May 21st. The ether was administered by Mr. Corkhill, and I was assisted by Mr. Laimbeer. After forcible or speedy dilatation of the vagina, the ragged ulcerated cervix was seized by vulsellum forceps, and drawn down. The posterior fornix of the vagina, by a semilunar incision, was opened into Douglas's pouch. A similar incision was made in the anterior fornix, and the utero-vesical connections separated, the bladder being lifted out of the way by a sound. The fingers were then passed into Douglas's pouch, and the fundus uteri hooked down; but retroversion could not be performed, the broad ligaments holding the uterus too firmly in position. They were, therefore, divided on each side for about one inch; but even then the fundus could not be brought down. Complete detachment of the peritoneum of the utero-vesical fold was next carried out, and a two-pronged hook was then passed up, guided and covered by the fingers, and fixed into the fundus uteri. Considerable traction was required to produce version and bring the fundus into the vagina. Two elastic ligatures were applied in the usual manner; and the whole of the organ, Fallopian tubes, and ovaries were removed by excision. Ligatures and clamp-forceps controlled hæmorrhage from the surfaces of the broad ligaments first divided. Two sutures brought together the vaginal flaps. Forceps and hare-lip needles guided the drainage, as usual, downwards into the vagina. Iodised carbolic lotion, salicylic cotton, and eucalyptic iodoform dressings were employed, as in previous cases.

10 P.M. The patient had been very restless since the operation. There was a pretty free discharge of sanguineous serum. She had no sickness. Pulse 92. There was slight pain.

May 22nd, 10 A.M. She had great pain during the night, and was sleepless. She had a sharp attack of collapse, which yielded to brandy and the application of hot bottles to the trunk and extremities. The discharge was serous and free. There was slight hypogastric tympany.

May 23rd. She died.

CASE IV. *Sarcoma Uteri: Evulsion of Sessile Polypus (Sarcomatous): Excision of Uterus by Vaginal and Abdominal Section: Death.*—T. L., aged 46, was admitted October 6th, 1883. Her previous history gave a record of illnesses lasting six years: jaundice, dropsy, vaginal discharges, of a purulent character; pain in the hypogastrium, spasmodic and recurrent; slight at first, but now increasing in intensity, and affecting the whole pubes and sacral region. It was now continuous, of a heavy bearing-down character, and attended by constant vaginal cream-coloured offensive discharges, and occasional attacks of dysuria.

October 14th. On examination *per vaginam*, the os uteri was somewhat dilated by a presenting polypus, growing from the left and posterior wall of the uterus, which was brittle and soft, easily breaking down by pressure with the finger. Dilatation with sponge-tents was ordered.

October 16th. The patient was put under ether; and, in the dorsal position, I removed a polypoid mass, as large as a duck's egg, having the appearance of an uterine fibroid.

January 20th, 1884. It was now evident that the disease was recurrent, the interior surface of the uterus giving to the finger the sense of touch of a fungating mass. The discharge was sanguineous and offensive. The uterus was enlarging somewhat. I ordered the vagina to be dilated, as it was small, and the uterus to be again opened up by tents.

February 13th. The disease was now diagnosed as recurrent sarcoma, and microscopic examination confirmed this view. It was, therefore, determined to excise the uterus. Dr. Briggs administered ether; and, assisted by Mr. Laimbeer, I proceeded to attempt removal by the vaginal method already described; but failed to retrovert the uterus, even although the fundus was firmly seized by the crotchet, and force applied. Abdominal section was performed in the median line to over three inches. With great difficulty the uterus was drawn out of the pelvic cavity, owing to the thickening and shortening of the broad ligaments. These, to one-half their extent, were clamped and divided. The utero-vesical *cul-de-sac* was then transfixed with a needle, and strong silk passed, by which means the remainder of the broad ligaments were secured. The whole of the uterus was then removed. The clamp-forceps were removed, and the vessels ligatured. The abdominal and vaginal sections were then closed; free drainage and the usual antiseptic dressings were employed. The immediate shock was great; but the patient rallied for several hours, and then quietly sank.

REMARKS.—I place these two last cases together, because, taken conjointly, they enable me to arrive at certain conclusions having a practical importance. Had I done the operation in Case III, previously to Case IV, I certainly never should have attempted to remove

the uterus in the latter. In Case III, the uterus was hardly twice its normal bulk, and yet there was the greatest difficulty and effort required to bring down the fundus to the vagina; while, in Case IV, this was found to be impossible. Hence abdominal section had to be resorted to, in addition to the vaginal antero- and retro-cervical section. This enormously increased the shock to the patient's system, and *de facto* was the proximate cause of her death.

These four cases lead me to the following practical conclusions.

1. In the early stage of cancer of the womb, while the organ is still mobile and not enlarged, the operation for excision is justifiable; and, as in Cases I and II, the patients recover, and rapidly regain health and strength.

2. The vaginal operation is to be preferred to all others, abdominal section enormously increasing the risks, and not being necessary in cases suitable for the operation.

3. Such Cases as III and IV are not suitable for operation; and, if I were again called upon to operate under such physical conditions of advanced disease, I would consider it unjustifiable, and decline doing so.

TUBERCULOSIS OF TESTICLE IN AN INFANT.

Read before the Wigan Medical Society.

By E. H. MONKS, JUN., L.R.C.P. and S.Ed., Wigan.

R. A. C., A CHILD, aged five months, came under my care on January 1st, this year, suffering from an enlargement of the right testicle, which had been noticed by the parents for some days previously to my seeing it. On examining, I found the testicle enlarged, painful, and hard; there was also thickening of the spermatic cord, which latter contained some hard nodules. On examining further, I discovered in the left ischio-rectal fossa a distinct fulness, as though an abscess were forming. There was no evidence of fluctuation in this part, and pressure seemed to cause pain. I came to the conclusion that injury must have been the cause of these two swellings in the first instance, yet the parents were unable to give any history of injury. I prescribed linseed poultices and hot fomentations to the swelling in the ischio-rectal fossa, and lead and opium lotion to the enlarged testicle, and an anodyne mixture internally.

In a few days, the swelling in the left ischio-rectal fossa softened, and I detected fluctuation. I made an incision into the part, and removed about two drachms of pus.

The enlarged testicle did not change much, but, if anything, seemed to become larger; I left off the application of the lotion, and applied strapping. Under this treatment, I thought there was some diminution in its size; but I must have been deceived. I then tried the application of iodine, and gave iodide of potassium internally, having now come to the conclusion that it was either specific (although I had no history) or malignant. Yet a malignant tumour of the testicle in such a young child must be rare. The child became weaker. I noticed a few enlarged glands in the inguinal region. The small opening in the ischio-rectal fossa was still discharging. The back part of the testicle became reddened and soft, as though the skin were about to give way. I proposed to the parents removal of the enlarged testicle, as the only remedy to give the child a chance of living. To this they objected. The child gradually sank, and died on March 7th from asthenia.

I could not get permission to make a complete *post mortem* examination, but was allowed to examine the testicle. On making an incision into the scrotum, and coming down on the testicle, I found the anterior surface hard, as during life, and the posterior part soft and breaking down, and containing a little pus. On making a longitudinal section of the tumour, I found the testicle proper, surrounded by a large amount of dense and firm tissue; the nodules also were hardened in the cord. I forwarded the specimen on to Dr. Dreschfeld, of Manchester, who very kindly examined it. The naked-eye appearances were exactly like those of a scrofulous testicle; and, microscopically, it showed embryonic tissue, giant-cells, and detritus where the mass was broken down; also, in the scrapings, several tubercle-bacilli were found. Dr. Dreschfeld also added, that "it is very likely the scrofulous testicle was the primary focus, and set up afterwards general tuberculosis. Had the parents allowed you to remove the testicle during life, probably the child might have been saved. Scrofulous testicle at such an early period is rare." I may mention, in conclusion, that the parents have no trace of tuberculosis in the family, and their other children are healthy.