half an inch from its raw edge, and the velum is cut through with a sawing motion of the blade upwards, as far as the commencement of the bony palate. A similar incision is made on the other side." He then goes on to say that the palate after this hangs down like a damp curtain, and that "the lateral incisions appear as a pair of large oval openings, through which one or two fingers could be passed." On the other hand, Mr. Pollock's plan for the division of the levator palati consists in simply passing the knife through the tissue of the soft palate by a mere puncture, and pressing its edge against the upper surface of the velum, so as to divide the fibres of the levator (which lies above the tensor), but without in any manner interfering with the integrity of the rest of the tissue. Thus, after division of the levator palati by this method, nothing is seen on the oral surface of the velum, except a minute puncture; and the risk to nutrition, which must be involved in the sweeping incisions of Dieffenbach, is quite avoided. The plan is a simple one, and very effective, as I can personally testify; but Mr. Fergusson has apparently found such good results from his own method that he has not thought it worth while to make himself acquainted with it.

We will conclude this notice of Mr. Fergusson's lecture by extracting the passage in which he endeavoured to explain his reason for preferring the recumbent position.

"As to attitudes in this operation, the patient may sit or lie, as may best suit convenience. Latterly, I have made most use of the recumbent. I find that the head can be kept best on the same line in this position; and as regards my own views on the anatomy and physiology of the parts concerned, I deem the subject of some importance. For instance, if the patient sits with the head slightly thrown backwards, the palato-pharyngei, when irritated, pull the soft palate downwards towards the epiglottis, so as to leave a space between the palate and the base of the cranium; but if the head be thrown far backwards, the axis of action is altered, and these muscles draw the soft parts upwards, or, in other words, bring the soft palate towards the base of the cranium, and thus add to the difficulties of the surgeon by limiting the space above the soft palate where he has to work with the needles in introducing sutures. Here, as in hare-lip, the surgeon has generally stood before his patient, but I invariably select his right side in preference to all other places."

Such were the main points which struck us in what Mr. Fergusson said about hare-lip and fissured palate. The impression which was left by the lecture on the hearers' minds must, we think, have been that Mr. Fergusson's experience in these operations has been very large, and his success beyond that of most surgeons; that as far as hare-lip is concerned this success must be due entirely to operative skill, while in staphyloraphy, Mr. Fergusson is justified in claiming the introduction of myotomy into the operation, an original and very happy suggestion.

NAVAL AND MILITARY HOSPITALS. Haslar costs about £14,000, and Netley Hospital about £12,000, a year.

UNIVERSITY COLLEGE, LONDON. At a session of the Council held last Saturday, a vote of thanks was given to the Hon. Rustumjee Jamsetjee Jejeebhoy, for a donation of £1,000 to the hospital. The title of Fellow of the College was conferred on the following former students of the College, who had graduated in medicine with honours at the University of London: C. H. F. Routh, M.D.; W. Roberts, M.D.; G. Buchanan, M.D.; and T. Hillier, M.D.

Lettsomian Lectures

ON

MIDWIFERY AND DISEASES OF WOMEN.

Delivered before the Medical Society of London.

BY

C. H. F. ROUTH, M.D.,

PHYSICIAN TO THE SAMARITAN HOSPITAL FOR WOMEN AND CHILDREN.

LECTURE III. (*Continued.*)

THE TREATMENT OF FIBROUS TUMOURS.

II. SURGICAL TREATMENT. The surgical treatment of fibrous tumours is one which requires greater consideration, and to which we must have recourse in many cases, as the tumours, if left to themselves, prove fatal. This may be of two kinds: 1. Enucleation of the tumour; 2. Removal of the tumour by Gastrotoomy.

1. *Enucleation.* My labours on this point have been considerably lightened by the papers of Mr. Hutchinson, published in the *Medical Times and Gazette* for 1857, regarding which it is difficult to state to which part of the subject so graphically described by him the greatest merit is due; whether to the collection of cases, and the succinct manner in which he has detailed them, or to the practical emphatic conclusions to which he has attained. His results were founded upon thirty-nine cases, in which enucleation was practised. To these, I have added twenty-one cases. It is upon these sixty cases that my observations will be founded.

The operation for the removal *per vaginam* of fibrous tumours will be best considered under two heads: 1. Primary enucleation, where the enucleation has been completed at the time, or within a day or two; 2. Enucleation by inducing gangrene—*i. e.*, when part has only been performed, and death of the tumour has been induced, which thus comes away with sloughing. I shall follow the same order, only I shall speak of incision of the os and tumour as a means of cure, and removal by gastrotoomy, as a third division.

Primary Enucleation. Mr. Hutchinson enumerates eighteen cases under this head. Of these, twelve recovered, or 66.7 per cent. In nine cases out of twenty which I have added, primary enucleation was performed, and followed by recovery in all but two. The principal rules laid down by Mr. Hutchinson are: 1. The tumour must be well depressed into the pelvis by an assistant. 2. The first incisions must be very free, and pass deeply down into the tumour; thus not only completely dividing the capsule, but facilitating its bisection, should that afterwards be found requisite. 3. The opened capsule must be separated by the fingers, or, if needful, by blunt-pointed scissors, the finger being used as a director. Strong and large vulsella, with midwifery forceps, should be at hand; to be used for traction, if necessary. 4. The grand object is to draw down, after separation of the tumour, the uterus inverted with the tumour to the external parts, or as near as possible to them, which facilitates the operation. 5. After eversion has been completed, an examination should be made with the finger, also *per rectum*, etc.,

TABLE I.—Cases of Fibrous Tumour of the Uterus for which Enucleation was practised.

No.	Operator and Locality.	M. or S.	Age	Previous History.	Size, Weight, etc.	Steps of Operation.	Immediate effects and after progress.	Final Result.	Remarks.
1	I. B. Brown. <i>Braithwaite</i> , 43, 318. London Home, 1850.	S.	35	Sickness, pain, floodings, of seven years' duration.	Intrauterine.	Os first incised. Three minutes afterwards a piece gouged out.	Suffered little. Tumour broke up. Dysmenor. wh. ceased 1860.	Recovered completely.	..
2	Ditto. <i>Ibid.</i> p. 219. Ditto, 1859.	M.	30	Hæmorrhage, quite anæmic, tonic and styptic treatment. May 27, losing blood freely.	Intrauterine. Fibrocystic.	July 5th. Os first incised; no bleeding subsequently. 26th. Tumour broken down with sharp scissors.	Tum. lessened. Offensive discharge. Sympt. of pyæmia in August.	Dec. 10, left Home relieved much. Tumour smaller.	..
3	Ditto. <i>Ibid.</i> p. 320. Nov. 1859.	S.	46	Hymen imperforate, intact.	Intrauterine. Duration 12 years. Size of a 6 months' fetus.	Nov. 19. Os divided, and tumour found embedded in left side of uterus as low as os internum. Capsule cut through; a piece gouged.	Little hæmorrhage. 20th. Rigors. Pyæmia.	Died. Pus in pleura.	Supposed due to having gouged and bkn. dn. hymen at same time. Died 29th. No P. M.
4	Dr. T. Robertson. <i>Path. Trans.</i> , xi.	..	50	Tumour growing five years. Began to protrude from labia, giving rise to much pain and flooding.	Found in vagina. Os not to be felt. mass seemed to extend above it.	Sept. 27th, 1860. A portion removed from vagina. Enclosing membrane bled freely, but not the tumour. After some days, another examination discovered os. On 17th Nov. whole mass removed by pulling. Os seemed to give way, and tumour came out.	At first favourable. Os found open; smooth piece of mucous membrane projecting as if tumour was attached there.	Rigors, 25th and 27th.	
5	Dr. J. Hall Davis. <i>Obst. Trans.</i> ii, 17.	W.	51	Once pregnant. Uterine hæmorrhage. Retention of urine. Cervix obliterated. Adhesions to anterior wall of uterus.	Intrauterine. Sound penetrated 4 to 5 inches.	Half lower portion enucleated 1st day. 2nd day whipcord applied with Gooch's cannula around separated portion. 3 days after, by much traction and manipulation, entirely removed.	Sickness, supposed due to chloroform. No hæmorrhage. Part of tumour putrefied, but greatest part removed.	Recovered.	..
6	Dr. F. Hinkle, <i>Amer. Journ. of Sciences</i> , 1856, 53, 365.	..	64	General fever, cramps, irritable bladder, bearing down pains almost continuous. Tumour resting on sacrum.	Sound penetrated 2½ inches. Tumour in posterior wall of vagina extending to uterus.	Post. wall incised. Tumour exposed. Ergot given. 5 days afterwards bistoury again used. 15th. Operat. repeated; about ¾ of tumour removed. Desisted from faintness of patient. 22d. Tumour entirely removed in two parts by tenaculum.	Bearing down pains increased. No hæmorrh. Metritis for 17 days after 1st operation, followed by diarrhœa.	Died from enteritis.	..
7	Alex. Ramsey. <i>Gaz. des Hôpitaux</i> , 1859, 290.	..	27	Primipara in labour; waters burst; placenta det., came agst. a body; semi-elastic tum. on ant. wall; punct. without result; next day from trochar op. tum. could be felt.	Parietal.	Trochar opening enlarged. Posterior tumour could not be detached. Next day, ergot being given, the remaining fibrous band cut with hysterotomy.	Fœtid discharge for several days. Tumour came away fourteenth day with some bleeding; after this, all favourable.	Recovered.	..
8	Alexis Moreau <i>Bulletin de la Société Anat.</i> xxv, 364.	..	..	Reg. up to preg.; deliv. of a living child; uterus aft. deliv. still large, sup. to be another child; 9th day aft. deliv. a sac gave way internally, exit of bloody serum up to 13th day; then great lochial flow.	15th day Professor Moreau called in, and recognised a fibrous tumour as large as a head.	Enucleation performed on three-fourths of tumour. No result. Next day repetition: desisting by reason of syncope in patient. At night, tumour having descended, is extracted.	Great relief at first, then fever returns, with faintings, etc.	Death 3 days after operation.	..
9	M. Marce. <i>Ibid.</i> p. 446.	S.	50	Large abdominal tumour felt in median line. Hæmorrhage. Leucorrhœa. Marked anæmia.	On examination, os open size of 5-franc piece, thro' which finger came on tumour. Tumour not adherent then. No pedicle.	M. Velpeau incised cervix on both sides; extr. tumour by pincers without much difficulty. Extr. part of inf.; vagina had to be cut to let out tum'r, which was large.	..	..	..
10	M. Parmentier. <i>Ibid.</i> xxix, 208.	..	51	Symptoms of uterine engorgement called for treatment twice at intervals of 11 years; last year uterine hæmorrhage supervened.	Tumour projecting from os, between mucous membrane and uterine walls; size 25 centimet. by 26.	Drawn down by forceps. Mucous membrane cut. Tumour enucleated with fingers and spatula, but owing to its large size removed in pieces.	Cold compresses applied; slight bloody discharge for a few days.	Recovered.	..
11	M. Berard. with Amussot. <i>Ibid.</i> xvi, 82.	..	..	Long continued menorrhagia.	Tumour parietal, anterior wall.	Transverse incision to enlarge os; also longitudinal on ant. lip. Enucleation now practised on exposed tumour, then left, and ergot given.	Action of uterus insufficient; became weaker.	Died of Peritonitis 3 wks. aft. op. P. M. Perit. adhesion of tumour to uterus very close.	..

TABLE I—continued.

No.	Operator and Locality.	M. or S.	Age	Previous History.	Size, Weight, etc.	Steps of Operation.	Immediate effects and after progress.	Final Result.	Remarks.
12	Amussat. <i>Annales de Chirurgie</i> , v, 192.	..	54	Severe menorrhagia; a fibrous tumour in anterior wall.	Size of an ostrich egg, weighing nearly 14 oz.	Anterior lip incised. Tumour extracted by a rotatory motion by pincers.	..	Recovered.	..
13	Chaubart. <i>Ibid.</i> v, 335.	M.	50	Multipara; retention of urine 24 hours; abdomen large; catheterism impossible; uterus reached 4 inches above pubes. Cervix not to be felt.	Large tumour filling pelvis; had passed cervix; this pushed up, and urine drawn 1 litre; violent labour pains; no advance: wgt. found to be 2½ kilog.	Pulled down by pincers, and brought down to vulva; a few days afterwards excised.	Slight bleeding checked by acidulous drinks.	Recovered.	..
14	Langenbeck. <i>Deutsche Klinik</i> , i, 1859. <i>Quart. Rev.</i> xxiv, 553.	M.	35	Two children; now in labour; severe flooding; tumour descended after 3 days' labour in vagina, mistaken for head of a child.	Pains ceased and patient became collapsed; tumour in cervix and anterior wall.	Entire part of exposed tumour beyond vulva incised. Under layer so cut, white fibrous mass appeared, which could be easily separated both by finger and scissors.	Hæmorrhage slight. Dead child extracted immediately afterwards. General collapse.	Died following night.	..
15	Langenbeck. <i>Ibid.</i>	..	37	Profuse menorrhagia; Nov. 26, very anæmic; os uteri high up, op.	Tumour as big as an egg; post. wall and cervix; anterior wall thin.	After eight days' attempt to expand os, tumour extirpated.	Bleeding very slight. Two ms. after normal catamenia.	Recovered.	..
16	Ditto. <i>Ibid.</i>	M.	35	After two normal labours and one miscarriage, menorrhagia; anæmic.	Tumour intrauterine, size of fist. Post. lip doubled in size, ext. to post. cervical wall. Ant. lip thin, through which a tumour size of egg is felt, projecting 1½ inch into rectum.	Extirpation practised. Difficult and long, tumour being nowhere distinctly bounded, and everywhere very resisting.	Slight bleeding at first followed by supuration from the uterus for 5 months.	Recovered.	..
17	Kiswisch. <i>Klinik Vorträge</i> , Bd. i, 8, 571. <i>Deutsche Klinik</i> , Jan. 1, 1859.	..	..	..	Size of a hen's egg; situated in anterior wall.	Operated two days after admission.	..	Recovery 10 days after operation.	..
18	I. B. Brown. Communicated	M.	35	Sterile; married 13 months; increase of pain and size last 9 months; menstruat. every 14 days; flooding; great anæmia.	Enormous tumour, occupying whole uterus.	Os and cervix incised Feb. 27. Tumour subsequently broken up March 27.	After incision of os, no bleeding; After 2nd operation, fetid discharge, with gradual diminution of tumour.	Recovered.	..
19	Ditto. Communicated	S.	..	One year ago, menorrhagia began; constant for last six months; tumour enlarging; extreme anæmia; os very high up.	Intrauterine fibrous tumour, as large as the head of a 9 months' child.	Os and cervix incised Feb. 27. Tumour broken up March 20.	Gradual decrease of tumour; menstruation normal.	Recovered.	..
20	M. Borlée. <i>Presse Médicale Belge</i> , 33, 1863.	S.	47	Regular; 3 years ago, got a blow from the horn of a calf; from this time menorrhagia and yellow leucorrhœa; very anæmic; micturition impossible, except on raising abdomen.	Tumour size of fist felt through a very narrow vagina; abdomen as large as at full period of gestation, ext. 3 in. above the umbilicus. First part removed weighed 1250 grammes.	First oper. attempt to remove with forceps failed. Then enucleated in part with hand; large portion like placenta removed. 30 days after 1st operation removed remaining portion of tumour now in vagina.	Favourably for 10 days aft. op., then pyæmia, death imminent. Treated with quinine intern. and chlorine injections; got better in 30 days. After 2nd operation, not one bad symptom.	Recovered.	..
21	Dr. Storer. <i>Bost. Med. and Surg. Journ.</i> 55, 101.	..	60	Menstruated at 13; catamenia ceased 10 years since; recurred with menorrhagia 4 years since threatening a fatal issue.	..	Ergot given & sp'ge tents appld. Tumour p'sent'd. Ecraseur attempted to be appl'd but fail'd owing to broad attachment of tum'r, chain slipping & finally breaking. Tumour now crushed by litho. forceps, & then as much rem. as poss. by Simpson's p'tome	Bleeding rather free, but arrested by plugging.	Recovered 52 days aft. operation.	..

so as not to cut through an inverted pouch of peritoneum in separating the final attachments of the uterine tumour. 6. The uterus is then returned. Ice, ergot, stimuli, etc., are to be given as indicated by the symptoms.

The views here epitomised are so very much in accordance with common sense and sound surgery that I do not wish as a whole to controvert them. To one point only of these I would take exception. I do not believe that the grand object is to draw down the

inverted uterus after separating the tumour, so as to bring the tumour as near as possible to the external parts, because this renders the operation easier.

It cannot be doubted that simple traction of the uterus will often suffice to determine inflammation in and about the peritoneum around the organ. In the fatal cases of enucleation, death seems to have been due to phlebitis or peritonitis. Upon this practical point we can learn a lesson from the experience of

practitioners in the removal of *polypi*, as a rule, a far easier operation if the uterus be pulled down.

One case is mentioned by M. Gaubrie (*Bull. de la Soc. Anat.*, vol. xvii, p. 209) where a polypus, supposed to be attached to the cervix (but found after death to be attached to the fundus), was pulled down forcibly. The pedicle yielded and it came away; yet that patient died from latent peritonitis. After death, the uterus was found healthy; but pus was found in the pelvis. Another case is mentioned by M. Demeaux (*Ibid.*, vol. xviii, p. 41) in which an enormous polypoid growth filled the cavity of the uterus. It was pulled down to the vulva, removed, and the parts replaced. There was no bleeding. Peritonitis followed, and death two days subsequently. The *post mortem* examination revealed pus in the pelvic cavity. No uterus could be found in the pelvis; but a puckering and sunken-in portion, within which the ovaries and a vaginal tumour, which was the inverted uterus, were found. This inversion, it is true, was supposed to have been the result of the weighty polypoid growth before traction had been employed. Yet death from peritonitis was the result of the operation. A more remarkable case, however, is quoted by M. Pigné (*ibid.*, vol. xiv, p. 11). This was a polypus as large as a fist, which was taken from a dead woman. During life an attempt was made to remove it; but the finger being first introduced within the rectum, no uterus could be felt. All extraction was now stopped, on the supposition that the tumour was an inverted uterus. Peritonitis and death followed. The *post mortem* examination revealed a pediculated polypus within a very small and anteverted uterus. No injury whatever of the peritoneum had taken place. The traction alone produced the peritonitis. Dr. Greenhalgh has informed me of a case which he saw at Würzburg, where the mere traction of the uterus downwards produced peritonitis and death.

In the recorded cases of enucleation, where traction is mentioned particularly as having been made, the results may be referred to two heads; viz., where the uterus or the tumour was pulled down by fingers, a string, or other violent means; and, secondly, where this was done by forceps. The result in the two cases is very different. Of eight cases, in all but two of which the operation was that of primary enucleation—one being secondary, the other failing altogether—in three, the uterus was for the time completely inverted. Three cases died; in one of these, eversion had occurred; in another, forcible attempts were made to pull down the uterus, which failed.

In eight other cases, in all of which but one (where the operation failed, although the tumour sloughed away afterwards) the operation was primary enucleation, and the forceps were used, no deaths occurred. In two, the uterus was inverted. In two cases, it was the uterus which is stated to have been pulled down by the forceps. In the remaining six, it was the tumour which was so drawn down. All did well, except one patient, who had phlegmasia, and whose convalescence was not established till two months. All the tumours, however, where it is stated, were small; except in the patient who had phlegmasia, where it was large; and in another, where the tumour weighed eighteen ounces, and the diameters were four inches by six.

Was this difference in the result due to the better regulated traction which can be exerted by a forceps, or to the better direction given by it? Probably,

where the forceps were used, the tumours were low down in the true pelvis, and so easily included in them. Short forceps were used in every case; and, therefore, it would seem that the traction was less forcible. Whenever these were used, the results were more satisfactory. The fact is indubitable. Still, it seems difficult to say to what cause the occurrence of peritonitis is due, where it so occurs; when we know that in very many other cases, where traction is employed, it does not occur.

In explanation, I have but three suggestions to make. In cases of retroversion, I have never seen peritonitis follow traction, to restore the organ to a straight direction, so as to allow the admission of the sound. Is it because in these cases the peritoneum is no longer in its normal state, already changed by the very unusual disturbances to which it has for some time past been subject? This is certainly true in many cases of ovariectomy, where numerous adhesions exist. Secondly, peritonitis, and accidents of like nature, are rare, if our patients have been well purged and prepared by remedies before operation; a precaution which, in the case of polypoid growths, is often neglected. Will this explain the difference? Thirdly, there is doubtless, in some cases, idiosyncrasy and a predisposition to peritonitis.

The practical conclusion, at any rate, to be deduced is, that the very traction which is necessary in these cases is often in itself a source of danger and a cause of death; and therefore, if possible, it should be avoided.

Enucleation by the Induction of Gangrene, or *Secondary Enucleation*, as it is called, is a much more tedious operation. Out of fifteen cases mentioned by Mr. Hutchinson, nine recovered, or 60 per cent.; and six died, or 40 per cent. In my table, of ten cases, in one the result was not stated. Of the remaining nine, four died, or 44.4 per cent.; and five recovered, or 55.6 per cent.

Mr. Hutchinson has concluded that, if other unpublished cases were taken into the account, the results of the two modes of operation would be identical. The above figures, however, so far as they go, prove that enucleation by the induction of gangrene is positively less fatal than primary enucleation. Is this due to the traction which is employed being less marked?

The modes in which this operation has been practised have been various. The French method consists in using the knife, in most cases without the use of ergot at all. Dr. Atlee's consists in using, in the first place, ergot in repeated doses, so as to influence the uterus to contract and forcibly eject the tumour. Then the incision is made through the capsule, the ergot being continued, and the tumour gradually separated from the cyst by the finger, cutting, by the knife or scissors, any adhesions which may interfere with such separation. This is continued from time to time; the tumour in the meanwhile sphacelates and comes out by pieces, until the whole has come away, or what remains is capable of enucleation and removal. There can be no doubt that Dr. Atlee's method is an improvement upon that of the French school. It provides a *vis a tergo* to assist the operator.

Again, Dr. Atlee does not limit his operation of enucleation to the *uterus*. In several cases where, from the size of the tumour or its position low down in the pelvis, while the uterus is high up or difficult

to reach, and in cases of extrauterine fibroid, which occupies similarly a true pelvic position, he does not hesitate to cut right through the *vagina*, so enucleating the tumour. This he performed in several cases; and, so far as I know, he was the first to attempt this mode of procedure.

In estimating the degree of mortality due to enucleation by the induction of gangrene, we learn again a lesson from what occurs in some cases of polypi, which are tied and allowed to slough away.

The experience of Drs. Robert Lee and McClintock gives the following numerical results of cases in which the ligature was applied.

	Cases.	Deaths.	Per cent.
Dr. Robert Lee.....	20.....	9.....	45
Dr. McClintock	10.....	3.....	30
	30	12	40

And, no doubt, with a large sloughing mass in the vagina, exposed to the air and putrefaction, the absorption of putrid pus is a natural result. The same is true with regard to the fibroid within its cyst, only to a greater degree. In the case of the polypus, we have merely mucous membrane, which is our absorptive surface. In the case of the enucleated fibroid, we have a raw ulcerated surface of the cyst, that part which is the vascular part of the tumour, and therefore eminently absorptive, ready to take into the system the vitiated pus. The surprise is that, in such cases, recovery ever occurs. Fortunately, the *vis medicatrix nature* is often powerful enough to accomplish it. It is for this reason that I think Mr. Brown overrates the beneficial results of his modification in the operation, in first incising the os and allowing it to heal before he proceeds to gouging or enucleation. It is of use, doubtless, as it removes one additional source of absorption; but others remain.

The practical lesson which is taught by these remarks, is the necessity of frequent injections and washings with disinfectants, and obviating the production and long contiguity with ulcerated surfaces of effete and putrid matters.

Enucleation by Gouging, and inducing gangrene subsequently, is a modification of Mr. Brown's.

The instrument which he uses I now show you. It has already been exhibited before this Society, and, therefore, need scarcely detain us long. It was originally devised by Mr. Philip Harper. It consists of a hollow tube of steel with cutting knives. Contained in this tube is a hook, which can be pushed up by a spring, and thus grasps the tumour, whilst circular knives are carried through by means of a screw. In this way, a piece can be actually cut out of a tumour much in the same way as the central piece is cored out of an apple.

In the *Obstetrical Transactions*, Mr. Brown has published several cases exemplifying this mode of treatment. I may remark, however, that it is restricted by him to *intrauterine fibrous tumours of the non-pedunculated form*, growing from the inside of the uterus from a broad base. Mr. Brown has given us four cases in which he gouged in this manner. In three, a cure followed; but in one, the operation led to a fatal result. This death he attributes to the absorption of putrid pus through the cut edges of the cervix, which was previously laid open to expose the contained tumours. Hence, at present, his mode is in the first place to lay open the cervix, and to wait two

or three days, or longer, till this has healed, before he proceeds to gouge.

The method pursued after the gouging, is to plug up the hole thus made by oiled lint, to arrest hæmorrhage and provoke sloughing of the tumour.

In three of his published cases, however, the tumours were not gouged. In one, the tumour was broken up by a pair of sharp scissors.

I may say that, through the kindness of Mr. Brown, (who has given me the notes of several of his cases, even hitherto unpublished), I know of two more examples in which, after the incision of the os, the tumour was broken up by scissors; in all of which recovery, in one case disappearance of the tumour, followed.

But a method which is likely to supersede in great measure these more bloody operations, is simple incision of the os, subsequently carried right through a portion of the tumour.

A published case of Mr. Brown, given in the *Obstetrical Transactions*, vol. iii, p. 76, is, however, peculiarly interesting, as the cure was open to ocular inspection, a piece of good fortune not always met with.

This was the case of a single woman, in whom, some seven years previously, he had removed from the os uteri a fibrous growth of about the size of a walnut; and in whom, at the time of the second operation, he had distinctly made out three fibrous tumours just within the os and projecting into the vagina. The os and cervix were freely cut open; and then each of these tumours was deeply cut into; the cut surfaces being dressed with oiled lint, and the vagina plugged. All these dressings were removed in forty-eight hours, and the vagina daily injected. A month afterwards, two out of the three growths had entirely disappeared, and the third was reduced to half its size.

In two other unpublished cases furnished to me by Mr. Brown, the same result was as conclusively observed. I do not dwell on these, because they are as yet unpublished. Altogether, he has mentioned to me ten cases in which this simple plan of incision of the external os was practised with the best results. As these are, however, only a few among several which will shortly be made public, I only ask you to wait and judge for yourselves.

Here we have, then, a practical lesson taught us. The mere incision will suffice to cause the absorption of the tumour. It is a lesson thus taught, from which Mr. Brown appears himself to have profited, as I now learn that in most cases he no longer gouges, but makes free incisions. The plan is safer. Sloughing in the tumour is thus set up, and this is disintegrated, and diminishes in size, and finally disappears.

The treatment which I have pursued in the Samaritan Free Hospital, where the tumour could be reached from the external parts twofold, has been the following: Sponge-tents from time to time; scraping the mucous membrane; and injecting iodine solution or the tincture of sesquichloride of iron. It is not in every case thought necessary to cut open the os.

In April 1861, I employed this method on a woman, aged 43, who suffered from menorrhagia induced by a large fibroid. This filled the pelvis, and was situated in the posterior wall. The os could be felt high up behind the pubes. The sound penetrated about

three inches. The os was dilated. An attack of peritonitis supervened; from which, however, she recovered well. She left the hospital relieved, feeling much better, and conscious that the tumour had diminished in size.

The supervention of peritonitis, after even so simple an operation as opening the cervix, should here be borne in mind in estimating the mortality. Mr. Brown has lost three out of the ten mentioned. I have known of two cases of death from the same cause, and several in which peritoneal symptoms supervened, but were happily successfully combated. Patients seem also liable to peritonitis for some time afterwards. In a case of flooding from a fibroid, a free incision through the os and tumour was followed by the most satisfactory results, both in stopping the hæmorrhage and reducing the size of the tumour, and the patient returned apparently cured to her own home; but in a few days subsequently peritonitis set in. The *post mortem* examination revealed cellular abscess, which had burst into the peritoneum.

We must, therefore, be prepared, even in so simple an operation as the mere incision within the tumour, for accidents. Upon the whole, however, if we bear in mind that the tumour, if once wounded, will not heal, and must undergo partial sloughing or absorption, it is clear that an incision, if performed within prudent limits, is equally as efficacious as the gouging or breaking down of the tumour. These limitations must, however, be attended to. A series of small and successive wounds will produce less constitutional disturbance than one large one. Between the operations, the patient has time to rally and gain strength. The operations may not be so grand and striking; but they are safer for our patients, and this, after all, is the great end of every surgical interference.

Another point, however, has to be touched upon. In my second lecture, I spoke of the difficulty of making a correct diagnosis of the exact position of fibroid tumours, if high up above the true pelvis. It is true, that I then pointed out to you how, by the pelvimeter, you might often make out the diagnosis more correctly. Still, if the cavity of the uterus be short, if the bladder do not extend high up, if the rectal examination be not satisfactory—then the diagnosis must be obscure; and you may, by incising the os, get into the peritoneum, as occurred in one case I then mentioned. There is another disadvantage, also, which will at once strike you from what has been before said; that, in attempting enucleation in a case where the fibrous tumour is above the true pelvis, and not easily reached from below, the traction exercised to bring it down must of necessity be more forcible, and the risk of the operation proving fatal by peritonitis following the traction be greater. Any attempt, therefore, at enucleation in such cases must be very doubtfully determined upon, and even mere incisions very carefully made, lest the peritoneum—of the posterior or anterior *cul-de-sac* especially—be wounded.

[To be continued.]

MORTALITY AMONG PHYSICIANS. Five members of the resident medical staff of Bellevue Hospital, New York, have paid the forfeit of their lives, and ten more have barely escaped death, since the 1st of May last, from fever, contracted in the discharge of their duties.

Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

ROYAL PORTSMOUTH, PORTSEA, AND
GOSPORT HOSPITAL.

TWO CASES OF NECROSIS OF THE BONES OF THE
GREAT TOE, TREATED CONSERVATIVELY
WITH SUCCESS.

CASE I. F. F., aged 52, was admitted November 10th, 1863, under the care of Dr. Page, with necrosis of the bones of the great toe. There was a fistulous opening and considerable enlargement; the fleshy parts were otherwise in a healthy condition. The patient was unable to walk on the foot. The operation was as follows. An incision was made in the track of the diseased bones, and another across the metatarso-phalangeal articulation; the first phalanx was removed with a forceps, and the head of the metatarsal bone nipped off. The wound was brought together with sutures, and water-dressing applied. The patient was discharged cured in twenty-one days.

CASE II. H. G., aged 54, was admitted March 1st, 1864, under the care of Mr. Porson, with partial necrosis of the phalanges of the great toe and the head of the metatarsal bone. The operation and result were the same as in the previous case. The patient was discharged cured in twenty-six days.

These two cases are interesting as examples of conservative surgery. Mr. Fergusson, in his second lecture at the College of Surgeons, alluded to one or two cases where the thumb or finger was saved; and a case is reported in the *Lancet* of June 4th last, at the West London Hospital, of partial necrosis of the phalanges of the forefinger, under the care of Mr. Teevan; several pieces of dead bone were gouged away, and an useful finger was the result. In both the cases treated at the Portsmouth Hospital, though the first phalanx of the great toe was removed, with the head of the metatarsal bone, no lameness followed. The patients, both labourers, are now following their usual avocations, doing heavy work. A short time ago, amputation would have been performed in both cases.

Original Communications.

FOREIGN BODIES ON THE SURFACE OF THE EYE: THE SUBSTANCE OF A LECTURE.

By HAYNES WALTON, F.R.C.S., Surgeon to the
Central London Ophthalmic Hospital,
and to St. Mary's Hospital.

GENTLEMEN,—You will not long be in practice before being called on to exercise your skill in the removal of substances from the eye. From the commonness of the accident, you cannot escape an application. The frequency of it, and the pressing necessity, causes the aid of non-professional persons to be sought.

The nature of the injury varies from the most trivial and temporary inconvenience to consequences