My first examination was as fruitless as his had been in discovering the mouth of the womb, but the impression conveyed to my finger was more that of a thick cystic ovarian tumour than of the fundus uteri. I purposely continued my examination during the persistence of two or three pains, and I thus verified his account of the real advance of the swelling during each period of uterine contraction, but I could not feel, as I thought I should do under such circumstances, any part of the foetus, nor any movement, through the walls of the swelling. External examination of the body next convinced me that the uterus was high up in the abdomen, as both the movements of the child could be detected, and the sounds of the foetal heart could be heard in an abnormally high position. This examination led me to make a careful inquiry into the history of the patient's pregnancy, and of her condition before pregnancy had existed.

My inquiries elicited the fact that she had, many months before, sought the advice of an eminent surgeon, for a distinct swelling in the left side of the body, and that, under his care, this swelling had, as she believed, disappeared. The "tumour," as it had been called, was at that time free, moved as she moved, and had given rise to very little pain or even discomfort.

I now felt certain I had an ovarian tumour to deal with, and repeated my examination *per vaginam*. I succeeded in gradually introducing my hand into the vagina, and I then found that I could insinuate my two forefingers between the tumour and the pubic bone, and could, with some difficulty, feel the os uteri, partially dilated, and the head presenting.

The question of the best mode of delivery now presented itself, and formed the subject of a most anxious consultation. Three plans occurred to us:—1. Firm and steady pressure to endeavour, if possible, to lift the obstructing tumour above the brim of the pelvis, and thus allow the uterus to descend. 2. Caesarean section. 3. To endeavour to diminish the bulk of the tumour sufficiently to allow the child to pass it.

The second of the proposed plans seemed to me to be the least feasible of any, as it involved not only Caesarean section, but ovariectomy at the same time; for I feared that, if the child were removed without the extirpation of the tumour also, it would probably be found impossible to prevent such protrusion of the abdominal viscera as might render their return impossible. I determined, therefore, at once to try the first plan, and, if that failed, to fall back upon the third. At this point, the patient's condition was carefully explained to her and to her friends, and they were informed of the necessity which might arise to destroy the life of the child, in order that we might be enabled to extract it. I was fully aware that ovarian tumours are sometimes so pressed down in front of the contracting uterus as entirely to obstruct all progress, but that, by watching for a favourable opportunity, they may often be pressed upwards above the pelvis, sufficiently to permit natural delivery to take place. My friend and late colleague, Mr. Samuel Smith, was in the habit of detailing such instances which had come under his observation. Again, therefore, introducing my hand into the vagina, I endeavoured, in the intervals between the pains, to press back the tumour, bringing, each time, as much force to bear upon it as I felt justified in using, and repeating the effort several times. So firmly, however, was it wedged, and apparently so matted was it to the surrounding organs, that, with all the force that prudence would permit me to use, I could not move it in the least degree. Finally, therefore, after much consideration, I determined to try whether I could so far lessen the tumour as to permit of the extraction of the child either alive or dead.

Before proceeding to this plan, I again satisfied myself that the tumour was adherent to the posterior wall of the vagina on the one hand, and to the rectum on the other, and that no ascitic fluid was interposed. I thus felt assured that the peritoneum was protected, and that the discharge, from any opening I might make into the tumour, would find free exit through the vagina, and that we should run no risk of effusion into the cavity of the body. With the ordinary midwifery perforator I pierced the tumour, and, using the instrument as I should have done in performing the operation of craniotomy, I broke down a considerable mass of its interior. At first, it appeared to be entirely solid, but, after a little time, I pierced the walls of a cyst, and a good deal of grumous fluid escaped. This allowed the tumour to collapse to a considerable extent—to such an extent, indeed, that, in the end, I succeeded in bringing the child away after opening the head and eviscerating the thorax.

For some weeks our patient appeared to be in a very critical condition, and we feared that she would sink; but, after a protracted convalescence, she seemed to recover, in some measure, from the effects of her confinement. What the final result with respect to the remains of the tumour was, I do not know; for, I regret to say, she suddenly left the town, and of her subsequent condition I have heard nothing.

ABNORMAL ORIGIN OF VESSELS FROM THE ARCH OF THE AORTA.*

By J. D. BROWN, M.D., and F. J. BROWN, M.D., Rochester.

S. C., aged 74, died at Rochester on February 22nd, 1867. The case was registered as "pericarditis and disease of the aorta, eighteen months; nephria and dropsy, six months". This man suffered from neuralgia of

Morbid Specimen.

Fig. 6, Pl. 7, from Quain.

Diagram of the Morbid Specimen, and a figure on Plate 7 of Quain and MacLise's Arteries, constituting the nearest approach to the specimen.*

the solar plexus and of the right brachial plexus from October 1866, and the tone of his voice was lowered. He died by syncope. He was a pensioner from the Royal Navy, and had lost a leg. His habits were temperate.

At the *post mortem* examination, there was found to be hydrothorax, with oedema of the lungs and emphysema. The pericardial cavity contained some serum; and there were adhesions to the posterior surface of the heart. There was no disease of the substance or of the valves of the heart. The ascending aorta was large; and atheromatous patches were present in the distal portion of the arch and in the descending aorta. The origin of the vessels from the arch of the aorta was abnormal. The two carotids arose by a common origin from one-eighth of an inch; next the left subclavian; lastly, the right subclavian, arising from the distal end of the arch, then coursing behind the trachea and behind the ascending aorta to gain its usual position on the right side of the thorax. The abdominal aorta was greatly diseased near the origin of the celiac axis. There were thick ossiform plates and some eroded points. There was atheroma for several inches downwards. The common iliacs and the internal iliacs were greatly diseased, and were eroded. The kidneys were granular; and there was wasting of the left organ, with many cysts. The liver was dark coloured and of nutmeg appearance, and was lacerable. The spleen was gorged and lacerable.

* Read before the West Kent District Meeting.

† It is to be regretted that the parts were not preserved. It was thought at the time that the arch was identical with that figured on Plate 7; but on comparing the diagram with Fig. 6, the difference was observable.

LIGATURE OF THE COMMON CAROTID ARTERY.—The last number of *Langenbeck's Archiv* contains a long article from Dr. C. Pilz of Breslau, on ligature of the common carotid. Included in this are statistical tables of 586 reported cases, which are arranged in the following manner: ligature for hæmorrhage, 220 cases; ligature for aneurism, 86 cases; ligature for tumours, 138 cases; ligature before and during the removal of tumours, 69 cases; ligature for nervous affections, 35 cases; ligature for Brasdor's operation, 38 cases. The total amount of cases is further increased to 600 by others, of which full details are not given. In 29 instances the common carotid was tied on both sides, in 257 on the right side, and in 194 on the left. The sex of the patient is not given in every case, but of 537 patients 403 were males and 134 females. The sympathetic nerve was in one instance included in the ligature. Affections of the nervous system followed the operation in 160 cases; hemiplegia occurred in 8 per cent.; and 76 per cent. of the patients so affected, died. Of the 600 cases, 319 were cured after the operation, and 259 died; the result in the remaining being unreported. The ligature in the majority of cases came away between the thirtieth and fortieth days after the operation. The nervous symptoms following deligation of the common carotid, are attributed by Dr. Pilz to deficiency of arterial supply and to venous congestion, and also to nutritive changes brought about by the establishing of the collateral circulation. In cases of aneurism, Dr. Pilz advocates the application of digital and mechanical compression, and holds the opinion that deligation of the carotid should be performed only as a last resource when all other methods of treatment have failed.—*Archiv für Klinische Chirurgie*, Bd. ix. - 1868.