's suggestion that, in these cases, the bilateral paralysis was only apparent, and not real. Both cases were carefully observed; and in both the appearance of the larynx during life was quite different from that which is found in undoubted cases of unilateral palsy of the larynx, of which I have seen several examples.

I now venture to suggest an explanation of the bilateral palsy of the larynx which certainly existed in these two cases of aneurism. The laryngeal muscles are pre-eminently bilateral in their action. Every one who has inspected the living larynx knows how impossible it is, in the normal condition, to move one vocal cord without at the same time moving the other in an equal degree. There is evidently, then, a very close central connection between the nerve-supply to the two sides of the larynx. In both Dr. Bäumlér's case and in mine, the aneurism compressed not only the recurrent nerve, but also the trunk of the pneumogastric. It seems, therefore, not improbable that, while the muscles on one side of the larynx were paralysed by direct pressure on the recurrent nerve of the same side, the paralysis on the other side may have been the result of a centripetal irritation of the pneumogastric acting on the nervous centre, and through it upon the nerve-supply to the laryngeal muscles on the side opposite to the aneurism. The palsy on one side was direct; on the other, reflex. It is no valid objection to this explanation, that bilateral palsy of the larynx does not occur in *every* case of pressure on one pneumogastric or recurrent nerve, but only in exceptional cases. It is probable that in some cases the centripetal irritation and disturbance are greater than in others.

In fatal cases of traumatic tetanus, we have an illustration of structural changes in the nervous centre resulting from peripheral nervous irritation. In the last volume of the Clinical Society's *Transactions* (vol. vi, p. 38), I have given the history of a case in which a piece of flint in a wound on the cheek caused facial neuralgia and numbness, spasm of the masseter and other muscles of mastication, and palsy of the orbicularis palpebrarum and other facial muscles on the same side. All the symptoms disappeared after the removal of the foreign body from the wound. These results of a peripheral irritation are, I think, fairly comparable with cases of bilateral palsy of the larynx consequent on pressure upon the nerves on one side only.

* I have fully examined a fibroma of the ovary, in which the ordinary processes revealed nothing but fibres, but which my litmus staining showed to be a compact mass of immature nuclei.