tion, still less of meningitis. The same is the result of the extensive pathological inquiries of Dr. Bednar, published in Vienna in 1851.

These reflections I adduce only in order to counteract a little of that fear, too general, of meningitis in children during the stage of febrile heat. The alarming aspect of febrile headache in a speechless child, however, cannot be denied; I will, therefore, consider that subject, and some others connected with fever, more closely in my next lecture.

ON THE DIAGNOSIS OF CHRONIC OVARIAN TUMOURS.

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"Hydrops ovariorum ut plurimum steriles annosaeque mulieres occupat difficulter cognitur et vix sine sectio cadavere."—Boerhaave (*Aph.* 1233.)

(a) *Ovarian Tumours may be confounded with Tumours of the Unimpregnated Womb.*

RETROVERSION and retroflexion of the womb have been mistaken for incipient ovarian tumours, fallen into the recto-vaginal pouch, or confined there by false membranes. On examining, by the vagina, a patient suffering in this way, we may find a circumscribed tumour at the posterior portion of the vagina, painful on pressure, and resembling the fundus of the womb; but on a more careful examination, the os uteri will be found in its proper position looking backwards, the body of the uterus forwards. The mobility of the tumour, by the uterine sound previously introduced, will show whether or not it be uterine.

Retroflexion of the womb is more likely to simulate incipient ovarian cysts; for, as in this affection the fundus uteri is thrown back upon itself like the belly of a retort, while the os uteri remains in its natural position, the finger feels a tumour directly behind it, between the rectum and the vagina, but here again the uterine sound soon clears away any doubt that may have arisen, for it will be found that the concavity of the instrument will be obliged to pass backwards, following the course of the cavity of the womb, and through the walls of the tumour; the point of the instrument may sometimes be felt by the finger placed in the vagina. By a careful manipulation the tumour may be made to disappear and to re-appear so often as it is restored to its natural position, or again directed from it by the sound.

(b) *Ovarian Tumours may be confounded with Abscess of the Walls of the Womb.*

Case.—Some years since Professor Recamier was consulted by a medical man for his wife, who had long suffered from what was called ovarian dropsy. On making a very careful examination, Recamier discovered a round tumour about the size of a pigeon's egg,

situated between the rectum and the uterus. On exploring the rectum with the index of the left hand, while that of the right remained in the neck of the womb, more than usually dilated, he felt fluctuation, and as the pus seemed nearest to the posterior wall of the neck of the uterus, Recamier determined on making an incision there. To perform this operation, he placed the index of the left hand in the neck of the uterus, and guiding a convex bistoury on the pulp of this finger, he plunged the extremity of the bistoury into the abscess, a few teaspoonsful of pus came out, and to facilitate its egress he enlarged the inferior angle of the wound, by completely cutting through the posterior lip of the os uteri, the index of the left hand placed in the rectum serving to guide the bistoury, and prevented too deep an incision. During the following day a small quantity of pus was voided. Frequent injections were made, and the patient soon got well. This case shows how to detect and to cure similar instances of disease.

(c) *Ovarian Tumours may be confounded with Abscess of the Cavity of the Womb.*

Husson presented to the Anatomical Society of Paris a case of this description, the neck of the womb was completely obliterated, and its dilated cavity contained two tumblers of pus. Maisonneuve saw a similar case in a woman who died from cholera; and Dr. Reignier has repeatedly observed the same appearances in the old women of the Salpêtrière—the asylum for aged women in Paris. In Husson's case, the woman had experienced no symptoms, but some of Dr. Reignier's patients were troubled with bearing down pains. We admit that a case of that description might be taken for an ovarian tumour, and then, if a careful recto-vaginal examination were made, the swelling would be referred to the womb. If, on making a speculum examination, the womb were found obliterated, the presumption would pass into conviction; and if not, then the uterine sound would show whether the womb was normal and the tumour ovarian. The rarity of the case must be borne in mind.

(d) *Ovarian Cysts may be Confounded with Hydro-metra, or a Collection of Water in the Womb,* and we do not doubt but that some of the cases described as cases of spontaneous cure of ovarian cysts are to be referred to the rupture of such uterine tumours. The distension of the impregnated uterus by an aqueous liquid has been lately contested by Nægele and by Stoltz, although it is difficult to see why the mucous surface of the womb should not secrete a large quantity of limpid fluid, as well as the mucous surfaces of the maxillary and frontal sinuses. The disease has been too well described by Ferrelas (*Patho. Liv. vi., chap. 15*), by Mauriceau (*Traité des Maladies des Femmes Grosses*, tom. i., p. 74), by Lisfranc (*Clinique*, tom. iii, p. 346), to be thus denied. Dr. Storrey has also described a case (*Haye's Journal*, 1850). It will not do to say that the aqueous discharge comes from the ovary, because Vesalsus, Blank, and Nicolai have opened women who had long suffered from this disorder, and found the womb containing 84lbs. and even 180lbs. of

serum. This disorder is accompanied by the symptoms of pregnancy, and is generally considered such until after the ninth month of its duration. Then it is generally regarded as ovarian. In a case carefully related by Blegny (*Journ. de Médecine*, tom. ii., p. 97,) it was allowed to exist for twelve years, and the noble lady subject to this infirmity was only delivered from it by the violent concussion of coughing, by which means a large quantity of water was discharged.

After fully ascertaining the impossibility of the womb being distended by a child, it would be well to imitate Lisfranc, who, in one of his cases introduced a sound into the womb, and cured the patient in a month. Cruveilhier says, that in the few cases of this description that he had met with the disease was always taken for pregnancy, and the mistake only found out by the evacuation of the water. We ourselves have been similarly deceived, as in the following instance:—A lady, 25 years of age, and married three years, was said to be affected with ovarian disease, and consulted us for that disorder. She complained of swelling of the abdomen, uterine pains, and slight leucorrhœa. Her breasts were swollen and painful, the nipples were surrounded by a dark circle, and a yellowish creamy substance came from them. The catamenia had desisted for three months. Suspecting pregnancy or an uterine affection, we examined her, and were confirmed in our diagnosis by a dilated orifice, and a softening similar to what is met with at the third month of pregnancy. On making a speculum examination, the vagina was more livid than in an unimpregnated woman, and the os uteri was similar to what it should be in the first months of pregnancy. We pronounced the patient to be in the family way; but unsatisfied with our report, she consulted another doctor, who considered her case to be one of inflammatory granulation of the os uteri. He cauterized the cavity of the neck with nitrate of silver; but the night after the second cauterization the lady was surprised at finding herself wet, and on placing herself on the commode, she passed (without making urine) two pints of clear water, "similar," said her mother, "to the bursting of waters in a confinement." For two days did this water continue dribbling from her, when the swelling of the abdomen disappeared, all other symptoms vanished, and the catamenia reappeared two months after. Thus the patient had neither ovarian dropsy, as was at first believed, nor uterine inflammation, as was afterwards stated; neither was she pregnant, as we imagined. Our diagnosis was founded on rational grounds; and the error could only have been made clear by passing the uterine sound into the womb, which would have been an *unwarrantable* proceeding; for as such cases are extremely rare, and as pregnancy is an event of every-day occurrence, the risk of abortion would have been too great. In this case, therefore, the patient owed her recovery to an error of diagnosis.

(c) *Ovarian Tumours have been Confounded with Cystic Tumours in the Substance of the Uterus.*

In the Museum of the College of Surgeons of England there is a preparation removed from a patient

in whom this mistake took place; (Home 980, uterus 23,) it displays a portion of the uterus in which a large encysted tumour had formed. The patient had been twice tapped, and the cyst emptied. By means of the sound such a tumour might have been shown to be uterine, before it attained to a considerable size, or after it had been emptied, but at other times the possibility of distinguishing it from an ovarian cyst would be very great, if not impossible.

(f) *Ovarian Tumours may be Confounded with the Uterus Distended by the Menstrual Secretion.*

Mr. Benjamin Travers, jun., witnessed such a case in St. Thomas's Hospital, under the late Dr. Williams. Examination per vaginam detected a fluctuating tumour, which was freely opened with an abscess-lancet, and a large wash-hand basin was filled with the retained menstrual fluid. The patient was in bad health, and presented general symptoms which led to the belief that the tumour was ovarian. Such a case Mr. Travers thought might again be mistaken for ovarian dropsy.

Roussell mentions a similar case, where all the symptoms of pregnancy were found, and only dispelled at the ninth month by a copious discharge of dark blood. A careful examination, corroborated by the fact of the patient's age, and by the history of the case, would, however, easily permit of a correct diagnosis. It may be well also to bear in mind, that the uterus, distended by retained menses, is not always regularly developed, but may increase to the right or the left, and give that obscure perception of fluctuation which is frequently found in a malignant mass. On each side of the central tumour may also be found smaller elongated tumours, formed by proportionally-distended oviducts, with obliterated abdominal ends, as in the case related by Dr. Jackson, in the *American Journal of Medical Sciences*.

(g) *Ovarian Tumours may be Confounded with an Accumulation of Gas in the Womb.*

Mauriceau, Schmitt, Lamotte, M. Lefevre, and many other authors, have seen examples of this singular occurrence. In Mauriceau's case the patient was 50, thought herself pregnant, had prepared every thing, when her hopes of progeny vanished in wind. The obliteration of the os uteri on the one side, and the clear sound furnished by the distended womb, will, we trust, enable the practitioner to prevent a woman in future giving so much trouble to herself, and so much amusement to her neighbours.

Although it be denied by Næggle and Stoltz, that the unimpregnated womb can be distended by gas, the fact is admitted by modern practitioners; by Peter Franck, (*Med. Pract.*) by Columbat de L'Isere, (*Traité des Maladies des Femmes*, tom. ij., p. 781,) and lately by Dr. Teissier, of Lyons, (*Gazette Med. de Paris*, Jan., 1844.) In these cases menstruation ceased, the patients were thought pregnant, one of them even said she felt the movement of the child, but after the noisy expulsion of foetid air by the vulva, the symptoms of pregnancy disappeared. Why should not the mucous membrane of

the uterus sometimes secrete air, as well as the bladder or the intestines? Why should it not be retained if the surface of the womb is agglutinated?

(b) *Ovarian Tumours may be mistaken for Uterine Fibrous Tumours.*

This mistake is much more liable to occur than any of the preceding, because the frequency of such tumours is great. Operators have often been deceived by these tumours, for we find that Messrs. Lizar, Heath, Otter, and Atlee have operated for ovarian disease, and only found an uterine tumour; and when they are pediculated, and thus easily moved, and central, as are ovarian tumours, it is difficult not to be mistaken. The absence of fluctuation, the hardness of the tumour, the very gradual progress of the disease, may indeed allow one to affirm that the tumour is solid; but were it not for the uterine sound, it would be difficult to affirm that it is not ovarian.

If we find that the uterine sound passes, as it were, into the morbid mass, if there is no possibility of separating the womb from the tumour, and if every movement given to the tumour conveys similar movements to the sound, we may consider the tumour uterine; but if we find the uterus small, and moveable, if the sound passes anteriorly to the tumour, and can be separated from it, and when thrown upon the rectum it appears healthy, then we may confidently affirm the tumour to be ovarian. The cavity of the womb may be lengthened, and the sound will indicate the modification of structure; but although the sound may only penetrate the womb to its normal depth, or two inches and a half, still the uterus may not be normal, for its enlarged cavity may be filled with a fibrous tumour, as in Dr. Atlee's fourth case.

Case.—In Dr. Simpson's ward at the Royal Infirmary, in Edinburgh, we saw a woman with a considerable enlargement of the belly, occasioned by a tumour, which had all the appearance of being ovarian, for it was central, moveable, and round. Such would have been the diagnosis of most medical men; but Dr. Simpson passed the sound seven or eight inches, and made us feel its extremity high up on one side of the tumour, whose nature and seat it thus indicated as uterine.

Such is the value of "a bent wire," when bent by the hand of genius, and it will long perpetuate the memory of its originator; but this instrument may still sometimes deceive us, and cause us to take an ovarian tumour for one of uterine origin, as in the following case related by Mr. S. Lee:—

Case.—A patient presented herself with an abdominal swelling on the right side, hard, and without fluctuation, not at all moveable, but it could be traced down into the pelvis; it had been a considerable time in its formation. The examination per vaginam discovered that the brim of the pelvis was occupied by a solid tumour; a small nodule was felt rather in front of the centre of the pelvic cavity, in which was the os uteri. The sound

passed upwards and forwards nearly four inches; it moved with difficulty, as through a cavity, the sides of which were much compressed. This examination was made in December.

Here, then, you have every characteristic of a fibrous tumour in the posterior walls of the uterus. The cavity is elongated, the uterus is fixed by the brim of the pelvis, and the tumour in the abdomen is hard and smooth, possessing no fluctuation. The tumour now rapidly increased, and in the January following had occupied the whole cavity of the abdomen. There was then distinct fluctuation in particular parts, and this fact disclosed to us the real nature of the case, viz., that it was a multilocular cyst, complicated with much solid matter. The reasoning from these symptoms was correct, although they were afterwards found peculiarly complicated; for instance, the uterus was quite healthy, and unconnected with the tumour, but the tumour had so elongated the left corner of its body, and so elevated it, that the uterine sound passed into the cavity thus formed, and the tumour itself contained such a large quantity of solid matter, that it pressed so strongly the uterus between itself and the pubes, as to cause it to become fixed and immovable, consequently leading us to suppose it to be a fibrous tumour.

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[To be continued.]

CASE OF INVERSIO UTERI.

By CHARLES MARSHALL, Esq., WOODBRIDGE.

Read at the Suffolk Branch Meeting, July 25, 1852.

THE following rare and interesting case of *inversio uteri* recently occurred in my practice:—I was called to Mrs. D., aged 38, at six, P.M., on the 14th of May, in labour with her sixth child, having previously attended her on five similar occasions. The labour was in every respect quite natural; she was delivered twenty minutes before eleven the same evening, the placenta was retained till ten minutes past eleven, or half-an-hour after the expulsion of the child; there was a slight pain at this time, and on introducing my finger into the vagina, I could distinctly feel the placenta lying there, and the slightest traction caused the whole to be expelled. Up to this period nothing occurred to cause either myself or patient the least alarm; whilst, however, I was preparing a bandage to apply to the abdomen, the patient called out, that "the whole of her body was coming out, and that she was dying." I immediately hastened to her side and found the skin covered with a cold perspiration, no pulsation perceptible at the wrist, and gasping for breath. Brandy happened to be at hand, a quantity of which I managed to pour down her throat. There was little *external* hæmorrhage, and I therefore concluded these alarming symptoms resulted from *internal* hæmorrhage. On attempting to