An Address

ON

SOME LATTER-DAY INTRUSIONS OF THE SURGEON ON THE ABDOMEN.

DELIVERED BEFORE THE SOUTHERN BRANCH OF THE
BRITISH MEDICAL ASSOCIATION AT PORTSMOUTH.

BY

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It has been customary for the president to inflict an address on the members at the annual meeting. With your permission I propose to take as my subject some warrantable intrusions of the surgeon on the abdomen of recent years—in other words, to define what appears to me to be the legitimate rôle of surgery in the more common abdominal diseases. Inasmuch as most abdominal cases in the first instance come under the care of the general practitioner, the proposition which I intend to submit to you to-day as to when and in what circumstances the surgeon's assistance is indicated should be of interest to the majority of my audience. There is no doubt that during the last quarter of a century the surgeon has become a somewhat pushful intruder on every domain of medicine, and nowhere has his enterprise been more conspicuous than in the abdomen. If we cast back twenty-five years, the abdomen was almost exclusively the physician's preserve, practically the only surgical interference within it being the removal of ovarian cysts, and that so rarely that such operations were regarded as quite an event in hospital practice, and would draw large audiences to witness them. As soon, however, as the Listerian system of treating wounds revealed to the surgeon the safety of entering the abdomen, he proceeded without scruple to annex his neighbour's vineyard, and I think it cannot be gainsaid that the net result has been an enormous saving of human life and alleviation of human suffering. Nevertheless, all good things come to an end, and the ever-swinging pendulum of science seems destined in the not distant future to give the physician back his own, and that perhaps with compound interest. I allude, of course, to the recent introduction of serums and vaccines, and various other treatments of a character menacing to the surgeon, which, should they fructify to the extent their advocates believe them capable of, will not only restore to the physician and pathologist their stolen perquisites, but may even lead to the almost total extinction of the surgeon. The passing of the surgeon, should it occur, will, I think, be acknowledged to be a great gain to the community at large and to the physician in particular. Meanwhile, as in all revolutions, there is just a danger of the reaction being a little previous. For instance, coli bacillus cystitis and its treatment by a vaccine is becoming, from all I hear, almost as fashionable as was formerly appendicitis and its treatment by operation. Now, while of course it would be very behind the times in a case of cystitis not to isolate the bacillus and give the patient the benefit of an autogenous vaccine, it is well not to forget that a patient may have pus in his urine and the *Bacillus coli* in his urine, and for all that have a stone in his bladder. Not long ago I heard of a case in which these phenomena were present and the treatment had been proceeded with on the most ultra-scientific lines, but the pathological examination of the urine had not revealed the stone which was present in the patient's bladder, nor had the vaccine succeeded in dislodging it. Also recently I was myself consulted in a case of extensive swelling of the cervical glands. The patient had been attending a physician once a week for a year, and had been receiving tuberculin injections at four guineas a time. To this treatment the glands had declined to respond. When I saw the case I expressed the opinion on clinical grounds that the glands were not tuberculous at all, but lymphadenomatous, an opinion which was confirmed by microscopical examination subsequent to their removal.

MALIGNANT DISEASE.

After this short precautionary digression, I shall proceed to the subject of my address. Let us consider, first, a

large class of abdominal complaints—namely, malignant disease. The only practical treatment at our disposal at the present time for malignant disease is the knife, whether for the purpose of saving or prolonging life. Where abdominal symptoms are present, malignancy should, therefore, in all cases be confirmed or excluded, and that at the earliest possible moment. For if it be confirmed, and is not situated in some inaccessible region, such as the liver or pancreas, there can be no two opinions about handing the patient over to a surgeon, at the only time when there is a possibility of saving his life—that is, while the disease is limited enough for complete removal. The claim that malignant disease, wherever situated, is not incurable if it can be excised early enough to ensure its complete removal, has been established practically beyond dispute, and theoretically follows as a logical sequence of all recent investigation into the nature of cancer, every conclusion of which stamps it as in its outset a local disease. In the case of the gastro-intestinal tract, which supplies the majority of intra-abdominal carcinomata, I would remind you that, except in the stomach, its degree of malignancy is low—in other words, its rate of dissemination is less rapid than in probably any other region. I would remind you, also, that its situation in the intestine lends itself particularly favourably to complete removal. From an operative point of view, the all-important point is that obstruction should not be waited for, as then the most favourable opportunity has slipped out of our hands. The reason is this. The anastomosis of the intestine necessary after removal of growth cannot be successfully accomplished in the presence of obstruction. In the event of complete obstruction, with the abdomen distended, it is, of course, out of the question, but even in the event of partial obstruction, where the abdomen is not generally distended and the bowels have been freely opened with purgatives, but where dilated coils of intestine can still be seen and felt through the abdominal wall, the operation of excision and anastomosis will not be successful. I have tried it in some of these latter cases; it has invariably been fatal, and I shall never attempt it again. So that if obstruction be present, either partial or complete, whether the growth be excised at the time or not and Paul's tubes inserted, or an enterostomy be performed above the obstruction and the excision of the growth be deferred to a future date, two, or possibly three, operations are required to complete the cure. On the contrary, if the bowel be empty, excision of the growth, anastomosis of the intestine, and closure of the abdominal wound is almost invariably attended with success, and completes the case at one sitting. That is why I say obstruction should never be waited for, and that if it occurs and refuses to yield completely to medical treatment the most favourable surgical opportunity has gone. In some instances a complete obstruction is the very first symptom, or at all events is present when the medical man is first called in; but this is not the rule, and usually attacks of partial obstruction occur at intervals, which yield to treatment and provide an empty intestine. That is the time to operate. Any symptoms of continued irregularity occurring in a person whose bowels have previously been regular, either constipation or diarrhoea or alternating constipation and diarrhoea, should be viewed with the greatest suspicion, and if the patient is advancing in years and has lost weight, these symptoms generally mean carcinoma of the large intestine. If a thorough examination be made in the absence of abdominal distension the tumour can usually, but not always, be felt. If while making the examination coils of intestine can be either seen or felt alternately hardening and relaxing under the hand, it is absolutely diagnostic of mechanical obstruction. As regards non-malignant tumours within the abdomen, the necessity for their early removal is scarcely less urgent. We know practically nothing of the origin of neoplasms, and of the circumstances determining transitions from simple to malignant characters. For instance, only lately I performed hysterectomy for supposed fibromyoma of the uterus. The tumour had been known to have been in existence for eight years and the patient had been advised against removal. It had undoubtedly in its beginning been a fibromyoma. After eight years left to itself in the abdomen it had become sarcomatous. Again, many times I have seen carcinoma present in a lump of mastitis in the breast,

which had been known to have been in existence for years. With such facts before us we come to the logical conclusion that it is safest for the patient to have any tumour, wherever situated, removed with the minimum of delay. Such an attitude is warranted on the part of the surgeon, because the immediate risk of operative interference has been reduced to such insignificant proportions. If this attitude towards neoplasms be correct, it applies with special significance within the abdomen for several reasons. First of all, the difficulties of diagnosis are admittedly greater here than in most regions, and mistakes between simple and malignant tumours are more likely to occur. Let me give you an instance which occurred to two of us lately.

A practitioner in the town sent into the hospital a case diagnosed as fibromyoma of the uterus. The woman's age was 35. The only history she gave was that she had had three attacks of pain, such as might have been attributed to and probably meant a mild peritonitis, during the past year, and she had felt at times a pressure on the bladder. On examination, I found, as her medical attendant had found, a firm solid tumour, somewhat irregular but quite smooth, which on bimanual examination was absolutely one with the uterus, and moved quite freely with it. The patient had had no intestinal symptoms whatever and no loss of weight. I came without any hesitation to the conclusion that the diagnosis was correct, and that I had to do with a case of fibromyoma on the left side of the uterus. On opening the abdomen, I found a large colloid carcinoma involving the ileo-pelvic colon and a loop of small intestine, so intimately attached to the uterus that separation was impossible without freely opening the gut. A double enterectomy has resulted in the at all events temporary recovery of the patient.

On carefully considering the notes of the case after the operation, it seemed that I could not reasonably have come to any other conclusion as to its nature. If you operate upon a sufficient number of abdominal tumours, the only thing you feel quite certain about is that you cannot be certain of the diagnosis of any abdominal tumour until you see it, and not always even then. A second reason for the early removal of all abdominal tumours is that, on account of the crowding together of many important organs in a closed cavity, a growth of any size in many positions is apt by its pressure to injuriously affect their function. A third reason is that tumours are prone to quietly contract adhesions to neighbouring viscera, and this may render an otherwise simple operation complicated and dangerous, if a time comes when they have to be removed. I shall only mention in this connexion one class of non-malignant tumours, which have been very successfully dealt with surgically of recent years—fibromyomata of the uterus. There is no occasion nowadays—indeed, it is bad treatment—for women to live lives of invalidism, suffering from the effects of hæmorrhage or pressure on important organs, chasing the “Will o’ the wisp,” their menopause, which usually escapes them in these cases till they are considerably over 50 years of age and their most active years are spent, fed on ergot till they develop incipient gangrene of their extremities, looking the wrecks they are and feel, when they can be restored to perfect health in a few weeks, without the induction of a premature menopause and its attendant objectionable symptoms, by the simple operation of subtotal hysterectomy or myomectomy. There are two points I should like to mention here. The first is that by far the majority of women with fibromyomata are already sterile, so that a reasonable objection that might be urged against removal of the uterus during the child-bearing age has little weight. The second is that women who have continually bleeding fibromyomata may easily arrive at a stage of anaemia which makes the operation of hysterectomy, undertaken with the object of averting death from hæmorrhage, positively dangerous. In a consecutive series of 70 cases of hysterectomy and myomectomy for fibromyomata, the only two patients who have not recovered were both in this stage of dangerous anaemia from hæmorrhage; and though they underwent the operation without mishap, both succumbed about a week afterwards through not having sufficient rallying power to recover. This is a very important point in connexion with bleeding fibromyomata, and is a cogent argument for their removal before extreme anaemia manifests itself.

CAESAREAN SECTION.

I ought not to quit the topic of operations on the uterus without a brief allusion to Caesarean section, employed of

late years in cases of obstruction to delivery necessitating formerly the sacrifice of the child. Nobody who has performed this operation, or seen it skilfully performed, can fail to acknowledge its immense superiority over such barbarous procedures as craniotomy or cephalotripsy, and it is safe to say that in future in almost all cases these crude and mutilating operations will be replaced by it or some modification of it. The important point is that, the practitioner having come to the decision that delivery *per vias naturales* will be in all likelihood impossible without destruction of the child, Caesarean section should be determined upon as the sole method of dealing with the case. Experience teaches unmistakably that it is the cases that have been previously plied with attempts at delivery of various kinds and with frequent examinations, and are afterwards operated upon as a *dermier ressort*, which furnish the maternal mortality. If it is Caesarean section and Caesarean section only, the mortality is trifling. Indeed, it is safer even for the mother than cephalotripsy and removal of the child through the natural passages; in addition, it saves the life of the child. My own small experience confirms this. I have performed Caesarean section four times, with three recoveries and one death. In all the cases in which recovery took place the operation was selected from the beginning as the proper method of delivery; in the one fatal case prolonged attempts at delivery had previously been made with forceps.

ACUTE ABDOMEN.

If any medical man, be he physician, surgeon, or general practitioner, reflects on the conditions producing the acute abdomen, I do not think he will dispute the statement that, apart from surgical intervention, nothing but pure luck and circumstances over which he has no control whatever will save his patient's life. I would invite you to consider this subject from an ordinary common-sense point of view. If with the abdomen laid open any one saw a loop of intestine rapidly becoming gangrenous from a band tightly constricting it, the first thing that would occur to him would be to sever the band. If with the abdomen laid open any one saw his patient bleeding to death from a ruptured blood vessel, the first thing that would occur to him would be to secure the bleeding point. If with the abdomen laid open any one saw the contents of the stomach or gall bladder or intestine leaking into the peritoneal cavity, the first thing that would occur to him would be to stop the leak. Yet it is only because such conditions (and such are the conditions producing the acute abdomen)—it is only because such conditions are concealed by some 2 in. or 3 in. of abdominal wall that their true interpretation and significance is apt to be overlooked. Whether it be a perforated gastric ulcer, a perforated gall bladder or appendix, a ruptured ectopic gestation, an internal hernia, a volvulus, intussusception, or other strangulation of the intestine, a gall stone impacted in the gut, or any other acute abdominal catastrophe, the conditions are entirely mechanical, and the only prospect of treating them with any general measure of success lies in mechanical, in other words surgical, measures. It is true that patients may recover, and no doubt have recovered, from all of these conditions without surgical intervention, but it is only by the purest good fortune and nothing else, whereas by timely surgical intervention the mortality from them should be low, instead of as at present unnecessarily high. Indeed, considering the general safety of entering the abdomen under a proper aseptic technique, the acute abdomen is behind the times, and remains still somewhat of an opprobrium to treatment. I have said that the reason lies not in the fact that the treatment for such conditions would be disputed by anybody—it is obvious to anybody—but in the fact that the true picture is not in sight; it is covered by the abdominal wall. In other words, the obstacle is the diagnosis.

But though the difficulty of making an exact diagnosis may be and often is considerable, the difficulty of diagnosing that we have to deal with a case of the acute abdomen is not so at all, provided we keep in front of us two symptoms and two symptoms only, and disregard all others. If we look for shock, it is usually present, but not always—certainly not at first. If we look for vomiting, it frequently occurs, but not always. If we regard the temperature or pulse, neither of them is a reliable guide. Two symptoms,

and two symptoms only, are invariably present. They are abdominal pain and abdominal rigidity. Let me give you an instance, as I am in this address just quoting my own experience, which, thanks to the confidence and kindness of my friends, extends to considerably over a thousand operations upon the abdomen, and it is meet that I should give chapter and verse for my conclusions.

About a fortnight ago the house-surgeon rang me up in the evening to say that a case had been sent up to the hospital as one of perforated gastric ulcer. The man's age was 35. He gave a history of indigestion, but not a typical one of gastric or duodenal ulcer. At 4.30 that afternoon he had been seized with sudden and severe pains about the umbilicus, and had taken some brandy which made him retch once. I saw him five hours after the attack. The man looked really quite well. He was warm, had no shock whatever, no sweating, his temperature was normal, and his pulse 84. He still complained of severe pain in the abdomen, but said it was less than it had been. On placing my hand on his abdomen it was just like a piece of iron. You could elicit no tenderness, as his abdominal muscles refused point blank to allow any pressure to be made on the contents beneath them. I came to the conclusion that he had a perforated gastric ulcer, or, at all events, a perforation of some kind, operated upon him at once, and found there was no mistake.

Now, this was a very acute diagnosis on the part of the medical man who sent him to the hospital, and who, presumably, had not seen a great many cases of perforated gastric ulcer, as the condition is not so common that any practitioner in a lifetime comes across a large number of cases. It was not, you will allow, at all a typical case of its kind, though I have seen one or two like it. The house-surgeon remarked to me: "I have seen a few cases of perforated gastric ulcer, but they were not at all like this." Five hours after the onset there was no shock whatever, no depression of temperature, very little acceleration of pulse-rate, no vomiting, except that he had just retched once after taking some brandy. The only symptoms present to indicate his serious condition were sudden and severe abdominal pain, and pronounced abdominal rigidity; and these are the only symptoms you can rely upon. They are always there. This case was further complicated by the fact that the patient had taken some colocynth pills the night before, and the pain itself might have been severe colic, but the combination of the two symptoms (pain and board-like rigidity) excluded this. If a patient, then, presents these twin symptoms—if he is seized with sudden and usually severe abdominal pains, and the medical attendant on placing the flat of his hand on the abdomen finds the whole of it or part of it rigid—so rigid that often you feel you could tread on it without its giving way—that patient has an acute abdomen, and the question of surgical intervention at once arises. Such a patient should be operated upon forthwith, or, if there is any doubt, should be watched hour by hour, and if not improving within twelve hours should be opened. If these cases are subjected to medical treatment for three or four days, and then, when the abdomen is distended and they are suffering from profound toxæmia, are operated upon, a large number of them die. I shall now point out why they should be operated upon early, and why if they are operated upon late they frequently die. The conditions producing the acute abdomen are serious conditions. They always produce great shock. I have said shock is not invariably present at the commencement, but it always develops with the oncoming toxæmia. You are going to add to this the shock attending an abdominal section. It is essential, therefore, that the abdominal section should be as easy and quick as possible. Now, no abdominal section is easy, and few are quick when the belly is distended. The patient should therefore be operated upon before distension sets in—the distension which inevitably develops on delay. Furthermore, delay means toxæmia, and if this has reached an advanced stage, however quick or skilful the operation, the patient may yet die of his toxæmia, which would have killed him in any case, whether he had been operated upon or not. My experience from operating upon a large number of these cases tells me this. However serious and unfavourable the lesion in the abdomen appears to be, provided conditions are such that the operation can be done quickly, and provided that the patient does not exhibit at the time signs of profound toxæmia, he will as a general rule recover. He may have a hard fight for it afterwards,

but he will recover. Let me give you an instance. Open the abdomen for acute perforative or gangrenous appendicitis. Find it full of pus, both upper abdomen and pelvis, not an adhesion of any kind limiting it. Let the patient's general condition be passable—a fair pulse, not in a cold sweat, not sunken and pinched in the face. Get the appendix out quickly and drain the abdomen. The patient usually recovers. These cases were an eye-opener to me at first. I could hardly believe it possible, but it is a fact. You can tell from the general state of the patient before you even open the abdomen and know the condition inside, provided nothing unforeseen greatly prolongs the operation itself, that the case is going to recover. Conversely, if conditions are such as to entail a prolonged operation (and distension is the chief outside factor determining this), or if the patient is exhibiting signs of profound toxæmia, however quick and skilful the operation may be, he will frequently die. The two essentials to success in these cases—a rapid operation and the absence of profound toxæmia—are directly dependent, so far as matters go which are within our control, on the interval of time between the onset of the attack and the operation. Such deaths as I have depicted here are commonly put down as deaths from operation, though a moment's reflection will show that exactly the reverse is the truth, that they are in reality deaths from want of operation.

Appendicitis.

Descending now from the general to the particular in the acute abdomen, I shall make a few remarks on the commonest of them all—that well-worn but ever-interesting subject appendicitis. It accounts for something like two-thirds of all cases of the acute abdomen, so it is worth while having some definite views upon it. I have no hesitation in saying, as the result of an operative experience extending to close upon 300 cases, that every case of appendicitis should be operated upon as soon as diagnosed. I make this unqualified statement for the following reason: However skilful the physician, surgeon, or general practitioner imagines himself to be, I do not care who he is or what symptom or group of symptoms he relies upon; however skilful he imagines himself to be in discriminating between the non-dangerous and dangerous cases—in other words, between the cases it is safe to leave and those it is dangerous to leave—if he puts his theories to the test, although he may so often have turned out to be right as to be reasonably proud of his diagnostic and prognostic skill, the time will surely come when he will leave a dangerous case believing it to be a safe one, and the patient will lose his life in consequence. It cannot be too strongly emphasized that if every case of acute appendicitis (it must be understood I do not include stomach-ache)—if every case of acute appendicitis were operated upon within the first twenty-four hours of onset, there would be no mortality. It is the cases that are left till the fourth or fifth day, in the Micawber-like hope that something will turn up to favourably influence the attack—such, for instance, as its natural subsidence or the formation of a localized abscess—and are finally operated upon when that something does not turn up, which furnish the mortality. The attitude I here advocate gives the practitioner a definite, simple rule to act upon, just as he does now in strangulated hernia. He knows such a course will result in his patient's recovery, whereas if he shilly-shallies he knows nothing about what is going to happen. There should be no compromise with the patient whatever, unless the latter declines operation, in which case the responsibility rests with him. Of course it may be retorted that appendices will be removed that would recover without operation. That is missing the point altogether. The point is that none would be lost. And if a patient has appendicitis, is it not better to remove his appendix in any case than to trust blindly to what may happen to him in the future, all the time in complete ignorance as to whether his next attack is going to be of the gangrenous or perforative type? For my part, as the result of what I have seen both in my own practice and in that of others, I would not take the responsibility of advising otherwise, knowing that I should not be in a position to base such advice on any reliable data whatever. Again let me give you an instance. Concrete cases are more convincing than abstract opinions.

One Sunday afternoon, about two years ago, I was called to see a boy at Lee-on-the-Solent. His history was this: Forty-

eight hours before he had been seized with pain in his right iliac fossa and vomited once. The doctor was not sent for. He was better on the following day and went out for a walk, though still feeling stiff in his right side. Next day his parents thought him not so well and sent for his doctor, who asked me to see him. His condition was the following: Pulse 90, temperature 99.5°; he did not look at all ill; he complained of tenderness in his right iliac fossa, and on placing the hand there, a distinct lump was felt. This turned out to be the appendix itself, though the lump one usually feels in these cases is not the appendix, but a piece of omentum encircling it. Now this looked, on the face of it, like a mild attack of appendicitis, with the appendix surrounded by a piece of omentum. I had formerly seen dozens like it, and had left them to subside, in view of an interval operation. I told the boy's father that all I knew was that the case was one of appendicitis, that it was apparently a mild attack and might get well, but that, as I could not see the condition of the appendix, if he wanted to be absolutely secure of the boy's recovery, it had better be removed at once. The operation was performed that afternoon. As soon as the abdomen was opened the appendix presented itself, lying perfectly free just beneath the abdominal wall, without the vestige of an adhesion about it. It was enlarged to the size of a small sausage, and was quite easily removed. After removal it was found to be converted into a bag containing about 1 oz. of very foul pus, and at its base was a slough in the wall as thin as a wafer paper, so that on gently pressing it with the blunt end of a probe it at once perforated.

Now, I should like to ask the most skilful diagnostician living this question, "Could such a condition be diagnosed from the symptoms?" The symptoms were those of a very mild appendicitis with a lump present—a quite ordinary picture of cases which spontaneously recover. The actual condition was an appendix converted into an abscess cavity full of foul pus, on the very point of discharging its contents into the peritoneal cavity without adhesion of any kind to limit its free diffusion. The reason of the mildness of the symptoms was no doubt that the pus was enclosed in the appendix, and that embolism of the neighbouring lymphatics and veins had prevented direct absorption of toxins into the blood. It may be said that an increased leucocytosis would have signalled the danger and shown that an abscess was present. I do not know whether it would or not, but what I do know is that before I had had time to secure a pathologist to examine the blood, the appendix would certainly have burst, and discharged its contents into the peritoneal cavity. All surgeons of experience with whom I have conversed on this subject are agreed that it is impossible to tell from any symptom or any sign the condition of the appendix in appendicitis, and that delay in removing it involves a risk the magnitude of which is an entirely unknown quantity. We as a profession are very conservative. It is difficult for us to rid ourselves of notions we have been accustomed to regard as established facts, especially if they have at any former time been stamped with the hall mark of high authority. It is still considered safe to watch an appendix case for a day or two to see if it is going to turn out a severe one. I have more than once seen the peritoneal cavity full of pus within thirty-six hours of the onset of an attack which appeared to be mild. It is still considered safe after a mild attack to wait and see if the appendix is going to give further trouble before removing it. I have seen the next attack after a mild one of the most virulent character, and the patient lose his life in consequence, through following such advice. It is still considered safest to remove the appendix in the quiescent stage. It is no safer than in the first twenty-four hours of the attack. It is still considered dangerous to operate on the third or fourth day of an attack in a case which is not doing well. It is much safer to do so than to leave the patient to the chance of a localized abscess forming which may never form, and the patient may lose his life instead by general peritonitis. It is still considered that if a patient has had a localized abscess in connexion with the appendix, the latter will be destroyed in the process, and that in all likelihood he will have no further attack. All one can answer from one's experience is that it is simply not true. All of the above doctrines accepted by many with regard to appendicitis are entirely fallacious, and are the direct causes of its high mortality. I repeat what I said at the beginning: If every appendix were removed within twenty-four or thirty-six hours of an acute attack, the mortality from this disease would be reduced to vanishing point. You may argue theoretically round and round this question till the crack of doom; but if you have actually seen and had much experience of this

disease, you are forced to but one conclusion: "If a patient has appendicitis, remove the appendix without any delay."

Intestinal Obstruction.

All acute intestinal obstructions are manifestly cases for immediate surgical treatment. Many of them are simply instances of strangulated hernia within the abdomen, instead of at one of the usual hernial openings. Nobody questions the advisability of immediate surgical relief of the obstruction in an external strangulated hernia. Why should there be any delay in a strangulated bowel because it happens to be covered by the abdominal wall? The dangers are obviously greater. The need for immediate relief is therefore all the more urgent. Such conditions as internal strangulated hernia, volvulus, strangulation by bands, intussusception, fall into the category. Enemas, inflation by air or water, standing the patient on his head, opium, purgatives, etc., are simply playing with these dangerous conditions.

Pelvic Cases in Women.

The special acute accidents overtaking the pelvic organs of women are ruptured pyosalpinx, ruptured ectopic gestation, and twists of the pedicles of ovarian or uterine tumours. Ruptured pyosalpinx is very rare. I have never seen a case of rupture of a suppurating tube into the peritoneal cavity, though rupture into the bowel I have occasionally met with. The disease is a very chronic one, as a rule, and allows plenty of opportunity for the exclusion of the general peritoneal cavity. Should rupture of a suppurating tube occur into the peritoneal space, immediate laparotomy is, of course, indicated. With regard to the twists of pedicles of ovarian or uterine tumours and ruptured ectopic gestation there can be no doubt that the sooner their possessors are placed in a position of safety by operation the better. Many cases of ruptured ectopic gestation will certainly get well without surgical interference, but the operation is so safe and simple that, in my opinion, it is unsurgical to leave the patient to the remotest possibility of a fatal haemorrhage.

Gastric and Duodenal Ulcer.

I shall next make a few remarks on ulcer of the stomach and duodenum. The position here is not so definite, and I am not by any means an out-and-out advocate of surgical interference in these cases. At the same time there are some in which it is imperative. One of the most important points to determine is whether obstruction exists to the outlet of the contents of the whole or any part of the stomach; for if mechanical obstruction the result of previous disease is present it is quite clear that no medicine or diet can overcome it, and the case becomes immediately surgical if a cure is contemplated. By the patient's symptoms and methods of diagnosis, into which I have not time to enter, it is not as a rule difficult to tell if there is mechanical obstruction, and by the direct surgical relief of such obstruction or by providing an alternative route for the stomach contents, the most brilliant results are obtained. Patients who have been to all intents and purposes starved for years, put on several stones in weight in the course of a few months and are restored to perfect and permanent good health by means which are only possible by surgical intervention. In such cases there is usually a history extending over many years, accompanied by great emaciation, quite as great as attends advanced malignant disease, for which it is frequently mistaken. Apart from obstruction, ulceration, I think it is generally agreed, should be treated in the first instance by medical means, and it is only if the symptoms persist in recurring that surgical treatment should be adopted. I shall here enter a caveat as to what constitutes a cure. There is no doubt that under careful and prolonged medical treatment the symptoms as a rule disappear, and in their intervals of good health these patients can often eat ordinary food without discomfort. Usually, however, you will find on questioning them closely that they instinctively are careful in their feeding. Sooner or later there is often a quite sudden recrudescence of all the symptoms for no apparent adequate reason, though it is frequently attributed by the patient to some error in diet, or exposure to cold or fatigue. What actually is the pathological condition during the quiescence of the symptoms and what determines this.

often quite sudden bursting into activity again are matters for future determination. There is no doubt of the fact. In a certain proportion of these cases, where the history is apparently very definite and includes all the classic symptoms of gastric ulcer as set forth in the textbooks, the surgeon will be disappointed to find no ulcer. This is especially apt to happen in young women, who may apparently present all the symptoms and signs of this disease without the presence of any, at all events demonstrable, lesion whatever. If this turns out to be the case, the surgeon must own up to his mistake, and on no account cover it by another, the performance of gastro-jejunostomy for the cure of an ulcer which does not exist. His operation will be unjustifiable, and moreover valueless, for the stomach contents will continue to pass by the natural route, and the anastomosis opening will not be used. If a demonstrable ulcer is not present, surgical treatment is not warranted. All ulcers of such small dimensions that they are invisible and impalpable are medical ulcers. I confess I can give no reliable diagnostic help in these difficult cases. It may be that after conversation with the patient the medical attendant will have some suspicion of neurosis, difficult to define in words. In some instances I have found all the symptoms aggravated round about the monthly period, a circumstance which should be viewed with mistrust. But, all said and done, some of these cases are, I believe, impossible to diagnose. On one afternoon I recollect at the hospital I operated upon 3 stomach cases, all in women between 20 and 30 years of age. I said before opening the abdomen that I was doubtful of all of them. Two of them had large chronic ulcers, the third had none. Though a hasty exploratory operation is never to be encouraged, just to see if the patient has a suspected disease, and though every effort should be made to arrive at a diagnosis without it, in these cases a laparotomy has certain advantages. In the first place the medical attendant knows positively that his patient has no ulcer, and will probably treat her on quite different lines, without being haunted by the fear that some latitude in diet will be doing her harm or be dangerous to her. Again, the exploratory operation no doubt cures some of these cases for a time at least by suggestion, as I myself have witnessed in two instances.

Gall Stones.

There is another common disease, to which women are especially prone, deserving a few remarks, namely, gall stones. It is my conviction that gall stones should in all cases be removed by operation as soon as diagnosed, so called cures from visits to Carlsbad and other similar establishments being too problematical to warrant any reliance being placed in them. Although it used to be believed and taught that gall stones very frequently caused no symptoms and were comparatively innocuous, they probably always cause symptoms, and there is certainly no pathological condition within the abdomen which threatens danger from so many quarters. As regards symptoms it is true that typical gall stone colic, or jaundice, or rigors with fever, may be late in developing or may never develop. But if by such classical symptoms it becomes at length certain that the patient has gall stones, it will invariably be found on inquiry that for years previously she suffered from painful indigestion which was considered functional. As regards their dangerous sequelae I have seen and operated for many examples in my own practice. For instance, acute inflammation, empyema, or gangrene of the gall bladder, due to impaction of a stone in the cystic duct and subsequent acute infection of the pent-up contents of the gall bladder, perforation of the gall bladder into the general peritoneal cavity, acute intestinal obstruction due to a large stone ulcerating its way into the intestine and becoming lodged there, acute cholecystitis owing to the presence of stones in the common duct, cholaemia from absorption into the blood of bile which had no natural outlet owing to the complete blocking of the common duct by stones, acute pancreatitis dependent on the presence of gall stones in the common duct, carcinoma of the gall bladder due to the irritation of gall stones which had been known to exist for many years—all of these conditions I have myself witnessed on more than one occasion, and you will allow that they constitute a pretty formidable category of the sequelae of a disease which till a few years ago was considered although a

painful a comparatively harmless complaint. All of these dangerous complications can be obviated by a timely removal of gall stones and drainage of the gall bladder. Another argument for early operation is that so long as gall stones are confined to the gall bladder the operation for their removal usually is an extremely simple and safe one, whereas after they have passed into the common duct the procedures are more formidable, may be very difficult, and are certainly attended by a higher primary mortality. Chiefly, then, on the grounds of the many dangerous sequelae of gall stones and of the safety and simplicity of their removal while confined to the gall bladder compared with the greater difficulties and dangers of their removal from the deeper ducts, I am of opinion that gall stones in all cases should be treated as foreign bodies requiring immediate operative treatment.

Retroversion of Uterus.

Far the most common displacement of any abdominal organ we meet with is backward rotation of the uterus. In many instances it gives rise to no symptoms at all, and the patient is unaware of her anomaly. If this be so, and the condition is discovered accidentally during an examination, she should not be informed of it, and it may be left to take care of itself. But these displacements very frequently give rise to real and distressing symptoms, and if this be so a surgical procedure for their replacement is indicated. Pessaries are dirty things for women to wear; they frequently cause great pain by pressing against a tender congested uterus or a prolapsed ovary, and they are generally inefficient. Intraperitoneal shortening of the round ligaments secures in nearly all cases a satisfactory and permanent replacement, without the disadvantage of any fixation of the uterus to the abdominal wall. This operation has, of course, in most cases to be supplemented by others on the vaginal outlet suitable to the conditions present.

I have in the foregoing remarks summarized from my own experience the views I hold of the present position of surgery in the more common abdominal complaints. I hope I have not drawn an unwarranted picture, but I am afraid I have left comparatively little of importance within the abdomen for the physician. The truth is that surgery, being the simpler science, has naturally outstripped medicine in the treatment of disease generally, and in the present stage of the evolution of the science of healing the abdomen is almost exclusively surgical. All must recognize, however, that, at best, surgery, notwithstanding all its modern refinements of technique, is a somewhat crude method of treating disease; and, as I pointed out at the commencement of my address, there are not wanting signs that many abdominal diseases, especially those of microbic origin, may in the not distant future revert to the province of the physician and be cured by methods less drastic and more scientific than the knife; and it is probably not a vain prophecy that future generations of medical men, with their hypodermic syringes in their pockets, will marvel at the barbarous methods we employed of treating abdominal disease early in the twentieth century. Let us hope that they will realize that we acted according to our lights and to the best of our ability, and that they will not pass too severe a criticism on the surgeon, whose knife may then only be seen in the collections of old curiosity shops.

In *The Midwives' Institute, Past and Present*, we have a brief pamphlet setting forth the original object, struggles, and present aims of the body thus entitled, and the reasons for joining either the institute itself or one of the thirty-four midwifery associations now affiliated to it. The institute was founded in 1881 in order to raise the efficiency and improve the status of midwives, and it is considered that there is ample ground for its continuance for the protection of the interests of the registered midwives brought into existence by the Act of 1901. A parliamentary campaign, lasting some twelve years, preceded the passage of that Act, and in the interval as many as eight bills of allied purpose had been introduced in the House. Copies of the pamphlet can be obtained at the offices of the institute, 12, Buckingham Street, price 2d. The institute is incorporated, and has attached to it a trained nurses' club. Its official organ is the monthly publication known as *Nursing Notes*.