patient could get ease was on her back with both knees drawn up. Sometimes when an attempt was made to relieve the bladder micturition was not possible until after the patient had lain on her back for half an hour or an hour, and by pressure on the tumour, first on one side and then on the other, enabled the bladder to be emptied. At other times great difficulty in defaecation was experienced. In fact life became such a burden that she was quite willing, and even anxious, to undergo anything in preference to continuing as she then was."

Fig. 1.—Drawing of tumour; one-third natural size.

Operation.—On May 13th, 1898, the abdomen was opened in the middle line. (Dr. Wade kindly assisted me, and the anaesthetic was administered by Mr. Morley Agar). Two fingers were inserted, and it was found that the tumour was wedged into the pelvis. The incision was enlarged, and the sigmoid flexure, which was adherent to the left side of the tumour, was carefully separated. By means of the fingers pushed down on the right side of the tumour, and a large pair of vulsellum forceps grasping its upper part, it was lifted out of the pelvic cavity. I have never seen a tumour so tightly wedged in the pelvic cavity. The tumour was attached by a long slender pedicle. The uterus was flattened against the symphysis pubis. The ovary on the left side was atrophied. There was no ascites. The pedicle was ligatured, and the tumour, which grew from the right ovary, was removed. The pelvic cavity was flushed with hot salt solution, and the parietal wound closed.

Fig. 2.—Photomicrograph of a section of the tumour; the interlacing wavy bundles of fibrous tissue are seen and the elongated nucleated cells.

After-History.—The patient made a good recovery. Dr. Wade wrote me on August 31st, 1898, that "Mrs. R. says she is in better health now than she has been for years. She has not had a day's illness; the only sensation she complains of is a feeling of emptiness in the abdomen." I heard in December, 1902, that she is still alive, and in the enjoyment of good

health four years and seven months after the operation. The abdominal scar is quite sound.

Description of Tumour.—The tumour removed was nodulated and firm. It measured 8 in. by 6 in., and had no trace of calcareous change (Fig. 1). Microscopically it was a fibroma (Fig. 2). Interlacing wavy bundles of fibrous tissue are seen throughout the sections, together with elongated nucleated cells. The blood vessels possess well-formed walls.

The fibrotic changes noted as occurring in the ovaries after their active functions have ceased would seem to favour the development of fibromata, although myomata have also been described. The museum of the Royal College of Surgeons of England, contains a specimen weighing over 7 kilograms, and described as an ovarian myoma. It was removed by the late Sir Spencer Wells from a single woman, aged 68 years, who had noticed its presence for eight years. "It had a good pedicle; the Fallopian tube and mesometrium were free from disease."

Leopold, in his paper entitled "Die soliden Eierstockgeschwülste" refers to a case recorded by Löbl.² The patient aged 73 years, died of septic peritonitis after an operation for the removal of a "nodulated fibroid" the size of a child's head growing from the right ovary.

Haase³ mentions a *post-mortem* specimen of an "osteoid tumour" obtained from a patient, aged 72 years. It measured 13 cm. in length, 10 cm. in breadth, and was 3 cm. thick. The weight is stated to be 250 grams. Haase does not state whether the growth originated from the right or the left ovary.

Briggs⁴ mentions a case where an ovarian fibroma was removed from a single woman, aged 68 years.

I have not succeeded in finding the record of a case successfully treated at such an advanced age as 73 years. Ovarian cysts, however, have been removed from patients who were much older, of which numerous records exist in the literature.

An admirable summary of our knowledge regarding ovarian fibromata will be found in the *Transactions* of the Obstetrical Society of London, vol. xxxviii, 1896, p. 187. In a paper entitled *Cases of Fibroma of the Ovary and Ovarian Ligament Removed by Operation, with a Series of After-histories of Cases Reported in the Transactions since 1879*, Doran mentions a case where a patient, aged 52 years (married), had a fibroma of the right ovary weighing 3 lb. removed by ovariectomy. Her menstrual periods had ceased for five years before the operation. She was reported "quite well" over six and a-half years after the operation.

Although both Leopold and Doran have shown that ovarian fibromata occur in very young women, still a sufficient number of cases is now on record where such tumours have been removed from patients whose menstrual functions had ceased.

It is of interest to the clinician to find that a solid ovarian growth may increase in size and probably even originate after the menopause and yet be of a simple character.

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NOTES OF TEN CASES OF HYSTERECTOMY FOR FIBROID DISEASE.*

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[THE author having discussed the operation of vaginal hysterectomy for cancer and related several cases with their after-histories, went on to describe ten cases in which he had performed extirpation of the uterus for fibroid disease as follows:]

CASE I.—A married woman, aged 43, but with no children. Menstruation had been profuse for three years, but the most prominent symptom was pressure on the bladder during the same time. For the last year she had only been able to hold the water for at the most forty-five minutes at a time both day and night; if she slept beyond that time she woke in great pain; this had told upon her health very much by disturbing her rest.

The whole pelvis was filled with a hard tumour which was attached to the uterus and was about the size of a child's head at term. With the able assistance of Messrs. Fenner and Dent and Dr. McClure abdominal hysterectomy was performed. The tumour was so tightly wedged into the pelvis that it was with difficulty withdrawn. Recovery was complete; she began from the very first to sleep soundly the whole night. The tumour was a single one and very hard.

CASE II.—A married woman, aged 50. She had had four children. Haemorrhage had been very profuse for the last nine years. The electrical treatment had been used for a long time without producing any effect. For the last four months before operation she did not cease to lose blood for a single day, so that she often fainted, and was extremely

* Abstract of paper read before the East Anglian of the British Medical Association at Southwold.

anaemic. The uterus contained several fibroids; the largest, about the size of a cricket ball, was felt extending nearly to the umbilicus, and was only slightly movable. Although her condition was very bad, yet I felt sure that her only chance of life was by operation, and with the valuable assistance of the late Mr. Waring and of Mr. C. J. Muriel, abdominal hysterectomy was performed. The difficulties of the operation were very great owing to dense adhesions, which prevented the tumour from being drawn upwards, so that the ligatures had to be passed and tied at a considerable depth from the surface. Convalescence was slow owing to the extreme condition of anaemia, and it was several months before she could walk, but at the present time—namely, four years after operation, she is strong and well.

CASE III.—Patient, aged 51, showed her courage by taking a return ticket from Australia and coming to England for the purpose of her operation. She had known of the existence of a tumour for ten years, and during all this time menstruation had been profuse, but of late her loss had been continuous, lasting, for instance, ten weeks at one time, so as to compel her to give up her occupation. There was a large tumour filling the pelvis which extended to the umbilicus. Abdominal hysterectomy was performed. On opening the abdomen the tumour was seen to bulge widely into both broad ligaments, so as to occupy both right and left iliac fossae, besides filling the pelvis. Owing to its attachment it was not possible to drag the tumour upwards with corkscrews, and the separation had to be commenced from above. Finally the whole uterus and the tumour were removed, the vagina and pelvic peritoneum closed, and the abdominal wound united. Recovery was uninterrupted, and in about five months she returned to Australia.

CASE IV.—Patient, unmarried, aged 55, no haemorrhage, but the prominent symptom was pressure on the bladder, which had been increasing for the last two years and was disturbing her sleep at more and more frequent intervals. The tumour felt very hard and nearly filled the pelvis. The tumour as shown in the photograph was removed by abdominal hysterectomy, the Trendelenburg position being used. It consists of a fibroid of the uterus filled almost entirely with calcareous plates, and so hard that it could only be divided with a saw. She recovered completely and is at the present time quite well.

Fig. 1.—Case IV.

CASE V.—Patient, a married woman, aged 60, under the care of Dr. Dent, of Cromer, to whose assistance the successful result was due. For the last two years there had been daily uterine haemorrhage which had left her in a very weak condition. The abdomen was occupied by a soft fibroid which extended to 1 in. above the umbilicus. On opening the abdomen in the Trendelenburg position a large soft gelatinous tumour of the uterus was found in which corkscrews would not hold. This was drawn well out of the wound and first the vagina was opened posteriorly—then the broad ligaments were cut through with scissors and the vessels as they appeared compressed with forceps several of the arteries were larger than the radial. Unfortunately the bladder was torn during its separation, but this was at once repaired with a double row of sutures and no harm resulted. Convalescence was tedious owing to her weak condition and to the formation of an abscess probably in connexion with the bladder sutures, thus throwing considerable strain upon the nursing staff of the Cromer hospital, but owing to the most unremitting care and attention to every detail of the after-treatment complete recovery eventually followed.

CASE VI.—Patient, unmarried, aged 40, was under the care of Dr. Burton Fanning. She had struggled successfully against phthisis ever since the age of 17, by wintering abroad; this disease at the time of operation was quite in abeyance. For five years, during which time the patient has been aware of the presence of a tumour, its size has steadily increased, so that the whole pelvis was filled, and the abdomen as high as the xiphoid cartilage, with a hard multinodular tumour. The os uteri could just be reached above and close behind the pubes. Haemorrhage had not been excessive, but the tumour was telling upon the patient's health by its size alone. Abdominal hysterectomy was performed. The Trendelenburg position was used, and a long incision having been made,

the tumour was drawn out with corkscrews. The veins of the broad ligaments were enlarged to the size of a forefinger. The vagina was first opened, using a pair of curved forceps as a guide to it; next the large vessels contained in one broad ligament were caught in a bunch and compressed between the thumb and forefinger while they were cut with scissors. Having secured their proximal ends, the other ligament was treated in the same way. The Fallopian tubes being much hypertrophied, were removed, together with the ovaries. The vagina was closed with a pursestring suture, and the pelvic peritoneum united across. The wound was then closed. The tumour was very hard and multinodular, weighing 8 lb. The patient made a rapid recovery.

Fig. 2.—Case VIII.

Fig. 3.—Case IX.

CASE VII.—Patient, an unmarried woman, aged 51, had had symptoms of haemorrhage and an abdominal tumour for 15 years. The tumour, she said, was sometimes larger and sometimes smaller during that time. For the six months preceding the operation there had been daily uterine haemorrhage. The abdomen contained a solid but not very hard tumour, smooth on the surface, and extending to 2 in. above the umbilicus.

The operation was performed with the assistance of Mr. Alexander and Dr. Panting, under whose care she was. On opening the abdomen in the Trendelenburg position a large single tumour appeared with the uterine tissue spread out over its surface. The tumour was so soft that corkscrews would not hold in it. Having drawn the tumour out of the wound it was separated from below upwards, the broad ligaments being cut through with scissors, and the vessels secured as they appeared. The tumour was of the soft oedematous variety, and owing to its large size was not preserved. Convalescence was tedious owing to her weak condition, but with much careful after-treatment her recovery was complete.

Fig. 4.—Case X.

CASE VIII. Patient was under the care of Mr. Dent, of Cromer, was aged 45 years, was married, and had had one child twenty-three years ago. For the last two years menstruation had been profuse and for the last six months there had been almost continual loss of blood from the uterus. She was very anæmic, and in consequence of her weak condition had to give up her occupation as a lodging-house keeper. She complained also of pressure upon the bladder; every night she was disturbed from her sleep four or five times to pass water. A hard single tumour could be felt projecting from the anterior wall of the uterus and quite filling the pelvis. With the assistance of Mr. H. C. Dent and Dr. Manby abdominal hysterectomy was performed. The Trendelenburg position was used, and having passed a sound into the bladder and a pair of curved forceps into the vagina as guides the vagina was first opened and the uterus, together with the tumour, separated from below upwards. The tumour was a single one rather larger than an orange, the greater part of its surface being submucous, but with a broad attachment to the posterior wall of the uterus. Complete recovery followed.

CASE IX. (See Fig. 3).—Patient was a married woman, aged 51, and had had three children, the youngest nine years ago, since the last confinement she had never felt quite well. Menstruation had been regular but profuse and especially during the last few years excessive, and such as to necessitate her remaining in bed for about a week each time, when large clots of blood would be passed, so as to produce faintness and to be followed by great exhaustion. I sent her to Dr. Galabin, who wrote as follows: "The fundus bulges in front with some irregularities and sound passes 4 in. I think she has small fibroids in wall of uterus but not enough to form abdominal tumour." This patient when staying in this neighbourhood had been seen by Mr. Dent about fifteen months previously. I therefore sent her to him again in order that he might compare her present condition with that of the year before. The result of his examination was to show that there was a distinct increase in the size of the uterus during the interval. As a result of this and considering also that the hæmorrhage was increasing, Dr. Galabin, who now saw her

again, advised me to perform a radical operation. Therefore with the assistance of Mr. Dent and Mr. C. J. Muriel I removed the uterus as shown in the photograph, choosing the vaginal route because of the small size of the tumour, and although more difficult to the surgeon, yet I believe making a less severe demand upon the patient's resources than does the abdominal route. This patient recovered completely, but was several months in recovering from her severe and prolonged loss of blood.

The photographs of Cases VIII and IX I wish particularly to call attention to, as showing that when a fibroid is surrounded by the uterine muscle and compressed by it it is futile to wait and hope for the menopause at an age when loss of blood is not so well borne nor so rapidly recovered from as in earlier years.

CASE X (See Fig. 4).—Patient was 38 years of age, was married, but had never had children. Menstruation had been regular up to the last three periods, which had been missed, and patient believed herself to be pregnant. The whole pelvis was filled accurately with a solid and very hard tumour, which was firmly fixed there and was steadily increasing in size. With difficulty the os uteri could be reached above and close behind the pubes. It was decided to remove the whole uterus by abdominal section. The photograph shows the specimen as it was situated in the body: the lower part is a very dense fibroid springing from the cervix and tightly wedged in the pelvis, while at the upper part is shown the placenta in the fourth month of gestation attached to a solid and non-contractile part of the tumour, from which severe hæmorrhage must have followed its separation.

RUPTURE OF THE UTERUS, WITH RECOVERY

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THE following is an account of a case I conducted which may prove interesting from its comparative rarity.

Mrs. C., aged 28, primipara, a delicate woman suffering from advanced aortic valve disease, was confined on July 4th, 1902.

When called in by the nurse attending at 4.30 p.m., I found the patient in the first stage of labour. Examination of the abdomen revealed a transverse presentation of the fetus, the head lying to the left side. Hydramnios was present. Vaginal examination revealed a slightly-contracted pelvis.

I turned the transverse into a head presentation, placed a firm binder on the abdomen, put the patient to bed, and administered 10 min. tr. digitalis every four hours combined with liq. strychninae $\frac{mij}$, as symptoms of failing compensation were present. The uterine contractions were infrequent and slight.

At 11.30 p.m. I was again sent for and found the following conditions present: The heart was beating rapidly and weakly, the murmur over the aortic region being extremely marked; patient's face was very pale and anxious-looking, tongue dry and coated. Temperature in the mouth 102° , pulse 112, respirations 28; there was a considerable amount of bronchitis present.

On examining the abdomen I found that the head had slipped into the left iliac fossa, that the uterine contractions were strong and frequent, and that the liquor amnii had come away. I found by vaginal examination that the os uteri was dilated to the size of half-a-crown; vaginal temperature about 103° . I converted, after considerable trouble, the oblique into a vertex presentation, replaced the binder, and kept the head pressed down into the pelvis. At 11.45 I sent to Cashel for Dr. George Russell, as I deemed it advisable to have help.

In the meantime I sterilized my forceps, etc., as I thought they would be needed. I took the patient's temperature at 12.30 a.m., and found it 104.5° ; pulse 140; respirations 30.

I immediately got the forceps ready and after great difficulty succeeded in applying them, the difficulty was greatly increased by want of room and incompetence on the attending midwife's part. However I was at length able to correctly apply them, and delivered the child alive at 2.40 a.m.

At 3.30 a.m. Dr. Russell arrived, and confirmed my diagnosis of rupture. He kindly sutured the vagina and perineum. I saw the patient again at 10 a.m.; found everything satisfactory. Temperature 100° ; pulse 98. I douched the vagina thrice daily for the following five days. Patient made a splendid recovery, the temperature never having risen above 101° .

The difficulty of the case will be understood when I state that the labour was conducted in a tiny room in a double bed, and that while applying forceps I had to support the patient's right limb by hanging it over my neck as the nurse was busy watching the heart. Chloroform was, of course, impossible, as heart failure was imminent; in fact, the patient was quite comatose and cyanosed. The placenta came away ten minutes later. Immediately after delivery I