The chronic course of the disease and the very gradual deterioration of health from the long-continued pain and discharge were also points which were against the probability of malignant disease. Upon the other hand, the uselessness of any mere scraping operation was so evident and the danger of ultimate malignant degeneration so real that I had no hesitation in suggesting hysterectomy. Dr. M. J. Halton was called in to consultation, and agreed that no curetting, however thoroughly carried out, could cure the condition as it existed. It is due to him that the patient and her relatives finally agreed to operation, which I performed a week subsequent to the consultation.

Operation.

The uterus was removed by the vaginal route. The cervical mucosa having been incised all round, a sound was passed into the bladder, which was then easily peeled off the anterior wall of the uterus and thrust upwards. The rectum was dissected from the vaginal wall, the peritoneum opened anteriorly and posteriorly, and each broad ligament clamped with a single 11-in. pressure forceps. A few snips with blunt-pointed scissors freed the uterus from all attachments and permitted its removal. There was no bleeding. Not a single ligature or suture was used. The vagina was lightly packed with iodoform gauze and the patient put back to bed. The clamps were removed under chloroform in forty-eight hours. The gauze packing was not replaced, a simple antiseptic pad upon the vulva being all that was considered necessary.

Result.

The temperature never rose above normal, and the discharge, which ceased entirely within ten days, was so scanty that the dressings were scarcely soiled after the first two days. During the forty-eight hours following operation—that is, before the clamps were removed—the catheter had to be passed several times. Within ten weeks of the operation the patient was serving customers in her shop.

I saw this patient again only a few days ago—that is, about ten months after the operation. She told me that she was enjoying perfect health for the first time during many years. She is able to perform all the onerous household duties which fall to the lot of women of her class, even including the weekly washing. It may be claimed that she is cured therefore in the fullest sense of the term.

Though I have been unable to find in the literature at my disposal that hysterectomy has been advocated as a routine treatment for chronic corporeal endometritis, this case has convinced me that it is a justifiable treatment under certain circumstances. Every practitioner knows how hopeless is the condition of many of these women. The minor procedure of curetting, while it may relieve some cases in which the disease is not of long standing and the tissues are still comparatively healthy, is at best but a palliative measure, more likely to determine the onset of malignant degeneration than to eradicate precancerous conditions. There seems to be no reason why any woman, within sight of the menopause, who is suffering from such a distressing complaint, should retain an organ which is not only useless but is even a constant menace to her health and existence, especially when that organ has already satisfactorily performed all the functions for which it was created. Vaginal hysterectomy by the double clamp method is so safe, so simple, and can be so rapidly performed, that I see no reason why it should not be the operation of election in cases of chronic endometritis which have failed to respond to more conservative and less effectual procedures.

A CASE OF TRAUMATIC PNEUMOTHORAX AND PLEURAL EFFUSION SUCCESSFULLY TREATED BY RESECTION.

BY

F. S. RHODES, M.R.C.S., L.R.C.P.,
SURGEON, FLEETWOOD COTTAGE HOSPITAL.

THE following case of traumatic injury to lung, followed by pneumothorax and then pleural effusion, which recovered after resection of rib and drainage, may be of sufficient interest to publish, as several authorities advise against drainage of the pleural cavity in effusion. Mr. Godlee, with Dr. Fowler, are emphatic on this point. They say, at page 596 of their book entitled *Diseases of the Chest*:

The surgeon is often asked to open these, especially if the fluid has become slightly turbid. My experience is that if this

be done the fatal conclusion is hastened. Such patients get along well with large accumulation of fluid in the chest, but when free opening is made they become short of breath, and as the discharge is copious for a long time, it is very likely that septic organisms will be allowed to enter. This is the beginning of the end.

Another interesting point is that while the remittent, and then intermittent, temperature, together with the general condition of the patient, strongly pointed to an empyema, a bacteriological investigation of the fluid showed it to be sterile.

History of the Injury.

On January 26th, 1909, G. B., aged 17, a farm labourer, left his horse and cart at the door of a shop. A passing lorry caused the horse to bolt. He immediately gave chase, and managed to gain a hold on the back part of the right shaft. After running like this for about a hundred yards, and finding he could no longer keep pace with the galloping horse, he threw himself sideways from the cart, but was caught by the wheel, and the cart, containing a load of five hundredweight, passed over his left leg about 3 inches above the ankle.

State on Examination.

I found the patient lying on the ground suffering from a compound fracture of the left leg, and complaining of great pain in the region of the right scapula. After seeing to his injuries he was placed on a stretcher and conveyed by train to Fleetwood Cottage Hospital. The leg was placed in splints and gave no further trouble. On the right side of the chest ill-defined crepitus could be elicited in the region of the scapula, but it was difficult to say whether it was due to injury of the scapula or to the ribs beneath it.

Progress.

In the course of a few days the patient's breathing became embarrassed, the right side of the chest was distended, the heart pushed over to the opposite side, the percussion note tympanitic, and all the signs of pneumothorax were present.

The temperature was 99° F. on admission, but rose steadily to 102° at the end of eight days, there being a morning remission to 100°. This remittent temperature lasted for two weeks, when the patient became suddenly very ill, and the temperature rose abruptly to 104° for twenty-four hours. A sudden drop to 99° was charted next morning, and for the next four and a half weeks the temperature was intermittent, averaging 98° in the morning and 100° or 101° in the evening.

Aspiration.—With the rise in temperature the signs of pneumothorax were replaced by dullness, etc. The question now arose as to whether the condition was pneumonia, traumatic pneumonia, or pleural effusion. As slight improvement followed, it was decided to watch the case and see if the condition would clear up. The improvement was not maintained, and on March 22nd I aspirated and withdrew nearly four pints of viscid brown fluid so thick that it flowed but slowly through the cannula. Improvement at once took place; the temperature fell to normal and remained there, and the general condition became more satisfactory.

Second Aspiration.—He left hospital on April 21st, 1909, but three days later became very ill; he felt too weak to stand, had rigors and dyspnoea, and on the following day was readmitted to hospital. The right side of the chest then gave the same physical signs as were present before aspiration. Aspiration was again performed, and about two pints of fluid similar to that removed on the previous occasion were withdrawn.

Resection.—Two days later, Dr. McKinnon of Fleetwood giving the anaesthetic, I resected a portion of rib in the posterior axillary line on a level with the nipple and drained the pleural cavity.

RESULT.

The sinus closed in about three weeks, and the patient has remained quite well since.

Some of the fluid was sent to Professor Delépine at Manchester for bacteriological examination. No organisms were found in cover-glass preparations, and no growth was obtained on inoculating tubes of various culture media.

At the present time—January, 1911—the patient remains in good health, and is able to follow his employment. The right side of the chest shows flattening, with droop of the shoulder and prominence of the scapula. The chest expands fairly well on inspiration, although the breath sounds are weak on the right side. Measurement shows the circumference of the right side of the chest to be 1½ in. less than that of the left side taken on level of nipple.

THE report submitted at the thirty-seventh annual meeting of the Central London Throat and Ear Hospital on May 9th showed that during the year 723 patients and 11,404 new out-patients had received treatment. Of the former, 58 per cent., and of the latter 37 per cent., were sent to the hospital by medical men. This fact, it was pointed out, not only indicated the esteem in which the institution was held, but disarmed any criticism as to abuse of its wards and out-patient department.