it was central. The increasing swelling she had observed for the last few weeks had undoubtedly been the uterus. One can hardly suppose the abscess had formed there when she had the so-called attack of inflammation after her third confinement, as her fourth and fifth pregnancies and deliveries had been normal. It is a curious circumstance that so large an abscess could have discharged itself without her having been aware of the pus coming away. The opening was very small, and its being within the external os would tend to make it ooze away slowly. The position of this opening accounts for our not seeing it when the cervix was exposed during the dilatation. The reason why the anterior wall of the cervix tore was made plain at the *post-mortem* examination. The thin partition between the cervical cavity and the sinus had given way.

A careful exploration of this tear would have led to the detection of the sinus, but nothing would have been gained as regards the result of the treatment. No operation would have been of any avail.

The reason why no hæmorrhage occurred during the day was, I think, due to the fact that the sinus so weakened the cervical wall at its upper part that the weight of the uterus while she was up caused an acute bend at the junction of the body and cervix, and thus closed the cervical canal.

Last year I saw a *post-mortem* examination on a somewhat similar case in the hospital. The patient was admitted under Dr. Oliphant's care in a very exhausted condition. She was a primipara, with a slightly contracted pelvis. She had been in labour for a considerable time, and several attempts had been made to deliver her by means of forceps by two medical men before sending her into the hospital. Craniotomy was done, and the child easily extracted, but she died in a couple of days.

At the *post-mortem* examination an abscess cavity was found in the left broad ligament. A tear in the left side of the cervix opened into a channel communicating with the abscess cavity. This sinus opened into the vagina by a small orifice in the posterior lip of the cervix. Her mother could give no history of her ever having had any illness pointing to such a condition of affairs.

Both of these cases illustrate how important it is to have a *post-mortem* examination in all fatal puerperal cases.

I am indebted to my late resident, Dr. Forbes, for the careful notes of the case.

SOME ILLUSTRATIVE CASES IN GYNÆCOLOGICAL SURGERY.

By ROBERT O'CALLAGHAN, F.R.C.S.I., Etc.,

Late Surgeon to the Carlow Infirmary, and to the Chelsea Hospital for Women.

CASE I. Abdominal Hysterectomy for Large Myoma.—Mrs. H., aged 49, was sent to me in May, 1897, by Dr. Clement Godson. She gave the following history: Owing to considerable loss she consulted Dr. Godson in 1893, for which he treated her successfully. For the past three years she had noticed a lump in her abdomen, which gradually increased until the last six months, when she began to have great irritability of the bladder, and frequent desire to micturate. Her periods became very profuse, lasting ten days to two weeks, and between these she had a watery discharge which required the constant use of a diaper. She presented a very bloodless appearance, and was very weak. On examination I found a large oedematous myoma rising as high up as the umbilicus, but uniform in growth, and about the size of a six months' pregnancy. I advised operation, and at once, as it was quite evident that if she were left much longer in her existing condition operative interference would become impossible. I performed hysterectomy on June 11th (kindly assisted by Dr. Clement Godson), Drs. Fagge and Scholtz, Mr. Hurry Fenwick, and others being present. The patient made an uninterrupted recovery, and left the Home in five weeks, already much improved in health. This is, I consider, one of the typical cases which justify mutilation so irreparable as hysterectomy, and the risk which such a serious operation must always involve; it is in striking contrast to the many excuses which are now made for so-called total hysterectomy.

CASE II. Vaginal Hysterectomy for Epithelioma of Cervix.—Mrs. M., aged 36, was brought to me by Dr. James Donelan in February, 1897, with a history of interperiodic losses since February, 1896, but during the previous three months bleeding had become profuse, was seldom absent, and necessitated the constant wearing of a diaper. She had also great irritability of the bladder. I found the uterus fixed on the left side, and a small growth protruding from the cervix, which bled freely; no foetus. Before giving a definite opinion, I curetted the uterus and removed the growth, under ether, next day. Dr. Donelan had it microscopically examined, and it was pronounced to be epithelioma. Dr. Granville Bantock saw her in consultation with Dr. Donelan and myself on March 10th, to decide upon the advisability of further operation. I pointed out the marked infiltration of the left broad ligament with the disease and slight cachexia. Dr. Bantock held, however, that the patient would be much more comfortable after operation, though holding out no hope of prolonged life. She decided upon operation, and I removed the uterus with great difficulty, owing to advanced disease. The left broad ligament gave much trouble, being very friable, and the ligatures cutting through time after time. In addition to this, the bladder wall was fixed and required very careful handling. I had the invaluable assistance of Dr. Bantock in the most difficult case of the kind I have experienced. The bladder gave some trouble for ten days, but otherwise convalescence was uninterrupted, and the patient left for the seaside in a month.

CASE III. Removal of Appendages for Double Pyosalpinx.—Miss M., aged 22, was a patient of Dr. Morgan Richards, who attended her a year previously for an attack of acute peritonitis. She sent for me in September, 1897. I found her suffering from localised peritonitis of left side: the temperature was 102°, and she was in considerable pain. On vaginal examination, which was very painful, I found acute tubal mischief, with cystic disease of left side, and marked tubal disease on the right side; the uterus was completely fixed. Dr. Granville Bantock saw her with me ten days afterwards, when by suitable treatment the temperature was going down, and agreed with me that the only treatment advisable was complete removal of the appendages, which were utterly useless, and a source of great danger to life. The patient drifted away, and after consulting many specialists in London, returned to say that the general consensus was against operation. After examination again, I reiterated my previous views and advice, and said that when she came and told me that she wanted the operation I would do it, as I knew that time would force it upon her. She then consulted Sir John Williams, who agreed with the necessity of operation. This advice, combined with another acute attack of pain, sent her back to me, and I removed the appendages with the greatest difficulty; the cyst in the left ovary was ruptured in trying to extract it. Both tubes and ovaries were embedded in a mass of old adhesions, and were very hard to bring up and tie off. Dr. Bantock gave me his kind and invaluable help in this case also, Drs. Richards and Wood being present. I washed out the abdomen with water at a temperature of 110°, and drained with Bantock's glass tube, which was removed on the third day. The patient made an uninterrupted convalescence, and left the Home in three weeks.

REMARKS.—I have much pleasure in selecting these 3 cases from my year's work to report, because I think they are all interesting to both surgeon and practitioner, and are undoubtedly cases which demand operation. In Case I the myoma was simply a large sponge of blood, which medicinal treatment had failed to squeeze, and the patient was slowly bleeding to death. In Case II the point is that the patient was saved a great deal of distress from profuse discharges, menstrual and fetid, as she was only 36. Case III illustrates a form of tubal disease which had got far beyond the stage of palliative treatment, and the condition would have ended sooner or later with an acute attack of general peritonitis.

PRESENTATION.—Dr. Thomas Easton has, on the occasion of his leaving Stranraer, been presented with a silver salver bearing a suitable inscription, accompanied by a cheque representing nearly £100. The presentation was made at a cake and wine banquet presided over by Provost MacRobert.