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

By CLAUDE BURGOYNE PASLEY, L.R.C.P. & S.I.,

L.M. Rotunda,

Medical Officer in Charge of Troops, Cahir, co. Tipperary.

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

administered $\frac{3}{8}$ gr. strychnine combined with $\frac{1}{100}$ gr. digitalin in brandy hypodermically. I gave patient a saline injection per rectum also. Hot bottles were placed around the patient's body and hot blankets wrapped round her.

On examining the abdomen as soon as patient recovered somewhat I found a mass of boggy consistence around the fundus uteri, which I diagnosed as blood clot. I injected ergotin in hypodermically and got the uterus well contracted. The mass found in the abdomen remained there for about a week and then gradually disappeared.

A CASE OF TRANSPLANTED UTERINE FIBROID GIVING RISE TO INTESTINAL OBSTRUCTION.

By E. PERCY PATON, M.S., F.R.C.S.,
Assistant Surgeon to Westminster Hospital.

E. C., aged 48, a single woman, was admitted into Westminster Hospital under the care of Dr. de Havilland Hall on March 29th, 1902, with symptoms of intestinal obstruction.

History.

Soon after her admission I was asked to see her with Dr. Hall. Her history was that fourteen days before, she had been attacked with pain in the abdomen, vomiting, and constipation, for which various purgatives were given without result, but the vomiting continued, and in four days' time (ten days before admission) became faeculent in character; this

Fig. 2.—Tumour showing adhesions to gut, mesentery, and omentum.

Fig. 1.—Posterior aspect of uterus; to the right of the + is the pedicle from which the tumour had become detached.

continued more or less, and the abdomen becoming more distended, and the patient collapsed, she was sent to the hospital. For the past four years she had suffered from myxoedema, for which she had been treated with thyroid extract. In October, 1901, she had a similar attack to the present one, but not so severe; this laid her up for three weeks, but she got well, though she had never felt very strong since, and had been losing flesh. There was no history of any uterine trouble of any kind.

When first seen she had the pinched appearance of advanced intestinal obstruction, and was considerably collapsed, the pulse being small and wiry. The abdomen was a good deal distended, but was not very tense. On the right side there was to be felt a tumour which extended from the loin almost to the umbilicus; it was oval in shape, very hard, and could be moved from side to side and somewhat up and down, it did not seem to have any pelvic connexion, although it felt very like a uterine fibroid, and was thought possibly to be such. Rectal examination showed the uterus to have several small fibroids in connexion with it, but bimanual examination did not reveal any connexion between the uterus and the tumour; there was nothing else abnormal to be felt by the rectum.

Operation.

The general condition of the patient was very bad, but it was decided to open the abdomen at once. This was done in the lower part of the right linea semilunaris and the tumour was exposed; it was then found to be attached to a considerable length of gut and mesentery, which was very much engorged; it was thought possibly to be malignant, and it was quite clear that it could not be removed or dealt with in such a way as to relieve the obstruction; and as the patient was very bad, and there appeared to be no reason to believe that any advantage would be gained by opening a piece of