The case, moreover, has taught me many useful lessons, whereby I hope to profit, should I again be called upon to perform a similar operation; and I will now describe an instrument which I would strongly recommend to be used in all operations of the kind, as a means not only of effectually preventing the cut portion of the cyst from slipping back into the wound before the vessels are secured, but of facilitating all manipulations which may be necessary to be performed on the remaining portion of the cyst previous to its being returned into the abdomen. A sketch of the instrument is given below, which, on inspection, will render the use at once evident. *Fig. I.* *a b* are two semi-cylindrical pieces of box-wood, seven inches long; these, when placed in apposition, form a slightly-curved cylinder, the end of which is half an inch in diameter. A brass screw *c*, furnished with a thumb-screw *d*, is fixed to each end of *a*, and passes through a corresponding hole in *b*. The branches of the instrument can thus be entirely separated, or they can be screwed closely together, so as to hold anything between them very firmly. *Fig. II.* gives another view of the instrument, which shows that it is slightly curved to adapt itself to the convexity of the abdomen, and there is also a slit *e e* on the side of the branches, which adds to their lightness, and gives them a firm grasp of any soft slippery body like an ovarian cyst.

When the water is evacuated, and the cyst drawn forth from the wound, one of these branches should be applied on each side of the cyst, and then screwed up so as to hold the cyst firmly between them. The cyst thus secured may be next cut off with a pair of scissors, an inch beyond the part where it is embraced by the instrument; the cut margin may then be carefully examined, and each bleeding point secured with great ease, the instrument in every respect serving the office of a tourniquet, and by preventing anything like slipping, enabling you to include both layers of the cyst in the ligatures, which I

consider important, as the two layers will then most readily unite, diminishing the cut surface exposed, and thereby lessening the risk of inflammation.

In conclusion, I think I am fully justified in recommending this operation as one simple in its nature, and easy of performance—as one more free from risk than any hitherto performed, and applicable to all cases where the contents of the ovarian cyst are fluid only, uncomplicated with solid enlargement of any kind, whether malignant or not, and, fortunately, these constitute the majority of cases we meet with. Should even adhesions exist to an extent which renders it impracticable to remove more than a small segment of the cyst, this plan of operation will enable that segment to be removed with comparative safety, and with every prospect of perfect success; I therefore cannot but hope that it will be sanctioned by the approval of many who object to the more formidable operations hitherto proposed, and by becoming more generally known and practised, it may be the means of saving the lives of many whom the fear of greater danger would cause to sink, *unrelieved*, into an early grave.

THREE CASES OF OVARIAN DISEASE.

ONE OPERATED ON—FATAL.

By THOMAS G. STOCKWELL, Esq.,

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Read at the Quarterly Meeting of the Bath and Bristol Branch, Dec. 19, 1850.

HANNAH HISCOX, aged 20, unmarried, a servant, had always enjoyed good health until the age of 16, when she suffered severely at each menstrual period. About September 12, 1848, she perceived a tumour in the right iliac region, which caused no pain, but increased rapidly in size, and she became unable to use any exertion without becoming immediately faint. She applied for admission into Guy's Hospital, where the tumour was pronounced to be ovarian, and the operation of extirpation was proposed, which her friends dissenting from, she left the hospital. A very severe attack of pain occurring in the right side, she was admitted into the Bath United Hospital, under Dr. Clarke. This attack was of long continuance and the pain very severe; upwards of fifty leeches were applied, but she was discharged still increasing in size. She then came under my care as a patient at the Eastern Dispensary. Her general state of health was then good, although she suffered from severe pain, accompanied by evident enlargement of the tumour at each menstrual period. The abdomen measured about forty-four inches at the umbilicus. The tumour appeared moveable, and could be slightly drawn upwards without affecting the uterus, which was but little displaced, the os being directed a little more backwards than usual; it was uniformly globular; its contents evidently fluctuated, and the skin of the abdomen moved freely over its anterior surface. Mr. Crouch, of Bruton, saw the patient at

this time and was of opinion that the operation could be undertaken with a very fair prospect of success. The patient herself earnestly requested its performance although perfectly aware of its danger, as she was unable to earn her livelihood, or even move at all without great exertion and distress. On Thursday, November 14, the operation was performed, with the assistance of Dr. Davies, Mr. Stockwell, sen., Mr. Bartrum, and Mr. Brace. The patient being under the influence of chloroform, and the room heated to about 75° Fahrenheit, an incision was made from immediately below the umbilicus to about an inch and a half above the pubes, the peritoneum divided to about the same extent, the tumour punctured and emptied with a large catheter. As it decreased in size it was withdrawn from the abdomen, the walls of the cavity being pressed together prevented any exposure of the intestines. There was no adhesion whatever, and the pedicle, which was very small, was transfixed by a double ligature and tied, the ends of the ligature were fastened externally, the wound closed by two sutures and some adhesive straps; there was scarcely any blood lost. In the course of the afternoon she suffered a good deal of pain at intervals, which was quieted by two grains of opium. The pulse rose to 120; she had passed water, had some sleep, and in the intervals between the pains was perfectly easy. At night the pulse was down to 100.

15th.—Has had a good night; was sick once; pulse 110; tongue moist; skin perspiring; pains much less frequent during the night. Seven P.M., has only had one attack of pain to-day, which came on when passing water; pulse 130; tongue moist; no general tenderness of abdomen.

16th.—Has had a good night; this morning a little feverish; pulse 120; tongue moist; skin perspiring; no pain on pressure of abdomen, except immediately over the pedicle; complains of much inconvenience from flatulence, which is confined to the stomach. Through this day the pain continued, and sickness came on, which at five P.M. was almost constant; she became very restless; pulse 160; countenance pinched; whole abdomen distended with air; general soreness; not increased on pressure. At eleven P.M. the sickness ceased for about an hour, when it returned and continued without any intermission until about three A.M. During the vomiting about two or three ounces of dark-coloured fluid escaped from the lower angle of the wound; the pulse rapidly became weaker, and she died at ten A.M. on the morning of the 17th.

Post-mortem examination twenty-six hours after death.—The wound was united throughout its whole extent sufficiently firmly to prevent the escape of the air with which the peritoneal cavity was distended. The peritoneum was found inflamed for about half an inch on either side of the incision, and upon the anterior surface of the uterus a thick layer of lymph was deposited, the posterior surface was only slightly reddened; this membrane in every other part was healthy, and there was no fluid whatever in its cavity. That which escaped from the wound during the act of vomiting, had come from a cavity formed round the

pedicle by the adhesive inflammation, glueing the uterus and pedicle to the abdominal parietes close to the wound, and completely separating the pedicle from the general cavity of the peritoneum. The tumour arose from the anterior and inferior part of the ovary on the posterior surface of which was a recent corpus luteum. It was composed of a very thick fibrous coat, covered by peritoneum, loosely attached, so that it moved very freely over the inner fibrous layer; it contained one smaller cyst about the size of a walnut, and in the pedicle a great number of smaller cysts about the size of peas were found. The sac contained about eleven pints of thick yellowish fluid.

During the last year and a half two other cases have come under my care; the first, which was fatal in about four months, occurred in a woman, aged 48, married, having had four children, she had suffered from dropsy of the ovary nearly two years. She was tapped four times, an interval of about six weeks intervening between the first and second tapplings; on both which occasions about eighteen pints were evacuated from a single cyst. An equal quantity of fluid collected in a shorter period previous to the third tapping. At the last tapping I was not present, but was called to her a few nights after, and found a portion of the sac, about four inches long, and one in thickness, hanging from the small wound made by the trocar, and a large quantity of fluid was escaping through this accidentally-formed oviduct, and continued to do so until her death, which occurred in about three weeks. The fluid was not purulent but always of exactly the same character as that withdrawn from the cavity by the trocar, she dying of the exhaustion consequent on the continuous albuminous secretion.

The second case was also a married woman, aged 54, with a family, who had been dropsical three years. The abdomen was of an enormous size. She was only tapped once, the fluid collected again in less than a month, and the patient died.

On examining the body, the ovarian cyst was found to have a few not very extensive adhesions to the abdominal parietes, and to two or three folds of the small intestines. The sack was in some part of its anterior portion an inch and a half thick, in the posterior portion not quite so thick. It consisted mainly of one cell, with the exception of two smaller ones in the posterior inferior part, containing the same yellowish fluid as the larger sac. The pedicle was large and broad, and from the weight of the attached ovary had dragged out of the pelvis the uterus and other ovary, which was natural. This patient died from exhaustion, caused by the disease, not from any surgical interference. The rapidly fatal termination of these two cases, had much weight in deciding me on the admissibility of the operation in the first-mentioned case, as I thought that she being only 20, and otherwise of good constitution, was justified in encountering the risk.

[The two last cases were not mentioned at the meeting.]