taken to be an advantage on the strength of Mr. Fergusson's authority, which, in matters of operative manipulation, must surely be supreme.

But a much graver and more uncertain question connected with Mr. Fergusson's method of performing lithotripsy is, whether he is right in recommending the instant removal of the *débris* in cases of crushing a stone of large size. We should remember that, in this case, the fragments are of uncertain size (for, after all, the width of the opening of the lithotrite only shows one diameter of the fragment); their angles are fresh and sharp; and the bladder has perhaps already borne as much manipulation as is prudent. Further, we should remember that (with the exception of the small shank of Mr. Fergusson's scoop) this is the method which was originally adopted, and abandoned on account of the pain, laceration of the urethra, and after-complications which ensued. It would, perhaps, be invidious to quote one author against another; but it is allowable to say, in general terms, that lithotritists of the largest experience, who have had ample opportunities of knowing the minutest particulars of Mr. Fergusson's system of manipulation, still avow their preference for the plan of awaiting the spontaneous expulsion of fragments. Evidently, therefore, the question resolves itself into one of experience; and, as to Mr. Fergusson's experience, his expressions were rather more vague than we could have wished. He said:

"In the last sixty cases I have adopted this practice generally, and, with few exceptions, have had every reason to be satisfied. Occasionally, when over-anxious for a rapid cure, I have extracted fragments rather too large to come readily along the urethra, particularly in the prostatic or membranous portion, or at the triangular ligament. In some, when the urethra nearest the neck of the bladder has been rather roughly used, there has been considerable irritation; in others, even under such circumstances, there has been no irritation whatever; and in many instances I have been able to effect in one or two operations within ten days what, according to custom, would take weeks, or possibly months. I have done, in fact, by a precise surgical manipulation, that which according to ordinary rule is left entirely to chance. Experience has taught me that it is almost hopeless to trust to chance in all such cases; that in many instances the fragments may be weeks, or months, in coming away, even with attempts to coax them through catheters with large eyes and other instruments devised for the purpose. Here are the fragments of stone crushed in a man whose bladder acted regularly, yet only a few of these passed spontaneously; all the rest were removed by the scoop in question in three or four operations. From first to last there was not a single bad or even troublesome symptom. The patient was detained scarcely an hour in bed beyond his regular period of rest. I never saw one suffer less distress; yet, before he came under my notice, he had been strongly urged by an eminent surgeon to submit to lithotomy."

If Mr. Fergusson had preserved such notes of his cases as would have enabled him to say precisely in how many cases he had removed the *débris* at the time of operation, how many of these had had troublesome symptoms, what these symptoms precisely were, and what were their results, it would have been more satisfactory, and would have put us in a better position to draw a comparison between his method (or rather his revival of the old method) and that which is in more general use. What struck us, after hearing what Mr. Fergusson said on this matter, was, that if a patient with stone were fortunate enough to be in Mr. Fergusson's hands, he might perhaps have his cure somewhat accelerated (though

probably at the risk of increased suffering at the time of operation) by this plan of removing the fragments; but that, if he had fallen into the hands of some less ingenious manipulator, he would be lucky if his surgeon were not in so great a hurry to send him away cured. In fact, we could not repress a latent suspicion that the old adage of "*Festina lente*" might, after all, express the better policy.

Lettsomian Lectures

ON

MIDWIFERY AND DISEASES OF WOMEN.

Delivered before the Medical Society of London.

BY

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LECTURE III. (Continued.)

THE TREATMENT OF FIBROUS TUMOURS.

2. *Treatment by Gastrotomy.* I have now to speak of another mode of cure; viz., *gastrotomy*. At the outset, I may say that, in the consideration of the cases in which this operation has been had recourse to, we labour under three disadvantages. 1. Several cases, I know, have been unpublished; and, therefore, the instances quoted fall short of the actual number of examples that have occurred. 2. The records of these cases are by no means full. The details are often so meagre as to leave little room for philosophical deductions. 3. It is possible, on the other hand, that I am exaggerating the number of examples, and that the same cases are repeated. This was undoubtedly so with one of Dr. Clay's cases; which that gentleman, however, kindly explained to me. In Atlee's cases, again, it is just possible that this source of error exists. In such instances, however, the mistake is due to the imperfect records and disagreements between them, more especially in regard to dates of recovery, of death, age, married or single state, size, weight of the tumour; in which particulars the records, otherwise resembling each other, disagree.

Altogether, gastrotomy for fibrous tumour has been performed forty-eight times. In fifteen cases, however, the tumour, either in whole or in part, was not removed. In the remaining thirty-three, the entire or part of the tumour was removed. This *resumé* admits at once of division into two classes.

1. The cases of uterine tumour in which gastrotomy was performed, and extirpation not completed, were fifteen. These include four of Dr. W. L. Atlee, one of Dr. Cutler, one of Mr. Lane, one of Mr. Lizars, one of Dr. R. D. Massey, one of Dr. N. Smith, one unknown, one of Mr. Walne, one of Dr. Deane, and three of Mr. I. B. Brown. (See Table II.)

In five of these, the exact locality of the tumour is not given: two were fibrocystic; one extrauterine; one a double example—i.e., intrauterine and extrauterine; six parietal, one of these last being combined with pregnancy.

Of these fifteen cases, eight recovered from the operation. But, of these, three subsequently died; one six months afterwards, from erysipelas; another seven

TABLE II.—Cases of Uterine Tumour in which Gastrotomy was performed, and Extirpation not completed.

No.	Operator and Reference.	Age	Previous History, etc.	Steps of Operation.	Progress.	Final Result.
1	Dr. W. L. Atlee, Philadelphia. <i>Am. Journ. of Med. Sci.</i> , April 1855. Clay's <i>Kivisch</i> , Table iv.	33	Single. Tumour noticed four years ago, since which irregular. Tapped, and blood only escaped. Uterine sound passed two inches and a half only.	Operated May 22, 1849. Incision from umbilicus to near pubes. A syphon tent placed in lower part of wound. No adhesion. Wound united by interrupted and twisted sutures.	Recovered operation, and sat up nine days afterwards.	Died 6 months afterwards from erysipelas.
2	Ditto. <i>Ibid. Ibid.</i>	43	Single. No account of duration, etc. Tumour after operat. found to be uterine, incorporated with large cystiform bodies. Fibrocystic.	Operated Oct. 13, 1849. Incision from near umbilicus to pubes. No adhesions.	..	Recovered. Died four years afterwards.
3	Ditto. <i>Ibid. Ibid.</i>	41	Unmarried. Woman of colour. No account of duration, etc. Uterine tumour not adherent.	April 13, 1850. Incision from near umbilicus to pubes. Intestines were forced out, and could scarcely be returned, in consequence of the anæsthetic agent inducing a catleptic cond. of muscular parietes.	..	Recovered. Still living, April 1855.
4	Ditto. <i>Ibid. Ibid.</i>	42	Married. No account of duration. An extrauterine fibrous tumour.	Operated Dec. 20, 1851. During the operation, an abscess deep in the abdomen was opened and a quantity of pus discharged.	..	Recovered. Still living, April, 1855.
5	Dr. Cutter, of Woburn. <i>Am. Journ. of Med. Sci.</i> , 1854.	33	Single. First noticed tum. 7 yrs. ago; 2 yrs. afterw. very percept. in l. hypogastrium. Developm. attended w. attacks of peritonitis & dysuria, leading to use of catheter. Catam. regular, lately accomp. w. hæmorrh. Soreness of abdomen followed by ascites, for which she was twice tapped since her health failed, Feb. 1853. Tumour felt low per vaginam. Simpson's sound penetrated 5 in. Case pronounced hopeless, but wom. so urgent for operat., it was tried. Cervix & fundus uteri involved. A large tumour from wh. several smaller ones projected in cavity of abdomen. Parietal.	Operation performed Oct. 12, 1853. Incision 9 inches in median line. Tumour found to be fibrous. Connexions forbade removal. Tumour punctured and bled profusely, so as to require ligature. Wound closed.	Several days suffered but little pain under use of opium.	Died 12 days after operation. P.M. Very little peritonitis. Intestum's healed and opening in uterus also.
6	Mr. Lane. London. Clay's <i>Trans. of Kivisch on Dis. of Ovaries</i> .	22	Single. Disease of many years' duration. Health good. Found after operation to be a large fleshy tubercle of uterus. Parietal.	Operated 1847. Incision from umbilicus to pubes. Tumour too much connected with uterus for removal. Wound closed by 15 interrupted sutures not through peritoneum.	Wound healed.	Recovered, but died five weeks after operation. Suicide suspected. A 3 months fetus found in utero.
7	Mr. Lizars. of Edinburgh. <i>Liz. Ext. of Dis. Ovaries</i> , pp. 19-20.	34	Unmarried. Tumour observed six years ago. Catamenia irregular; urine occasionally suppressed; general health good; had considerable muscular strength, but earnestly entreated something might be done to relieve her.	Operated April 24, 1825. Incision from sternum to pubes. The tumour was pierced and incised twice, but nothing but pure blood followed. The wound was then closed by sutures and adhesive straps.	..	Recovered in a fortnight. Died Nov. 23, of Apoplexy. <i>Edinburgh Journal</i> , March 1851.
8	Dr. R. D. Massey. America. <i>Hamilton's Rep.</i>	..	No account of duration, etc. After operation found to be a tumour in uterine walls. Parietal.	Operated 1850. Large incision.	..	Died from exhaustion fourteen hours afterwards.
9	Dr. N. Smith. America. <i>Lyman's Rep.</i> , Boston, 1856. Case 248.	..	No account of duration.	Long incision. Uterus found to be involved, and constituting largest part of tumour. Wound closed.	..	Recovered.
10	Unknown. Germany. <i>Scanzoni's Beiträge</i> , 1858. <i>Sim's Table</i> .	36	Hard tumour in abdomen, with ascites.	Found to be cancerous tumour connected with uterus. Wound closed.	..	Death in three days.
11	Mr. Walne, of London, 1844. <i>Med. Gaz.</i> , Mar. 10. p. 47.	45	Uterine disease; fibrous tumour; cysts of ovary, solid and fluid. Parietal.	Long incision.	..	The tum'r resting agst. incision was supposed to have caused inflammation and death.
12	Mr. J. B. Brown. London Home.	43	Admitted Oct. 12, 1860. Tumour first noticed right side of abdomen, about size of an egg, 9 years ago; increased gradually; general health good. <i>Examination</i> . Large mass of fibrous tumour discovered within the uterus; also a fibrous tumour attached externally to fundus, to be felt through parietes. After the first operat. the tumour was found to be growing, and having a feeling of fluctuation not to be defined. Fibroid, vascular, intrauterine and extrauterine.	First operation, os uteri and cervix uteri incised on each side, under chloroform. Jan. 24, 1861. Exploratory incision made through abdominal parietes. A large fibrocellular tumour discovered by which whole pelvis was modelled, and which had grown above brim, and was so firm as to be immovable. Fluctuation evident. On cutting in, tumour was found to be made up of a number of engorged vessels which bled freely. The incision was deep. Brought together by 3 silver sutures. Abd. closed in ord. way.	Not a bad symptom after gastrotomy. Wound healed. Left the Home.	Recovered imperfect health. Tumour passive, no inconvenience.

TABLE II.—Continued.

No.	Operator and Reference.	Age	Previous History, etc.	Steps of Operation.	Progress.	Final Result.
13	Mr. I. B. Brown. London Home-Communicated	30	Married four years. Admitted Nov. 26, 1862. No children. Always healthy till six years ago, when she first perceived the tumour. This increased at each epoch, subsiding with its cessation. Catamenia copious. Health failing in 1860, was tapped. Two quarts of dark fluid drawn off. Catamenia regular. Examination. Large multilocular ovarian tumour diagnosed; also what appeared to be undoubted umbilical hernia of omentum. <i>Fibrocystic.</i>	Operated Dec. 11, 1862. After primary incision, large quantity of ascitic fluid escaped. A cyst then came into view, which looked like intestine, and on exam. tumour was fnd. to be composed of several hard masses (like scirrhus) and very adherent in every direction. It was attached to the whole omentum, liver, and uterus, being also quite immovable. A quart of pale yellow fluid was drawn off from 2 of the cysts, and the wound closed with silver sutures.	Went on well till 17th, when coughing violently, wound was forced open, serous fluid coming out. Contd. for a few days. Dec. 26, small abscess opened at upper part of wound. Stimulants, wine, and acid given. Tumour refilling. Sickness. Wnd. gaping.	Died, January 6, 1863.
14	Mr. I. B. Brown. Ditto.	41	Married 7 yrs.; no child.; 2 miscarr. Admitted Feb. 2, 1863. Irregul. since marr. 18 mths. since had severe pain, l. hip, wh. persisted spite of treatm. Six mths. after perceived a sm. tumour in r. ovn. region. This increas'd gradually & became central. Latterly menstr. more irregul., suppressed since Nov. last. Whole abdomen filled w. tumour larger than full twin pregnancy. Irregular in outline, w. 2 small outgrowths superiorly. In parts indistinct fluct. or elasticity. Pelvis was so filled up with tumour and os so drawn up behind pubis that sound could not be introduced. General health bad. Patient urgent for operation. Diagnosis obscure. <i>Parietal.</i> Fibroid complicated with pregnancy.	Feb. 26. Exploratory incision, 3 inches long. Tumour found very vascular, more like muscle than cyst of ovary. Trochar plunged in to make sure, giving exit only to a little blood. Closed by silver wire. Abdominal parietes also.	Some tympanitis, yet prog. well till Mar. 3. when she had a rigor; fever persisted till 12th. 13th, inflamtn. of tissues around right eye. Insensible; tenderness of abdomen. Fœtus came away.	Died exhausted, 17th. P.M. 2 pts. of pus in peritoneum. Tumour adherent to pelvic fascia, and to about 2 square inches of liver. Tumour size of a peck basket, with smooth & regular surface, with two small lumps of size of a filbert attached. Tumour all fibroid, involving whole left side of uterus. Fœtus must have lain to left side, also occupying position parallel to tumour, half being impregnated uterus, and half tumour. Parietes containing fœtus in no way contracted. Several purulent points in kidneys and liver.
15	Dr. Dean. <i>Brit. Med. and Surg. Journ.</i> , 39, 221., Oct. 1848. <i>Amer. Med. and Surg. Journ.</i> , vol. 43, 258.	..	A globular symmetrical tumour, resting on pubis in front and sacrum behind. Raised in recumbent position and free impulse given to it. In erect immovable. Length perhaps 8 or 9 in. long by 5 or 6 brd. Seems to spring from right ovary, still might be uterine. Functions of uterus normal, no deviation. No pain, but increasing rapidly. <i>Uterine. Parietal.</i>	Incision made on the left side of umbilicus, carried down to pubes. Round polished solid tum. expos. covered with very large vessels. No adhesions. Intestines forced out. Found to be a solid fibrous tumour of uterus involving left half. Operation stopped after consultation, and parts returned. No bleeding of any note occurred.	Inflammation, fold, with spasmodic twitchings which continued till 8th day; removed by depletion.	Recovered in a fortnight.

months afterwards, of apoplexy. The third, one of the fibro-cystic disease cases, died four years afterwards.

The remaining seven died. In two of these the tumour was combined with pregnancy. One died five weeks after the operation, and there was some reason to suspect suicide. The second seems to have died of peritonitis. One died of slight peritonitis, in twelve days; another, of exhaustion, in fourteen hours after the operation. Another died of inflammation of the tumour; one of abscess. The cause of death in the last is not stated.

The first two fatal cases here mentioned should clearly be excluded. We cannot doubt that the diagnosis was most difficult, if not impossible, during life. This we are assured of from the character of those in whose practice the cases occurred. Still, if the principle so forcibly insisted upon by Dr. Greenhalgh had been adopted, and in which I fully concur—never to operate unless you can introduce the sound *in uterum*—which was in one of these examples, at least, tried several times, and without success, these cases would not have been operated upon. Thus we have thirteen cases and five deaths—a mortality which seems to justify the operation, if an operation be imperatively called for. One of the fibro-cystic cases, indeed, recovered and lived four years afterwards. It is not to be presumed, therefore, that she was otherwise than benefited from the operation.

[To be continued.]

Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

BIRMINGHAM GENERAL HOSPITAL.

HEMIPLEGIA ON THE RIGHT SIDE, WITH LOSS OF SPEECH.

Cases under the care of JAMES RUSSELL, M.D.

IN a very interesting letter to this JOURNAL (May 21st, 1864), with the title prefixed to the present paper, Dr. Hughlings Jackson makes the following statement: "I have noticed that when defect of speech occurs with hemiplegia, the hemiplegia is, so far as my experience goes, invariably on the right side." Any statement by so laborious and accurate a student of cerebral pathology as Dr. Jackson must be received with much respect; and he had interested me in the subject by a conversation a short time before his letter appeared. I am, therefore, led to present the result of an examination of my case-books, as a contribution towards the inquiry which Dr. Jackson invites.

The cases from which the following abstracts are made have, of course, been reported entirely without regard to the question raised by Dr. Jackson; therefore, if the testimony they afford be sometimes defective, it has the advantage of being unprejudiced.