THE TREATMENT OF FIBROMYOMA UTERI.¹

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I THINK that I shall best fill the place I am in if I give briefly my present views, the outcome of an experience extending over twenty years, with large and increasing opportunities for studying this most interesting subject. I will not recapitulate the variety in minute structure, in situation as regards the natural tissues of the uterus, and in relation to neighbouring organs which these abnormal growths present; you know them as well I do, or, if you do not, I would advise you to study them carefully in some recognised textbook before you presume to study them in the living subject or attempt to advise their unfortunate and unwilling hosts, for the advice we give must depend greatly in each individual case upon these differences of structure, of situation, and of environment. There are a very large number of cases in which the patient suffers no sort of inconvenience, and is quite unconscious that there is anything wrong. Such cases should be left entirely alone, and I hold that if they are discovered accidentally in the course of examination for some other disease it is cruel and unnecessary to mention their presence to the patient. If you once tell a woman or her friends that she has a fibroid tumour of the womb her peace of mind is gone, and, unless she has greater character than falls to the lot of most women, she will go about seeking advice, and she will be examined and pulled about till some irritation is set up, and mischief follows. Leave it alone and it will leave her alone in a very large number of cases.

Besides these cases, which are only discovered by accident, and not because they are giving trouble, there are a considerable number in which there are trifling discomforts which may be easily relieved by a little care in diet and mode of life or by a little simple medical treatment. Let me give a few illustrations. A patient presents herself with constipation, a sense of weight and discomfort when walking or, more often, on standing or kneeling, or bending the body in some particular direction, and perhaps some bladder discomfort—either too frequent micturition or difficulty or pain—all these, or any of them, being aggravated by, or only present just before, the period. Menstruation is quite regular, is not excessive, and not remarkably painful. On examination one finds one or more distinct bosses on the uterine surface; they are hard and smooth, and not tender on pressure, and they will vary in size from a filbert to a hen's egg.

I am not speaking now of tumours which are palpable in the abdomen, but only of those which require vaginal examination for their discovery. Cases such as this have frequently come to me, in the greatest state of alarm and misery, because they have been suddenly told that they have tumour or tumours of the womb, and that they must be operated on at once. All I can say is the man who gives such advice in such a case is either a very ignorant or a very wicked person. Nature is in these cases very wise, even in her distribution of disease; the cases which least require operation are precisely those in which the experienced surgeon at once recognises the difficulty, or often the impossibility, of successful operation. The cases which urgently require surgical aid are usually (of course not always) those most suitable for radical cure by operation. How, then, shall we relieve such a case as I have briefly described? Regulate carefully the diet, restrict the red meat, forbid red wine and heavy stimulants, or better cut them off entirely, advise regular walking exercise between the periods, but not to distinct fatigue, and rest in the recumbent position during the period, or at any rate during its oncoming; and in medicinal treatment advise the patient not to take blood-making tonics, and especially preparations of iron, and to take from time to time an ergot mixture during the intervals between the periods, but never during the flow. In nine cases out of ten this will make the patient quite comfortable, and in many cases the ergot will altogether stop increase of growth, and in some few will entirely starve the growths. I have known several cases of

complete cure when the patient has been able and willing to persevere with the ergot in this way for some years, giving it an occasional rest and then taking it again.

If, in addition to the discomforts I have named, there be added pain, the ergot often gives immediate relief the pain in such cases being due to chronic congestion. When the pain is due to increase in the size of the cavity and clotting the ergot is still useful, but it will be much aided by the passage of graduated dilators; usually the occasional passage of 8, 9, or 10 shortly before the period will be all that is required, but if the tissues of the cervix are involved in the fibroid growth it may be advisable to give an anæsthetic and rapidly dilate up to 16 or so. All dilatations should be followed by a thorough cleansing of the uterine cavity with a probe armed with cotton wool and dipped into tincture of iodine. If hæmorrhage be troublesome as well as pain ergot between the periods and full dilatation are still indicated, and will often suffice to check it; if they do not, hamamelis or red gum will in some cases be found very useful, but if these simple means fail the curette may be necessary as well as the dilator; to be really efficient, the scraping should be thorough, and especially upon the angles towards the openings of the Fallopian tubes.

I have almost unconsciously passed from the case which requires nothing but a little regulation of diet, etc., to those requiring some amount of surgical treatment, and this gives a good indication of the nature of the disease, for the various cases pass by such fine gradations into one another, that it is almost impossible to classify them, or to lay down hard and fast rules for treatment. All I am attempting to do is to give you my general impressions. Everyone who sees much of the disease will meet with exceptional cases, which will require special study, and it may be special treatment. Hitherto I have spoken only of cases in which the growths are still small enough to be confined to the pelvis, but in practice fully half the cases met with will have already become large enough to rise above the brim, before we are asked to advise as to their treatment. If the growth is a single mass, more or less involving the whole of one wall of the organ, it is quite likely that it will give no trouble at all when once it rises into the abdomen, and that all we shall be called upon to do will be to try and keep its growth in check, by regulating diet and mode of life, and by the administration of ergot. In such cases a well fitting abdominal belt with some elasticity is of great service; it steadies the mass and prevents its irritating the peritoneal surfaces by constant rubbing and swinging about, and it also prevents congestion by supporting and aiding the action of the abdominal muscles. In a certain number of cases even very large tumours require no treatment at all, or only such palliatives as I have been alluding to, and we must never forget that the largest, equally with the smallest, will entirely disappear after the menopause in most cases. I have watched some cases in which enormous masses have entirely disappeared a few years after the menopause.

The questions then which we must ask ourselves when discovering a fibroid are: Is it right to say anything about it at present? If it is, shall I call it a fibroid, or shall I merely say there is a little thickening, a statement giving much less alarm, and in many cases strictly true? If the patient already knows that there is a fibroid, or if one feels bound to tell her so, one must then carefully consider her symptoms, the probable duration of the life of the tumour, and her age, and I think that one should never give decided advice as to surgical interference at a first interview, unless fortified by the knowledge of a medical attendant who has been long watching the case, and has at last unwillingly come to the conclusion that nothing but surgical interference will avail.

Before proceeding to discuss the surgical treatment of fibroids, however, I must clear the ground a little, by a word as to the use of courses of baths and mineral waters, and of electricity.

With regard to the treatment by baths and mineral waters, I have not the least doubt that in some cases, much good is done by a course, but I have no ground whatever for believing that any single case has ever been cured by any number of courses. Patients derive benefit by the improvement of their general health and tone, and by the reduction of œdema and congestion of the tumours, and where patients are ple-

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thoric, over fed, and of too full habit, much good may be done by a visit to some foreign spa. I must confess that I prefer the foreign spas to those at home, because I think much is due to the complete change of diet, life, and surroundings, and though the waters may be equally valuable at some of our own places, I doubt if the patients ever get the same benefit they get from a visit to Kreuznach, or Swalbach, or Marienbad, or some other foreign spa.

I have had no personal experience of the use of electricity; it has been tried in so many things before and failed so signally that I was not encouraged to personal experiment; then I was at Copenhagen when Apostoli read his paper there, and it impressed me not at all. I have studied since all that I have come across in the journals and in books, and I have found nothing to make me alter my early ideas about it. I have never yet been satisfied that any case of fibroid has been cured by it, and if half that those who believe in its virtues say of it be true, then the cures ought to be hundreds by this time with such a common disease, and with patients so ready to submit to treatment which does not involve the knife.

That it does in some cases check hæmorrhage by its local action on the diseased mucous membrane I fully believe, but so do many less troublesome applications, and so will one curetting, if more severe measures be necessary. That it does in some few cases cause the tumour to shrink for a time I also admit, but unfortunately they very often only rest, and then start off and grow again, and sometimes faster than before. Then it is within my personal knowledge that in the hands of the most skilled operators serious mischances do occur, and also that instead of reducing the tumours it does occasionally induce great rapidity of growth, and pain and discomfort which were never there before. I have operated on several cases after it has either failed to relieve them or made them distinctly worse, and this not precipitately, but after long and patient waiting for the benefits that were not apparent at first, but were to be so in three months, or in six months, or so on after the actual treatment had ceased. Then I have been told by many patients that if they had only known what the disagreeables of the thing were, they would far rather have faced at once a serious surgical operation than faced the thirty sittings. I wonder why thirty is the magic number. It seems to be so in the hands of the chief operators. I am ready to admit a little prejudice, but it is only the offspring of a conscientious endeavour by a study of the published cases to arrive at the truth. Show me the cures and I will believe. They ought, I repeat, by this time to be so many that the most sceptical could not fail to become a believer.

Before passing to the question of treatment by abdominal operation, we must briefly consider vaginal enucleation. This is a proceeding of which I have had no great experience, but such as I have had has been singularly unfortunate, not only as regards the immediate results of my own operations, but also in what I have seen in the practice of other men. In these days, any surgical proceeding, if it is to hold its place, must not only be fairly free from immediate risk to life, but it must give a pretty certain prospect of cure when the immediate dangers of the operation are past. How does enucleation stand these tests? I should say that it is enormously more dangerous to life than any abdominal operation, that it is very uncertain in its results because it is so difficult to be sure that there is only the tumour or tumours which we detect and remove, and if we do make a clearance at the time, others are very likely to form. In fact the very damage which we unavoidably inflict upon the uterus during enucleation is a most likely cause of new growths. I say this fully believing that actual physical injury to the uterine tissues must be credited with a very large share of the cases in which fibroids develop. The cases suitable for enucleation are those in which the growth is tending to enucleate itself into the cavity, and especially those involving rather the cervix than the body of the uterus. Small growths from the size of a filbert to that of a hen's egg may, if causing hæmorrhage or other serious trouble, be dealt with by enucleation, and larger growths, which have begun to slough before they come under the observation of the surgeon, must be thus dealt with. I have had a few cases of remarkable success in the removal of very large masses under apparently most un-

favourable conditions, but, on the other hand, I have seen these cases very quickly fatal.

My general advice would be: avoid enucleation if you can. If you cannot, then take every possible precaution to make your proceeding thoroughly aseptic. There is no operation in surgery in which this is so important, and there is no operation in which it is more difficult. The external organs should be thoroughly cleaned with some antiseptic soap; the vagina should be freely douched at short intervals for some days beforehand with an efficient antiseptic, and immediately before operation with a 1 to 1,000 corrosive sublimate lotion. If possible, the uterine cavity should be thoroughly mopped out with pure tincture of iodine. There are differences of opinion among experts as to the best methods of dilatation. I have no sort of doubt myself that, if tenting could be made surely aseptic, it is far better than rapid dilatation; but I have failed altogether to make it so, and I have seen it introduce the septic element which has brought about the fatal result; therefore, I prefer rapid dilatation in most cases, with its risks and difficulties; in some few it is quite impossible to do everything by rapid dilatation, and a tent or two must be used to soften the parts and fit them for the more rapid process.

I am convinced that the internal os is almost always more or less lacerated, often very deeply and seriously, when dilatation has to be carried to the extent necessary for the enucleation of any but the smallest growths. Such lacerations are not only immediately dangerous from the surfaces which they offer for septic absorption, but they have an element of danger about which we know little, and that is the effects of the resulting cicatrices, should the patient become pregnant after a successful enucleation.

With regard to the after-treatment, I think it should greatly depend upon the size of the growth enucleated and upon our impression as to the asepticity of our proceeding. If the growth be small, the proceeding aseptic, and the anticipation of discharge slight, then I prefer to plug the vagina at once with 20 per cent. iodoform gauze, and leave the plug untouched for some days, or even a week, carefully watching the temperature and pulse, and removing it sooner and thoroughly douching with antiseptic solution if there is the least suspicion that everything is not keeping sweet. If there is much damage to the uterine wall or to the internal os and much oozing, I think it is a good plan to touch over the oozing surfaces with solid perchloride of iron, washing the clot, etc., freely away afterwards, and then plug right into the cavity with strips of lint soaked in tincture of iodine. Such plug will usually be found in twenty-four hours nearly expelled by the uterus, and if it is not there is no difficulty in extracting it.

After all these manipulations, free douching with antiseptic lotion is essential, and if the vagina is not plugged the nurse should douche every two or three hours for the first few days, and then three or four times in the twenty-four hours, till the discharge practically ceases. The can douche or the funnel douche is much safer than the syringe, unless the nurse has an unusually delicate touch. Very few nurses should be trusted to syringe with a Higginson under such circumstances. The patient should be kept in bed for at least ten days after any such proceeding, and cautioned to be specially quiet and careful at the first return of menstruation.

But suppose we meet with cases which positively require relief on account of hæmorrhage, pain, or rapid growth, and serious pressure interference with other vital organs, are we at the end of our resources when we have tried some or all of the various palliative or curative measures which I have thus far briefly discussed? Fortunately not; but, on the contrary, we have still at our command two well-tried and most successful surgical procedures, either of which may much more certainly cure than any of the methods I have been talking about.

Before proceeding to discuss the relative value and proper application of these two operations, I would recall a warning which I have often given before in discussing this subject. However firmly you may be of opinion that the one or the other may be the proper operation for the individual case, never absolutely commit yourself till you have the abdomen open and the organs under your immediate touch

and, it may be, sight. You cannot in every case so completely remove the ovaries as to bring about the changes you desire, and yet perhaps you can completely remove the uterus with the ovaries, that is, the uterus all but its vaginal portion. On the other hand, a case which before the abdomen was opened appeared specially suitable for hysterectomy proves, after that great aid to diagnosis has been given, far more suitable for removal of the ovaries. I always say to the patient and her friends, "I believe the one or the other operation is the proper one for you, but I cannot promise which I shall do till I can actually handle the parts, and in consenting to operation you must leave me to decide at the time which it is best for you that I should perform."

How far can you recommend removal of the ovaries for the cure of fibromyoma uteri? is a question I am often asked, and I feel warranted, from my own experience and from what I have seen of the work of others in this operation, in replying: I believe you can depend upon a certain cure if you can completely and cleanly remove every bit of ovarian tissue; if you cannot then I think you had better leave it alone, because small portions of ovarian tissue remaining on the proximal side of your ligatures will very likely keep up congestion and hæmorrhage, and entirely nullify the operation. If you can thoroughly remove the ovaries then you will certainly cure your patient in a number of months, or it may be years, varying as much as the variations seen in the natural cures at the menopause. In the majority of my cases the cure has been not only rapid but complete, in some very slow, and accompanied by occasional troublesome hæmorrhage, but in every case where there has been no fresh interference and some reasonable patience the cure has come. The one exception which rather proves the rule is that of a lady now past the age of natural menopause, who still has her tumour, not a large one, but little altered since I operated many years ago. I stopped its growth and her menstruation, but it did not go away; this is, however, an exceptional case in other ways, because I operated for the removal of the second ovary and the cure of the fibroid some years after another surgeon had very imperfectly removed an ovarian tumour from the other side, and, though I tried to remove his remains, I could not feel confident that I had done so. Then I am not sure how far the doing of the operation in two sections, and with an interval, may have affected the result. Still, even this is not a failure, for the tumour was growing rapidly and ceased to grow, and, though the change is small, still it is in the right direction of diminution.

The mortality of the operation in my hands has been just over 4 per cent., and has, I believe, been entirely due to the accidental puncture of large vessels in the pedicles, with subsequent thrombosis or embolism. When this accident happens—and happen it will occasionally, however careful you are—I believe the ligatures should be withdrawn, and a fresh transfixion made on the proximal side of the first, that is, if there is room to get a second puncture in this way. The risk of this accident is much lessened, and the firm and satisfactory hold of the ligatures much increased, if transfixion be made through the utero-ovarian ligament, but in some few cases this is impracticable in consequence of the way it gets thinned and spread out over the tumour.

To what class of tumours is this operation most applicable? Undoubtedly to those general enlargements of one or other uterine wall, which form a smooth, rather oval, tumour, pretty central in its position, and varying in size from a fetal to an adult head. I have, however, operated successfully for much larger and more complex masses, and I have also got excellent results in cases of multiple subperitoneal and intramural tumours, still confined practically to the cavity of the true pelvis.

It is not necessary for me to enter into any description of the method of operation; it is simply ovariectomy performed on both sides, and with such modifications in the application of the ligatures as may be rendered necessary by the presence of a larger or smaller solid growth tending to open up the broad ligament, and thus spread out and lengthen the parts involved in the pedicle. Two cardinal points must be kept in mind in selecting the points for transfixion; the ligatures must, when tied, not only leave room for complete removal of the ovary, but they must leave room for this without such undue shortening of the stump as to endanger slipping and

hæmorrhage. It is a good plan to leave the appendages first ligatured in the abdomen (not cut them away) till the other side has been dealt with, as the pulling and straining in extracting the second lot of appendages is very apt to loosen the ligatures if they are on the cut stump merely; when both sides have been tied both can be cut away at the same time, and there is no necessity to do anything afterwards to disturb them.

The after-treatment of these cases corresponds with that after an ordinary ovariectomy, except that they require more care; thus, after ordinary ovariectomy, I always keep the patient strictly to bed for two weeks; after this operation it is more often three or more, my rule being that the patient does not get up till all coloured discharge has ceased, and the metrostaxis, which nearly always follows the operation within the first forty-eight hours, often lingers on as long as this, and the more it lingers the more rapid is the tumour in disappearing. In the great majority of cases, when it once stops it never reappears, but some cases have occasional returns at irregular intervals, and some very few actually troublesome hæmorrhages from time to time. This reminds me that I have said nothing as to the time best for operation; I always, if possible, operate shortly before the menstruation is expected, not, as used to be the rule, soon after it is over. There are two good reasons for choosing this time: (1) the patient is generally at her best at the time, having picked up after the previous period; and (2) the period is naturally due and the machinery for its production in preparatory action, and the operation only hastens it, hence it appears quickly and with less disturbance than it does if the operation is done when all has settled down just after a period, and the effort necessary to reproduce it proportionately upsets the patient.

I am afraid that I have already occupied so much of your time that I must be very brief in what I have to say on the important subject of hysterectomy. There are many ways of performing this operation, but I shall only describe two of them, as I think the others have little, if anything, to recommend them.

Supravaginal hysterectomy, with extraperitoneal treatment of the stump, is the operation I have most often performed, and it is the one which will, I think, be found most applicable to the majority of cases. Sometimes it is necessary to remove one or both ovaries, and sometimes one or both can be left behind; theoretically, it might seem unwise to leave either of these organs in the peritoneum when their functions can no longer be properly performed, and their normal blood supply is more or less interfered with, and the Fallopian tubes sealed at their uterine outlets; but, practically, I believe it is a distinct advantage when one or both can be left; the woman is less unsexed, and is, I feel sure from observation of the cases in which I have been able to leave one or both ovaries, less inconvenienced by the troubles which attend the sudden and artificial production of change of life. This is especially true if she be a married woman or one likely to be married. I have in several cases performed supravaginal hysterectomy, removing the tumour or tumours, and the whole abdominal part of the uterus, in order to enable the patient to marry, and in these cases I have always, when possible, left one or both ovaries, and with the happiest results as far as the after married life is concerned. The functions of the ovary seem to be exercised in the normal way, and I presume that the ova merely drop into the peritoneum and are quickly absorbed. In some of these cases there is a slight menstruation from the remaining cervical portion of the uterus, but it rarely comes regularly or continues for any length of time.

If both ovaries are removed, and Kœberlé's wire *serre-nœud* be used for fixing the stump in the lower angle of the external incision, it is possible, in some cases, to pass the wire at once round the uterus and both broad ligaments, so that no ligatures are necessary, the tumour, body of the uterus, and appendages all being cut away in one mass; but more often it is necessary to ligature off the ovaries and tubes by transfixing the broad ligaments on each side, and then, after removing these organs, apply the wire round the base of the tumour (usually it goes on best just about the level of the internal os). When this method is adopted it is a good plan to pass the wire through the broad ligament on each side of the uterus close to the points of transfixion in each broad

ligament; this steadies the wire, and prevents it from slipping up or down during tightening. In many cases it is necessary to do a good deal of enucleation before the wire can be applied; thus the capsule of the tumour may have to be incised right across the anterior surface, and the bladder carefully peeled back, and a similar enucleation may have also to be performed behind or even on both sides as well; in the latter case two layers of vessels have often to be secured, and as they are usually of great size this is, when necessary, a part of the operation requiring great care, or very serious hæmorrhage may occur; the ureters are often in very close relation to the vessels, and great care is necessary to avoid including them in the ligatures or drawing them into the wire as it is tightened.

As soon as the wire is tightened and before the tumour is cut away, a strong pin should be passed through the base of the tumour just outside the wire, and a little screw cap fitted on to its sharp end. This prevents the stump slipping back into the abdomen, and holds it in the external wound. As soon as this is applied the tumour is cut away, the stump neatly trimmed and packed round with dry antiseptic dressing, and then its cut surface is lightly smeared over with solid perchloride of iron. This is far preferable to any sewing over of peritoneal edges, which only serves to confine discharges, which are very likely to be septic, as the opened uterine cavity is in the middle of the stump. This cavity should be very carefully dried as soon as it is exposed in cutting away the tumour, and it is a good plan to clean it well out with little pledgets of cotton wool soaked in tincture of iodine or corrosive sublimate lotion. Putrefaction always occurs in the stump sooner or later when it is thus treated extraperitoneally; indeed, it is a necessity for the separation of the stump, but it is well to delay its onset till the tissues all round about are well sealed by the natural healing processes. A dry antiseptic, or rather aseptic, stump is a very troublesome thing to deal with, and often greatly delays the convalescence. This sloughing and separation of the stump is the great danger in and objection to this extraperitoneal method, but practically it rarely leads to any trouble if the stump is allowed time to separate, and not pulled and messed about too much when the wound is dressed. Sometimes it is advisable to cut the wire and remove it about ten days after the operation, but sometimes it separates with the whole external part of the stump about this time or a little later. It is well, when cutting away portions of the stump, or cutting the wire, or removing the pins, to have some perchloride of iron at hand, as troublesome little hæmorrhages sometimes occur from cutting a little too deeply into the stump, or from tearing at its union to the parietes, and it is better to seal these up at once, or septic absorption may take place. When the stump finally separates a deep granulating pit remains, and this sometimes takes weeks before it is thoroughly healed, and during the whole of the healing the wound should be carefully supported with strapping, or a weak place in the scar and rupture may result.

The only other method of performing hysterectomy to which I shall direct your attention is the complete intraperitoneal one, which we owe originally to Schroeder. The early steps of the operation are the same as those I have already described, except that an elastic ligature is used instead of the wire, and is removed when the suturing of the stump is complete. The great advantage claimed for the operation is that, as in intraperitoneal ligature and dropping of the ovarian pedicle, nothing is left outside to slough and separate. After the tumour is cut away each portion of the stump is separately sutured with rows of fine interrupted points of silk, which are cut short and buried by the next row. Mucous membrane is sutured to mucous membrane, uterine tissue to uterine tissue, and finally peritoneum to peritoneum, the sutures being applied so closely that they also completely control hæmorrhage.

Theoretically this is a perfect method, as nothing remains outside to putrefy and separate and no raw surfaces are left in the peritoneum; but practically it has certain great difficulties and dangers. First, it is very difficult in many cases so to suture that hæmorrhage is efficiently controlled, and, if it is at the time, oozing is very likely to come on later as the uterine tissue contracts. Secondly, it is very difficult, and in some cases impossible, to make the inside of the stump

thoroughly aseptic. The opened uterine cavity must always be in the centre of the stump, and the sutures which close the mucous membrane may acquire putrid material during application, and from them putrefaction may spread into the stump. This is, of course, more likely to occur if there be some oozing and tension. Such a condition of affairs must obviously be still more dangerous than a putrid stump outside, for, though there is a possible outlet for discharge through the cervix into the vagina, it is a very uncertain one, and one very likely to be blocked.

I have, however, had some excellent results from this method in cases in which I found it impossible to get a stump for external treatment, and when cases do do well their convalescence is much quicker than by the extraperitoneal method. I have no doubt, however, that the mortality is and will be higher in any series of cases thus treated than in a similar series treated by the extraperitoneal method. I shall not occupy your time with any description of the method by complete enucleation and suturing of large flaps of peritoneal capsule in the abdominal wound, for I can see nothing to recommend it, and it is, so far as I have seen it performed, a clumsy and needlessly bloody and dangerous proceeding.

It only remains for me to thank you for the patience with which you have listened to this very inadequate sketch of one of the most important questions which we have to face in the treatment of the diseases of women, and to express the hope that any shortcomings will be amply rectified by the speakers who follow my lead, so that the whole result of our discussion may be a clear exposition of the present state of our knowledge and practice.

CASE OF PORRO'S OPERATION FOR IMPACTED LABOUR WITH ACCIDENTAL HÆMORRHAGE.

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Mrs. P., aged 33, had been married ten years, during which time she had been under my care at intervals. She had had four miscarriages and four children born dead; and finally, after prolonged administration of mercury, two healthy living children aged respectively, at the time of her present illness, 4 and 2½ years. The confinement 2½ years ago was normal, and nothing unusual was discovered about the pelvic organs.

On March 14th, 1892, labour commenced, she being then in the ninth month of pregnancy. When I arrived at the house, she complained of a constant pain in the abdomen. On examination, I found the uterus about its normal size at full time, but in a state of tonic contraction, extremely hard and tender to touch; the os would hardly admit one finger, and from it dark blood was slowly running. The pelvic cavity was occupied by a semisolid tumour which appeared about 3 inches in diameter; in front of it the os uteri was with difficulty reached close behind the pubes and high up. I endeavoured to push the tumour up into the abdomen, but failed, owing to its being fixed in the pelvis; at the same time it was ascertained to be separate from the uterus and not compressible.

Hæmorrhage continued slowly, and the pulse gradually rose from 80 to 100 per minute. Dr. Burton-Fanning and Mr. Walters saw her with me shortly afterwards, and we decided that she must be delivered by abdominal section. It was now nearly nine hours since the commencement of labour, and the pulse was becoming empty and more rapid; the face also was getting pale and respiration was quickened.

Dr. Burton-Fanning gave ether; the abdomen was opened as rapidly as possible by an incision 4 inches long in the middle line; the uterus was of a purplish colour. I passed my hand round the uterus and felt the tumour in the pelvis, where it was firmly adherent. Great difficulty would have attended its removal while the enlarged uterus was in the way. I therefore freely incised the uterus. No hæmorrhage took place. I introduced my hand and pulled out by the leg a dead fetus of the usual size at full time. The placenta, which was lying loose in the uterus, followed easily, as also