On June 20th, 1903, by Dr. Gray, who was of opinion that she had a pelvic tumour which would prevent the passage of a child by the natural way. She was in fairly good health, and had no symptoms of haemorrhage or pressure from the pelvic tumour. The examination of the abdomen showed the top of the uterus well above the umbilicus. The uterine walls showed prominent nodules at the top and upper part, and parts of the fetus could be felt in utero. The pelvic examination showed a rounded mass in Douglas's pouch which was firmly wedged and extended to the pelvic wall, displacing the uterus forwards.

Operation.—On June 23rd chloroform was administered and the abdominal wall divided by a long median incision extending from above the umbilicus almost to the pubes. On exposing the uterus a large fibroid tumour was found on its anterior wall, which was pedunculated and bled somewhat freely on attempting to bring out the uterus. A thick band of omentum was adherent to the upper part of the uterus. The omentum was first divided between ligatures; the broad ligaments on each side were tied in two places and divided between the ligatures. The loose tissue on each side of the uterus was then separated with the finger, and the uterine arteries felt low down on each side. Macewen's needle threaded with thick silk was passed round the arteries, and on the right side this ligature was tied, but the left ligature was not tightened. The uterus was then drawn out at the abdominal cavity and packed round with flat sponges and towels. An incision was made in its anterior wall about 5 in. in depth, and the muscular wall torn through to the same extent. The membrane was then carefully opened and the finger passed in, to find the position of the placenta.

The opening in the membranes was then enlarged, and the child readily withdrawn. Respiration set in at once, and the cord was cut between two pressure forceps.

The liquor amnii was drained over the side to avoid soiling the peritoneum. The cord with the forceps was returned, and a flat sponge placed in the uterine cavity, while the margins in the opening of the uterus were pressed together. The uterus was then drawn forwards, and with some difficulty the fibroid tumour was drawn out of the pelvis. Both uterine arteries were now tied securely, and the uterus cut through low down, so as to make two flaps of uterine tissue. There was very little haemorrhage from this stump, which was brought together with buried catgut sutures and silk sutures through the peritoneum. The pelvis was then cleared of clots, etc., and a Keith's drainage tube inserted in the pelvis, with its upper end projecting from the lower part of the wound. The abdominal wall was brought together with silk-worm-gut sutures, the separate layers being united with buried catgut sutures. The operation lasted one hour, and at its termination the pulse was 80 and good in character.

After-history.—The patient made a good recovery, the only incident to be noted was a small collection of pus in the pelvis which necessitated the reintroduction of a drainage tube for some days.

The special point in the operation was the small amount of shock which the patient suffered, in fact, the pulse was better than after the termination of an ordinary labour. This was due chiefly to the small amount of haemorrhage which was easily controlled by the ligatures. The question of tightening the second ligatures on the uterine artery before extracting the child is one for future consideration.

A CASE OF VESICULAR MOLE OF UNUSUAL SIZE.

By THOMAS SLATER JONES, L.R.C.P.LOND., M.R.C.S.ENG

Mrs. C., aged 48 years, had had eight children. Five years ago she passed a similar mole, but much smaller. Two years ago she had a child at full term. This child is distinctly syphilitic. She had an attack of rheumatic fever about eighteen months ago. Menstruation had ceased for seven months. The patient told me that for a month she had a more or less bloody discharge, with uterine pains off and on.

On August 15th, 1903, when I saw her, she had strong labour pains, a copious, weak sanguinous discharge in which could be seen an occasional cyst of the hydatidiform mole. On external palpation the uterus was felt to be very much distended; it extended up to the ensiform cartilage. No fetus could be felt (as she was thin this would have been an easy matter to make out). The os was fairly dilated, and masses of the cysts, which felt soft and peculiar to the finger—not like the feel of placenta praevia at all—but with a sensation to the finger quite characteristic of the condition, presented.

After the patient had been put under chloroform, I introduced my hand into the uterus, and got the whole of the masses of cysts away without much difficulty. This was fortunate, as frequently in these cases there are considerable adhesions to the interior of the uterus, whose wall may be very much thinned in places. Haemorrhage, too, is often excessive, but by keeping one's hand well over the uterus and by injecting ergotine hypodermically, this anxious complication did not occur. Subsequently the patient made an uneventful recovery.

The mass of cysts weighed 5 lb. 4 oz. The cysts presented somewhat the appearance of grapes; the largest measured about 1½ in. longitudinally, the smallest being smaller than a pin's head. They contained a gelatinous material slightly

Fig. 1.—Photograph of a very small portion of the mole.

tinged with red enclosed in a translucent, glistening, ovoid envelope. Each cyst was attached by an independent peduncle, which did not arise from a common stalk as in grapes, but apparently one from another.

Report from Clinical Research Association.

This section exhibits chorionic villi in various stages of mucoid degeneration. Masses of epithelium have resulted from proliferation of the syncytium covering the villi, and some of these are also degenerating. There is no definite growth like "deciduoma malignum."

SOME DECEPTIVE ABDOMINAL CONDITIONS AND THE QUESTION OF OPERATION.*

By A. H. TUBBY, M.S., F.R.C.S.,
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WHEN I was honoured by being asked to read a paper before this Branch of the Association, it appeared to me that I could not enlist your interest better than by choosing this subject, because it is common ground to all of us, and the questions of operation and of no operation are constantly arising. The maze of symptoms in these abdominal cases is sometimes so tangled that we welcome any clue, however slight, to guide us in our difficulties. It must be admitted that the method of settling the diagnosis by making an exploratory operation in all doubtful cases is one which is certainly not feasible in private practice, and it cannot be justly said to be in the best interests of any patient if constantly employed. It is indeed strongly to be deprecated, because it savours merely of the art of surgery, and not of the science. He is a poor surgeon who finds himself compelled to cut the Gordian knot of his difficulties by acting on the formula: "Let us open the abdomen and look inside." The risks of a simple section are, it is true, small, but they are appreciable, and no patient

* Read at a meeting of the East Surrey District of the South-Eastern Branch of the British Medical Association.