TUBAL GESTATION WITH RUPTURE AND HÆMORRHAGE INTO THE PERITONEAL CAVITY.

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ON August 31st I was asked to see a married woman, aged 26. She had the appearance of a person who had suffered a severe hæmorrhage. She was blanched and quite pulseless. The skin was cool and moist, and there had been recent vomiting. She complained loudly of pain in the lower part of the abdomen.

History.—She believed herself to be pregnant, but there having been several slight discharges of blood, she thought she might be going to miscarry. She had had three children naturally, the youngest 3 years of age, and at this, the last, confinement there had been some difficulty with the placenta. A year ago and nine months ago respectively, she had miscarried at about three months, and on one occasion at any rate, aid was required to remove the products of gestation. On July 7th—that is, seven and a-half weeks ago—there was a natural menstrual period. A fortnight ago there was a slight fainting attack, with pain and some discharge of blood from the vagina, but the symptoms passed off after resting. The same symptoms recurred a week ago, but again passed off, though she did not feel quite right. There was some sickness similar to what she had had in former pregnancies.

Present Attack.—This began with a faint a few hours before I was called to see her. The abdomen was protuberant and tender, but neither tense nor resistant. The tenderness seemed greater on the right side. The temperature was 99.2° ; the pulse could not be felt at the wrist. Vaginal examination showed the os to be patulous, and nearer the left than the right side of the pelvis. The fornices appeared shallow, but no defined swelling could be made out. The examination caused some pain, and the finger was stained with gummy blood. Morphine (gr. $\frac{1}{2}$) was given, and arrangements were made to have the patient removed to the Cottage Hospital. This was done with some difficulty in the afternoon, the slightest movement causing an access of pain. In the evening the pulse was slightly better, and the pain was less severe, but the abdomen was more protuberant.

Diagnosis and Treatment.—Dr. Hall and Dr. Lawson now saw the patient with me. They concurred in the diagnosis of tubal gestation with hæmorrhage. Morphine (gr. $\frac{1}{2}$) in suppository was given at night, and the patient was prepared for operation. On the following day there was some improvement in the general condition, but the abdomen remained swollen and tender, and there were intermittent pains. An enema of soap and water failed to move the bowels. Drs. Hall and Lawson again saw the patient with me, and afterwards kindly assisted with the operation.

Operation.—On opening the abdomen in the middle line fluid blood at once issued forth, and later on a quantity of dark clot. The right ovary and tube were brought up into the wound, but were found natural. On searching for the left tube the fingers entered a mass of dark blood clot, from which, however, an enlarged tube with ovary was easily extricated. After ligaturing the broad ligament the ovary and tube were removed. The latter had, quite near its fimbriated extremity, a small sac about the size of a pigeon's egg, ruptured in its whole length towards the free border of the broad ligament. The clot was then cleared out as thoroughly as possible from the cavity of the abdomen, principally by means of the hand. It was not found practicable to remove it entirely, however. A small part of the clot showed signs of organisation, but there was no adventitious membrane, and there were no adhesions to the bowel or pelvic walls. The embryo was not found. The amount of blood and clot removed was about sufficient to fill a pint measure. The abdominal cavity was irrigated with hot saline solution, and then closed without drainage.

After-History.—There was considerable collapse after the operation, but the injection of saline solution into the areolar tissue under the breasts and also into the rectum seemed to do good. After the collapse had passed off the patient did

not have a bad symptom. For a few days the urine contained a small quantity of albumen, probably caused by the absorption of blood clot. On the third day after the operation a complete cast of the uterus, along with a small quantity of blood, was discharged from the vagina. On the eighth day the wound was dressed and found to be soundly healed. On the twenty-eighth day there was a natural menstrual period, and thereafter the patient went to a convalescent home.

REMARKS.—The right tube was thought to be the one involved, from the greater tenderness on that side of the abdomen, and from the fact of the os being nearer the left side of the pelvis. It was not so, however, and it seems probable that the lessened space between the os and the pelvic wall was due to bulging of the soft parts by blood in the peritoneal cavity.

HYSTERECTOMY FOR A SOFT FIBROMYOMA WEIGHING 53 LBS.

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EGYPTIAN women appear to have a special capacity for carrying enormous abdominal tumours without apparent discomfort, tumours which in a European woman must have produced most distressing pressure symptoms, and, indeed, would never have been allowed to attain such dimensions without seeking surgical intervention.

History.—The patient was an unmarried Egyptian woman, aged 18, whose principal trouble was that she had had amenorrhœa for the last two years. For six months prior to this she had lost a considerable quantity of blood at each menstruation. When menstruation stopped, a small swelling appeared low down on the right side of the pelvis, and gradually increased in size, until on admission to hospital it seemed to more than occupy the whole abdominal cavity (*vide figure*). There were no special symptoms during the enlargement of the abdomen, but in the last few months the patient had become somewhat emaciated. She could not lie on her back for any length of time, but was quite comfortable lying on her side or sitting up nursing the tumour like a great pumpkin between her knees.

State on Examination.—The abdomen was enormously distended, but the skin had evidently been stretched very gradually, as there were very few lineæ albicantes, and the skin was not tense and shiny as occurs in more rapid distensions such as ascites. The superficial veins on the upper half of the abdomen were much dilated, and the umbilicus was pushed downwards and protruded. The surface of the swelling was everywhere quite smooth, and distinct fluctuation was felt from side to side, being more marked low down in the loins, which were much overhung by the lateral parts of the tumour. The whole swelling was dull on percussion, and an aspirating needle had been inserted in the middle line before admission to hospital, but no fluid was withdrawn. The greatest circumference of the abdomen was $49\frac{1}{2}$ inches (125 cm.); the circumference at the level of the umbilicus was $43\frac{1}{2}$ inches (111 cm.). The distance from the ensiform cartilage to the umbilicus was $15\frac{1}{2}$ inches (40 cm.), and from the umbilicus to the pubes $7\frac{1}{2}$ inches (19 cm.). On vaginal examination there was found considerable prolapse of the vaginal walls, the fornices were obliterated, and the cervix of the uterus was felt quite low down. The ovaries could not be felt, and it could not be definitely made out whether the tumour moved with the uterus or not, as the mass was altogether too large to manipulate. The most probable diagnosis seemed to be an ovarian cyst, with a thick wall of multilocular cysts around one large central cavity. Dr. Sandwith, under whose care