rupted, and she was allowed up on the tenth day. The material removed showed hundreds of cyst-like formations, some about the size of peas or currants, others very small, like pinheads; each contained a clear jelly-like fluid, giving the appearance of small white berries.

The case was thus, undoubtedly, one of vesicular or hydatidiform degeneration of the placenta. It will be noticed that the cardinal symptoms of the disease were all present:—

1. The more rapid development of the uterus than occurs in ordinary pregnancy.
2. The repeated attacks of uterine hæmorrhage.
3. The disappearance of the embryo.
4. In this case the absence of "ballotement" was somewhat suggestive.

A CASE OF TRUE HÆMATOSALPINX : LAPAROTOMY : RECOVERY.

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UNTIL recent years the term "hæmatosalpinx" has been used by writers to denote two distinct morbid conditions: the one arising from the retention of menses, as in cases of atresia vaginæ; and the other a local disease characterised by hæmorrhage into the lumen of the tube. Since Dr. Martin, of Berlin, in 1889 discovered that in a case of hæmatosalpinx under his care there were present in the wall of the tube chorionic villi, though no trace of a fœtus could be found, it has been assumed that all cases of the latter variety arise from abortive extrauterine gestation.¹ This view has in the more recent works overshadowed the older, and until November 4th, 1891, when Dr. Herman showed a case which he termed hydro-hæmatosalpinx before the Obstetrical Society of London, there was no example illustrating the manner in which a simple hydrosalpinx may develop into a true hæmatosalpinx. The compound name given to this unique case sufficiently explains its nature. It occurred in a young woman, the tube was distended and in its cavity was found blood containing serous fluid. There was, however, no evidence found on microscopic examination of the wall to show the manner in which the extravasation of blood took place. In short, this proved to be an example of a mixture between hydrosalpinx and hæmatosalpinx. No definite clinical symptoms appear to have been associated with this morbid state.

In the case herein described one tube—the left—was found in the state described by Dr. Herman as hydro-hæmatosalpinx, and the other—the right—which gave rise to the symptoms, proved to be, I think, an example of true hæmatosalpinx, that is, a hæmatosalpinx in which no trace of ovum structures could be detected. The suggestion to which the case of hydro-hæmatosalpinx above alluded to gives rise—namely, that a hæmatosalpinx may arise from a pre-existing hydrosalpinx—receives, it seems to me, definite confirmation from the following case.

HISTORY.

M. A. K., aged 32, was admitted into Addenbrooke's Hospital, Cambridge, on August 29th, 1896; married, six children, the eldest 16 and the youngest 2½ years; pale, depressed, but healthy-looking; pulse 110, regular and moderately strong; tongue slightly furred and tremulous; very thirsty and bowels somewhat constipated; no cough; urine normal. There is present a more or less constant bloody vaginal discharge. In the inner and lower part of the right inguinal region, just above Poupart's ligament, there is a lobulated slightly tender swelling situated immediately beneath the anterior abdominal wall, and therefore in the pelvis. This was found by vaginal examination to be in the right and anterior part of the true pelvis, lying on the bladder, freely movable and distinct from the uterus, which was not enlarged but displaced backwards and to the left. The cervix uteri was enlarged and patulous, and the vaginal mucous membrane swollen and rather hot.

History.—In November, 1895, she suffered from an abortion after three months' amenorrhœa; a membranous bag came away. After this she got about, but suffered from periodical bleedings, and in between times from a blood-stained discharge. A week or two after this abortion she discovered the lump that can now be felt in the right inguinal region, and she says that it was then of smaller size. This state continued with

hardly any change until July 2nd, 1896, when, while walking about, she was suddenly struck with lancinating pains in the lower part of the body, and simultaneously suffered a great loss of blood from the vagina; no clots. Mr. Ord, of Mildenhall, who was called in to see her, found the lump already referred to in the pelvis, and came to the conclusion that probably it was of the nature of an extrauterine pregnancy. All the symptoms soon quieted down. On July 29th she went to Bury, and while walking about was again attacked with similar pains, and a blood discharge from the vagina. Again all symptoms subsided with rest in bed. On August 23rd, while returning home from Bury, she was again attacked in a similar way. Six days later she was conveyed to the hospital.

On September 1st, 1896, I performed laparotomy, and found that the swelling on the right side involved the Fallopian tube which was removed, together with an enlarged ovary, by transfixing the pedicle and tying a Staffordshire knot. On examination of the left side of the pelvis, the left Fallopian tube was found distended and occluded at its fimbriated end, and, in consequence, it was deemed advisable to remove it. Recovery uneventful.

DESCRIPTION OF THE SPECIMENS.

The Right Fallopian Tube and Ovary.—The outer end of the Fallopian tube is distended into a lobulated congested fluctuating cystic mass with the omentum attached to the lower part of the anterior surface. The wall of the sac is very thin near the upper part. Behind is the enlarged cystic ovary. On manipulating this swelling and endeavouring to deliver it whole, the thin part of the wall ruptured, and much dark coagulated blood escaped, leaving the mass a good deal smaller. The inner part of the tube appears to be natural. In a longitudinal section through the tube and ovary it is seen (as in a diagrammatic representation Fig. 1) that the free

Fig. 1.—Coronal section through right Fallopian tube and ovary (natural size).

end of the tube consists of a thick-walled cyst, 1½ inch in diameter, containing clotted blood, with a portion of omentum adhering to its lower part. The wall is in most places one-sixth of an inch in thickness, and appears to consist in the main of fibrous tissue. The inner surface of the cyst is everywhere uneven and rough. The part of the tube next to this is distended with blood clot, so that it is about half an inch in diameter, but its walls are merely thinned from distension, and not otherwise altered. From this part the tube rapidly diminishes to its normal size, and becomes of normal appearance. The ovary is enlarged, and in its substance there are three cysts, one about 1 inch in diameter and the others each about one-sixth of an inch. The wall of the cystic end of the Fallopian tube is found under the microscope to consist of a thick fibrous wall, containing unstriated muscular fibres, lined by a layer of granulation tissue in many parts of which there are degenerative changes, and into which many small hæmorrhages have taken place. The muscle fibres, which are in the outer part of the wall, are of small size, and are widely separated by much fibrous connective tissue. The bleeding no doubt arose from the lining of granulation tissue. The part of the tube next to the cystic outer end, though distended with coagulated blood, is thinned only, and not otherwise altered; and the tube near the uterine end is

¹ Mr. Bland Sutton, in the last edition of his *Surgical Diseases of the Ovary*, etc., emphasises the view that many of the cases hitherto regarded as hæmatosalpinx belonging to the second variety are in reality examples of abortive tubal gestation, and he makes reference to several instances in which this mistake arose, and especially to a specimen in the Pathological Museum of St. Bartholomew's Hospital. He does not even consider the subject of what I herein describe as true hæmatosalpinx.

natural, being lined by the usual folded mucous membrane covered by columnar ciliated cells. There are no traces of placental villi or of anything that would indicate the former existence of a fetus.

The Left Fallopian Tube and Ovary.—In its outer two-thirds this tube is moderately distended, and the fimbriated end is closed, the fimbriae having, with the exception of remnants of two, quite disappeared. (See Fig. 2.) The wall is everywhere

Fig 2.—View of posterior surfaces of Fallopian tube and ovary (natural size).

thin and of a dark colour, as if intensely congested. The inner end of the tube is natural, both in size and structure. The tube contained a dark-coloured serous fluid, in which there were many red blood corpuscles. The wall is everywhere thin, and the mucous membrane is almost devoid of folds, which are stretched out. Under the microscope the mucous membrane is seen to be reduced to a very thin layer, with occasional and short simple folds projecting into the lumen. On the folds, which are very thin, the epithelium retains its columnar ciliated character, but elsewhere it is reduced to a layer of small flattened cells of irregular shape, devoid of cilia. The muscular wall is not structurally altered, being merely attenuated from the stretching. The left ovary is natural.

REMARKS.

In reviewing the clinical history of this case it is clear that in November, 1896, there occurred an abortion after three months' amenorrhœa; soon afterwards a tender swelling was detected in the right inguinal region. Recovery was slow, and the menses returned in due course. Nothing of any note occurred until July 2nd, 1896, when she was attacked while about by acute, stabbing pain in the lower part of the body, which was followed by profuse bleeding from the vagina; recovery from this was pretty rapid, although there was present, more or less constantly, some bloody vaginal discharge. Two similar attacks followed during July and August, and at the end of August she suffered from a considerable bloody vaginal discharge which was associated with a defined, movable, lobulated, and tender swelling in the anterior part of the right half of the true pelvis. During each attack there was great loss of blood through the vagina, accompanied by collapse. These symptoms could, so far as my knowledge went, only be explained by supposing the existence of an extrauterine pregnancy, with recurrent hæmorrhages and escape of blood from the tube into the uterine cavity, and thus through the vagina to the exterior. An alternative supposition was that the bleeding came from the uterus, and that the swelling was independent and playing only a secondary rôle in the case. On exploration it was soon seen that we had to deal with a bleeding cystic distension of the right Fallopian tube, the cyst being situated in the outer end and the fimbriae sealed together so as to close the abdominal opening. The tube nearer to the uterus was obviously free; it only contained recently clotted blood (see Fig. 1). The left Fallopian tube was also diseased, containing a dark blood-stained serous fluid, as above described.

In the absence of any trace of the structures of an ovum either in the sac of the right Fallopian tube or in its interior, it is but fair to conclude that the condition on the right side is only an advanced state of that on the left; and that the lining of the distended tube on the right side lost its epi-

thelium, and that this was replaced by a hæmorrhagic layer of granulation tissue. This change is indeed comparable to that which occasionally occurs during the development of simple hydrocele of the tunica vaginalis into a hæmatocele. It is of interest to note that there is no evidence that the right tube ever ruptured into the peritoneal cavity, and to all appearances the escaped blood made its way to the uterus and so to the exterior before the tube became overstretched. The attachment of the omentum to the distended tube may be fully explained by the chronic inflammatory state of the cyst wall.

PUERPERAL FEVER TREATED BY ANTISTREPTOCOCCIC SERUM, FOLLOWED IMMEDIATELY BY ENTERIC FEVER; RECOVERY.

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A PRIMIPARA, aged 21, of spare build, was delivered of a large child on August 15th. Forceps were used. The perineum was torn into the rectum, but was not stitched. No douche was used. The patient was said to have been all right on the fourth day, but finding the temperature up on the sixth day a medical man gave a vaginal douche in the evening and next morning.

When I first saw the patient, on the evening of the seventh day, the temperature was 105°, and lochia fetid. A bichloride vaginal douche and biniodide was prescribed, alternated with nux vomica and quinine, but all these had to be stopped within twenty-four hours owing to diarrhœa. On the eighth day I gave an intrauterine douche, and applied iodised phenol to the interior of the uterus. Intrauterine douching was stopped on the eleventh day owing to tenderness of perineal wound; from that date a douche of boiled water and permanganate of potash was given twice daily, and an iodo-

form pessary inserted. The temperature up to this point had remained between 104° and 105°, frequently touching the latter figure. The pulse was rapid, the tongue dry, there was loss of flesh, little or no lochia, and diarrhœa (partly du)