appearance. The faecal discharge, however, continued more or less for twelve days, and then stopped, the wound discharging only a little pus, and the cavity caused by the sinking of the stump lessening every day. The patient daily improved in appearance; but eight days later, that is, on July 17th, a small quantity of faecal discharge again came through the lower angle of the wound; but she was able to leave her bed and lie upon a sofa, and is now almost quite convalescent.

The PRESIDENT, in inviting discussion, expressed his own opinion that, in cases in which no other treatment availed, and in which the woman's life was threatened, it was obviously correct to remove the appendages.

Dr. PLAYFAIR (London) said that every one would fully acknowledge the great value of Mr. Tait's paper. It was impossible not to recognise the enthusiasm with which he worked at this subject, and the value of the results he had to show. He would venture to suggest, however, that Mr. Tait had first made his enemy, and constructed his opposition, which he had demolished with such knock-down blows. So far as he knew, all advanced gynaecologists fully recognised the importance of this operation in all suitable cases of bleeding myomata, and were grateful to Mr. Tait for the work he had done with regard to it. He rather thought that Mr. Tait had confounded the opposition made by many to his views on the removal of the appendages in other cases, such as in certain chronic forms of ovarian or other disease, with a supposed opposition to this. His own experience was strongly in its favour. Of course, his personal experience was small, but the results in the few cases he had operated on were all that could be desired. He should like, however, to have some information from Mr. Tait as to what were the precise indications for it, and what he would call prostration sufficient for it. That was really what was wanted. If the tumour were not producing bleeding, and the patient were strong and well, he could not see how the patient should be subjected to such risk, especially as in the larger tumours there would be a chance of having to remove all the tumour. One of his nurses, who worked hard, had had such a tumour, reaching to the ensiform cartilages; he removed it all. Mr. Tait, however, must not be surprised that he met with opposition. It was the case with all who introduced new things in practice; and on the whole it was good, as it kept down excess, and threshed out the subject. He had himself experienced this in other subjects, and it was inevitable.

Dr. IMLACH (Liverpool) remarked that, meanwhile at least, hysterectomy was a more dangerous operation than that of removal of the uterine appendages, which, therefore, should be preferred. If operation for bleeding fibro-myoma were too long delayed, the safer operation was sometimes impossible. He had removed the uterine appendages twenty times for uterine tumour, and all the cases had made a good recovery. It was important to distinguish between cure of the menorrhagia and diminution in the bulk of the tumour. In all but one of his cases, the menopause had been immediately induced, but the volume of the tumour only diminished slowly. Where the bulk of the tumour caused paralysis, intestinal obstruction, etc., hysterectomy was the better operation, as removal of the appendages would fail to relieve these symptoms for an indefinite period. Often, when there was pain as well as menorrhagia, with an intrapelvic uterine tumour, hydrosalpinx, pyosalpinx, or even hæmatosalpinx would be found; in such cases, removal of the uterine appendages had a very satisfactory result.

Dr. M. CAMERON (Glasgow) said that he had under his notice the case of a young German lady, which illustrated the good result following the modern treatment of uterine myoma. This patient suffered from severe flooding, due to the presence of a myoma in the posterior wall of the uterus. Considering that an operation was needful, she consulted a surgeon noted for his success in abdominal surgery. He recommended removal, but afterwards, when the patient was in his ward, changed his mind, and dismissed the case as one unsuitable for operation. The patient was very much distressed over her condition, thinking her case was one beyond relief. Feeling the necessity of some operation, Dr. Cameron urged the patient to consult Dr. Keith. On examination, Dr. Keith agreed as to the immediate necessity of operation, and would not allow the patient to return to Glasgow. He found that the tumour could not be removed without danger to her life, and, therefore, removed the uterine appendages. Some months after, on examination, Dr. Cameron found that the tumour had diminished much in size, but now the hypertrophied posterior lip became greatly enlarged; but a simple operation removed this condition. The patient was now well.

Dr. EDIS (London) remarked that there could hardly be a better comment upon Mr. Lawson Tait's able paper, and the method of treat-

ment therein advocated, than the specimen of myoma which Dr. Walter had exhibited. Mr. Tait's statistics of the operation for removal of the uterine appendages showed that the risks were extremely slight, and the advantages gained very considerable. In a large majority of the cases, the myoma ceased growing, and the hæmorrhage was checked; whereas the mortality in those cases where hysterectomy was performed, even in the most skilled hands, was very large, and appalled any but the most experienced operators undertaking the management of such cases. Dr. Edis hoped the day would soon come when such specimens of large uterine myoma would be so rare as to be real curiosities. They should never be allowed to grow to such dimensions; provided, of course, that the symptoms to which they gave rise were such as to justify interference. The whole art of the medical profession was now directed to the prevention of disease, whether in the form of epidemics or of local conditions; and the sooner the fact was recognised that the growth of these uterine myoma could be cut short by such a comparatively simple operation, the better for all concerned. It was not correct to state that none of these patients suffering from myoma died from hæmorrhage. They did; and, as to waiting for the menopause, this was a myth. Dr. Edis had seen numerous cases where hæmorrhage continued long after the age of 50, the patients having been advised by others to wait for the climacteric.

STRANGULATED UMBILICAL HERNIA: REMOVAL OF SIX INCHES OF SMALL INTESTINE: RECOVERY.

Read before the Staffordshire Branch.

By W. H. FOLKER, F.R.C.S.,

Surgeon to the North Staffordshire Infirmary.

LOUISA K., a married woman, aged 47, residing in Longton, was admitted into the North Staffordshire Infirmary on February 28th, 1884, suffering from strangulated umbilical hernia.

About 12 years ago, whilst carrying a basket, she suddenly felt something give way at the umbilicus, and a swelling arose, accompanied by pain and sickness. These symptoms subsided in three days, but since that time she had had several recurrences, generally lasting only a few hours, and being relieved by her assuming a recumbent position.

On February 25th, the patient had a return of all the symptoms, but attended with a burning pain, which continued to increase. She was induced to send for a medical man, who urged her to apply at once to the infirmary. At first she declined, but the pain and sickness increasing, she came in on the 28th.

On admission, the patient, a corpulent woman, appeared to be in a most exhausted condition, suffering from almost constant vomiting of a faecal character. She had a large umbilical hernia, evidently not only strangulated, but gangrenous, for even the skin covering it was quite black, and smelt most offensively.

Immediate operation was resorted to, the patient being cautiously etherised. An incision was made, of the length of the tumour, opening the sac, when a large piece of bowel was found to be quite black, the contents having escaped into the sac through an opening about an inch and a half in length; the omentum and everything within the incision was gangrenous. The skin and everything that was sloughing, except the bowel, was first removed, and the cavity well washed out with carbolic lotion, and then the bowel (which was small intestine) was drawn well forward till a sound portion was reached at each side; the inner halves of each portion were cut through and carefully stitched together, with their peritoneal surfaces in contact, the outer half of each piece of bowel affording a secure hold whilst this was being done; these were then removed, and the cut edges secured to the skin, forming an artificial anus. The edges of the skin below were brought together by two harelip-pins, and the parts dressed with oiled lint (carbolic oil 1 in 20), covered with absorbent wool, a wide flannel roller being applied over all. She was ordered to have the urine drawn regularly with the catheter, and to take ice and soda-water.

February 29th (the day following the operation). The temperature was normal. There was faecal discharge from the bowel-opening. The patient was looking better, although vomiting, with a faecal odour, still continued, and she had some little pain. A subcutaneous injection of morphia was given, which relieved the pain and checked the sickness. The skin over the abdomen was covered with oxide of zinc ointment spread on lint.

March 1st. The faecal discharge continued, and the temperature remained normal, although the sickness still persisted, but without any odour. Hypodermic injections and dressing were repeated.

March 2nd. The upper pin was removed, as it was threatening to cut through, the parts being very tense. The sickness had nearly ceased. Temperature 100.4°. The treatment was continued.

March 6th. She was doing well; the temperature was normal; there was no sickness. As the external parts were giving way, the last pin was removed, which caused the skin-wound to gape very much, though the edges of the intestines remained perfectly adherent to each other and to the abdominal wall. Strapping was used to support and to bring the parts as much together as possible. The use of the catheter was discontinued.

March 10th. I sponged the edges of the wound with solution of nitrate of silver, 10 grains to the ounce; and gave an enema of soap and water, which returned without bringing anything. Morphia had to be continued, on account of the patient's sleeplessness.

March 18th. The edges of the wound, looking somewhat undermined, were packed with iodoform-gauze. This was ordered to be repeated as often as necessary; for, from the constant welling up of faecal matter, the patient required dressing several times a day. This afternoon, an attack of sickness came on, which lasted from 3 o'clock till 7, but was stopped by a draught of morphia and bismuth.

March 20th. She complained of pain in the wound from the iodoform-gauze, and had a little sickness occasionally.

April 9th. The patient to-day said that she thought she was pregnant, as she discovered milk in her breasts. She was, therefore, carefully examined, and such was found to be the case.

April 17th. A consultation was held, to consider the question of allowing the pregnancy to go on, when it was decided that it would be better to cause abortion. Accordingly, on the following day, a sound was passed by the house-surgeon, Dr. Hatton; but no pains followed.

April 18th. I introduced the sound myself; slight pains followed, but passed off again very shortly.

April 22nd. I passed a whalebone sound, and left it in for about half an hour. Pains came on, but passed off again about midnight. The next day, some ergot of rye was given, and early the following morning the foetus came away.

May 10th. The patient having now recovered from all effects of the abortion, it was determined to try to close the artificial opening in the bowel; accordingly, at 2 P.M., a blade of Dupuytren's enterotome was introduced into each opening of the bowel, and brought very lightly together. At 2.45 sickness came on; but, under the influence of a morphia draught, ceased towards evening.

May 13th. There was no pain or sickness. I tightened the enterotome a little more, having screwed it up a little on the 10th. Flatus passed *per anum* to-day for the first time.

May 15th. I screwed up the enterotome as tightly as it would go. This was followed in the evening by very sharp pain, which was entirely relieved by morphia.

May 21st. The enterotome came away to-day (that is on the eleventh day). Flatus passed in abundance, but no faecal matter yet, *per anum*.

May 25th. The temperature rose to 101.4°, with some pricking pain and general uneasiness. An enema of soap and water was administered, which brought away some hardened faeces and flatus, and relieved all the other symptoms.

May 27th. In the hope of restoring the continuity of the intestinal passage, and of preventing the faeces from being discharged through the artificial opening, a piece of stout India-rubber tubing, three-fourths of an inch in diameter, and about 5 inches in length, was introduced, one end into the ascending, the other into the descending portion of the bowel. It was secured at the centre by a strong piece of silk, the ends of which were left hanging from the opening.

May 28th. The tube was forced out of the wound this morning. Dr. Hatton reintroduced it, but it was again forced out at 9 P.M.

May 29th. The tube would not remain in; it was, therefore, discontinued.

May 31st. I reapplied the enterotome to-day; this was followed, as on the former occasion, by pain and sickness, which was relieved by morphia.

June 9th. The enterotome came away (the tenth day).

June 12th. The edges of the opening were brought together by a broad piece of plaster, but without effect.

June 18th. Hitherto the patient had had no solid food, and complained of feeling hungry; the diet was, therefore, changed to ordinary solid food.

June 23rd. An enema of soap and olive-oil brought away a fairly natural motion. This was repeated on the 26th, when the bowels were freely relieved. They were moved again by the natural effort, an hour afterwards, and again a second time in two hours.

July 1st. I refreshed the edges of the external opening, and brought the parts closely and accurately together, with five deep, and three superficial sutures. Solid food was ordered to be discontinued for a few days.

July 2nd. Faecal matter was forced through the wound, and in a day all broke down, the stitches were removed, and the discharge was as free as before.

July 16th. She got up for the first time; the discharge was the same.

July 29th. On making a digital examination to-day, both ascending and descending portions of bowel were found to be quite free, and of uniform calibre, the slight prominence, the remains of the spur, could only just be felt by the extremity of the forefinger when introduced to its full length. An enema produced an ordinary motion. Another plastic operation was therefore performed, but with no better result, for in two days the discharge began to force its way through between the stitches.

Enemata were now administered every other day, and a fortnight afterwards the edge of the wound was cauterised, in the hope of causing it to contract. This was continued for some time, the application being varied from time to time between nitrate of silver, fuming nitric acid, and the thermo-cautery.

September 22nd. She had a natural motion for the first time to-day, and again on the 29th; but as this did not occur again, enemata were regularly administered, and always acted copiously; but still faecal matter continued to well up through the wound, although it was reduced to the size of a threepenny-piece.

At the end of October, wishing to go home, she was discharged at her own request, all the various attempts to close the wound having failed. She has presented herself from time to time at the infirmary, but remains exactly in the same state as when she left. The remains of the spur could be felt with a probe at about an inch and three-quarters from the surface.

REMARKS.—This is not a case commonly met with; and, as the discussion may perhaps bring forth different opinions as to the treatment adopted, I would first say that, six inches of intestine having sloughed and burst, its entire removal was imperatively required. Then came the question as to how the remainder was to be treated.

The sloughing was so extensive, that I dared not rest content with opening the bowel and leaving it to form an artificial anus by adhesion, as has occasionally been done in inguinal hernia when the bowel was not fit to be returned; and for the same reason I was afraid to attempt to unite the two ends of the bowel together and return it, and therefore decided upon the method of treatment which I have described.

When the patient was found to be pregnant, the question of allowing her to proceed to the full time gave rise to some little doubt. If pregnancy had been allowed to go on, it would not have been prudent to have attempted Dupuytren's operation, as it might have caused miscarriage whilst the clamp was on the bowel, and possibly have been fatal; and danger was also to be apprehended from the extreme distension of pregnancy, and the straining pains attending it; and, lastly, there was the great delay. All this was fully explained to the patient and her husband, and consent was at once given.

The application of the enterotome, on both occasions, only caused a little nausea and sickness, which was easily controlled by a dose of morphia, until it was finally screwed up tightly, when some sharp pain was experienced, but was easily relieved.

The instrument came away on the tenth and eleventh days, which, I believe, is about the average time.

The chief point, however, on which I am anxious to hear the opinion of others is, why does the opening not close? and wherein have I been in fault in my attempts to produce its closure?

There must be a clear passage in the bowel, both ascending and descending, of at least an inch in diameter, as was proved by the introduction of the three-quarter-inch India-rubber tube; the lower level of the bowel is nearly two inches from the surface. There seems no impediment in the bowel, or why should faecal matter pass as it does when an enema is given? and why should it force through a small narrow opening in the upper part, when there is a free and much larger channel on a lower level?

UNIVERSITY OF VIENNA.—Drs. Hofmök, Ultzmann, and Anton Wölfler have been appointed extraordinary professors of Surgery, and Dr. Mauthner extraordinary professor of Medical Chemistry.

MOSS AS A SURGICAL DRESSING.—For some months past, moss has been employed as a surgical dressing in the Teaching Hospital in St. Petersburg; it costs 50 kopecks a pood (a shilling for 36 pounds). The results have been very satisfactory.