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

pass my hand into the pelvis, I found the vagina blocked up by a large mass, which was in fact the *uterus completely inverted*; having never seen anything approaching to a similar case, I was at a loss how to act best for the safety of my patient. I had ordered the husband to call in one of my brother practitioners, and Mr. Jones was kindly in attendance in a very few minutes, whose account of the case I subjoin:—

"I saw Mrs. D. at forty minutes past eleven, P.M., found her pulseless, with her eyes turned up, and apparently sinking. I instantly placed her head in a depending position; upon applying my hand to the abdomen I missed the uterine tumour, and immediately suspected the uterus was inverted, which, upon examination, I found to be the case. My first impulse was to apply pressure to the most depending point, counter pressure being used with my right hand upon the abdomen, (where I could distinctly feel the os behind the pubes,) this produced no effect; I then grasped the uterus firmly for a short time, with the view of diminishing its size, and then applying the back of my fingers half closed to the *upper and posterior part* of the uterus, I was enabled gradually to return the part nearest the os, and when about half its volume was reduced, the fundus went up with a jerk."

A dose of ergot with brandy was now administered, the patient having previously swallowed half-a-pint of brandy in little more than a quarter of an hour; the pulse at the wrist became perceptible; the uterus contracted; a full dose of tincture of opium was given, and no untoward symptom has since occurred. I strictly prohibited Mrs. D. from leaving her bed till after the third week. I have seen her this day, five weeks after her confinement, she could walk across the room without any symptom of prolapsus uteri, and quite as well as in the same period after her previous confinements.

I consider the alarming symptoms I before alluded to, after the expulsion of the placenta, to have been caused by the second shock the nervous system sustained from such an event as *inversio uteri*, and not from *hæmorrhage*, which was by *no means excessive*.

CASES IN PRIVATE PRACTICE.

By ROBERT MARTIN, Esq., HOLBROOK.

Read before the Suffolk Branch Meeting, held on the 25th of July, 1852.

CASE OF CALCULARY DEPOSITS IN THE EXCRETORY DUCTS OF THE SUBLINGUAL GLANDS.

RANULA is by no means an uncommon disease of the sublingual glands, and must have fallen under the observation of many present, but the case I am about, (as briefly as possible) to lay before you, the complete obstruction of the excretory ducts on both sides the frenum linguae by calculary deposit, is I believe somewhat rare. I have never before seen an instance of it in my practice, which extends over a period of thirty-seven years.

Benjamin Page applied to me, stating that he had long suffered from "sore mouth," the factor of which was intolerable, the whole mucous membrane of the mouth was highly inflamed, tongue swollen, and its point elevated by enlarged sublingual glands; at the bottom of a puffy swelling of the mucous covering of the right gland, was a small yellow spot, presenting the appearance of an ulcer, but on touching it with a probe, I was satisfied that it was a calculus. A free incision was made over it, and this calculus extracted. The left sublingual gland being even larger than the right, highly inflamed but not ulcerated, I made a free-deep incision over it, the bistoury grated against a hard substance, which was for awhile, however, obscured by hæmorrhage, but on passing a probe into the wound, I readily picked out the calculus, measuring three-fourths of an inch in length, and nearly an inch and a half in circumference. The wounds healed kindly, and in a few days the man was perfectly well.

ON SEVERE INJURY OF THE KNEE-JOINT.

THE following case is one of practical interest, establishing the fact contended for by modern surgery, that severe injuries to large joints, with even extensive penetrating wounds into their cavities, do not invariably require amputation.

John Rumsey, aged 37 years, while mowing grass, March 8th, 1849, fell with his bent knee on the edge of his scythe, which divided the whole anterior part of the joint, the ligamentum patellæ, with the external and internal lateral ligaments. To all appearance the leg hung by the integument on the back of the limb, the posterior ligaments, and flexor tendons. The patella was retracted, and a breadth of four fingers could be readily inserted between the head of the tibia and condyles of the femur; much blood was lost. Being from home, my partner, Mr. Jarmain attended, and the question of immediate amputation suggested itself, but being without assistance, he contented himself by placing the limb in as comfortable a position as possible till my return, with the heel well raised, and he brought the edges of the wound together with sutures, having previously freed them and the joint from coagula and all extraneous matters.

On visiting the case some hours after, I found him free from pain, the limb comfortable, and no constitutional disturbance present. All went on *thus* prosperously for three days, when heat and pain with profuse discharge, rendered it necessary to remove the dressings, the edges of the wound retracted, the sutures were sloughed out, the whole interior of the joint was exposed, and the fearful extent of the wound was fully apparent; extensive abscesses formed in the course of the vastus externus and biceps muscles, constitutional symptoms of disturbance set in—rigors, irritative fever, and profuse night sweats. These symptoms, however, gradually yielded to treatment, and after a confinement to his bed for fourteen weeks, to his house for twenty-six weeks, and an inability to return to his usual employment of