frequent irrigation of the colon through an appendicostomy opening.

As already stated, the proper time to perform appendicostomy is as soon as the condition has been diagnosed; but in practice it has been my experience that the surgeon is usually not called in until medical treatment has been tried for months and failed. Then when appendicostomy is suggested it is argued that the patient is in such a poor condition that he will not stand the operation. This is, however, not the case, as the operation can quite well be performed under local anaesthesia without running any risk at all.

In a bad case the patient should after the operation be treated by continuous saline irrigation for six or eight hours at a time. This is easily arranged by using a metal bed-pan with a tap and a rubber tube attachment. Very careful nursing is, however, necessary to prevent the formation of bedsores.

As soon as the diarrhoea has been checked and improvement has set in, a 3 or 4 pint wash through twice or three times a day will be sufficient. On no account should any antiseptic be added to the fluid used for irrigation, as poisoning symptoms are almost sure to result. Solutions of silver nitrate or protargol can be used, but in the case of the former only for a short time. I have seen a very bad case of staining of the skin with silver which resulted from frequent washing through with silver nitrate. Salt water seems to give the best result in most cases.

There still are people who think that an appendicostomy opening is an objectionable thing and that it results in the escape of gas and faeces. This is, of course, not the case with a properly made opening. In ulcerative colitis the opening should be kept patent for at least six months after all symptoms have subsided, but after this it may be allowed to close, which as a rule it will readily do.

CONCLUSIONS.

1. Chronic ulcerative colitis is a very serious and often fatal disease.
2. The best treatment is by frequent washing through with saline solution after an appendicostomy opening has been established.
3. The operation should be performed as soon as a diagnosis has been made and not left as a last resort, although it may sometimes succeed even then.
4. The diagnosis should always be confirmed by sigmoidoscopy.

FIBROIDS COMPLICATING PREGNANCY: HYSTERECTOMY: RECOVERY.

BY

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PREGNANCY with fibroids of the uterus, especially subserous ones, is, of course, not uncommon, but a case which I have recently had to deal with presented somewhat unusual features, and showed what a remarkable condition may be associated with a normal menstrual history and pregnancy, in the early months.

A healthy nullipara of 38, from whose mother I had, by the way, removed an ovarian cyst and subserous fibroid some years ago, had been married fourteen months, and the menstrual periods, which had always been perfectly regular and normal, had ceased for four and a half months. She had had some morning sickness, and the breasts were enlarged and tender. Pregnancy had therefore been diagnosed, but no suspicions of abnormality aroused. I was sent for on account of troublesome vomiting for two days, constipation, and sharp abdominal pain.

A rounded movable tumour, about the size of a fetal head, was felt in the upper abdomen as high as the ensiform cartilage. It was attached below to what appeared to be a pregnant uterus reaching well above the umbilicus, irregular in shape, and unduly high up. On vaginal examination the pelvis was found to be occupied by a large fixed firm rounded mass lying between the rectum and vagina, and displacing the uterus upwards, so that the cervix could only just be reached round the front of the tumour. A diagnosis of fibroids complicating pregnancy was made, and operation advised, as, owing to the size and position of the tumours, symptoms suggestive of commencing pressure, and the risk of degeneration and infection, it seemed unsafe to wait for viability of the child.

The patient was brought into a nursing home; an enema produced a fair result, the sickness and pain ceased; her general condition was good. A catheter, passed with a little difficulty, showed no distension of the bladder.

Operation.

In the Trendelenburg position, under ether, skilfully given by Dr. A. Simpson with Shipway's apparatus, an incision was made from the pubes to well above the umbilicus. A gravid uterus was revealed, covered with subserous fibroids of all sizes; many were small, but from the fundus grew two large pedunculated masses, each the size of a fetal head. These were delivered from the wound with the uterus. On lifting the viscus forward sharp haemorrhage occurred from the posterior part of the cervix, where it was attached to the pelvic tumour. There were many large veins, and everything was very vascular. The bleeding could only be controlled by pressure with pads, for it took place from a considerable torn surface in dense tissue, and no vessels could be secured. Efforts to bring up the pelvic mass, which was extra-peritoneal, by traction with strong vulsella, helped by the pressure of an assistant's fingers in vagina and rectum, failed. In view of the risk of meeting with uncontrollable bleeding if further attempts were made to remove the pelvic block, hampered as one was by the presence of the bulky uterus, it was judged that the right course was to diminish its size and vascularity, at the cost of the child. Pituitrin was therefore injected, the uterus incised where it was free from growths, and the fetus and placenta removed. The edges of the incision were clamped together, and haemorrhage quickly arrested. In spite of the advantage now obtained it seemed impracticable to save the uterus, and a subtotal hysterectomy was performed, the ovaries being spared. On the right side a small dermoid cyst, intimately adherent to the pelvis, was encountered, but left to be dealt with if necessary subsequently. The peritoneum over the pelvic fibroid was now freely divided and separated off, and the tumour brought up with the vulsellum sufficiently to give room for the fingers being worked down and round it, gradually enucleating it from its bed, a watch being kept for the ureters. No definite connexion with the cervix could be identified. Haemorrhage was readily arrested, all peritoneal edges brought together with catgut sutures, and the abdomen closed.

The patient made an uninterrupted recovery, and was back at home in three weeks.

The case was of special interest to me in connexion with Dr. Herbert Spencer's Lettsomian lectures. Dr. Spencer states that he has never found it necessary to remove a uterus in the early months of pregnancy, and expresses the opinion that the practice of hysterectomy in this condition is much too common, but I believe the difficulties encountered in this case justified what I did.

Instead of panhysterectomy, subtotal hysterectomy was performed, as the position of the cervix made it easier; nor did I split the cervix for drainage, as Sir John Bland-Sutton suggests, as all looked so dry and tidy that I was tempted to leave it.

On section the tumours presented the ordinary appearance of myomata, no "red degeneration" being observed; but the pelvic fibroid showed signs of fibrocystic change. This, Dr. Herman states, is often associated with rapid growth, which presumably was the case here.

PHAGEDAENA OF HUNTERIAN CHANCRE

FOLLOWING TREATMENT WITH NOVARSENO BENZOL.

BY

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In both these cases there was bacterial infection of the Hunterian chancre. In both chancre, bacteria, and the "reacting" tissue became more or less completely shut up together by the very effect of the reaction on the tissues around the chancre.

CASE I.

A labourer, aged 39, six weeks after coitus, noticed a painless lump on the under side of the penis, and three days later a "running," thin at first, then thicker. During the ensuing seven days he noticed slowly increasing discharge and difficulty in passing water, but had no pain. He denied previous gonorrhoea or chancre.

Examination showed a thick yellow discharge from meatus, and, on micturition, thin, twisted, interrupted stream. On the ventrum of the penis, in the line of the urethra, about 4 cm. from the meatus, could be seen and felt a dull red, hard mass, 1 by 0.5 cm., not tender, apparently including the urethra. The inguinal glands on both sides were large, hard, and discrete. There was no rash. No attempt was made to pass instrument.