In spite of our fears to the contrary, she went to term, and when she came into a nursing home on January 20th I was delighted to find her in very fair condition and free from serious symptoms. There could, however, be no doubt as to treatment, for the head was mobile above the pelvis, and could not be made to enter it, while a large, solid tumour occupied the pelvis and could not be pushed up. The liquor amnii began to be discharged on January 21st.

Operation.

The operation was performed on January 22nd. Mr. Hann administered chloroform, and Mr. L. R. Braithwaite assisted me. Through a median abdominal incision I drew the uterus forwards and removed the child by an incision in the fundus. On drawing up the uterus I was glad to find that below the myoma in the cervix there was space for a satisfactory supra-vaginal amputation. The right ovary was not removed. I tied the vessels with catgut, drew the edges of the stump lightly together with a few catgut sutures, and sutured the peritoneum over it in the usual way. No drainage was necessary. The abdomen was then closed as usual.

This operation, which has superseded the old Porro, is to any one accustomed to hysterectomy a quick and easy one, for the size of the abdominal incision and the laxity of the tissues make it very easy to see and deal with all the parts concerned. The child was a very well developed male weighing 8 lb., and having a chest girth of 18 in. Except for a little temporary difficulty on the second day with intestinal distension, which yielded to treatment, the mother made an uncomplicated recovery. She had an abundant supply of milk, and suckled the child entirely from the fourth day onwards; the wound healed without suppuration, and the husband was able to take her home at the end of two weeks. She has progressed well since, and the child has gained on an average about $\frac{1}{2}$ lb. a week.

The specimen removed was shown at the Leeds and West Riding Medico-Chirurgical Society on May 7th; it measures after retraction and hardening $8\frac{1}{2}$ in. by 7 in. It shows three myomatous nodules in the corpus uteri, and one as large as a fetal head in the cervix. It does not project into the cervical canal, and could not have been removed by the vagina before delivery. A portion projected downwards towards the sciatic notch, and probably pressed on the nerves.

CASE II.

This bore a close resemblance to Case I. A woman, aged 31, married three years, primigravida, was brought to me, when three months pregnant, by Mr. H. J. Roper of Leeds, in July, 1908. She was a spare but not unhealthy woman, and had suffered from no serious degree of menstrual excess. The myomata had not been discovered before pregnancy. The uterus reached nearly to the navel, and at least three distinct and rather mobile myomata could be felt through the abdominal wall.

Per vaginam several nodules could be felt in the lower uterine segment, threatening obstruction in labour, although not so great as in the last case. The usual signs of pregnancy were present. Labour was due about January 18th, but she did not go quite to term, but came into the nursing home on January 6th with the liquor amnii discharging.

Operation.

The operation was performed on January 7th, its details being almost exactly the same as in the previous instance—supra-vaginal amputation, right ovary not removed, retro-peritoneal treatment of stump, no drainage, no difficulties. The child weighed $5\frac{1}{2}$ lb.; female. The mother was not able to suckle through failure of secretion. The wound healed without suppuration, and the recovery was uncomplicated.

The uterus removed shows an extraordinary number of interstitial, subserous, and submucous nodules; there must be about twenty in all, larger or smaller. One of the submucous nodules was almost detached in the uterine cavity. There was no appearance of degeneration in the myomata.

I may refer, in closing, to a case on which I operated several years ago, where a myoma complicated a four months' pregnancy and was causing pressure symptoms. It was felt in the pouch of Douglas, and was supposed to spring from the cervix and lower part of the uterus. It turned out to be a myoma springing from the fundus of a retroflexed pregnant uterus, and could be drawn out of the pelvis on abdominal section. The uterus is now in our museum, and the case illustrates a difficulty in diagnosis which is worth noting.

The safety of modern Caesarean section, whether conservative or mutilative, is so well established as to need little emphasizing, but I think that there are many women with a sufficient degree of pelvic contraction to lead to loss of child after child who might well be encouraged to undergo delivery by abdominal section for the sake of having a living child.

UNDER the will of the late Miss Ann Hill of Peterborough, who died on March 20th, the Hunstanton Convalescent Home and Peterborough Infirmary each receive a sum of £2,000. They are also entitled to share in the residuary estate, and from this source will probably each receive some £700 or £800 in addition.

A SUCCESSFUL CASE OF HYSTERECTOMY FOR PUERPERAL INFECTION.

By A. KNYVETT GORDON, M.B.CANTAB.,

MEDICAL SUPERINTENDENT OF MONSALL HOSPITAL, MANCHESTER.

In my own experience it is very rarely indeed that the question of performing hysterectomy for puerperal septic disease presents itself. In a series of 250 cases of the more severe type of puerperal fever, I have only attempted the operation once with a good prospect of success in the following case, though I have removed the uterus unsuccessfully in 5 other cases (twice by the vagina and three times abdominally) as a last resort and at the urgent solicitation of the relatives or of the medical attendant. As a rule, the patient is either in a condition of general septicaemia with streptococci in the circulating blood when she arrives at the isolation hospital, or if the lesion is well localized, reacts to vigorous disinfection of the uterus.

F. G., aged 23, a previously healthy primipara, was delivered at full term of a normal child on August 21st, 1908. A midwife only was in attendance, who is stated to have made vaginal examinations very frequently until the birth of the child, the labour lasting thirty hours. Half an hour after delivery, the placenta having partially come away, there was severe *post-partum* haemorrhage, and a medical man was summoned, who found it necessary to introduce his hand into the uterus in order to detach the remains of the placenta. He did not wear gloves, and was unable, owing to the absence of any facilities, to disinfect his hands, or even wash them satisfactorily. Half an hour later, as the bleeding recurred, he repeated the manoeuvre, and then gave an intrauterine douche.

Sixteen hours later the temperature rose and the patient had a rigor. She became rapidly worse, and ultimately—seventy-two hours after delivery—was notified as a case of puerperal sepsis and removed to Monsall Hospital.

Condition on Admission.

Her state was very grave. The pulse rate was 144 and the temperature 103° . The extremities were cold, and there was intense anaemia with much prostration. The abdomen was uniformly distended but there were no signs of general peritonitis; the fundus uteri could be felt externally 1 in. above the umbilicus. On further examination the vagina was found to be sloughing, with large necrotic masses on each labium and on the posterior wall. The cervix was split bilaterally, and the posterior lip was covered with greyish membranous exudate. The os was widely dilated, and fetid pus was flowing freely from the interior of the uterus, the cavity of which measured no less than 10 in. in length. The uterine wall was everywhere softened, and it would have been possible to push the finger through its substance without difficulty. At the fundus were several partially loose masses of placental tissue.

The advisability of removing the uterus forthwith was considered, but as the patient was worn out from want of sleep and in a very dirty condition from the absence of proper attention, and as it also appeared desirable to investigate the bacteriology of the blood before operating, I decided to temporize. Accordingly, under the analgesia afforded by a dose of alcohol followed by morphine subcutaneously, I scraped the interior of the uterus thoroughly with a large sharp curette, and swabbed the resulting raw surface with pure iodo solution, packing the cavity subsequently with gauze soaked in a 1 in 100 solution of the same preparation. Three pints of saline solution were then given subcutaneously.

Operation.

On the morning of the next day the patient had rallied somewhat, but the pulse-rate had not diminished, and the temperature remained at 103° . Two rigors had occurred. The cultures taken from the blood showed no growth (and remained sterile subsequently), while those from the interior of the uterus showed *B. coli* and *B. proteus* in large numbers. I came to the conclusion that there was no general bacillary infection, and that it would probably not be possible adequately to disinfect the uterus by further local palliative treatment, so I opened the abdomen and amputated the uterus at the level of the internal os, leaving both ovaries, and covering the stump with peritoneum in the usual manner. A rubber tube was placed in the remains of the cervix, and the peritoneal cavity closed without drainage. After the effects of the ether had passed off the patient was propped up in the sitting position, and three pints of saline solution given subcutaneously.

After-History.

For the next ten days the temperature remained at about 101° until the discharge of pus from the cervix and sloughing vagina had ceased, but her progress after the operation was otherwise very favourable. She left the hospital sixty days after the operation with a firmly healed abdominal wound, and free from vaginal discharge. A month later I saw her again, and found the vaginal vault firmly healed. She had resumed her work as a tailoress, and had menstruated since her discharge.

I have only to add that the reason why I did not remove the cervix as well as the body of the uterus was because the patient's condition rendered it desirable that the operation should not be prolonged. In this case it had lasted for twenty minutes, and it then seemed that the further ten minutes or so which would be required to remove the cervix might turn the scale against the patient. On theoretical grounds, however, I should prefer the total operation in a similar case.

"CLEAN MIDWIFERY" IN GENERAL PRACTICE.

By ARTHUR H. GREGSON, M.B., Ch.B.,
BLACKBURN.

For five years no doubt had ever entered my mind as to the efficacy of mercury perchloride as a hand and labial disinfectant and a sure preventive of puerperal fever; but in December, 1905, a midwife sent for me to attend one of her septic cases, which proved fatal within a week; and after that, though none were fatal, several of my own had unpleasant rises of temperature; it seemed as though the infection would not be got rid of, so I determined to use rubber gloves.

At first they were carried in a glass bottle containing glyc. ac. carbolic. diluted ten times at one end of my bag; a yard of cotton-wool was also put in, and the midwifery forceps transferred to a sterilizer made by a local tinsmith for 7s. 6d. The nurse was required to find an enamel pan and some soda to boil the gloves, a bowl for lysol to transfer them to, another for perchloride to wash the labia with, as the lysol is too irritant, besides the usual washhand basin, the whole making a somewhat formidable array.

Before long, however, a case occurred in which elaborate preparations were out of the question; even a pint basin for the perchloride had to be borrowed—just such a case where perfectly clean midwifery would be held an impossibility. In these poor houses the gloves are put into the kettle and transferred to the mercury solution instead of to lysol, and this is found to do quite well. Of course the soda is omitted, and then the gloves must be boiled in it at home to remove any trace of blood or fat before being used again; whereas this is usually done at the patient's house, the pan being kept at one side throughout the case and used repeatedly.

The gloves having been boiled, one's own hands are washed with soap and water, all the folds of the patient's genitals and adjacent parts cleansed with perchloride and the vagina swabbed as thoroughly as possible with cotton-wool wet with the same solution and never dipped into it a second time; then one's hands are sterilized in the ordinary way and the gloves put on without filling with water, a pad of cotton being used to work them on, and the examination made without any lubricant except the 1 per cent. lysol when convenient, contamination from the anus being prevented by keeping a pad of dry wool over it. The patient is always instructed to have an enema before she sends for me, but too often she omits it. If during the vaginal examination the rectum is found overloaded and the os not fully dilated, an enema is given.

If instruments are found to be required, boiling water is poured into the tin, the gloves put in, and 2 per cent. lysol added. The whole are then boiled for five minutes with the spirit lamp, half the solution poured into a jug as a reserve, and cold added to the tin.

Such a change in routine had its disadvantages. Tactile sensation required re-educating, but half a dozen cases were sufficient to complete this. The waste of time was at first about an hour, but now it is only fifteen minutes, and is fully compensated for by not having to give intra-uterine douches later. If any rotating or turning is required, lysol makes the gloves too slippery, and perchloride must be used instead.

The greater peace of mind is worth much, although two or three cases of puerperal fever have occurred in my own practice since.

The first was one in which the patient had taken plenty of castor oil, and refused to have an enema, with the result that faeces contaminated my glove during the

rotation of an occipito-posterior into an occipito-anterior presentation, and taught me to leave the pad at the anus.

The second might easily have been a mystery, but that on my arrival a neighbour said, "She won't be long now, doctor." "You have examined her?" I asked. "Yes, but my hands are clean; I am washing," she answered. A washerwoman making a vaginal examination! In this case the mother-in-law remarked, "There should be no blood poisoning here," when she saw my preparations to prevent it.

The third was an occipito-posterior presentation delivered by rotation and instruments; the perineum was torn. There was swelling of the abdomen six hours later, which disappeared after defaecation next day. The temperature never rose above 99.6°, and became normal after removing a painful suture on the fourth day; the pulse fell from 108 immediately after delivery to 80 during the same time. Satisfactory progress reported on the seventeenth day. At noon on the eighteenth day I was called in again. She had vomited; was suffering from pain in the right iliac region; the temperature was 102°, and the abdomen again swollen. On vaginal examination there was tenderness limited to the right fornix; an intrauterine douche brought away nothing and caused no improvement. Involuntary defaecation commenced soon after, and a rigor occurred on the twentieth day. A consultation was held on the twenty-first day; the uterus was normal for the time, and the perineum healed, but the abdomen was more distended. Septic peritonitis was diagnosed, and the appendix mentioned as a possible source; but, owing to the circumstances, it was decided to regard the genital canal as the route of infection. She had always been much troubled with wind—a complaint which I remembered (when too late) that two of my male patients have recently been completely cured of by removal of the appendix.

Patients themselves like the gloves, because they slip in more readily than the bare fingers, and one commented that I had not scratched her.

The greatest enemies were the neighbours, who declared unanimously against the innovation, one admitting that she had not sent for me "because Dr. Gregson is so faddy"; another asking if I was afraid of blood; but the most annoying incident was the setting out of the report that a certain patient must have had syphilis, or gloves would not have been used, after which I put up a notice that an extra charge of 2s. 6d. would be made for rubber gloves.

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

PRIMARY EPIDIDYMITIS IN MUMPS.

On the evening of April 16th, 1909, I saw a youth, aged 18 years, lying in bed and complaining of a pain in the right testicle. This on examination proved to be due to epididymitis, the body of the testicle being quite sound. The temperature was 99.4°, and the history of the onset quite sudden and non-traumatic.

There was no urethral discharge or scalding, nor had there been any; the boy (a country lad) denied any sexual history, nor was there anything about the meatus urinarius to cause me to doubt the truth of his statement. I recommended supporting the testicle on a pillow covered with mackintosh, and hot fomentations, giving at the same time a saline purge. The next day the true nature of the case revealed itself. The left parotid swelled out in the typical way, and also the right submaxillary gland. The temperature rose to 103° and a little over. The body of the testicle began to swell the following day. In about ten days the fever and swelling subsided, and salivary glands and testicle resumed their normal appearance.

The unusual feature of the case is the primary manifestation in the epididymis. The so-called metastatic orchitis frequently precedes mumps, but in no case can I find a record of the epididymis taking the lead. The testicular manifestations are almost invariably unilateral and are frequently followed by atrophy of the gland, which fortunately did not occur in this case.

Whittlesey.

J. J. WADDELOW, F.R.C.S. Eng.