4. In one case, related to me by my colleague Mr. Jessop, the liver dulness had entirely disappeared, apparently owing (a) to the liver having become diminished in size from the loss of blood, and (b) to the bowels having been pushed up by the effusion of blood in the pelvis.

In nearly all the cases there was dysmenorrhœa for some time before the catastrophe, and in several the pain of the pregnant tube led the patients to seek advice before rupture occurred.

In three cases I made the diagnosis of tubal pregnancy before rupture; in one, Case 13, the rupture occurred into the broad ligament, and after a long, tedious illness the patient recovered without operation. In another, Case 19, I removed the unruptured tube containing the ovum; and in a third, Case 6, I made the diagnosis and arranged to operate, and the rupture actually occurred on the way to the operating theatre, where I removed the tube still bleeding.

In the class of cases not seen until some time after the first rupture, the presence of a painful tumour fixing the uterus, often more marked at one side, usually filling up the pouch of Douglas, and sometimes reaching above the pelvic brim, when taken with the presence of metrorrhagia, the passage of decidual membrane, and the characteristic onset following on previous dysmenorrhœa with one or two missed periods will usually lead to a right conclusion.

TREATMENT.

Had it not been that quite recently I saw the report of a fatal case of ectopic pregnancy in which a surgeon was called in but declined to operate because of the collapsed condition of the patient, I should not have thought it worth while to remark on the treatment of these cases, as I think we are nearly all agreed that the arrest of hæmorrhage by the ligature and removal of the bleeding tube should always be adopted when the rupture has taken place into the peritoneal cavity.

A reference to my table of cases will show that three of the patients were pulseless at the time of operation, and in all three a pulse had returned at the wrist before the operation was finished, doubtless due to transfusion through the peritoneum by the absorption of the saline solution used in washing out the abdominal cavity to clear it of blood and clot.

My former remarks will show that I believe there will seldom be any doubt in diagnosis, but even if there should be, it is infinitely better to make a small exploratory incision in the middle line than to stand idly by and allow the patient to die of hæmorrhage when the simple application of a ligature could save her life. Such an exploratory operation need not necessarily open the abdomen, as in case of intraperitoneal hæmorrhage, the blood shows through on exposing the parietal peritoneum.

Even where the patient has partly recovered from the first hæmorrhage I would urge operation, since a second hæmorrhage may at any moment occur and prove fatal before operation can be arranged. Where rupture has occurred into the broad ligament, operation is not called for, unless the hæmorrhage be very excessive, or unless at a later stage it ends in suppuration.

When it is borne in mind how fatal this accident is, and what a terrible condition the patient usually is in when the surgeon arrives, it is as astonishing as it is gratifying to know that the operation is so safe and satisfactory. For instance had it not been for the accidental death from pulmonary embolism in a patient pulseless when operated on, I should have been able to record an uninterrupted series of recoveries; as it is, the one death in 23 only gives a mortality of 4.3 per cent.

A CHEQUE for £10,000 has been publicly handed over to the Leicester Infirmary by Mr. Councillor Herbert Marshall as a Jubilee endowment to the institution. The amount was wholly raised by Jubilee subscriptions at the instance of Mr. Marshall, ex-Mayor of the borough. This sum has been augmented by over £2,500 raised by a bazaar promoted by the Duchess of Rutland, the Countess of Warwick, and others, as well as by largely increased annual subscriptions.

CONSERVATION OF THE OVARY IN HYSTERECTOMY AND HYSTERO-MYOMECTOMY.

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"WHAT'S in a name?" is a question often asked, with the implied answer that the name is really of no importance at all, and yet nothing has done more to perpetuate bad surgery than ill-chosen names. For example, the names "cystocele" and "rectocele" given to the prolapsing soft tissues of the anterior and posterior vaginal walls have been the causes of innumerable operations upon these inoffensive parts of the anterior and posterior vaginal walls, while the real injury which let them protrude lay at the vaginal outlet; in like manner, the name "prolapse of the womb" given to the hernia ("sacropubic") at the inferior strait has been responsible for many useless operations for the removal of the prolapsing uterus, curing the ailment only in name, and losing sight of the fact that a patient with a vaginal pouch hanging out between her limbs was no better off even if the uterus were out of it.

On the other hand, I feel that much has been lost to the surgical world, and the progress of the conservative treatment of the pelvic disorders of women retarded by the changing of a name given by the older anatomists, with remarkable insight, to the essential female organs of sex, from "testes muliebres" to that of "ovaria" or "ovaries," and so losing sight of the homology between these glandular organs in the male and in the female. Had the older proper name of the ovaries been kept, and were they to-day called "testes" instead, radical executive surgery would have advanced far more slowly, and would never have gone so far, as the well-known conservatism with which the male is treated would then inevitably have been reflected upon the gynecological field.

Sir Spencer Wells struck the first telling blow in favour of conservatism in his *Ovarian and Uterine Tumours* (London: 1882, p. 342) when he reported 1,000 cases of ovariectomy in tabular form, in which the ovariectomy was unilateral—that is, one ovary was left, in 228 women who survived the operation and were under 40 years of age; 120 of the 228 women bore 230 children, very nearly an average of 2 children to each woman. Of the women over 40 years of age there were four who bore children. C. Schröder¹ by the resection of the ovaries; A. Martin,² in the resection of ovaries and opening closed tubes; and Dr. W. M. Polk³ by his repeated demonstrations and earnest insistence upon the possibility of restoration of function in diseased adherent tubes and ovaries, and of the functional value of opened and amputated tubes, have in later days laid the foundation stones for the important conservative gynecological work in the immediate future.

C. Schröder, in a spirit of ultra-conservatism, stated that one of his reasons for the preservation of part of an ovary was to retain the function of ovulation, even if it were accompanied by but a theoretical possibility of conception.

We are now beginning to realise that so long as the cyclical changes of menstruation persist they hold most important fundamental relations to the well-being of the body at large; and while we are as yet unable to state what is definitely accomplished by the act in the way of excretion, or its influence on metabolism, we do know only too well that the sudden artificial induction of the menopause is often a source of extreme and lasting discomforts.

There is a growing conviction that the ovary belongs to the same group of organs as the thyroid, thymus, and pineal glands, and that in addition to its function of ovulation, it secretes a substance which is absorbed and consumed in the animal economy, and which is necessary to it in retaining its physiological balance.⁴ Martin⁵ says:

"It is probable that the ovaries, like the liver and thyroid gland, modify the blood circulating through them, and add to the blood some peculiar product of their metabolism. It may be that some of the climacteric symptoms are due to the loss of this substance from the system."

An active principle called "spermin," found in sperm by Schreiner in 1878, has been found in the thyroid and thymus glands, and in the spleen, ovaries, testes, and blood, from all of which it has been extracted in the form of an insoluble spermin phosphate.

A. Poehl⁶ has elaborately studied this product, and found it in both the male and the female reproductive organs, and as a normal physiological constituent of the prostate, testicles, ovaries, thyroid, thymus, pancreas, and spleen, as well as in the blood. The crystals of spermin were separated from the semen in a form similar to the Charcot-Leyden crystals of Boettcher, with which they were for a long time confused. Spermin is, as A. Gautier has declared, a leucomaine, believed up to now to be a product of the retrogressive metamorphosis of an albumen, either injurious or indifferent to the organism; evidences now in hand, however, go to show that spermin possesses most valuable functions in connection with the activities of living beings, and the spermin secreting and elaborating organs may be called the "apothecaries" of the body, secreting many important medicaments, much more active and more accurately representing its true nature under varying conditions than artificially administered drugs.

Spermin is an active oxidising agent, assisting by its catalytic action in restoring the oxidising power of the blood without having recourse to the oxygen derived from the air. Spermin has also shown a favourable action when given to patients suffering from diabetes, scurvy, etc., in which such auto-intoxications are manifestly the result of an accumulation of retrograde products. Injected subcutaneously it acts as a physiological tonic in all kinds of depressed conditions such as neurasthenia, anæmia, etc. Poehl declares that it increases the nitrogenous excreta of the kidneys. Its action is enhanced by the alkaline condition of the blood.

More positive evidence for an internal secretion of the ovary are the experiments on bitches made by G. E. Curatulo and L. Tarulli.⁷ These authors, after regulating the diet of the animals until a certain average quantity of nitrogenous materials and phosphates were excreted daily, removed the ovaries. In each experiment they found the phosphates in the urine greatly and permanently reduced in quantity; in one case where the nitrogenous materials averaged 9.93 g. and the phosphates 1.50 g., a series of daily observations was continued over three months, and demonstrated the fact that, while the nitrogen remained about the same in quantity, the phosphates decreased down to 0.60 g.

The experiments of Curatulo and Tarulli would go to explain the utility of castration for the relief of osteomalacia, by permanently diminishing the excretion of the lime salts which form the solid elements of the bones. Associating Curatulo's results with the evidence given by Poehl of the high oxidising power of "spermin," we may ascribe the effects of castration in decreasing the phosphates in the urine, not to the lessened quantity taken in the food but to a diminished oxidation of the organic phosphates contained in the tissues, which, combined with earthy bases, are finally deposited in the bones in the form of calcium and magnesium phosphates.

Routh⁸ gives further important evidence of the existence of an internal ovarian secretion in citing Dr. Airstoff's investigations, which show that when one ovary is removed in a rabbit the other one undergoes a compensatory hypertrophy, increasing both in size and weight, the follicles mature and wither more quickly, and the medullary increases. These changes begin within two months after the operation, and in three or four months the remaining ovary has become nearly double its original size.

Since the ill-effects of castration, whether the structures are diseased or not, are often so disastrous, it becomes a question of paramount importance to determine whether we can in any way substitute the lost ovarian tissue, and to this end two natural lines of experiment have been tried. E. Knauer⁹ in a communication entitled *Einige Versuche ueber Ovarientransplantation bei Kaninchen*, has shown that the ovaries may be completely severed from their normal surroundings and successfully transplanted, either to a part of the broad ligament or between the muscles of the abdominal wall. In one of the rabbits examined six months after the

transplantation, one ovary excised and implanted in the broad ligament was found as big as a lentil, and abundantly nourished, with a normal stroma and numerous follicles of all sizes containing ovules; a number of degenerated follicles were also found, perhaps more than usual. The ovary implanted in the fascia of the abdominal wall was only about a third its original size, but was in other respects normal.

The second line of experimental substitution of the lost ovarian tissue is that of feeding to the women deprived of ovaries one of the organic juices. This has been tried by R. Chrobak¹⁰ in a few cases with distinctly encouraging results. The ovaries of cows, washed in ether and alcohol, and dried at a temperature of 45 to 50° C., with an air pump, and then pulverised and made into tablets containing 0.2 gr. of ovarian substance each were used. Two, three, or even four of these tablets were given daily to women suffering from the severe symptoms of an induced climacteric; in one case, after taking two or three tablets daily, the attacks of giddiness, flushes, and sweatings, which the patient had been having on an average ten times daily, were reduced to three, and disappeared entirely at night; another patient was entirely relieved of attacks which had been distressing her five or six times a day.

A valuable contribution to this line of observation has been made by Dr. H. B. Stehman, of Chicago,¹¹ who gave thyroid tablets to a series of patients suffering from various forms of mental and other disturbances, such as excessive flow, amenorrhœa, extreme nervousness, and ovarian pains, all of which might on the present hypothesis be attributed to deficient ovarian secretion. Each tablet given three times daily represented about one-sixth of a sheep's thyroid. In each of the six cases reported in detail, such a remarkable improvement was observed within several weeks, that the conclusion seems well founded that "in these cases of neurasthenia, with poor nutrition, and in consequence disordered pelvic function, ovarian tissue is indicated. The extract not only modifies the nutrition of the ovary but also general nutrition, and this return to the normal makes physiological processes possible."

While the verdict of "not yet scientifically proven" must still be written under some of these citations, the evidence is still strong enough to present cogent reasons to the gynaecologist for the utmost conservatism in treating the essential organs of sex. With these important observations in mind the efforts, and, if I may use the term, the experiments, of the conscientious gynaecologist at the operating table must henceforth lie in the direction of conservatism.

Strongly imbued as I am with these convictions, I make no apology for the presentation of the following chart carrying out a line of conservatism which may at first sight be deemed extreme, but which must, however, be judged by its results. Since the spring of 1895 I have invariably made an effort to retain the ovaries even in those cases under my care in which it has been necessary to remove the uterine tubes and the uterus; the result of this has been a remarkable diminution, and in some cases complete absence, of the distressing nervous symptoms of the menopause.

The table which I present here shows only those cases in which this plan of operating was tried where the uterus was removed for myomatous or fibroid tumours. There were twenty of these cases, three of them in black women and the remainder in white. The first operation is recorded as performed May 11th, 1895.

No general hospital cases have been included in the list of later date than December, 1896, although 18 cases have been operated upon since that time; the two cases dated February 17th and March 18th, 1897, were operated upon in my private hospital.

It will be seen by consulting the list, which has been prepared with great pains by Dr. Jay H. Durkee, that a brief but satisfactory analysis is given of each case. I would call particular attention to the column showing what organs were removed. It will be noted that this includes in every case the uterus, in 11 instances one ovary, in 6 instances one, and in 10 both uterine tubes. The column to the right of this shows what organs were left behind, not removed. In the larger column in the middle of the table the symptoms of the patient before the operation are given. The four columns

Conservative Treatment of the

Gynaecological Number.	Date of Operation.	Initials of Patient.	Age.	Race.	Marital Condition.	Menstruation.	Anatomical Diagnosis.	Organs Removed.	Generative Organs Left.
3501	May 11, 1895	A. B.	47	White	Married : 1 para ; labour normal	Irregular. Dysmenorrhœa increasing	Cyst R. ovary. Small. Solid L. "	Uterus, R. and L. tube, L. ovary	R. ovary
3590	July 21, 1895	C. T.	59	Black	Single "	Menopause, 5 years	Myoma uteri. Extensive adhesions	Uterus, R. tube, and ovary	L. tube and ovary
3628	July 8, 1895	S. E. H.	40	White	"	Irregular and profuse	Myoma uteri. Omental adhesions	Uterus, R. tube, and ovary	L. tube and ovary
3867	Oct. 22, 1895	M. S.	45	Black	Married : 1 para ; labour normal	Profuse 4 years. Dysmenorrhœa increasing.	Myoma uteri	Uterus, R. and L. tube, R. ovary	L. ovary
3806	Sept. 23, 1895	R. R. McL.	18	White	Single	Irregular and profuse hæmorrhages	Myoma uteri	Uterus and R. and L. tube	R. and L. ovaries
4369	May 11, 1896	M. E. R.	36	"	Married : 4 para ; labours all hard	Irregular 6 years. Increasing menorrhagia	Myoma uteri	Uterus, L. tube, and ovary	R. tube and ovary
4252	Mar. 30, 1896	A. C.	40	"	Married : 1 para ; labour normal	Normal	Myoma uteri. Strong adhesions	Uterus, tubes, and L. ovary	R. ovary
4423	June 6, 1896	B. R.	38	"	Single	Menorrhagia 7 years. Hæmorrhages	Myoma uteri	Uterus, tubes, and L. ovary	R. ovary
4526	July 25, 1896	R. R.	46	Black	Married : 6 para ; labours normal	Irregular for 3 years	Myoma uteri. L. salpingitis and oöphoritis	Uterus, L. tube, and ovary	R. tube and ovary
4635	Sept. 12, 1896	E. H. McG.	37	White	Married : o para o mis.	Constant flow for 4 months	Myoma uteri (submucous)	Uterus and tubes	Ovaries
4894	Dec. 28, 1896	C. R.	45	"	Married : 2 para	Menorrhagia	Cystic myoma	Uterus and tubes	Ovaries
4845	Dec. 1896	E. B.	32	Black	Married : o para o mis.	Increasing menorrhagia	Myoma uteri	Uterus, tubes, and R. ovary	L. ovary
4849	Dec. 5, 1896	I. M. J.	27	White	Married : 1 mis. ; no bad results	Irregular, scant. Severe dysmenorrhœa	Pelvic peritonitis. Hydrosalpinx duplex. Retroflexed uterus	Uterus and tubes	Ovaries
4771	Nov. 2, 1896	N. W. D.	42	"	Single	Increasing Menorrhagia. Hæmorrhages	Myoma uteri	Uterus, L. tube, and ovary	R. tube and ovary
4832	Nov. 25, 1896	F. G.	28	"	Married 4 years : o para	Regular	Myoma uteri. Multinodular	Uterus	Tubes and ovaries
4733	Nov. 2, 1896	M. R. B.	40	"	Single	Profuse	Myoma uteri	Uterus and tubes	Ovaries
4902	Dec. 30, 1896	C. E. E.	36	"	Married : 1 para ; labour normal	Regular	Myoma uteri	Uterus, R. tube, and ovary	L. tube and ovary
4903	Dec. 30, 1896	C. W. T.	35	"	Married : o para	Increasing menorrhagia for 3 months	Myoma uteri	Uterus	Tubes and ovaries
San	Feb. 17, 1897	G. W. C.	51	"	Married : ? para	Regular. Free	Myoma uteri	Uterus	Tubes and ovaries
"	Mar. 18, 1897	K. D.	46	"	Single	Excessive menstruation. Regular	Myoma uteri	Uterus	Tubes and ovaries

This Chart contains no hospital cases later than December, 1896. Since then 18 cases

which follow this furnish an analysis of the condition of the patient since the operation; in 3 cases, Nos. 5, 6, and 7 on the list, I have not been able to hear from the patients at all. The remarkable columns are the last, and the next to the last; it will be seen by consulting these that in no single instance has the operation given rise to any of the aggravating symptoms so commonly, I might almost say invariably, associated with the artificially induced menopause.

The utmost discomforts experienced were slight flushes, and in 9 cases absolutely no symptoms of a menopause are noted. Some of the letters received from the patients were quite remarkable for their enthusiastic expressions as to the relief experienced. One of my patients in the thirties, after experiencing no symptoms of the menopause beyond that one which is, of course, common to all cases of uterine extirpation, namely, the cessation of menstruation, began two years after the operation, and fully from four to six years earlier

than natural to pass through the various nervous phenomena of a menopause of an ordinary character.

The technique of the operation is simple; the ovaries are the important organs to conserve, and the uterine tubes may be removed or left in as the operator may decide best. I think the operation is easier if the tubes are left, and the enucleation is begun by tying off the broad ligament at the uterine cornu, including the isthmus of the tube and the utero-ovarian ligament in the first tie, tying the round ligament next, and then exposing the base of the broad ligament, ligating the uterine vessels, amputating the uterus at the vaginal junction, clamping the uterine vessels of the opposite side, and then pulling the uterus up and out, and ligating the round ligament, the tube, and the ovary at the opposite cornu.

I have not carried my conservatism so far as to add considerably to the length of the operation by attempting to retain

Ovaries in Hysterectomy.

Condition of Patient in Hospital.	Symptoms before Operation.	General Health since Operation.	Symptoms now Suffering from.	Symptoms of Artificial Menopause.
Relieved of symptoms	Tumour. Duration, 12 years. Increasing. Dysmenorrhœa. Sharp pain in the lower abdomen	Better	Constipation	Slight flushes for 6 months, no other symptoms.
Recovery uninterupted	Tumour. Dull pain in the abdomen	Greatly improved. Has gained a great deal	None	None.
Bladder torn in operation. Recovery good	Tumour 7 years. Began with sharp pain lasting 3 weeks, followed by gradual swelling without pain. Discharge during exertion	Much better. Now takes a great deal of exercise	Headaches and pain in bladder, which are better since operation	Palpitation and flushes. Suffered before operation more than now.
Recovery good. Relieved of symptoms	Tumour 4 years. Pain in the abdomen. Drawing sensation at umbilicus	Better	Weakness. Frequent micturition	No symptoms for 20 months, now gradually increasing.
Recovery uninterupted	Uterine hæmorrhages 9 months. Irritating watery discharge	—	—	Not heard from since.
Recovery slow, but uninterupted	Tumour. Profuse leucorrhœa. Sharp pain in lower abdomen for 6 years, periodical and changeable. Profuse menstruation, and irregular for 6 years. Ten years increased frequency and burning micturition.	—	—	"
Recovery slightly delayed by nervous manifestations	Tumour. Throbbing in the head (worse on exertion, increasing in severity). Constant backache, tenderness of right side, palpitation, increased frequency of micturition	—	—	"
Recovery uninterupted	Tumour 3 years. Hæmorrhages, constant headache, profuse menstruation for 7 years. Great weakness, leucorrhœa, feeling of heaviness slowly increasing during 3 years	Suffered slightly after leaving hospital. Much better last two months. Has gained in flesh	Dull pain in back. Worse when reclining	Slight sweating and dizziness, not until two months ago; thinks they are increasing.
Recovery uninterupted	Dull aching in lower abdomen. Leucorrhœa for 3 years. Bearing-down pain, pressure on bladder, frequency of micturition, irregular menstruation	Good	None	None.
Recovery slow, some temperature (reaching one time 103°)	Tumour. Dysmenorrhœa gradually increasing. Profuse menstruation, irritating leucorrhœa, frequency of micturition	Decidedly better	None	None.
Recovery uninterupted	No history. Impossible to get interpreter	—	—	No symptoms, 2 months after operation.
"	Abdominal tumour. Increased menorrhagia, profuse leucorrhœa. Constant dull pain in abdomen	Decidedly better. Relieved of all symptoms. Has gained flesh	None	None.
"	Pain in back and right side. Inability to have movement without enema. Menstruation irregular, scant. Severe dysmenorrhœa. Profuse leucorrhœa, constant pain and soreness in abdomen, increasing in severity	Much improved	Periodical attacks every 3 weeks, growing less each time	None.
"	Great weakness, hæmorrhage. Tumour noticed for 6 months. Menorrhagia increasing for 1 year	—	—	No symptom 1 month after operation.
"	Abdominal tumour, noticed for 1½ year. Steady growth, tenderness	Much improved. Has gained in weight, and is better able to exercise	"Sick headaches" and pain in back, less than before operation	Slight flushes and palpitation the first month; none since.
"	Increased frequency of menstruation	Greatly improved	None	None.
"	Tumour 5 years. Pressure on bladder	"	Frequent desire to urinate. Headaches	None.
"	Tumour 2 years. Dull pain in lower abdomen. Increasing menstruation	Greatly improved. Has gained in weight	Slight pain in abdomen, much less than before operation	Very slight flushes.
Recovery uninterupted. Slight pain upon micturition	Tumour. Inability to exercise, weakness, pain	Good	None	Absolutely no symptoms.
Recovery uninterupted	Profuse menstruation. Tumour, weakness, pressure on bladder	"	—	None.

have been operated upon. They have been omitted on account of the short time elapsed.

inflamed or diseased tubes and ovaries, which can be much more quickly and safely removed in conjunction with the uterus.

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GUY'S HOSPITAL.—The Council of the Prince of Wales's Hospital Fund for London has forwarded to the Treasurer of Guy's Hospital a cheque for £7,912 10s., part of which, £1,312 10s., is a "special donation given in honour of Her Majesty's Diamond Jubilee." The remainder, amounting to £6,600, has been allocated to Guy's Hospital out of the in-

come of the Fund in order to "encourage the Committee to take in hand the work of opening both the wards now closed, containing 114 beds." A meeting of the General Court of Governors was held on January 12th, at which, in acknowledging the munificent gift of the President of the hospital, it was decided to proceed at once with the reopening of the closed wards, in accordance with the wishes of the Council of the Fund. Before, however, the full equipment of beds can be placed at the disposal of patients, it will be necessary to provide temporary accommodation for a portion of the nursing staff. Meanwhile the paying beds in the general wards at one guinea a week have been once more made free to the sick poor. The governors hope by means of increased subscriptions to be able to meet the annual expenditure necessary to maintain the reopened wards. The increased number of patients renders it necessary to undertake extensive structural alterations in the laundry and other departments.