constant need of post-graduate study as an antidote against premature senility. Daily contact with the bright young minds of our associates and assistants, the mental friction of medical societies and travel are important aids. Would you know the signs by which in man or an institution you may recognise old fogeyism? They are three: First, a state of blissful happiness and contentment with things as they are; secondly, a supreme conviction that the condition of other people and other institutions is one of pitiable inferiority; thirdly, a fear of change which not alone perplexes but appals.

Conservatism and old fogeyism are totally different things; the motto of the one is, Prove all things, and hold fast that which is good; of the other, Prove nothing, but hold fast that which is old. Do not suppose that you have here a monopoly of the article, which is a human, not a national, malady, for we see a very virulent type in America. In its illuiveness and in the disastrous consequences which have often followed its hunting, old-fogeyism is a sort of Snark in the medical profession. Before the Boojum, in the form of an entrenched variety, many good men and true have softly and silently vanished away, like the beamish nephew of the bellman, sacrificed to intellectual staleness in high places. One of the best correctives is the plan followed at Harvard, which compels (?) every teacher to take the Sabbatical year, ensuring in this way intellectual rest of the mind, if not refreshment. To maintain mental freshness and plasticity requires incessant vigilance; too often, like the dial's hand, it steals from its figure with no pace perceived except by one's friends, and they never refer to it. A deep and enduring interest in the manifold problems of medicine, and a human interest in the affairs of our brotherhood—if these do not suffice, nothing will.

As I stated at the outset, during the past three centuries English students have frequented in turn different countries, drinking deep, deep draughts at the great fountains of learning. Think of the debt we owe to these men and to their foreign masters! Linacre, and his successors, Caius, Harvey, and Glisson brought the new learning from Italy, and, moreover, gave to English medicine that smack of culture, that tincture so peculiarly its own. From Holland a succeeding generation drew rich stores of knowledge, and the methods of teaching of the great Boerhaave were quickly adopted by English and by Scotch students. From France came next the new science of Bichat, the new art of Laennec, and the new methods of Louis. To another group the great teachers of Austria contributed accuracy in clinical methods, a zest for the study of special branches, and a much-needed, at the time, therapeutic nihilism. The debt of the present generation to Germany can never be paid. Think of the scores who have found inspiration in our common master Virchow; and in the scientific study of disease the Fatherland is still in the van. The great republic of medicine knows, and has known no national boundaries, and post-graduate study in other lands gives that broad mental outlook and that freedom from the trammels of local prejudice which have ever characterised the true physician.

The course of Empire has opened new fields, in which problems new and old have been presented for solution, some of which are of great interest to you on this side of the water. In any comprehensive survey of the educational field in medicine, perhaps the most important single event during the past quarter of a century has been the silent revolution which has taken place in the United States, a revolution which has a direct bearing upon the matter in hand. Everywhere in the schools the entrance requirements have been strengthened, the course of study prolonged, and the character of the examination changed. The hospital equipment has been enormously improved and the clinical facilities correspondingly increased. But a still more striking change has been the cultivation of the scientific branches of medicine. Twenty-five years ago physiological laboratories were few and far between; now the output of a score of well-established laboratories supports one of the best journals of physiology in the world. The study of pathology has shown a corresponding growth. The most hopeful feature is a restless discontent which, let us hope, may not be allayed until the revolution is complete in all respect. Meanwhile, to students who wish to have the best that the world offers, let me suggest that the lines of

intellectual progress are veering strongly to the West, and I predict that in the twentieth century the young English physicians will find their keenest inspiration in the land of the setting sun.

A CASE OF ACUTE AND CHRONIC TORSION OF THE OVARIAN PEDICLE IN THE SAME SUBJECT.

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TWISTING of the ovarian pedicle is a well-known condition, and much has been written about it on account of its high importance, both from clinical and surgical points of view. Among recent cases, I may quote Dr. Boxall's, where torsion of the same pedicle, manifested by distinct symptoms, occurred twice at an interval of eleven months.¹ According to Dr. M. Storer, a great authority on the literature of torsion, bilateral rotation is not uncommon. The case which I here relate is, however, unusual. One pedicle underwent gradual torsion, the other became suddenly twisted, affording a perfect study of the two varieties of torsion in the same subject.

Mrs. A., aged 60, was admitted into the Samaritan Free Hospital under my care on April 22nd, 1900. Dr. G. Fisher, of Shere, near Guildford, had detected an abdominal tumour, which caused much pain in the hypogastrium and left iliac fossa. These symptoms began in December, 1899. The patient had been married for over thirty years; her eighth and last pregnancy occurred over twenty years ago; the menopause was not complete till she was over 52. The abdominal walls were somewhat distended and tender. The left fornix and Douglas's pouch were occupied by an exceedingly tender bilobed swelling which rose for an inch or so above the left groin; the uterus was displaced forwards. A little to the right of the middle line lay an irregular mass reaching nearly to the umbilicus. On the night of April 24th the patient took 10 grains of pil. colic. et hyoscyam. On the next morning, immediately after a slight action of the bowels, acute abdominal pain and vomiting set in, with distension. Flatus passed and there was no rise of temperature. The tumour on the right of the middle line was now extremely tender to touch. In a few hours the acute agony was replaced by a continual dull pain uniform with that in the left iliac fossa.

On the morning of April 26th I operated, assisted by Mr. Butler-Smythe. On making the abdominal incision a cluster of livid cysts came into view. I passed my hand behind them and turned out the whole tumour; the pedicle was firmly twisted two turns, very oedematous, and engorged with blood. There were no adhesions, nor was there any free fluid in the abdomen. I untwisted the pedicle, ligatured and divided it: the tumour, developed from the right ovary, came away. The second tumour, also made up of a cluster of smaller cysts, was then raised from behind the uterus and lifted out of the wound. Its pedicle, rather short, was twisted two turns, and atrophied in consequence. A long narrow piece of omentum was involved in the twist, running on to the pedicle from the left, posteriorly. The pedicle was ligatured and divided; the tumour originated in the left ovary. No flushing or drainage was required, the abdominal wound was closed. On recovery from chloroform the patient declared that she felt absolutely free from pain. She did not complain of any unpleasant feeling, which is the rule when even only one short pedicle has been ligatured. In this case there were two such pedicles, but so great was the relief from the pain caused by the torsion that the patient felt perfectly comfortable. Convalescence was uneventful.

The right tumour weighed 1 pound 9 ounces, and was made up of a cluster of cysts purple through ecchymoses. This appearance has been mistaken for gangrene. The cysts contained much grease. The left tumour, half a pound in weight, also consisted of a cluster of dermoid cysts. Their walls were not ecchymosed.

In this case I made the abdominal incision about 4 inches long, as directly I saw the right tumour I concluded that it would be best to take it out entire. The left, much smaller, came out easily. Not a drop of the greasy contents of either escaped before extraction. I find that small, non-adherent cysts with suspicious contents are best extracted entire; this is especially the case in pregnancy, when as little disturbance of the peritoneum as possible is important. A 4-inch incision and a peritoneal cavity found clean and left clean are better than a 3-inch incision and a peritoneal cavity fouled, however carefully it may be flushed or drained afterwards. It is quite otherwise with big multilocular cysts, which in favourable cases can be readily removed through an abdominal incision under 3 inches in length.

The literature of torsion of the pedicle is voluminous. Perhaps the most complete essays on the subject are those written by Dr. Storer of Boston U.S.A.,² and Professor Martin.³ Dr. Cullingworth⁴ has recently turned attention to cases where acute torsion has led to the diagnosis of an unsuspected ovarian cyst; in the present case chronic torsion of one cyst

led to its detection, whilst purgation preparatory for ovariectomy caused acute torsion of a cyst of the other ovary.

Tumours irregular in form, are very liable to become twisted, and short pedicles are particularly subject to torsion. It has for long been known that dermoids are specially exposed to this complication. Where there are two tumours the one may cause the other to rotate on its pedicle. All these predisposing conditions were present in my case. Irregular dermoids, forming a cluster of cysts, usually, as in this instance, have very small pedicles, consisting of the Fallopian tube and mesosalpinx, hardly if at all hypertrophied. The same is seen in malignant ovarian tumours of the same irregular form and also in fibroma. It is not clear why the pedicle does not in these instances undergo the well-known hypertrophy so familiar in the common multilocular ovarian cyst. But it is not hard to understand that an irregular tumour longest in its horizontal axis may easily rotate around a short and narrow pedicle. I observed this condition once in an ovarian fibroma. I made a 4-inch abdominal incision, lest the parietes should be bruised by the hard tumour during extraction. The pedicle was twisted half a turn to the right, causing œdema of the Fallopian tube. This pedicle was relatively short, though fairly long for a fibroma, where shortness is the rule. In this case, as in that which is the subject of these notes, the tumour was extracted entire and the twist of the pedicle was detected before extraction. We must not forget that when a big cyst is tapped during ovariectomy it often produces, as it empties and slips out of the abdominal wound, a torsion which did not exist before. I have observed rotation of a collapsing cyst many times; it must not be registered in statistics as torsion existent before the operation.

Dermoids specially tend to rotate on their pedicles, partly because they are often irregular in form, and partly because they are often overweighted at one point by masses of bone or other solid, heavy structures. The phenomenon of one tumour twisting its fellow has been noted more than once. In the present case the right tumour probably pushed against the left and caused it to roll over into the pelvis. Some other cause, however, may have brought about the torsion of the left pedicle, which was typically chronic. The acute torsion of the right pedicle is of greater interest. It followed immediately upon the action of the bowels about twenty-four hours before operation. The subsequent enema thrown up six hours before operation did not, by the way, aggravate the symptoms. The contraction of the abdominal walls against the right tumour during defæcation, when little was passed though not without much straining, must have been the chief, if not the sole, cause of the torsion. The action of the abdominal muscles seems more likely to be effectual than peristalsis or the passage of feces along the intestine in making a tumour rotate.

Authorities are divided on this question, but Cario believes that all these agencies in defæcation unite in causing torsion. If so, it seems strange that torsion is not even commoner than statistics show it to be. In one instance the complication was caused by the struggles of a patient under nitrous oxide at a dentist's (Fântes, Martin). Here rigid contraction of the abdominal muscles was probably the sole cause, and this contraction may as probably be the only cause of torsion set up during defæcation. I admit that when a large irregular ovarian tumour lies down in the pelvis, the passage of scybala may cause it to rotate for a quarter of a turn or so, but in my case the right tumour, which underwent acute rotation, lay entirely above the pelvic brim.

As to treatment, no delay was indicated in this case. The acute torsion was an accident caused by the preparations for ovariectomy, decided upon before it occurred. Both tumours were removed before peritonitis had been set up by the complication. It is not torsion of the pedicle in itself, but the secondary disturbances which it causes within a short time that so greatly increase the difficulty and danger of ovariectomy. This fact is very manifest in neglected cases where the torsion is associated with pregnancy and labour.

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TWO CASES OF CONCEALED ACCIDENTAL
HÆMORRHAGE.

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CONCEALED accidental hæmorrhage, according to Galabin, occurs only once in nearly 50,000 cases. It is very rare and very fatal, more so than placenta prævia. In accidental hæmorrhage, when there is hæmorrhage from the vagina, the treatment is to rupture the membranes at once in order to induce uterine contraction. In both these cases there was no hæmorrhage from the vagina, and the amniotic fluid was so scanty that very little effect would have resulted from rupture of the membranes, and it was evident that labour had commenced in both cases. They were both suffering so much from shock that one was loath to do much. Their general condition did not get worse, and in all probability the internal hæmorrhage ceased after the first few minutes. The uterine contraction was sufficient to stop the hæmorrhage.

Mrs. C., a strong, healthy woman, aged 33, seven and a-half months pregnant with her seventh child, was sitting in a chair one afternoon at 2.30, when without obvious cause she became suddenly faint, and fell on the floor unconscious. When seen shortly afterwards she was lying on her bed with a weak, quick pulse, greatly blanched and collapsed, but conscious.

There was continuous uterine pain of a very severe character, a sensation of pressure over the pubes, and desire to micturate. The uterus felt hard, and was tender to touch; it had increased in size since the beginning of the attack. There was no hæmorrhage from the vagina; the os uteri admitted the tip of the finger only; the membranes were felt in close contact with the fetal head, and did not bulge. Owing to the collapsed state of the patient, active treatment was postponed, and she was given quinine, ergot, and fluid nourishment. Her general condition remained the same or slightly improved, and at 10 P.M. the os admitted two fingers. The next morning, at 2 A.M., slight vaginal hæmorrhage occurred, and the membranes were ruptured, but the liquor amnii was very scanty, amounting to less than 6 ounces. The head descended into the cervix, and the patient suffered excessive pain, which was continuous with exacerbations. Whiffs of chloroform were given.

As the os remained rigid, Champetier de Ribes's bag was introduced to dilate it, but this burst. An effort was then made to seize a leg and perform version, but, owing to the clots tightly surrounding the fœtus, it was impossible to bring the leg down. Forceps were applied, and after some difficulty the child was delivered dead. The placenta was expelled with ease, and fully two chamberfuls of blood clot followed it. The uterus contracted well, and no post-partum hæmorrhage occurred. The patient was doused with perchloride of mercury, and ergot was given. She slept for some time afterwards; the pulse remained quick and weak, and she was much blanched. The head was kept low, liquid food, in the shape of Carnrick's liquid peptonoids, milk, etc., was given, also alcohol. Her pulse remained at 120 for some days, but her temperature never rose above 100°. She made a slow recovery, complaining for some time of severe temporal headache. She is now quite well.

Mrs. M., a weak anæmic woman, aged 37, when about full time of pregnancy with ninth child, was taken suddenly faint at 8 A.M. without obvious cause, and had to go to bed. Labour pains commenced, she had vomiting and several fainting attacks. When seen at 10 A.M. she was very blanched, pulse weak and slow, but she was conscious, and said she felt very ill. There was continuous pain in uterus, with exacerbations; patient stated that the uterus had increased in size since the attack began. There was no hæmorrhage per vaginam, the os was the size of a two-shilling piece, the head presented, and the membranes were intact.

The patient was evidently suffering severely from shock; stimulants were given, also ergot. The pains increased, but the os remained rigid, and did not dilate. Her general condition remained the same. At 12.30 the membranes were ruptured, but the liquor amnii was scanty; the os was dilated by the fingers. As the head did not come down forceps were applied, and delivery took place at 1.30 (5½ hours after first symptoms). There was no loss of blood per vaginam before delivery, and immediately after the dead child was born the placenta was in the vagina. The uterus contracted well, and clots amounting to half a chamberful were pressed out. The patient was doused. The foot of the bed was raised and the head kept low. Owing to vomiting she could retain very little nourishment. Two hours afterwards she had not rallied; she had two or three convulsive attacks; the pulse was weak, but she was conscious. The uterus remained well contracted, and there was no hæmorrhage. Rectal injection of hot water and brandy was given, and strychnine and digitalis administered hypodermically. She died at 6 P.M. in convulsions.

Intravenous injection was not performed, as in the first case one thought the condition was a recoverable one, and in the second the patient's death in a convulsion took one by surprise.

The second case presented symptoms more of shock than hæmorrhage. She had few of the symptoms of death from hæmorrhage, such as loss of sight, noises in the head, hallucinations, sighing respiration, and imperceptible pulse. She was a woman of weak health, and had had much domestic worry and trouble, and from the first was under the fixed impression that she was going to die.