ovum was unfortunately missed at the time of the operation, and the sac was empty on examination afterwards. Probably the gestation was of about five weeks' duration.

2. The satisfactory result of the adoption of the Fowler position, pelvic drainage, and absorption of saline solution by the rectum on the peritoneal infection.

A CASE OF RETAINED MENSES RELIEVED BY OPERATION.

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THERE are various sites in which the menses are retained—as, for instance, in the uterus, in a cul-de-sac between the os uteri and a part of the vagina; in the vagina as a whole, due to atresia; in one part of a double uterus; or in an imperforate second vagina. Of these I have only seen two examples; perhaps a third may be partially classed with them. When a student a young woman who desired to be married came to St. Bartholomew's Hospital with the vagina full of menstrual fluid, and no outlet for it. A powerfully built married woman consulted me for vaginismus, which had after marriage made her life miserable for years. A strong fleshy band as thick as my finger crossed the vagina, resting against the os uteri but not attached to it, and caused a certain amount of mechanical obstruction. I cut through and removed the band; in two or three weeks married life became and remained enjoyable, and pregnancy shortly after resulted. In the case described below, by the light of subsequent events I have no doubt that the cyst (so called) was a second vagina, running parallel originally with the patent one, without any outlet therefrom—hence the accumulation of menstrual fluid within it, whilst menstrual fluid discharged into the other vagina found a normal outlet. There was no doubt an imperfectly developed uterus also, having two outlets, one of which discharged into a patent vagina and one into an occluded vagina.

In 1898 a lady consulted me for symptoms of distress, not only during menstruation, but also for indefinite symptoms between the menstrual periods. On vaginal examination a large, irregular, boggy swelling was felt between the left vaginal wall and pelvic bones, pushing the sides of the vagina together, so as nearly to block it up. Well back at the roof of the vagina there was a pin-hole point, believed to be the external os of the uterus out of position. Above the pelvis no enlargement was felt. A specialist believed the swelling to be an ovarian tumour and advised its immediate removal. Though satisfied an operation was needed, I concluded that if the tumour were ovarian it differed from all others I had encountered.

On opening the abdomen a large, beefy-red mass was found in the left pelvis intersected with large blood vessels, and adjacent thereto an imperfectly developed bicornuous uterus. The appearance of the mass differed from anything I had seen before, and it was found difficult to understand its precise nature. An incision was made into the tumour, one horn of the uterus was removed, and the contents, which were of deep chocolate colour and very viscid, evacuated. The walls of the tumour were from $\frac{1}{2}$ in. to $\frac{3}{4}$ in. thick everywhere, and resembled thickened placental tissue. The tumour was stitched to the abdominal wall and a drainage tube inserted. The specialist diagnosed the case as one of impounded menstrual fluid in a cyst originating in a congenitally occluded tube.

It soon became clear that the operation would not give permanent relief. Proposals to reopen the cavity and apply acids, with the object of producing adhesions, were not approved by me, and the lady would not then entertain another operation.

After a time menstruation occurred through the sinus, as well as by the vagina. In due course there was also a purulent discharge through the sinus, and then the wound healed and remained sound for six months at a time, breaking down from time to time. After the wound closed pain in the left groin became worse and dullness, due to distension of the cyst, extended as high as the spleen, the abdomen remaining absolutely flat, and there being no fluctuation. In 1899 and 1902, after the wound had broken down, there was copious discharge of very fetid purulent material mingled with viscid, chocolate menstrual fluid. In 1902, the abdominal sinus being closed, there was a bulging tumour pressing down the roof of the vagina, with the same boggy feeling at first observed. A small opening formed through the roof of the vagina, not far from the imperfect os uteri. Through this there was a considerable daily discharge of viscid, inoffensive chocolate fluid, which, escaping at the most dependent part, gave great relief, until after some months this opening closed again.

Early in 1905 the lady began again to have pain, accompanied by vomiting and general malaise. In June there was dullness over the left abdomen, and no outlet in the vaginal roof. Life became a burden, and was almost reduced to lying down in the garden. In July she again consulted the same specialist and another doctor. Operative interference was suggested, but not accepted. In October she consulted me again, and I wrote a detailed account of past symptoms to Dr. Christopher Martin. Armed with these particulars, and an experience of a dozen cases more or less bearing on the case—less rather than more—an operation was suggested, which was readily assented to.

A general anaesthetic (ether) having been administered, the vagina was made as aseptic as possible, and a speculum inserted to expose the interior and keep its posterior wall from protruding forwards. A long director was then passed down the abdominal sinus, through the cavity of the tumour, to the roof of the vagina, and there held in position. An incision was made through the roof of the vagina into the cavity of the tumour; the incision was afterwards made more or less radiate, and the radiating tongues were everted and firmly stitched to the vaginal wall, care being taken also to stitch the margins of the cyst wall to the vagina proper. A hot solution of hydrogen peroxide was then run through the abdominal sinus and cavity of the tumour, which, emerging through the incision made by Dr. Martin, passed outwards through the vagina proper. The lady returned home in less than a fortnight very much relieved.

The ultimate permanent success of this operation depends entirely upon whether the artificial outlet made should in course of time contract and either become closed or be virtually closed to such an extent as again to permit the menses to be impounded. Four years have now elapsed; menstruation is fairly regular and rarely painful. She has learned to swim and to ride a bicycle, and sea-bathing has not been followed by ill effects. She walks three or four miles without discomfort, attends to household duties daily, runs about the house and garden, goes upstairs two steps at a time, does a little gardening, and feels such a delight in romping, after having been obliged to lie down or crawl so long, that she has a difficulty in keeping her movements within the bounds of prudence.

Assuming that the horn of the uterus removed at the first operation was the point of origin of the retained menses, the only explanation I can offer for a subsequent retention is that, although the stump was firmly ligatured, it probably sloughed, and thereafter permitted the menstrual flux from the other horn to escape into both the patent and the occluded vaginae.

If the true nature of the swelling could have been diagnosed in 1898, it is possible operative treatment of another kind, though attended with risk of severe septic infection, would have been suggested. However, between 1898 and 1905 a few specialists gained considerable experience of isolated cases of a similar nature, and on the whole I am inclined to think no other operation in 1898 would have been attended with more success than in this case, and that the signal success of the operation in 1905 was largely due to experience gained after 1898, and the clear history I was able to give Dr. Martin of antecedent circumstances, including a description of what was seen and imperfectly understood at the first operation—in other words, the success of the second operation was largely secured by the partial failure of the first.

At the invitation of the Argentine Republic a Pan-American Congress of Medicine and Hygiene will be held at Buenos Aires in May, 1910. The opening session will take place on May 25th. An exhibition of hygiene will be held in connexion with the congress.

The annual dinner of past and present students of the Royal London (Moorfields) Ophthalmic Hospital will be held at the Trocadero Restaurant on Wednesday, January 26th, under the Presidency of Mr. Edward Nettleship, Consulting Surgeon to the hospital. Tickets (10s. 6d., exclusive of wine) may be obtained from the Honorary Secretaries, Mr. Arnold Lawson, 12, Harley Street, W.; and Mr. J. Herbert Parsons, 54, Queen Anne Street, W.

A, Sinus in abdomen below umbilicus, down which director was passed to roof of vagina, and through which hydrogen peroxide gravitated; B, part of uterus capable of discharging contents into patent vagina; V, vagina with normal outlet; C, approximate position from which second horn of uterus was removed and stump ligatured; S, sac, which contained impounded menses, believed to be a second vagina with no outlet, and which was much nearer to point marked D prior to first operation, when it was pushed up and stitched to the abdominal wall; R, position of stellate or radiating incision, and everted ligatures of its margins, made at second operation.