Doran received a false report of the patient's death, but on February 12th, 1908, a patient came to see him at the hospital. She complained of dyspepsia, due, it appeared, to excessive tea-drinking, but she added that she had gone on wonderfully well since her operation. Then, on looking into his notebook, Mr. Doran found she was Case II, and there was a report of her death. On further inquiry it transpired that the report referred to some other patient with a similar name and complaint, who had never been under his care. The patient looked very healthy, just as she appeared before the operation, and had distinctly gained flesh. There had been no period since the operation, and the menopause symptoms had passed away soon after her last visit in 1905. On examination, the abdominal cicatrix was found to be perfectly healthy, and the parietes supple. There was no evidence of the existence of any abdominal tumour. The cervix had become very small, and was still fixed, the two fleshy wattles in the left fornix had almost disappeared. There was a little resistance above the left fornix just definable on bimanual palpation. The right and posterior fornices were free. Such was the patient's condition two years and seven months after the operation. Mr. Doran declared that in the whole of his operative experience he had never come across a case where the after-history so thoroughly belied operative and pathological evidence.

These cases show the imperative necessity for careful observation of all patients from whom uterine fibroids have been removed. Only by such observation can we expect to gain anything like accurate knowledge as to the effects on the patient's organism of the removal of the fibroid uterus with or without cervical or ovarian tissue, so that we may see how far clinical experience agrees with the physiological experience of Blair Bell, Bond, Carmichael and Marshall, and others; and only by such observation can we expect to calculate with something like precision the chances of malignant, or apparently malignant, changes being overlooked or misinterpreted.

SOLID FIBROID OF OVARY OBSTRUCTING DELIVERY.

By J. STEWART, M.B., M.Ch., M.A.O.,

LEEDS.

THE following case occurred in a lady married two years, and who was attended by me in her first confinement.

Before her marriage the patient, who was aged 26, had complained at times that she felt something roll about in her abdomen, this being accompanied by sudden faintness and sickness. No opinion could be formed at the time as to the cause of this, but subsequent events made things clear. When called to see her in labour, it was found that there had been pains for two hours. On making a vaginal examination the finger impinged upon a smooth mass, so tender and so exquisitely sensitive that it immediately flashed through my mind, without any attempt at a differential diagnosis, that I was dealing with an ovarian tumour which was being compressed. This smooth tender mass was opposite the right sacro-iliac synchondrosis, and wedged between the brim of the pelvis and the head of the fetus, advancing in front of the latter. The cervix could be felt high up and just within the true pelvis. It was soft, dilatable, and about the size of half a crown. Rectal examination assured me that the mass was not faecal, although that was negatived by the great tenderness present.

Under chloroform the hand was passed into the vagina, the uterus and fetal head pushed to one side, when the tumour gently slid back into the abdomen. With the hand still in the vagina the cervix was dilated, forceps applied, and child delivered. The puerperium was uneventful. Six weeks afterwards I removed a solid fibrous tumour of the ovary, somewhat irregular in shape, and about the size of an orange. It was very easy to remove, there being no adhesions, and a sufficiently long pedicle to allow it being brought to the surface. Convalescence was without interest. The train of symptoms mentioned at the beginning, of something rolling about with faintness and sickness, have entirely disappeared.

Of all forms of pelvic obstruction the most interesting and by far the most frequent is obstruction caused by an ovarian tumour. McKerron gives the frequency of ovarian tumour complicating pregnancy as about 1 in 2,500. The mortality is appalling when Nature is allowed to take its course, the maternal being about 25 per cent. and the infantile nearly 50 per cent. The question of treatment is debatable, and in pursuing the course I did I am afraid

ran counter to the best English opinions. Bland-Sutton says:

When an ovarian tumour is discovered during labour and it impedes delivery, ovariectomy should be performed.

McKerron says:

Ovariectomy is the best treatment, and should be preferred when the patient can be placed under an experienced operator. When time and place does not admit of ovariectomy try reposition.

On the Continent there are two schools—one advocates Caesarean section, and this has the greater following; the other, ovariectomy.

On one point, however, every authority is agreed—never to attempt delivery until the tumour is removed either by reposition, puncture, or ovariectomy. The objections to ovariectomy are (1) great length of incision, because, as a rule, the surgeon has to get the uterus outside the abdomen to get at the tumour; consequently there is (2) great risk to the life of the fetus; (3) the surgeon must return the pregnant uterus, and sew up the abdomen over it.

Puncture is only mentioned to be condemned; it could have been of no use in the case of solid tumour reported here. There is just one possible exception, where the head is well engaged in the pelvis, and there is a cystic tumour low down in front of the head. In such a case puncture, and perform ovariectomy after delivery.

There are two objections to reposition. In pushing back the tumour, if a cyst it may rupture, or the pedicle may become twisted, and, as a rule, a long pedicle is present. As to the first, there is not much risk if gentleness be used. Instead of pushing at the tumour, push up the head of the fetus and the uterus out of the way. As to the second, axial rotation with twisted pedicle, it will be announced by great pain, tenderness and vomiting, accelerated pulse, and rise of temperature. If these should supervene in a case in which reposition had been performed, there should be no hesitation about opening the abdomen. Personally, I would much prefer to open the abdomen after the uterus had been emptied, and to perform ovariectomy, than to do it when the abdomen was crowded with a pregnant uterus.

It is almost too much to ask of human nature not to try and replace, if it can be easily accomplished. By doing so, at the same time emptying the uterus, a difficult situation has been surmounted, leaving the tumour to be dealt with in the near future.

If the tumour cannot be pushed up from the pelvis into the abdomen, then, in spite of the teaching of Mr. Bland-Sutton (and there is no authority whose opinion would carry greater weight), I should not hesitate to perform Caesarean section, at the same time removing the tumour after closing the uterine incision; as these tumours have long pedicles, it would add hardly anything to the operation. By so doing the necessity of an incision from ensiform cartilage to pubis is obviated, the life of the fetus through eventration of uterus is not endangered, and the difficulty of closing the abdomen over a fully distended organ is done away with.

A NOTE ON ABDOMINAL HYSTERECTOMY FOR CANCER OF THE CERVIX, AND ITS IMMEDIATE MORTALITY;

WITH AN ANALYSIS OF SEVENTEEN CASES.

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THE value of statistics of surgical operations is undoubted, yet they are often misleading owing to the predominant influence of the personal factor—the individual skill and experience of the operator. More especially is this true of any modern and extensive operation such as Wertheim has introduced to the profession, and which not many English surgeons have had the opportunity of performing in any large series of cases.

In a recent instructive article by Messrs. Berkeley and Bonney,¹ a table was given of 18 cases with 3 deaths (mortality 16.6 per cent.), a result of which these authors