therefore he secures the advantages of the intraperitoneal method without the risk of hæmorrhage when it is attempted to tie uterine tissue.

There are, however, many countervailing disadvantages which have not been considered, I should say have not yet entered the minds of those who are its most enthusiastic supporters. The present paper is specially for the purpose of reviewing a discussion reported in the *BRITISH MEDICAL JOURNAL* as having occurred at the meeting of the British Gynæcological Society on January 14th. A paper was then read by my colleague and former assistant, Mr. J. W. Taylor, on Two Cases of Panhysterectomy after Previous Treatment by the Clamp Operation.

In the discussion the cases were used as arguments for the operation of complete hysterectomy as against the clamp amputation, and it was said that the British Gynæcological Society had declared for the last three or four years that "panhysterectomy was the best operation for myoma." If the Society had said any such thing (and I can find no evidence that it has done so) its opinion has been, to say the least of it, premature. Mr. Bowreman Jessett went further, and is reported as having said that Mr. Taylor's cases showed that by using the clamp "one or several myomata might be left behind, needing such a second operation," as in Mr. Taylor's second case. This allusion to Mr. Taylor's second case is clearly a mistake, seeing that the first tumour was a cystic tumour of the ovary, when for reasons good enough in themselves Mr. Taylor had to revert to the clamp treatment of the pedicle, as he frankly confesses that at that time he knew no better way of treating the condition found. But the uterus was perfectly healthy, and it remained so for some five years, during which time it fulfilled its function of pregnancy. Surely in these days when we have to run the risk of hearing our surgical judgments overhauled by a jury of inquiry, and our surgical operations condemned in the witness box by nurses, it becomes us to repudiate such advice as is given by Mr. Bowreman Jessett. Still more is this conclusion to be advanced when we consider Mr. Taylor's first case, which is probably the one to which Mr. Jessett referred. Mr. Taylor's experience of her was "that she was an unmarried lady" 33 years of age, who had been operated on four years ago by another surgeon. At the second operation Mr. Taylor found that practically the whole of the uterus appeared to have been retained by the patient, as the appendages of both sides were discovered beneath the greater mass of tumour. Mr. Taylor removed the tumour with the whole of the uterus and the appendages. He does not describe in detail the relations of the tumour to the uterus, whether it was uninodular or multinodular; nor, indeed, does he give any reasons why the uterus and the appendages were removed with the tumour. There may have been good reasons, but they are not given.

It happens that the first operation was performed by me on July 18th, 1892. There was a uninodular mass attached to the fundus by a good thick pedicle, which I clamped in the ordinary way. The ovaries, tubes, and the uterus were perfectly healthy, and in accordance with surgical rule I left them.

In his description of the case¹ Mr. Taylor says she was much disappointed at the result² of the previous interference, and this may be true of the patient, but it is a very mild description of the position taken up by a relative who accompanied her in a visit to my consulting rooms just before she was placed under Mr. Taylor's care. The attitude of the latter was that I was to blame for not operating, so that a further growth of tumours should have been prevented. Of course the evident answer to this absurd complaint was threefold: First, that regrowths of myoma under such circumstances are to me a wholly new experience. A suggestion that it might occur would of course have to be entertained, but that it ever had occurred up to that time required proof. The second answer: Why should I have removed a perfectly healthy uterus and set of appendages in a young woman of 28, seeing that our rule is, and always has been, against such a proceeding? We might just as well expect complaint that a surgeon had not amputated at the hip-joint for a crushed tarsus because two years after the patient got a badly-crushed thigh. Thirdly, who would dare, after our experience of the actions against Dr. Cullingworth, to remove

healthy organs in such problematical contingency as the one before us? Verily the surgeon's lot will in future be a most unhappy one if he runs risk of action at law on the one hand for removing healthy organs, and on the other hand of being abused for not removing organs in which no trace of disease existed. In any event, these two cases of Mr. Taylor's contribute not a scrap of evidence in support of the contention of Mr. Bowreman Jessett. The materials for a full discussion of the respective merits of the two ultimate alternatives for the treatment of the myomatous uterus are not yet in existence, and both patience and care must be exercised till they are obtained.

REFERENCES.

¹ *Medical Press and Circular*, February 3rd, 1897. ² Of course Mr. Taylor is mistaken here in the word he uses. The second growth was a *sequence* of the first operation, but in no sense a *result*.

A CASE IN WHICH THE TONSIL, FLOOR OF MOUTH, AND HALF THE TONGUE, WERE REMOVED BY EXTERNAL PHARYNGOTOMY FOR EPITHELIOMA.

By CHARLES A. MORTON, F.R.C.S.,
Surgeon to the Bristol General Hospital.

I WAS induced to undertake the very extensive removal of malignant growth in this case by a study of the records of similar operations in Mr. Watson Cheyne's *Lettsomian Lectures* for last year. The important points in connection with the operation are so fully discussed in those lectures, and such a complete table of the recorded cases there given, that I need do little more than relate the details of my own case.

Secondary hæmorrhage has so often followed ligation of the external carotid artery in what cannot be an aseptic wound (as it communicates freely with the throat) that I decided not to tie this vessel, but to divide and turn apart the divided portions of the lower jaw, so as to gain free access to the tonsillar region for the purpose of dealing readily with all bleeding vessels. I did not simply drain the wound with a drainage tube, but packed it with cyanide gauze, as is usually done after Kocher's excision of the tongue.

To feed the patient by a tube passed into the stomach and left there is also, I think, a very great advantage, as no food gets into the mouth, and painful and difficult attempts to swallow are not necessary; moreover, the patient at once begins to take large quantities of liquid nourishment. Before operating in this case, I used this method of feeding the patient in a case of Kocher's excision of the tongue and floor of mouth, and at the present time I am employing it in a case of excision of the body of the lower jaw and tongue, and in both cases with great advantage. The patient now under my care, on the third day after the operation, was taking four pints of milk with brandy and beaten-up eggs in the twenty-four hours, without any difficulty or discomfort. In using this method I followed a suggestion of Mr. Arthur Barker, given in his record of a case of Kocher's excision of the tongue, published in 1887. The tube (which should be about the size of No. 14 of the œsophageal tubes) is apt to get blocked with milk curd, and to prevent this it is well to syringe a little water through after each time of feeding.

T.J., aged 55, came under my care at the Bristol General Hospital, on June 3rd, 1896, with a history of a "pricking soreness" at the back of his tongue and in his throat, which had only been present for five weeks. At the time he came under observation he could only swallow liquids, and those only on the left side of his throat, and with much pain and difficulty. Inspection of the interior of his mouth showed a hard, ulcerated, warty growth on the back of the right side of the tongue, which involved the floor of the mouth between the back of the tongue and the jaw, and the junction of the tongue and anterior pillar of the fauces, and extended on to the tonsil. There was only one enlarged submaxillary gland to be felt. When under the anæsthetic at the time of the operation I felt the hard growth in the tongue extending to the middle line, and was just able to get the tip of my finger below it, down the pharynx.

Operation.—The operation was performed on June 12th. I first opened the trachea and inserted a Hahn's cannula, and

later on plugged the lower part of the pharynx with a sponge as well. This effectually prevented the entrance of any blood into the trachea during the operation. After the examination of his throat and tongue by the finger when under the anæsthetic, he got very cyanosed. The cause was not very apparent, but directly the trachea was opened much blood-stained mucus was expelled by coughing, and his colour at once became natural. No doubt this blood-stained mucus had passed into his trachea at the time of the digital examination. The tracheotomy was not performed on account of the cyanosis, but as a needful stage in the operation. The left lingual artery was then tied, and the mouth on the right side opened exactly as is done in Kocher's excision of the tongue, the right lingual artery being tied at the same time. Some enlarged submaxillary lymphatic glands were removed. The growth was found to have infiltrated deeply into the tongue towards the hyoid bone, and I had to divide the tongue close above the great cornu, and somewhat beyond the middle line, thus leaving rather less than half the organ. I then separated the cheek upwards from the jaw just in front of the masseter, and divided the jaw at the junction of the body with the ascending ramus, so that on traction outwards of the latter I could see fairly well into the tonsillar region. I found the growth fixed to the external pterygoid muscle, a portion of which I removed with it. The pharyngeal wall, where infiltrated by the growth, was also adherent to the external carotid artery, but I managed to peel it off. I did not separate the tongue from the tonsil and diseased portion of the pharynx, but removed them all in one piece. The growth had not invaded the jaw, but I had to strip off the periosteum with it. I wired the jaw at the end of the operation, and sutured the stump of the tongue to the soft tissues on the inner side of the front of the jaw. There was very little shock from the operation, which was a long one, and at the end his pulse was only 100.

The Growth.—The mass of growth in the tongue was about the size of a walnut, and of the typical hardness of epithelioma, and presented its microscopic appearance.

After-History.—The tracheotomy tube was retained for ten days and the stomach tube for rather more than a month, but by firmly plugging the external opening into the pharynx he could swallow fairly well three weeks after the operation. By July 18th the opening in the neck had so far contracted that it would just admit the end of the thumb; and on August 22nd, when he was discharged, it was only a minute sinus. He could then eat mincemeat, and speak so as to be understood, and had gained flesh to a considerable extent. He had no pyrexia after the operation or any lung trouble. When seen in October the sinus in the neck was found to have closed, and he had returned to work as driver on a locomotive engine. I showed him at a meeting of the Bristol Medico-Chirurgical Society on November 11th, 1896, five months after the operation, and there was then no sign of recurrence of the growths, nor is there any recurrence at the present date—January, 1897.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

FATAL TRAUMATIC RUPTURE OF HYDATID OF LIVER.

A. C. came under observation in April, 1896, aged 17½, complaining of sickness and five months' amenorrhœa. She was found to have an abdominal tumour, suggestive of a six or seven months' pregnancy or a large uterine fibroid, lying quite symmetrically, inseparable from the liver either by palpation or percussion, but with difficulty capable of being separated from an apparently normal uterus by bimanual examination. The tumour was hard and firm throughout, except in one spot below and to the left of the umbilicus, where fluctuation could be made out. In the right iliac region a hard, irregular, tomato-like mass could be felt. The tumour was stated to have been discovered six years previously near the right groin, and to have gradually grown upwards and to the left. It was thought to be probably

ovarian; but as the removal of the indigestion left the patient in excellent health and spirits, and as the tumour remained apparently quiescent during six months' observation, no operative interference was suggested.

In March, 1897, the patient accidentally stumbled in her muddy farmyard, falling upon her face on the grass; she went indoors, and soon afterwards, feeling sick, went upstairs and lay down, vomited, and died within half an hour. On palpating the abdomen shortly afterwards, the large central tumour could no longer be felt, although as distinct as ever two days previously; but the tumour in the right groin remained as of old. On opening the abdomen, the liver was found firmly adherent to the adjacent parts, and about thrice its normal size, due to five large hydatids. Three of these were as large as coconuts, very tense, full of colourless liquid, one occupying the right iliac fossa, another the left hypochondrium, and a third projecting from the under surface; a fourth extending down from near the portal fissure, was of similar size, but full of bile-stained liquid; while the fifth, as large as one's head, lay collapsed in the middle line, and contained some blood-stained liquid. All the cysts contained daughter cysts, varying in size from a currant to a peach, while the cyst walls were profusely studded inside with brood cysts. The other organs seemed healthy.

Kendal. WM. RUSHTON PARKER, M.A., M.D. Cantab.

CASE OF FEMORAL HERNIA IN WHICH THE VERMIFORM APPENDIX WAS FOUND IN THE SAC: EXCISION OF SAC AND APPENDIX: RECOVERY.

Mrs. McK., aged 21, was admitted to the Stanley Hospital on January 29th, 1897, suffering from a painful swelling in the right groin. She gave the following history: Two years ago, when lifting a heavy garden seat, a lump appeared in the groin, and attained the size of a hen's egg. It disappeared on lying down, and caused the patient no inconvenience; her bowels were always regular. On January 27th, two days before admission, whilst lifting a heavy bedstead, she felt a sudden sharp pain in the situation of the swelling in the groin, and this gradually became worse until she came to the hospital.

On admission, there was a hard, tense swelling, the size of a hen's egg, in the right groin; it was tender, gave rise to no impulse on coughing, and was irreducible. Her bowels had not moved for three days, and, though she was not sick yet, she complained of nausea and was rather collapsed.

Under an anæsthetic I cut down on the tumour, and opened a hernial sac which contained the vermiform appendix. This was thickened and congested. Having pulled the appendix down I removed the damaged portion, and brought peritoneal flaps over the cut end of the stump. I then returned the stump by pushing it back with a director into the peritoneal cavity. The ring was very small, and would not admit the tip of the little finger. The sac was then removed and a radical cure effected. There were no bad symptoms, and the patient left the hospital cured on February 20th, 1897.

On looking up the literature of the subject I can only find two recorded cases of this form of hernia—one by Annandale, in which the appendix was perforated, and the other by Jacobson. Annandale removed the appendix and fixed the stump in position. Jacobson returned the appendix after division of the border of Gimbernat's ligament, but states that he would remove the appendix in another case if there was time to make the necessary suturing secure. I removed an inch and a half of the appendix, and it contained no concretions.

G. P. NEWBOLT, F.R.C.S.,
Honorary Surgeon, Liverpool Stanley Hospital.

METHYLENE BLUE IN RHEUMATOID ARTHRITIS.

In looking through the recent works on rheumatoid arthritis I find no mention of the use of methylene blue in the treatment of this disease. In several very obstinate cases which have lately been under my care, I have administered this drug with the greatest benefit, each case showing marked improvement soon after commencement of treatment. Not only does the arthritic process appear to be altogether arrested, but the drug has a favourable influence on the general condition, improving nutrition and leading to increase of body weight. A 2 gr. tabloid (prepared by Messrs.