Case 17.—III-para, aged 23. Os about half a crown. Pituitrin 1 c.cm. given. Delivery followed in fifty minutes. No haemorrhage.

Case 18.—VII-para, aged 35. Os about half a crown. Pituitrin 1 c.cm. given. Delivery followed in thirty-five minutes. No haemorrhage. At five previous confinements this patient had post-partum haemorrhage; but with pituitrin it was absent.

Case 19.—VI-para, aged 34. Os about half dilated. Pituitrin 1 c.cm. given. Delivery took place in thirty minutes. No haemorrhage.

Case 20.—VII-para, aged 36. Os about half dilated. Pituitrin 0.75 c.cm. given. Delivery in twenty-five minutes. No haemorrhage.

Case 21.—III-para, aged 21. Os about half a crown. Pituitrin 0.75 c.cm. given. Os fully dilated seventy minutes. A second injection 0.5 c.cm. given. Delivery followed in ten minutes. No haemorrhage.

Case 22.—I-para, aged 18. Born before arrival. Severe post-partum haemorrhage, patient collapsed and almost pulseless. Pituitrin 1 c.cm. injected. Controlled and made excellent recovery. The patient has exophthalmic goitre.

Case 23.—III-para, aged 27. Os about half a crown. Pituitrin 0.75 c.cm. injected. Delivery after forty minutes. No haemorrhage.

Case 24.—V-para, aged 35. Os half dilated. Pituitrin 0.75 c.cm. given. Delivery followed forty-five minutes later. No haemorrhage.

Case 25.—V-para, aged 33. Os half a crown. Pituitrin 0.75 c.cm. given. Delivery followed in thirty-five minutes. No haemorrhage.

Case 26.—III-para, aged 25. Os half dilated. Pituitrin 0.75 c.cm. given. Delivery after thirty minutes. No haemorrhage.

Case 27.—I-para, aged 25. Os admitted two fingers. Pituitrin 0.75 c.cm. given; os fully dilated sixty-five minutes. A second injection of 0.5 c.cm. given. Delivery followed in twenty minutes. No haemorrhage.

Case 28.—III-para, aged 26. Os half a crown. Pituitrin 0.75 c.cm. given. Delivery after forty minutes. No haemorrhage.

Case 29.—III-para, aged 28. Os half dilated. Pituitrin 0.75 c.cm. given. Delivery after fifty minutes. No haemorrhage.

Case 30.—I-para, aged 19. Os admitted two fingers. Pituitrin 1 c.cm. given; os fully dilated in fifty-five minutes. A second injection of 0.75 c.cm. given. Delivery after twenty minutes. No haemorrhage.

Case 31.—IV-para, aged 23. Os half dilated. Pituitrin 0.75 c.cm. given. Delivery followed after thirty minutes. No haemorrhage.

Case 32.—IV-para, aged 27. Os admitted two fingers. Pituitrin 0.75 c.cm. given. Delivery followed in thirty-five minutes. No haemorrhage.

Case 33.—I-para, aged 18. Os admitted two fingers. Pituitrin 1.0 c.cm. injected. Os fully dilated after seventy minutes, a second injection of 0.75 c.cm. given; delivery followed twenty-five minutes later. No haemorrhage.

Case 34.—III-para, aged 27. Os about half a crown. Pituitrin 0.75 c.cm. given; os fully dilated in forty minutes; 0.5 c.cm. injected; delivery followed in twenty minutes. No haemorrhage.

Case 35.—II-para, aged 26 (vide supra Case No. 2.) Os about half a crown. Pituitrin 0.75 c.cm. given; os fully dilated after sixty minutes; a second injection of 0.5 c.cm. given, delivery following fifteen minutes later. No haemorrhage.

Case 36.—XII-para, aged 45. Os half dilated. Pituitrin 0.75 c.cm. given, delivery followed thirty minutes later. Secondary post-partum haemorrhage followed after six hours, but this was well controlled by pituitrin 1.0 c.cm., the patient making an excellent recovery.

Case 37.—IV-para, aged 30. Os about half a crown. Pituitrin 0.75 c.cm. given; delivery following in forty-five minutes. No haemorrhage.

Case 38.—I-para, aged 19. Os admitted two fingers. Pituitrin 1.0 c.cm. given. Os fully dilated sixty minutes later. A second injection of 0.75 c.cm. given. Delivery with forceps thirty-five minutes after. No haemorrhage. There was a slight pelvic contraction in this case.

Case 39.—I-para, aged 33. Os about half a crown. Pituitrin 1 c.cm. given. Os fully dilated seventy minutes after; a second injection of 0.75 c.cm. was given, delivery following in thirty minutes. No haemorrhage.

Case 40.—III-para, aged 30. Os half dilated. Pituitrin 0.75 c.cm. given. Delivery followed after thirty-five minutes. No haemorrhage.

Case 41.—III-para, aged 33. Os about half a crown. Pituitrin 1 c.cm. given, delivery following forty minutes later. No haemorrhage.

Case 42.—I-para, aged 33. Os admitted two fingers. Pituitrin 1 c.cm. given. Os fully dilated sixty minutes after; a further injection of 0.75 c.cm. was followed by delivery in thirty minutes. No haemorrhage.

Case 43.—I-para, aged 18. Os about half a crown. Pituitrin 1 c.cm. given. Os fully dilated in fifty-five minutes; a subsequent injection of 0.75 c.cm. resulted in delivery after twenty minutes. No haemorrhage.

Case 44.—II-para, aged 20. Os about half a crown. Pituitrin 1 c.cm. given. Delivery took place forty-five minutes later. No haemorrhage (vide supra Case 4). This patient having had it before, begged for a repetition of the pituitrin.

Case 45.—III-para, aged 27. Os half a crown. Pituitrin 1 c.cm. given. Delivery resulted after thirty-five minutes. No haemorrhage.

Case 46.—VIII-para, aged 38. Os admitted two fingers. Pituitrin 1 c.cm. given. Os fully dilated in forty-five minutes; a second injection of 0.75 c.cm. resulting in delivery after fifteen minutes. No haemorrhage.

Case 47.—II-para, aged 26 (vide supra Case 8). Os about half a crown. Pituitrin 1 c.cm. given. Os fully dilated after fifty minutes; a second dose of 0.75 c.cm. being followed by delivery in twenty minutes. No haemorrhage.

Case 48.—III-para, aged 24. Os about half a crown. Pituitrin 1 c.cm. given. Os dilated in forty-five minutes; a second dose of 0.75 c.cm. resulting in delivery twenty minutes later. No haemorrhage.

Case 49.—I-para, aged 33. Os admitted two fingers. Pituitrin 1 c.cm. given. Os three quarters dilated after 60 minutes; a second injection of 0.75 c.cm. resulting in delivery thirty-five minutes later. No haemorrhage.

Case 50.—V-para, aged 30. Os about half a crown. Pituitrin 1 c.cm. given. Delivery followed forty-five minutes later. No haemorrhage.

Case 51.—I-para, aged 37. Os half a crown. Pituitrin 1 c.cm. injected. Os fully dilated sixty minutes later; a second injection of 0.75 c.cm. resulting in delivery thirty minutes later. No haemorrhage.

Case 52.—I-para, aged 20. Os admitted two fingers. Pituitrin 1 c.cm. given. Os fully dilated after fifty minutes; a second injection of 0.75 c.cm. resulting in delivery twenty minutes after. No haemorrhage.

Case 53.—V-para, aged 35. Os half a crown. Pituitrin 1 c.cm. given. Delivery thirty-five minutes later. No haemorrhage.

Case 54.—XIII-para, aged 44. Os half a crown. Pituitrin 1 c.cm. given. Delivery twenty-five minutes later. No haemorrhage.

Case 55.—VII-para, aged 46. Os half a crown. Pituitrin 1 c.cm. given. Delivery thirty-five minutes later. Some haemorrhage followed, which was well controlled by a second injection of 1 c.cm.

Case 56.—I-para, aged 35 years. Os admitted two fingers. Pituitrin 1 c.cm. given. Os fully dilated seventy minutes after, a second injection of 0.75 c.cm. resulting in delivery thirty-five minutes later. No haemorrhage.

Case 57.—III-para, aged 35. Os admitted two fingers. Pituitrin 1 c.cm. given. Delivery forty-five minutes later. No haemorrhage.

Case 58.—III-para, aged 27. Os half a crown. Pituitrin 1 c.cm. given. Os fully dilated forty-five minutes after, a second injection of 0.75 c.cm. being followed by delivery twenty minutes later. Some secondary haemorrhage followed. Ernutin failed to control this, so a further injection of pituitrin (1 c.cm.) was given. This succeeded in arresting the bleeding.

Case 59.—II-para, aged 23. Os half dilated. Pituitrin 1 c.cm. given. Delivery followed thirty minutes later. No haemorrhage.

Case 60.—II-para, aged 19. Os half dilated. Pituitrin 1 c.cm. given. Delivery resulted twenty minutes later. No haemorrhage.

REFERENCE.

¹ *Journal of Physiology*, 1906, p. 24.

TWO CASES OF PREGNANCY IN UTERUS SUBSEPTUS.*

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IRREGULARITIES in the form of the genital organs arise from the mode of their development by the formation of the Müllerian bands, their subsequent hollowing and their progressive union from the lower end proceeding upwards to the level of the attachment of the round ligaments. How frequently malformations occur it is impossible to say, but the question of their influence on the genital functions is of some practical interest. Possibly in most cases the discovery of their presence is a matter of chance, not essentially involved with the processes which have attracted our attention to the individual patient. During the last six months I have discovered three cases of septate uterus. One of these Dr. Valentine and I have already described, and the others—the subjects of this note, both came under my observation in October last.

CASE I.

Mrs. S., aged 30, had a normal delivery at term in 1909. In August, 1913, when three months in her second pregnancy, she had bleeding, but recovered for the time. The bleeding, however, recurred, and persisted without miscarriage till it became necessary to clear the uterus. For this Dr. Laing asked my assistance. The os dilated to the fingers, and I removed the fetus piecemeal. During the manipulations I found an aperture on the right wall of the uterus about the level of the internal os. It suggested rupture, but on further investigation I found that it was the orifice of a second uterine loculus, and in it I

* Read to Forfarshire Medical Association.

found a detached foot. The septum ran wedge-shaped to the fundus, which was single.

CASE II.

Mrs. K., aged 27, who had had two pregnancies, five and three years previously, which terminated normally at term, came at the fourth month complaining of bleeding. The os was closed, and the fundus reached half-way to the umbilicus. She was advised to rest. A month later she returned, saying that she felt no life, and that she was not increasing in size. She was asked to come into hospital, but declined. At Dr. Rogers's instance she returned in February, eight months after the beginning of pregnancy. The fundus was lower than formerly, and she was admitted for the treatment of the missed abortion. The os was closed, and was dilated with Hegar dilators to 2 cm. A slight tear was noted at the external os, and on inserting the finger to separate the ovum as far as possible a depression was noted at the left posterior part of the internal os. Again the idea of rupture suggested itself. Labour did not set in, but there was inflammatory infiltration of the right broad ligament, and five days later I decided on the removal of the ovum. This was found lying in the cervix, and was fetid. On palpation of the cavity the opening on the left side was found to lead to a second uterine cavity. The fundus was single, as in the other two cases.

The discovery of a uterine anomaly in association with disturbance of pregnancy in these two cases does not warrant the conclusion that the occurrence was more than a coincidence. In each we have the history of previous normal pregnancy and delivery. The chief disturbances which have been attributed to the malformation in cases where it was supposed to be a factor are:

1. The second cavity has been said to explain cases of menstruation occurring during pregnancy in the other.
2. The formation of decidua in the second cavity may call for its definite expulsion at delivery, and may give an unusual form of haemorrhage, intra-partum or post-partum.
3. The unequal development of the uterine walls may provide a source of irregular contraction during labour or post-partum, causing delay in delivery or post-partum haemorrhage respectively.
4. Rupture of the irregularly developed uterus has been recorded with relative frequency, both at the fundus and at the cervix.¹

REFERENCE.

- ¹ Wertheim, *Winckel's Handbuch der Geburts-hülfe*; Zalewski, *Arch. Gyn.*, 1914, cii, 189.

CARCINOMA OF THE STOMACH: GASTRECTOMY.

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The patient, Mr. A., was well until November, 1913, when he began to have epigastric pain and vomiting. By the end of January, 1914, the vomiting became constant, and even water was not retained. There was marked anaemia, loss of strength and weight. On January 24th Dr. F. W. E. Kinneir, under whose care the patient was, and at whose request I subsequently operated, asked me to see Mr. A. in consultation with him.

Condition on Examination.

The patient was in bed, looking pale and haggard. No sleep had been obtained on account of pain in the epigastric region. Pulse 112, temperature 99°. The abdomen moved freely. On palpation there was a hard rounded swelling, the size of a Tangerine orange, situated in the epigastric region, a little to the left of the middle line. It was rather tender and did not move on respiration, but was easily moved from one side to the other of the middle line. The liver was not apparently enlarged, and no other swelling was discovered. The blood count showed slight secondary anaemia, but nothing else abnormal was discovered. The vomit was acid in reaction (litmus); free HCl was absent. Microscopic examination showed undigested food, salivary streptococci, sarcinae, yeast, and Oppler-Boas bacilli.

Thinking that the growth was in the pyloric portion of the stomach and that its mobility offered some prospect of its successful removal, I advised exploratory laparotomy. Consent was refused until February 5th, by which time it was obvious that the patient was declining fast.

Operation.

On February 6th an incision was made through the left rectus muscle from the costal margin to the level of

the umbilicus. The swelling felt was found to be the left extremity of a large growth involving the whole of the right half of the stomach. The liver was natural. No secondary growths were found, except one in the omentum immediately beneath the growth. The tumour was

Fig. A.—Specimen as removed. 1, Duodenum. 2, Cut edge of gastro-hepatic omentum. 3, Cut edge of stomach. 4, Cut edge of transverse mesocolon. 5, Secondary growth.

delivered through the incision and gastrectomy commenced.

1. Two clamps were placed on the duodenum immediately beyond the pylorus and two across the stomach above the growth. The last two crossed the stomach from a point on the lesser curvature 2 in. below the cardiac orifice to a point on the greater curvature about a third of the distance from the cardiac orifice to the pylorus.

Fig. B.—Specimen laid open. 1, Sphincter of pylorus. 2, The growth. 3, Gastro-hepatic omentum. 4, Secondary growth; 5, Cut edge of stomach.

2. The gastro-hepatic omentum and the transverse mesocolon lying between the first two pairs of clamps were clamped in sections.

3. The stomach, growth, and portions of omentum lying in the quadrilateral outlined by the four sets of clamps were excised. The cut edges of the omentum were then tied in sections.

4. The edges of the upper cut end of the stomach were united with through-and-through catgut sutures from