bladder by suprapubic puncture. I cannot understand how a competent man, with an elastic male catheter, the use of his eyes, and a good light can fail to pass a catheter in these cases. The figures I have read to you show that in twenty years, in the two largest hospitals in London, not a case was met with in which the catheter could not be passed; and therefore, suprapubic puncture of the bladder was never done.

I have spoken of this subject at greater length and with more emphasis than I should have done had it not been that in some textbooks, meritorious in many ways, abdominal section is recommended for retroversion of the gravid uterus. But when one finds that it is apparently not known that a retroverted gravid uterus will nearly always right itself within forty-eight hours if the patient is kept recumbent and her bladder empty, the force of the advice to do abdominal section is considerably weakened.

I can see no reason for performing abdominal section. The only cases in which it can possibly be beneficial are those in which the uterus is fixed by adhesions in a position of retroversion: and as adhesions generally lead to sterility, such cases will always be of extreme rarity. And in such cases the breaking down of adhesions and replacement of the uterus will be attended with more haemorrhage than usual, owing to the greater vascularity of the pelvic organs brought about by pregnancy. Nevertheless, I think in a case of retroversion fixed by adhesions it would be better to free the uterus by manipulating within the peritoneal cavity than to try to break down adhesions by pressure from below. Death has been caused by injuries inflicted during such manipulations. The operator who tears through adhesions by pressure from below cannot know what pus cavities he may open or what vessels he may tear across. The operator who opens the abdomen can at least tell if he liberates pus or if there is haemorrhage, and in the latter case he can do something to stop it. But if there is no other indication for abdominal section other than retroversion of the uterus causing retention of urine and not easily replaceable, it is not necessary to replace the uterus. Either the pregnancy will go to the full term, the uterus enlarging at the expense of its anterior wall or else spontaneous abortion will take place. If the gestation goes to full time, in the course of pregnancy the adhesions will get looser, softer, and probably in time will be absorbed.

Abdominal section is not free from risk. The case of an adherent pregnant uterus is just the one in which oozing from severed adhesions is likely to be free and difficult to stop. The danger of abdominal section is greater than that of a week's frequent use of the catheter, and greater than that of letting pregnancy go to term with part of the uterus in the hollow of the sacrum.

It has been proposed and recommended in some textbooks to puncture the uterus by the rectum or by the vagina, draw off the liquor amnii in order to reduce the bulk of the uterus, and thus make reposition easy. This proposal ought to be respectfully considered because it was made by William Hunter. It will prevent too much weight being attached to the fact that Hunter thought the uterus was sometimes irreducible if we remember that Hunter had no anaesthetic. If the uterus is really irreducible it may seem a reasonable thing to do; but before doing this it is desirable to be sure that the uterus is really irreducible. We should remember not only that in the great majority of cases the uterus will go up if the patient is kept recumbent and the catheter frequently passed; but that even in cases in which attempts at reposition had failed, when the patient was kept lying down with her bladder empty the uterus went up, to use an expression I often find in the notes, "of its own accord."

It is also sometimes recommended to induce abortion. When the cervix is high up it is not an easy thing to get a sound or tent into the cervix. But looking at the facts, that in the large majority of cases the uterus will right itself if the patient is kept recumbent and the catheter frequently passed, and if the uterus does not right itself the pregnancy may go to term and natural delivery take place in spite of the displacement, provided retention of urine is avoided, the induction of abortion seems to me unnecessary.

REFERENCES.

- ¹ There are several such sacs in the Museum of the Royal College of Surgeons of England. Nos. 3,681-2,3,552-6. ² *Edin. Med. Jour.*, 1883-4, p. 100. ³ There is a specimen in the R.C.S. Eng., No. 3652, showing this. ⁴ *Arch. f. Gyn.*, Bd. XII, 1881. ⁵ *Obst. Trans.*, vol. XXII, p. 129. ⁶ *Med. Times and Gazette*, 1857. ⁷ *Gaz. Méd. de Paris*, 1856, p. 20. ⁸ *Glasgow Medical Journal*, January, 1857, p. 412. ⁹ *Monats. f. Geb.*, xxiv, p. 414. ¹⁰ *Das Geschlechtsorgan der Weib.*, Bd. III, s. 583. ¹¹ *Des Déplacements de la Matrice en Arrière pendant la Grossesse*. ¹² *Lancet*, May 21st, 1893, p. 1397.

EXTRAUTERINE PREGNANCY.

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THE following case of extrauterine pregnancy, in which rupture occurred at the third month, and death took place on the tenth day after an operation from pulmonary embolism, presents points of interest.

History.—Mrs. L., aged 31, had had three children, youngest aged 6, but no miscarriage. On September 23rd she called in Dr. O'Connor, of Gorey, who found her suffering from abdominal pain. She had vomited several times. She had not been feeling well for some days, and had felt pain more or less for a week. She was lying in bed on her back. The abdomen was distended and hard. The pain was referred chiefly to the right iliac fossa, and she could not bear the slightest pressure in that region, no dullness could be detected. She declared that menstruation had occurred every three weeks and that she was not pregnant. The bowels had not acted for more than a week. Pulse 110, feeble. Temperature 101.8°. Heart sounds normal. Urine normal. The patient was ordered to remain in bed. Diet: milk and beef tea only. An enema was given with satisfactory result. Her condition gradually improved and when seen on October 18th she said she felt quite well. There was then no pain on pressure, but the abdomen was still distended. Pulse 80. Bowels very obstinate. Eight days later she again called in Dr. O'Connor. He found that she had been downstairs every day, and that whilst in the kitchen that afternoon she was suddenly seized with violent abdominal pain and fell unconscious.

When seen she was in a state of collapse. She lay on her back, knees drawn up, face pale and pinched, running pulse, respirations feeble and rapid, abdomen most painful.

State on Examination.—On the following day, October 27th, I was called by Dr. O'Connor to see the case, and decided to open the abdomen without delay. The patient was breathing very quickly. Pulse rapid and less tension. Face very pale. Abdomen distended and immobile, especially over the lower half; painful and tender all over. She was too ill to be removed to the hospital four miles away. In the attic of a poor labourer's cottage, with the help of Mr. Tweedie we set to work with such precautions against sepsis as we could command.

Operation.—The abdomen was opened by a 4-inch incision through the sheath of the right rectus, and the lower part of the abdomen and the pelvis were full of blood, mostly clotted and dark. Some difficulty was found owing to the distension of the intestines, and while washing out the blood there was a sudden rush of water from the pelvis, and a fetus about 3 inches long appeared, still attached by its umbilical cord to its torn and anaemic placenta. There was only one definite adhesion between bowel and sac, and the sac was apparently continuous with an enlarged portion of the fimbriated extremity of the Fallopian tube, distal to the ovary. The fetus and sac were easily removed and the Fallopian tube ligatured. After clearing out the abdomen as completely as possible the wound was closed and dressed, and a large hot water and salt enema was given and retained.

Progress.—The patient passed a good night after the operation, with the exception of some vomiting, which was relieved by a dose of calomel. After this there was slight diarrhoea, but the wound healed and convalescence was uninterrupted till the tenth day. On November 7th the patient was cheerful and wanted to get up. She seemed quite well, except that the breathing was rather more rapid than one would wish and the pulse still rather feeble. There was no pain or tenderness over the abdomen. Ten minutes after I left her she suddenly collapsed and died.

Necropsy.—Wound perfectly healed. Pelvis contained some blood-stained fluid (? post mortem). No injection of peritoneum. Slight sign of a localized peritonitis between two coils of intestine in one place. The remainder of the peritoneum quite healthy. Stump of tube firmly held by silk ligature partially imbedded. The pulmonary artery contained a large clot, which, although branched, was not altogether fixed. It was laminated on section and in parts hollow. Its laminated structure and variegated colour suggested that parts of it were not of recent formation.

REMARKS.—I have no doubt that death was caused by the clot described becoming detached and causing a complete block. It had doubtless been slowing forming. There was also some engorgement of the posterior parts of both lungs, which I do not think was a post-mortem change, but probably due to the obstruction of the pulmonary arteries. How long that clot had been in the pulmonary artery before getting moved and causing death one can only surmise. The rapid breathing had been a prominent feature of the case from the first time I saw her, namely, before the operation. Such an accident is apt to follow any operation, and I cannot see how it can be guarded against. I do not think that sepsis has anything to do with the causation. Twice previously have I had similar trouble. Once on the tenth day after removal of a large fibroid, and once after ovariectomy (on the fourteenth day). In neither case was there the slightest sign of any septic infection at any time of the case.

An anonymous offer to defray the cost of the erection of an operating theatre for the High Wycombe and Earl of Beaconsfield Memorial Cottage Hospital has been accepted.