administered ether, and as soon as I got my hand into the abdomen, which was full of blood, I clamped the right broad ligament with a long-curved forceps. The cavity was then rapidly cleared of many handfuls of clots and several tumblersful of fluid blood, when the uterus became visible with the forceps attached close to the ruptured tube. When the forceps was relaxed, blood poured out of the ruptured tube. The tube and ovary were removed close to the uterine cornu, and Fig. 1 (from a photograph) shows the exact size and condition of the parts. The rupture is on the anterior and upper surfaces of the Fallopian tube within $\frac{1}{2}$ inch of the uterus, and the placenta is attached to its inferior and also slightly to its lateral walls. The lumen of the tube on the uterine side does not admit a horsehair, whilst a thick probe is easily passed up to the placenta from the fimbriated extremity.

It is hardly necessary to state that the operation had to be done on the bed, as a removal of the patient would probably have been fatal. For the first forty-eight hours after the operation it required the constant care and skill of Dr. Biggs to combat the various and varying symptoms, and I am quite convinced that but for the timely administration of champagne, of opium, and for the resort to transfusion after the operation, the result would have been different. On the fifth day the patient had fish, and afterwards rapidly got well.

The left tube was normal, and the left ovary contained a large corpus luteum. Sister Yates stated in her note before the operation that on two occasions she thought the patient was dead.

CASE II: LARGE OVARIAN FIBROMA: ELEPHANTIASIS OF THE ABDOMEN.

Fibromata of the ovary are extremely rare according to Tait, Greig Smith, John Williams, Bland Sutton, and others, whilst the series recorded by Mr. H. Briggs¹ are not altogether of the pure type, and consequently are not quite so common as the title of his valuable paper would lead one to conjecture. A woman, aged 42, was sent to me by my friend Dr. Powell (Newcastle Emllyn), who had been compelled to tap her five times to relieve dyspnoea, as she would not submit to abdominal section. The result was that when I saw her in June, 1895, her abdominal wall was of enormous thickness, the skin being coarse, tuberculated, and covered with a

Fig. 2.—Ovarian fibroma. The gap in right half is the place from which microscopic section was made.

foul secretion, looking like an advanced case of elephantiasis. There was a large solid tumour in the right lower half of the abdomen, and a cyst extending up to the ensiform cartilage. The patient's suffering had been agonising for some months before operation. The abdominal wall cut was like the subcutaneous tissue of elephantiasis, and no trace of muscle was seen. The cystic tumour was attached in all directions to intestines, abdominal wall, and bladder, whilst the fibroma itself was comparatively free from adhesions. Recovery was retarded by carboloria and albuminuria. Eighteen months after operation the abdominal wall was quite smooth, there was no tendency to hernia, and the scar was 14 inches long.

The macroscopic appearance of the fibroma is well shown in the photograph reproduced in Fig. 2. It is resting on the collapsed wall of the papillomatous cyst to which it is attached. It cut like a dense fibroma, and looked typical of one. The report of the Clinical Research Association is: "The tumour is a dense fibroma composed of wavy fibres arranged in interlacing bundles." The section was taken from near the periphery of the tumour (shown in the figure on the right hand). It weighed 5½ lbs.

CASE III: PAROVARIAN CYST IMPACTED IN DOUGLAS'S POUCH.

The causes of impaction of cysts in the pelvis are commonly the following: Adhesions, malformation of the pelvis, gravid uterus, and rotations; but in the following case I believe it was due to confinement under the reflections of the recto-vesical fascia and peritoneum.

Miss —, aged 20, had been treated with pessaries for nearly four years for prolapsus uteri. There was a history of difficulty in micturition for six years. Menstruation occurred first at 16, and had been irregular ever since every three or four weeks. There was in Douglas's pouch a firm cystic swelling which moved with the uterus. The uterine cavity was 3 inches long.

On September 8th, 1896, I opened the abdomen in Trendelenburg's position, and found a tumour behind the uterus, the fundus of which was higher than the cyst; I failed to release it until one of my colleagues introduced two fingers into the rectum, when after three or four strong pushes the cyst suddenly darted out into the wound and was easily removed. The cyst was the size of a lady's fist; was parovarian in origin, and had no adhesions; it had two atrophic patches the size of a threepenny bit on two opposing surfaces, probably due to pressure against the lateral walls of the pelvis. It is rather strange that she had had no trouble in defaecation. The fundus uteri was thickened. It is probable from the history that this parovarian cyst commenced at an unusually early age, for Mr. Bland Sutton in his *Surgical Diseases of the Ovaries* states that he has not found one recorded under the age of 16.

REFERENCE.

¹ BRITISH MEDICAL JOURNAL, May 1st, 1897.

REMARKS ON THE TREATMENT OF CUT THROAT,

WITH NOTES OF A CASE TREATED BY IMMEDIATE SUTURE IN LAYERS.

By R. G. HOGARTH, F.R.C.S.ENG.,
Salisbury.

Late House Surgeon, St. Bartholomew's Hospital; and
Senior Resident Medical Officer, General Hospital, Nottingham.

OUT of seven cases I have had to treat, the following is the only one of which I have full notes. Of the others, in one the wound was situated above the hyoid bone, three were through the thyro-hyoid membrane, one through the crico-thyroid membrane, and one through the trachea. Unfortunately the immediate suture treatment was not adopted in all the cases.

J. R., aged 48, was admitted to the General Hospital, Nottingham, on February 12th, 1896, at 10 A.M. The skin was cold and clammy, the pulse rapid and feeble. He was covered with blood and vomit. There was one extensive wound in the neck, deeper on the left side than on the right, opening the larynx and pharynx by dividing the thyro-hyoid membrane. The epiglottis was completely divided at its base, and the middle constrictor of the pharynx was cut on each side. The thyroid cartilages were uninjured. The sterno-mastoid muscles were notched, but the large vessels had escaped injury. The wound gaped a great deal, and through it bubbled with expiration a mixture of saliva, vomit, and blood; by the look of the tissues the wound had been made some hours, and there was only a little oozing of blood, the primary hæmorrhage from the division of the superior thyroid or lingual vessels having stopped. The larynx and pharynx were well sponged out, and made as clean as possible, all hæmorrhage carefully stopped, and the severed tissues of the larynx brought together and fixed in position with chromic catgut. The epiglottis was done first, and came well and easily into position. The air passage was apparently rendered quite tight. The whole wound was then well washed out with biniodide of mercury solution, 1-500 first, then 1-2000, and the cut tissues united layer by layer with chromic catgut, except the skin, which was brought together with horsehair. A small drainage tube was inserted on each side at the ends of the wound, and an antiseptic dressing applied.

At 6 P.M. the temperature was 101°, the pulse 90 and of good volume. He was fairly comfortable. Now and then breathing was noisy. He had morphine $\frac{1}{4}$ gr. early in the day. He coughed very little, but when he tried

to feed by the mouth much severe coughing was produced. He was ordered a nutrient enema every four hours.

On February 13th the wound was dressed and looking very well. His general condition not so good; the pulse was irregular and small; the breathing was good, but there was slight stridor. There were no signs of pneumonia. Hypodermic injection of strychnine was ordered, $\text{m} \times \text{v}$ of a 1 per cent. solution every six hours. He was fed by nasal tube night and morning (milk Oj , brandy 3j , egg 1). The rectal feeding was continued every six hours.

On February 14th he was restless, excited, and complained of headache. The temperature 102° ; the pulse 104 and stronger. He was given morphine gr. $\frac{1}{4}$ hypodermically.

On February 15th the wound was dressed; it was looking very well. The tubes were removed. The pulse was 90 , and the general condition much better. The strychnine and rectal feeding were stopped. He swallowed custard and did not cough, and could talk in a whisper.

On February 16th feeding with the tube was stopped; the patient going on well.

On March 11th he was discharged cured from the hospital, the wound having healed by first intention.

I have to thank Mr. Anderson, under whose care the patient was in the hospital, for permission to publish this case.

From a consideration of the matter I think that every case of cut throat should be treated by immediate suture unless the patient is in a dying condition from shock and loss of blood. In such a case it should be done as soon as the patient recovers sufficiently to stand it.

It is very rarely necessary to give chloroform. I have always been struck by the condition of the patient in cases of cut throat. There is great depression of the nervous system, and the patient will allow the wound to be cleaned and sutured without appearing to feel in any way, although perfectly conscious of everything going on around him.

In consequence it is hardly ever necessary to administer chloroform, which must, taking the condition of the patient into consideration, add greatly to the risk. The wound must be very thoroughly cleaned after the air passage has been securely closed; it can be washed out with some strong antiseptic: hydrag. biniodide, 1 in 500, or carbolic acid 1 in 20.

The suturing should be done carefully layer by layer from the bottom, the air passage completely and tightly closed, and muscles and the fascia taken in order up to the skin. For the buried sutures chromic catgut or silk is best. The skin wound is everted and brought into apposition with horsehair or silk worm gut, and if the wound is deep and extensive a small drainage tube can be put in at each end.

If the cleansing of the wound has been done thoroughly, in most cases the wound will heal by first intention, the period of recovery will be much shortened, and the patient will not run the many secondary risks that occur after the old treatment.

With regard to the use of a tracheotomy tube, it is never, I think, necessary to put in a tracheotomy tube at the time of suturing the wound; should the patient subsequently get oedema and severe dyspnoea, the larynx or trachea should be opened below the wound, and a tracheotomy tube inserted. This will very rarely be necessary, but in any case it must be better to do it when it becomes a necessity, rather than to leave a tube in the wound itself, or to make a fresh opening below at the time of suture. The head should be inclined slightly forward, and fixed in some way to prevent movement, and much depends on good nursing.

In the majority of cases feeding by the mouth is easily accomplished, but in cases in which the epiglottis, pharynx, or oesophagus are involved, it is best to rely for a time on rectal feeding or the nasal tube.

A CASE OF ACUTE PULMONARY GANGRENE.

By T. ARMSTRONG BOWES, M.D. CANTAB.

Herne Bay.

A SAILOR, aged 52, was taken ill at sea, and when removed on shore was delirious for about seven days. The nature of the illness could not be ascertained. There was no history of dysentery or liver disease, but he had "something wrong" with his left lung some years ago when abroad.

When first seen on December 23rd, 1896, immediately after the delirium, he was a sallow-complexioned man, perfectly rational, and quiet by day and night. He complained of slight pain in the left side of the chest, but no abnormal condition could be discovered on this side. On the right side, however, just above the liver dulness in the nipple line,

was a small area of impaired resonance, with a few *râles*, but no bronchial breathing. The heart and remainder of the right lung were natural. Over the sacrum, for the size of half a crown, the skin was abraded.

On December 25th the sputum became a little rusty, and expiration harsh over the area above mentioned.

On December 27th the temperature rose to 100.4° , the area of impairment was slightly increased, the sputum became darker in colour with a grey tinge, and began to smell. From this date to December 31st the temperature remained about 103° F., and rose on the evening of this day to 104.8° F. He was very ill, the sputum copious, very foul, and of a blackish-green colour, containing on microscopical examination pus and elastic tissue. The impairment increased rapidly, reaching to the second rib, and in the second and third interspaces bronchial breathing and coarse *râles* were present.

During the next four days his condition slightly improved, the sputum being less foul, the temperature varying between 101° and 102° F., and from this date onwards to January 29th it never reached normal, being usually about 101° , with extremes of 99° and 102.5° .

On January 10th the discoloration of the sputum was less; three days later it was slightly increased, but it finally disappeared on January 20th, the sputum after this being mucopurulent.

While slowly gaining ground, the signs of consolidation steadily progressed, till on February 7th impairment and bronchial breathing reached from the clavicle to the liver dulness. In the upper three interspaces a tympanitic note and amphoric breathing were present for a few days, but there was no bell sound. The sputum was fairly copious, and mucopurulent, and he periodically coughed up a quantity of it (about 1 ounce) which he felt collect about the second interspace. Great improvement in general condition had occurred during the last week.

On February 14th he complained of a cutting pain running up the junction of the ribs with their cartilages on the right side on drawing a deep inspiration. The condition of his chest was then as follows: On quiet respiration the left chest moved more than the right, and on the latter side expansion was shallow and deficient, the lower intercostal spaces being drawn in on inspiration. Vocal vibrations were increased from the apex to the nipple. There was impairment to percussion from the apex to the third rib from the sternum to the anterior fold of the axilla, and to a less extent below, merging into the liver dulness. The highest pitch of the note was in the third interspace near the sternum. The left lung was resonant everywhere.

On auscultation bronchial breathing and ægophony were heard in the second and third interspaces over an area 3 inches in diameter, the inner edges commencing 2 inches from the right edge of the sternum. Coarse *râles* were general on expiration and inspiration. Behind there was general impairment, with *râles* over the whole of the right lung, with bronchial breathing over the lower half of the scapula. The sputum was less in quantity, mucopurulent, and did not contain tubercle bacilli.

By March 25th the sputum had gradually ceased, and the abnormal signs in the right lung had entirely cleared up, except for harsh inspiration in the region of the right nipple. From this date the patient made an uninterrupted recovery.

DISAPPEARANCE OF A CARDIAC MURMUR.

By C. J. WHITBY, M.D.,

Limpley Stoke.

Mr. W. P., aged 59, came under my care in a hydropathic establishment on March 9th, 1897. He had been subject to persistent colds, usually following an attack of influenza. He complained of pain in the anterior mediastinum, with a feeling of constriction, "as by an iron band," across the chest. He has been an abstainer from alcohol for years, and had never smoked. Seven years ago he had what appears to have been an abortive attack of enterica, and twenty-nine years ago had nephritis after a chill. The pulse was 65, and its tension markedly high. There was no evidence of cardiac hypertrophy, but the second sound, as heard at the apex of the heart, was