origin. It has been said that the inflammation is always due to some septic condition in the abdomen. It has also been attributed to a sympathetic nervous influence.

It seems to me probable that a direct septic infection from the mouth may account for the parotitis in some cases, and perhaps in all. There is no doubt that the conditions under which the patient is usually placed contribute very materially to the occurrence of such an infection. The patient is made to retain the dorsal position for a time, and thus the force of gravity tends to prevent the emptying of the parotid ducts. The diet is at first liquid, hence the jaws are not used in chewing, and thus another powerful aid to the emptying of the ducts of the gland—namely, the intermittent pressure of the muscles—is in abeyance. The feverish condition following the operation, by reducing the quantity of the secretion, leads to a still further stagnation. The dryness of the mouth in fever is well known. Under such circumstances septic organisms in the mouth must be far more likely to affect the parotid gland than under normal conditions. Moreover, it is often extremely difficult to give the desirable attention to cleaning the teeth for some days after an operation without inducing nausea.

In the two cases I have observed the opening of Stenson's duct was certainly inflamed as soon as attention was directed to the gland. I have not had an opportunity of examining other cases since the above explanation occurred to me, but in a case temporarily under my care after both glands had been incised for parotitis a small abscess formed in the right cheek close to the opening of Stenson's duct, and I succeeded in arresting the formation of an external fistula only by a free incision inside the mouth. At that time, many years ago, I thought the infection in the cheek was secondary to that in the gland, but it now seems to me much more reasonable to suppose that the abscess in connection with the duct was due to an infection from the mouth. I have shown that many arguments may be brought forward in favour of the suggestion that parotitis may be thus induced, and this view has at least the merit of attributing the inflammation to a series of conditions which may be logically associated together. It has always seemed to me that the suggestion that the parotitis is due to a septic condition connected with the operation is, to say the least, a hypothetical one, for a parotitis comes on at a very varying period after a laparotomy, and it may occur after a simple operation in connection with which from first to last there is no other complication. The idea that there is a nervous association between the parotid gland and the rest of the intestinal tract might account for a proneness to parotitis after an abdominal section, but a direct infection seems to explain the condition more fully.

A CASE OF MYOMECTOMY FOR SUBPERITONEAL MYOMA COMPLICATING PREGNANCY.

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THE following case appears worthy of record:

Mrs. L., a young married woman, aged 26, consulted me on August 26th, 1899, complaining of pain in the left groin, which was gradually becoming more severe. She had reached the end of the fourth month of her first pregnancy. She complained of obstinate constipation, but the sickness of the earlier months had passed off.

On examination, I found a hard movable lump in the left iliac region, which appeared to spring out of the pelvis and not to be attached to the uterus. The uterus itself was of a normal size for a four months' pregnancy. On vaginal examination the same lump could be felt as a mass about the size of an orange, lying at the pelvic inlet to the left of the enlarged uterus. The ovary was not discoverable apart from the tumour. It appeared to be probably a tense cyst of the ovary, or a solid tumour of that organ. The possibility of its being a myoma did not occur to me, as it did not feel as if it were attached to the uterus, although a thorough examination was made under chloroform in consultation with Mr. H. A. Ballance of Norwich.

As the growth of the tumour and its position rendered the possibility of hindrance to labour a very likely one, I performed laparotomy on August 30th, thinking it highly probable that the removal of the tumour in the fourth month would not interrupt the natural course of pregnancy.

On opening the abdomen by the usual median incision, the tumour was found to spring from the left side of the uterus low down, and the hand in the abdomen readily made out the appendages to be healthy immediately below it. With a little difficulty the tumour was delivered through the wound, when it appeared as a mottled whitish yellow solid body, rather more than 3 inches in diameter, hard and nodular on its surface; a pedicle could be defined, not containing much fibrous tissue, about an inch in diameter, attaching it to the uterus. It was decided to remove it, and the

pedicle was accordingly ligatured in two portions, and the tumour snipped away with strong scissors. The stump was hollowed out somewhat by snipping away the central portion so as to allow the peritoneum to be drawn across it, which was then stitched carefully together with chromic catgut. There was no bleeding and no adhesions had to be dealt with. The wound was then stitched up by deep and superficial silk sutures, a separate series of catgut sutures being applied to support the rectal sheath. Cyanide dressing was used, carefully supported with a many tailed flannel bandage.

During the first twenty-four hours after the operation some painful uterine contractions occurred which were controlled by morphine suppositories. The temperature was 100.5 the first evening, but fell the next day and remained under 99° throughout. The bowels were opened by an enema on the third day. With the exception of some slight rapidity of the pulse, 88 to 100, which lasted for the first ten days, there were no unfavourable symptoms. Three weeks after the operation the patient quickened. The wound healed throughout by first intention, and she was up at the end of a month, and is now able to follow her usual course of life without inconvenience, the body being supported with a well-fitting abdominal belt. On examination of the tumour its structure was found to be typical of a fibromyoma of the uterus and does not call for any further remark.

Several questions arise for consideration in this case. What is the proper treatment of a pedunculated fibroid of the pregnant uterus of such size as to produce a well-marked tumour at the inlet of the pelvis? Kelly in his *Handbook of Operative Gynaecology* gives several rules for the treatment of myomata complicating pregnancy. He says that we should remember that there are two lives to consider and that operation as prophylaxis against possible complications is unjustifiable, in fact, that we should reject all radical measures unless the symptoms are urgent. He does not counterbalance operations for small fundal tumours, nor except in exceptional circumstances for interstitial fibroids.

The rapid growth of a tumour and excessive pain may necessitate operation. Kelly's rule for intraligamentary and subperitoneal cervical fibroids is that operation should not be undertaken unless the fibroid is of such size as to encroach upon the pelvic room and the superior strait in such a way as to prevent labour.

Now, the above case seems to me to belong practically to this last division; the tumour was of such a size and in such a position that when labour began, it would, in my opinion, have been forced into the pelvis, though it is open to argument whether the increasing size of the uterus and tumour would not have removed it from its dangerous proximity to the pelvic cavity.

The fact that in my case the pedicle could be easily ligatured decided me in favour of extirpation; if the tumour had been sessile the operation would have been fraught with more danger to the mother, and would have been more likely to produce abortion, while there would have been more likelihood of the tumour being gradually lifted out of the pelvis as the pregnancy advanced.

Fortunately the result justified the procedure in the case described, but there is always the other aspect to consider, what would have been one's reflections if the case had not done well. Was the risk of complications at the time of labour equal to the risk of removing the tumour? In connection with this, one should recall the published statistics of this operation. The mortality of myomectomy for pediculated fibroids of the pregnant uterus is stated by Kirschheimer¹ to be 18.87 per cent. This probably does not represent the mortality of the operation when carried out with modern aseptic methods, but it is sufficiently high to make one hesitate to operate unless the indications are clearly among those enumerated above.

REFERENCE.

¹ *Inaug. Diss.*, Halle, 1895, quoted by Kelly.

DANGERS OF "HEADACHE POWDERS."—Dr. J. Sobel, of New York, has published in the *Medical Record* the case of a woman, aged 25, who was a sufferer from headaches and had been in the habit of taking powders called "antiheadache or half-hour headache healer," a quack remedy which is "guaranteed" not to contain any dangerous drug. The patient foolishly relying on the advertisement took three powders for a violent headache, with the result that shortly after taking them the most distressing symptoms supervened. She became very cyanosed, her pulse and respiration grew feeble, and she fell into a state of collapse, her condition being decidedly serious. Under suitable medical treatment she however recovered. A specimen of the "antiheadache" powder was submitted to analysis and found to contain a large proportion of acetanilide.