CASE IV.

Miss W., aged 61, was placed under my care in the McAlpine Nursing Home by Sir H. C. Cameron in last May. She informed me that the menopause had occurred fully ten years previously. For nearly two years there had been vaginal haemorrhages. At first these had been irregular and slight, but eventually they had become more profuse and constant. Beyond a feeling of pelvic uneasiness there was no other symptom. Upon examination under an anaesthetic the uterus was found retroflexed and slightly enlarged, but there was no disease of the cervix. Suspecting the condition to be an adeno-carcinoma of the uterine body, I curetted the uterus; in doing so my curette went through the uterine wall. This, however, was attended with no ill-effects. Dr. Teacher reported that the curetted tissue was an adeno-carcinoma. A few days later I removed the entire uterus and a small part of the upper portion of the vagina. Upon examining the uterus after the operation it was found that the tumour tissue extended over the whole internal surface of the body. In some parts it penetrated so deeply into the uterine wall as to almost reach the peritoneum. The patient made an uninterrupted recovery.

CASE V.

Mrs. McK., aged 55, a widow, was sent to me by Dr. Muir, Possilpark, in July, 1908. The patient informed me that she had never been pregnant. The menopause had not occurred, but about three years previously menstruation began to be a little irregular. Eighteen months ago bleeding from the vagina became continuous. At first she had no pain, but during the last few months she had had a good deal of pain in the lower part of the abdomen and back. On examination under chloroform in Miss Tisdall's Nursing Home, the uterus was found to be slightly enlarged and displaced backwards. The appendages were normal. The cervix appeared normal. Suspecting malignant disease of the body of the uterus, I curetted the uterus. The scrapings were examined by Dr. Hasler Wilson, Pathological Institute, and pronounced to be typical adeno-carcinoma. Upon July 22nd I removed the entire uterus and upper part of the vagina. The examination of the uterus after its removal showed it to be extensively invaded by a diffuse friable tumour. The tumour tissue had penetrated in some parts almost through the whole thickness of the uterine wall. The patient made an uninterrupted recovery.

In considering the above cases the first striking feature is the menstrual history. In two cases a distinct menopause had occurred, but in the three others the menstrual discharge had been irregular, then more profuse, then finally more or less continuous. In the former class of case, when bleeding occurs some time after the menopause, there is little likelihood of the condition being overlooked, for a recurrence of bleeding always attracts attention. In the other class, however, both patient and doctor are apt to take up the attitude of presuming that this excessive discharge is simply a feature of the menopause. Such an explanation is only justifiable if the uterus is curetted, and the scrapings have been pronounced non-malignant.

The second point of interest is the age of the patients. The youngest was 52. This is in agreement with the experience of all gynaecologists that the maximum morbidity is between 50 and 60 years of age.

The slow progress of the disease is another matter of interest. In all, except Case I, the disease had been in existence for a very considerable time.

Yet another feature is the fact that three of the cases were unmarried, and only one of them (Case III) had borne any children. It would appear that while carcinoma of the cervix is favoured by the occurrence of previous parturitions, carcinoma of the body is not, and in fact is relatively more common amongst those who have not borne children.

The frequency of the coexistence of adeno-carcinoma and fibromyoma is another striking feature. In the five cases recorded two had distinct multiple tumours, while one had a few small myomatous nodules. This is a matter well worthy of attention. If one looks over recorded cases of fibromyoma of the uterus, in quite a distinct proportion of cases, 2 or 3 per cent. at least, adeno-carcinoma of the body of the uterus was found. I have now performed hysterectomy for fibromyoma of the uterus in nearly 150 cases, and in four of them an adeno-carcinoma of the body of the uterus was present.

Except for haemorrhage there are no characteristic symptoms, pain is seldom a marked feature. A feeling of uneasiness and bearing down may be mentioned by the patients, but these are common complaints amongst women. Severe pain is complained of usually only when the disease is far advanced. Small multiple fibroids occasionally are associated with considerable pain. In only one of my cases was severe pain complained of, and in that case there were several small fibroid tumours. The

haemorrhage varies very much in amount. Occasionally it is very profuse, but it is often quite moderate. It is most likely to be overlooked when it occurs at or about the menopause, for there is often excessive menstruation at that time.

There is only one way of making certain regarding the nature of the condition—namely, to curette the uterus and examine the scrapings. Curettage of the uterus in this condition must be performed with great caution, for if the disease is far advanced the uterine wall is so friable that the curette may very easily perforate it. This happened in one of my cases (Case IV). As a rule perforation of the uterus with a curette is not attended with serious symptoms provided the operation is performed with all aseptic precautions, but with advanced adeno-carcinoma there may be a septic condition of the uterus. In the case referred to no evil effects followed.

The absolute importance of curettage in all cases in which there is the slightest doubt is well illustrated by the following one, which was under my care eighteen months ago:

The patient was 61 years of age. She came to me two years previously, and informed me that she was attending another gynaecologist on account of occasional bleeding from the uterus. I advised her to return to her medical attendant and insist upon having the uterus curetted. She did not take this advice, however, and I did not hear of her for two years. She then consulted me and said she wished to place herself in my hands. At the same time she sent me a small portion of tissue which had come away from the vagina, and which on examination proved to be an adeno-carcinoma. When I removed the uterus a few days later the whole cavity was filled with tumour tissue, and the uterine wall was almost completely destroyed.

As I have already indicated, the condition is in many cases associated with fibromyomatous tumours of the uterus, whilst in other cases the uterus may be so distended by the tumour tissue that by reason of its size it simulates a myoma.

In the cases in which there are co-existing fibroids, especially if the patient comes under one's care about the time of the menopause, there is a tendency amongst some practitioners to encourage the patient to wait until the menopause is over, with the idea that in time the fibromyomata will cease to give further trouble. Such a procedure is always very questionable, and, as I have said, is only justifiable if the uterus is curetted, and the scrapings are found to be of a non-malignant nature.

There is another important and practical point in this connexion. In cases where the uterus is very much distended with a malignant tumour, and the condition is mistaken for a fibromyoma because of the size of the uterus, the operator, if he performs supravaginal amputation of the uterus, will leave the cervix behind, and may only discover that he has to deal with adeno-carcinoma when he splits open the uterus after the operation is finished and the patient has been placed back in bed. In two of my cases this occurred. In both I removed the cervical stump by the vagina a few days after performing abdominal hysterectomy.

All the patients made uninterrupted recoveries, and left the respective nursing homes within the month. At the present time they are all absolutely well.

RUPTURED TUBAL PREGNANCY AT FOUR MONTHS: OPERATION IN A COTTAGE: RECOVERY.*

By T. LISTER LLEWELLYN, M.D., B.S. LOND.,
BARGOED.

I WAS asked on May 19th, 1908, by Dr. C. Reidy, of Bargoed, to see a case which he had diagnosed as one of tubal pregnancy.

History.

Mrs. J. E., aged 24, married in February, 1906, had had in May, 1907, one child, which was nursed up to May, 1908.

Menstrual History.

The periods started at 17, but were very irregular for the first two years. From the age of 19 they had varied not more than a day. After the birth of her baby in May she missed four periods. Menstruation started again in October, 1907, and remained regular up to January, 1908, after which date it stopped.

* Read before the autumn meeting of the South Wales and Monmouthshire Branch of the British Medical Association.

Previous History.

She had had no illnesses except constant attacks of epigastric pain since the age of 16. In her first pregnancy she was very well throughout, and had none of the usual unpleasant symptoms. Since January, 1908, she had had repeated attacks, sometimes twice a day, of temporary faintness lasting for two to three minutes, associated with a general feeling of weakness. She had no vomiting, but felt sure she was pregnant.

History of Attack.

At 5 a.m. on May 19th she awoke with severe pains in the lower part of the abdomen. They lasted fifteen minutes, but did not prevent her from getting her husband's breakfast at 6 a.m. She then felt as well as ever, and was able to do a full day's washing. While scrubbing the floor at 5 p.m. she was seized with very severe pains in the lower part of the abdomen. She lay down on the couch, and felt herself getting very weak. She had a hazy idea of Dr. Reidy's visit, and of being carried upstairs. I saw her with Dr. Reidy at 11 p.m. on May 19th.

Condition on Examination.

The woman was absolutely blanched, restless, and unaware of her surroundings. Her breathing was hurried, short, and gasping. The pulse could be felt at the wrist only with difficulty, and it could not be counted. The abdomen was slightly distended and tense, but nothing was made out on palpation. Vaginal examination was quite negative.

Diagnosis.

The history of four months' suppressed menstruation, together with the sudden onset, severe abdominal pain, and obvious internal hæmorrhage, at once suggested the diagnosis of ruptured tubal pregnancy.

Operation.

Dr. W. A. Reidy gave chloroform. The abdomen was opened in the middle line below the umbilicus, and a large quantity of fluid blood at once escaped. On introducing my hand I found a fetus $4\frac{1}{2}$ in. long quite free among the intestines; the umbilical cord had been torn close to its attachment. The right tube was greatly enlarged and funnel shape. It had been ruptured at the extremity. I ligatured the tube, removed the enlarged portion, and left the ovary intact. The left appendages were normal. I then removed several large clots of blood and pieces of the placenta from the pelvis. There was some slight hæmorrhage deep in the pelvis which I was unable to see or locate. To control this bleeding I placed a gauze plug in the pelvis, and then sewed up the abdomen, bringing the plug out through the lower angle of the wound.

The general condition of the patient was still very bad. Six pints of saline were run into a vein at the elbow with very satisfactory results, the pulse improving very rapidly.

After-History.

May 20th.—Plug removed and not replaced. Slight oozing of blood.

May 21st.—Considerable oozing of blood through lower angle of wound.

May 23rd.—Bowels open after calomel.

May 26th.—Stitches removed. Wound completely closed.

The patient made a good recovery. There was no temperature above 99° F. during her stay in bed. Her only trouble was that she was unable to pass her urine for the first week. She came downstairs at the end of four weeks.

Present Condition.

December, 1908.—She menstruated six weeks after operation, and regularly since. The abdominal scar is quite sound, and there is no trace of a hernia.

The case is interesting from several points of view. Rupture of a pregnant tube is rarely delayed until the fourth month. The chief interest, however, lies in the conditions under which the operation was performed. The room was small and almost completely filled by a large, wide, and low bedstead, which had to be pushed against the wall on one side and left 3 ft. clear on the other. The patient lay in, not on, a large feather bed. The light was very bad; a small tin lamp was nailed to the wall above my head and another lamp stood on a table at the foot of the bed. It was practically impossible for Dr. Reidy to give me any assistance beyond handing me instruments.

No sponges were used, their place being taken by a roll of cyanide gauze taken straight from its package. The case ran an aseptic course throughout, and the precautions taken may be of interest. All instruments, needles, and ligatures were boiled. The operation area was surrounded with towels which had been boiled in water for five minutes. Skin and hands were cleaned with soap and

water and lysol. The nursing was entirely left to her neighbours, who were colliers' wives.

I publish this case in the hope that it will encourage other general practitioners to deal with these cases themselves. Delay of even an hour or two may make all the difference between success and failure. I am convinced that sepsis is not difficult to attain even in a cottage.

I am deeply indebted to Dr. Reidy for his skilful treatment of the patient after operation, and for his help in preparing these notes.

PYELITIS OF PREGNANCY TREATED WITH COLI VACCINE.

By H. T. HICKS, F.R.C.S.,

HONORARY GYNAECOLOGIST TO THE DERBYSHIRE ROYAL INFIRMARY.

The following case is a very typical example of a moderately virulent infection of the right renal pelvis during pregnancy:

S. T., aged 20, was sent to my out-patient department by Dr. Mackay suffering from acute pain in the right side of the abdomen. She was at the fifth month of her second pregnancy, the first pregnancy and labour having been normal in every respect. During the present pregnancy she had been very much troubled with constipation.

The illness started three weeks before admission with aching in the right renal region, beginning behind, but spreading rapidly round to the front of the abdomen and downwards toward the right iliac fossa. The pain was quickly followed by a rise of temperature and a general feeling of malaise. There was no frequency of micturition nor any sign of cystitis.

In spite of a fortnight of incomplete rest in bed at home the symptoms became more marked, and the patient's general condition began to give cause for anxiety. During the first

three weeks the temperature had been irregular, and when I saw her it was 103° F. The pulse was rapid and feeble; the tongue dry and furred. The patient looked pale and ill, and complained of intense pain over the right side of the abdomen. On examination the maximum point of tenderness on deep pressure was below the twelfth rib behind, and there was a definite history of the pain having started here, and of it having spread downwards and forwards into the appendicular and right iliac regions.

There was slight rigidity over the right half of the abdomen, and it was interesting to note the extremely well marked superficial tenderness, which is so often a characteristic sign of pyelitis occurring during pregnancy. The uterus was enlarged to about the fifth month of pregnancy and seemed quite normal. The patient was admitted and was put on a milk diet and a mixture consisting of urotropin (10 grains) and potassium iodide (3 grains). The urine contained pus and a few epithelial casts. It was acid in reaction. There was no tenderness over the bladder, nor was there any evidence of cystitis. A pure culture of *Bacillus coli* was obtained from a catheter specimen of the urine, and a vaccine was prepared. After four days' rest in bed, on the milk diet and medicine, the temperature and pain did not abate; 10 c.cm. of the *coli* vaccine was then injected. The temperature dropped almost immediately and remained normal, except for one small rise two days later. The pain decreased in severity in a marked manner, so that within a few hours the patient hardly complained at all. She had one or two attacks of slight pain during the rest of the time she was in hospital, but the improvement in her general condition was most satisfactory. The pyuria persisted, but for more than forty-eight hours at a time the urine would be free from pus, and then a large quantity would be passed. After being in hospital a month and a half, the patient went out apparently well in