administered $\frac{3}{8}$ gr. strychnine combined with $\frac{1}{16}$ 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.,
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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

small intestine, the abdominal wound was closed. She died some few hours later.

Necropsy.

At the necropsy, in addition to the general distension of the intestines and the ordinary signs of obstruction, the tumour, which was examined at the operation, and which at first sight appeared to be malignant, was found to be a transplanted fibroid of the uterus, from which organ it had become entirely separated, but upon the posterior wall of which was to be seen a short stalk, and from this there could be little doubt that the tumour had become disconnected. The tumour itself was oval in shape, with some irregularities on its surface; it measured 6 in. by 9 in. in its two greatest diameters, and weighed 5 lb.; it was adherent for about 2 ft. to the mesentery on the right side, and for nearly the same distance to the small intestine a foot or so above the ileo-caecal valve; there was also an extensive connexion with the omentum, from which it received most of its blood supply, as the large vessels seen in the adhesion show; there was also a very considerable twist of the mesentery, to which no doubt the constriction was to a very large extent due; the mesentery and gut connected with it were in a very congested condition. Microscopic examination showed the tumour to have the ordinary structure of a uterine fibroid.

The accompanying photographs show very well the tumour and its attachment to the mesentery and omentum, and also the short pedicle on the posterior aspect of the uterus from which the tumour almost certainly became separated.

Remarks.

Transplantation of an ovarian cyst does not seem to be very uncommon, and I have myself had an opportunity of seeing more than one case, but the transplantation of a fibroid, so far as I can gather from a somewhat rapid survey of the literature, seems to be very rare. Twisting of the pedicle in a fibroid rapidly, as a rule, terminates in gangrene of the tumour and its serious consequences; but that connexion may take place to other parts and complete separation follow is mentioned by Herman,¹ Haultain,² Barbour,³ Kelly,⁴ and others, but no references to cases is given by them. Pozzi⁵ refers to three cases, but on turning to the original references I have been unable to identify the case in one of them, and in the other two the description leaves one in some doubt if the cases were really what they were supposed to be; Jacobs⁶ gives an account of one case, and Turner⁷ describes a case in which a fibroid which had become calcareous had become completely separated and was lying quite free in the pelvis.

The method by which separation has taken place has been suggested to be by the fibroid becoming adherent during pregnancy, and, being of the subperitoneal pedunculated variety, the thin pedicle becomes separated as the uterus returns to the pelvis; this, of course, cannot be the cause in the case above described, as she had never been pregnant.

[Since the above was written two other cases have come under my notice.]

REFERENCES.

¹ Herman, *Diseases of Women*, p. 826. ² Haultain in Allbutt's and Playfair's *System*, p. 576. ³ Hart and Barbour's *Diseases of Women*. ⁴ Kelly's *Operative Gynaecology* p. 345. ⁵ Pozzi's *Diseases of Women*, vol. i, p. 283; *Huguier, Gaz. des Hôp.*, 1860, p. 411. ⁶ Nélaton, *ibid.*, 1862, p. 77. ⁷ Jacobs, *Bull. de la Soc. Belge de Gyn. et d'Obstet.*, vol. xii, 1901. ⁸ Turner, *Edin. Med. Journ.*, 1861, p. 698.

GANGRENOUS FIBROID POLYPUS OF THE UTERUS.

By JOSEPH SCOTT, M.B.,

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THE history of the case I wish to record is as follows: The case was that of Fatima, a Persian, aged 32, whom I was hurriedly called to see, and on arrival found her very ill, anaemic, and that there was a most disagreeable odour in the room. Four years ago she had had an abortion, since when she had suffered much from haemorrhage. Fifteen days before I first saw her, on washing herself after micturating, according to Mohammedan custom, she discovered a small tumour in the vagina, about the size of a walnut, which became larger daily, and easily came down on straining at stool. A native midwife having been called in diagnosed a dead child, and did her best to remove it by force, causing the poor woman great pain. She succeeded in tearing off a portion of the tumour.

On examination a firm, round tumour was found filling the vagina, the pedicle of which could easily be made out. Having satisfied myself that no inversion of the uterus

existed, I tried removal by means of a wire *écraseur*, but unfortunately the wire broke before I had cut through the pedicle. The tumour was then seized with a vulsellum and pulled well down; a female slave held the vulsellum, while the stalk of the tumour was cut through with a pair of scissors curved on the flat.

The tumour was easily removed from the vagina. It measured 10 in. in circumference; part of it was decomposed, which would no doubt account for the bad odour. The tumour had the usual appearance of a fibroid.

CASE OF RUPTURED ECTOPIC GESTATION.

By J. GAY MOFFAT, M.D., C.M.,

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THE following case seemed of interest chiefly on account of the somewhat misleading character of the symptoms complained of for a week or ten days prior to the final attack which terminated in operation.

Mrs. L., widow, in domestic service, 29 years of age, was, about midnight on January 23rd, 1902, awakened up by very acute pain in the region of the stomach. She got up out of bed, walked about for some little time, but as the pain showed no signs of abating, she went downstairs and roused her mistress. She was then put back to bed and hot poultices applied, but in spite of this and morphine administered hypodermically, no relief came until 10 o'clock next morning. Before the morphine was given she had vomited bile-stained mucus freely. There was not at this or any future time any jaundice. No history of any indiscretion in diet was given. The diagnosis made was "biliary colic." The patient got up on January 25th, but could not bear the pressure of her clothing, nor could she stand erect on account of abdominal pain. On January 30th she had another similar seizure, but this was much less severe, so that she was able to be up the same day, and on the day following she went to stay with friends to recuperate.

On February 2nd I was urgently requested to see the patient whom I found in bed retching and vomiting bile-stained mucus as before, and looking extremely ill. She was blanched, with a weak runaway pulse of 140, and was complaining of severe pain in the lower part of the abdomen, which was distinctly distended, more particularly over the left iliac region. The history I got was this: On the previous evening, feeling comparatively well, she went out for a walk, but had not gone very far when she was seized with acute pain in the left iliac region accompanied by faintness and sickness. She was at once conveyed home, put to bed, and hot flannels applied, but her condition grew steadily worse until my visit next day, when I found her as described. I also learned that she had had twins in 1892, since which time she had suffered more or less from pain in the left iliac region. Menstruation had been regular until the previous December, during which month she was unwell three times, for a few hours each time. During January of this year she was unwell several times, also for a few hours each time, and accompanied by pain. A vaginal examination showed the uterus slightly enlarged and the cervix softened; there was tenderness in the left fornix, but no parauterine tumour could be made out.

The woman was evidently suffering from some form of internal haemorrhage, probably from a ruptured ectopic gestation, and was manifestly in a very grave condition. I therefore advised operation without delay, and with her consent had her taken into hospital. I operated as soon as possible—which was about midnight—after her admission. In opening the abdomen in the middle line between the umbilicus and pubes, dark blood clot could be clearly seen through the peritoneum, and on entering the cavity a large quantity, probably about 3 pints, of dark fluid blood and clots escaped, in which was floating a three months fetus. I found the sac continuous with the left Fallopian tube, which I ligatured and removed. Haemorrhage, presumably from broken-down adhesions, was troublesome, but was controlled by flushing the cavity with hot saline solution. This, also, I feel sure, very materially helped to combat the collapse, as when I commenced the operation the pulse was 144, and when the patient was returned to bed it had fallen to 128. A Keith's tube was left in the lower end of the wound, and was removed on the third day. A complete decidua was passed, also on the third day. Nothing more remains to be said, excepting that her recovery was uneventful, being, however, protracted, owing to