did about two pints of dark blood clot; the uterus immediately contracted and was drawn out of the wound; two pins were passed through the cervix, and, while Mr. Warlters was adjusting and tightening Koerberlé's *serre-nœud*, I enucleated from its adhesions in the pelvis a dermoid ovarian cyst rather larger than an orange. The uterus and tumour were cut away; the abdomen washed out with sterilised water and sponged dry; the wound was united round the stump, no drainage tube being used. The operation was completed in half an hour.

The shock which followed was very severe, and was vigorously treated with artificial heat and brandy. The pulse remained feeble for many hours. She slowly rallied; then followed complete suppression of urine for sixty-eight hours, so that I began to fear lest the ureters had been included in the clamp. However, by the greatest care in the after-treatment, and especially at this time, after prolonged hot sponging, the kidneys began gradually to act. At first only 4 ounces of urine were passed in twenty-four hours; next day 8 ounces; then 13 ounces, then 15, and so on until the normal amount was reached. Portions of slough were cut away, and the clamp came off on the seventh day.

She had the best nursing, and the most careful attention to dieting and after-treatment, her convalescence extending over six weeks, after which her recovery was complete, and she went to the seaside.

At the present time—January, 1893—she is in perfect health.

NOTES OF A CASE OF VAGINAL MYOMECTOMY PAR MORCELLEMENT.

By JAMES MURPHY, M.A., M.D.,

President of the North of England Branch of the British Medical Association.

I HAVE been waiting for several years to find a case of uterine myoma suitable for removal by the vagina by the method of *morcellement*—taking it away piecemeal—invented and practised almost daily by my friend and former teacher, M. Péan. I have had the advantage of having assisted M. Péan in at least twenty similar operations, and to see him do the operation is to me one of the most interesting sights in the whole field of surgery, and shows him as the original, brilliant, and dexterous surgeon that he is.

I am indebted to my friend Dr. Drummond, of South Shields, for the opportunity of doing my first case, as he was good enough, in January, 1892, to place under my care a patient with the following history.

History and Condition before Operation.—Mrs. S., aged 42, mother of one child, aged 18, had suffered from a myoma in the posterior wall of the uterus for some years. For the past few months it had caused her great inconvenience from its pressure on the rectum and bladder, necessitating the almost constant use of the catheter. The pain was severe and the tumour was growing. Some hæmorrhages had occurred, but the reasons for removing it were—increasing growth, pain, and the rectal and bladder troubles caused by its pressure. On examination, a large tumour could be felt in the posterior uterine wall blocking the pelvis. The os was represented by a slit high above the pubes, and the tumour presented in the vagina a condition very similar to a pregnant retroverted uterus. On examination of the abdomen the tumour reached nearly to the umbilicus.

Operation and After-history.—On February 3rd, 1892, she was placed in the lithotomy position, her legs supported by Clover's crutch. I then incised the capsule of the tumour from before backwards, stripped it off as far as I could, then, applying a powerful forceps to the tumour, snipped off a portion the size of a Tangerine orange, with a strong scissors. I then removed a similar portion at each side, and in this way, always working from the circumference to the centre, removed piecemeal more than three-fourths of the tumour, when I was enabled to enucleate the remaining portion. As there was considerable oozing of blood, I plugged the cavity with some wood-wool, a small portion of which I unfortunately overlooked in removing the plug next day. This had the effect of sending the temperature up to 104° on the sixth and seventh days; otherwise she made an excellent recovery, and the uterus now feels like an ordinary multiparous uterus, and she is in perfect health.

REMARKS.

The accompanying excellent drawing, for which I am indebted to the kindness of my friend Dr. Baigent, explains the mode of operating. From the position of the myoma, situated as it was in the posterior uterine wall, and protruding into the vagina and completely filling up the pelvis, it would have been impossible to have removed it by abdominal section and extra-

peritoneal clamp, and to have removed it through the abdomen by first tying the vessels in the broad ligaments, and then removing the whole mass, both uterus and myoma, would have left an enormous opening between the abdomen

and vagina, difficult, if not impossible, to close; whereas by removing it as here recorded, the peritoneum is not opened and the uterus is left behind.

THE GRAPHIC METHOD APPLIED TO THE DIAGNOSIS OF OBSCURE ANEURYSMS.

By W. SOLTAU FENWICK, M.D.LOND., M.R.C.P.,

Physician to Out-Patients to the Evelina Hospital for Sick Children, Medical Tutor to the London Hospital;

AND

WALKER OVEREND, B.A.Oxon., B.Sc.,

Late Radcliffe Fellow, Oxford.

In a paper read before the Medical Society of London recently Dr. Richardson drew attention to a method of intrathoracic auscultation which he proposes to employ as an aid to diagnosis in cases of commencing stricture of the œsophagus, in certain diseased conditions of the stomach, and in cases of aneurysm of the larger thoracic arterial trunks. It so happens that during the early part of the year 1890 we made a series of experiments in the same direction. In the first instance it was the great difficulty experienced in the diagnosis of an aneurysm of the descending portion of the arch and of the thoracic aorta which induced us to employ an intrathoracic method. By its means we hoped to obtain graphic records of movements communicated to various parts of the œsophagus. We also imagined that the method might prove serviceable in the diagnosis of aneurysm in the upper part of the abdominal aorta, and, when introduced into the rectum, in the recognition of aneurysm of the common and internal iliac trunks.

The apparatus consisted of a long soft rubber œsophageal tube, to the end of which a piece of very thin elastic membrane, capable of inflation, was firmly secured. At the opposite end the tube was connected with a Marey's tambour and with a