to land on furnishing satisfactory names and addresses, and it is precisely here that the weak point of the Local Government Board Regulations lies As you know the Aliens Act comes into force on Jan. 1st, 1906, when greater powers will be possessed for questioning and even detaining passengers and it is hoped that in this way we might be able to get more satisfactory addresses after that date." (The local facts and the extracts from the above correspondence are published with the permission of the medical officer of health.)

Articles 15 and 21 of the November, 1896, regulations state that "no one shall be permitted to land unless he satisfy the medical officer as to his name, intended place of destination, and intended address at such place." Counsel's advice has been sought as to the significance of the word "satisfy" in Articles 15 and 21. He writes: "The word 'satisfy' is important: it clearly shows that a mere statement is not sufficient. No rule can be laid down applicable to all cases. It is a matter on which each medical officer must form his own judgment in each particular case which will be largely based on his experience. In the words of the Article he must be 'satisfied.' If the mere statement by an immigrant were sufficient the words 'state,' 'tell,' or 'give' would have been used instead of the word 'satisfy.'"

After consideration of the replies of the port medical officers' and counsel's opinion one is inclined to believe that port medical officers have greater powers under the Local Government Board's Regulations than some of their number feel justified in assuming. Still it is difficult to understand how anyone can be satisfied with an unconfirmed address given by an alien immigrant if he is aware that many of the addresses received are wrong. If port medical officers expressed dissatisfaction with unconfirmed addresses given by passengers then according to the Regulations such passengers would not be allowed to land. This would cause delay and great inconvenience to both passengers and shipping companies. Great numbers of these immigrants go to large towns in which the sanitary authority is usually in a position to give immediate attention to the question of the authenticity or otherwise of addresses given. If the shipping companies instructed their agents at infected ports to telegraph the names and addresses of immigrants, also the port of disembarkation, to the medical officers of health of the districts of final destination 24 hours before the time of arrival of the ship in a British port it would then be possible in most cases for the medical officers of health of these districts to inform the port medical officers which addresses were incorrect before the arrival of the ship. This method would cause less delay in voyages of fair length (Amsterdam, Rotterdam, Hamburg, and Bremen) but would necessitate early booking in the case of short Channel routes. The cost of telegrams would not be heavy except in the case of Russia (Holland, Belgium, France, and Germany, 2*d.* a word; Denmark, 3*d.*; Sweden, 3½*d.*; and Russia, 5½*d.*). If no information had been received from the medical officers of health concerned at the time of arrival of the ship the port medical officer could take it for granted that the addresses were correct. A fair chance would in this way be given to the various authorities to protect themselves.

The Aliens Act, 1905, will have an important bearing on this subject and it is hoped that more satisfactory information will thus be obtained after Jan. 1st, 1906. The powers conferred by this Act are therefore worthy of consideration.

Section 1 gives power to prevent the landing of undesirable immigrants from immigrant ships ("immigrant" is defined as an alien steerage passenger; "undesirable" indicates that he is likely to become chargeable to the rates or otherwise a detriment to the public from disease, destitution, lunacy, &c.; an "immigrant ship" is a ship carrying more than 20 alien steerage passengers). Immigrant ships must land immigrants at a port where an immigration officer and medical inspector have been appointed. The immigration officer may refuse admission if the immigrant is undesirable. Appeal may then be made to the port immigration board when conditional disembarkation may become necessary.

In Section 1 there are no special powers given to deal with persons from infected ports, although the necessity of the immigrant being able to show that "he has in his possession or is in a position to obtain the means of decently supporting himself and his dependents" will lead the shipping companies to make inquiries before embarking the lowest class of emigrants. The class of immigrant is thus likely to improve

and their number will decrease. Undesirable immigrants will probably not be shipped in numbers under 20 to avoid inspection and prevention of landing by the immigrant officer, as in Section 4, paragraph 2, the expense of expelling and repatriating such persons falls on the master or owner of the importing ship if proceedings for such expulsion are taken within six months.

Section 5.—1. The master of any ship landing or embarking passengers at any port in the United Kingdom shall furnish to such person and in such manner as the Secretary of State directs a return giving such particulars with respect to any such passengers who are aliens as may be required for the time being by the Secretary of State; and any such passenger shall furnish the master of the ship with any information required by him for the purpose of the return. 2. If the master of the ship fails to make the return required by this section or makes a false return he is liable to a penalty not exceeding £100 (Sec. 7 (1)), or if any alien refuses or gives false information he shall be liable on summary conviction to imprisonment not exceeding three months with hard labour.

Section 5 makes the giving of false information severely punishable but it is almost certain that it would require to be proved that the information was knowingly false before any penalty was inflicted.

So far as one is able to judge at present the efficient working of the Aliens Act, 1905, will lessen the risk of spread of cholera and plague to this country by (1) decreasing the number and improving the class of immigrant; and (2) giving the port medical officer a better chance of judging of the reliability of the immigrant's information. The whole bearing of this Act, however, is indirect and, however helpful it may be, there is still reason for urging (1) that the port medical officers should exercise the full powers given under the Cholera, Plague, and Yellow Fever Regulations; and (2) that further regulations should be drawn up providing for the conditional disembarkation of those who give an unsatisfactory address, with powers to keep them under observation during the maximum incubation period, at their own or at the shipping company's expense, in the latter case allowing the shipping company the option of repatriating them if it prefers to do so.

Manchester.

FOUR CASES OF HYSTERECTOMY.

By SKENE KEITH, M.B., C.M. EDIN., F.R.C.S. EDIN.

THE operation of removal of the uterus for fibroid enlargements has been so often described that an ordinary case presents no points of interest, one operation as a rule resembling the others more or less, some tumours being larger and some opening up the broad ligaments more than others. But in the early part of last year I had a run of four cases, each case presenting some points of great interest and each one differing from the others.

The first case was that of an unmarried woman, 37 years of age. She told me that she had never been very strong but had not ailed in any particular way until about four years before she consulted me. Somewhere about that time she noticed that she was getting fuller and that there was some pain in the lower part of the abdomen. The enlargement gradually increased and she often lay awake the greater part of the night, being unable to sleep on account of the pain. Someone had been consulted before I saw her and it is interesting to note the different way in which two people may look at the same thing. The first advice was that the growth must be removed immediately and that even one week's delay was dangerous. I could not agree to this, but as I diagnosed the growth to be a fibro-cyst I said that while an operation was necessary there was no immediate hurry but that it could be done at the convenience of the patient. The growth, an irregular one, extended to within two inches of the ribs. The pelvis was filled by a mass which evidently contained fluid and the cervix was drawn up out of reach in front of this mass. The special point of interest was, that while the upper part of the tumour consisted of a number of more or less distinct fibroid masses the pelvic portion was one large single cyst containing the usual fluid met with in a fibro-cyst. The whole growth weighed between 7 and 8 pounds, fully half of which was

fluid. As was to be expected in a patient who had never been strong, strength came back very slowly.

The second case also occurred in an unmarried woman. She was 40 years of age. I saw her first in 1894. At that time there was a rounded tumour of the uterus extending to one inch above the umbilicus. There were scarcely any symptoms, but as the patient was only 30 years of age I advised and carried out Apostoli's treatment with the expectation—an expectation I have usually found realised—that the growth of the tumour would be arrested. As the result of the treatment the tumour was reduced to one inch below the umbilicus, the diminution being much less than usual. I saw the patient occasionally, perhaps once in two years, and found that the tumour, instead of lying dormant, grew slowly and in nine years had reached to one inch above the umbilicus, the height it had been before the Apostoli treatment was carried out. Then some six or eight months before the operation, and apparently without any reason, it started to grow rapidly and had reached up to and under the ribs on both sides. There were still scarcely any symptoms but the disfigurement was so great that something had to be done.

The operation was much as usual except that I had to go very far down, leaving scarcely any cervix, and when this has to be done there is usually more trouble with hæmorrhage from the stump. There was this trouble, but eventually all hæmorrhage was arrested and the peritoneum was stitched over the stump. I had put in and had begun to tie the stitches in the wall (I use the single stitches through the whole thickness of the wall; these when properly put in make a better wound than when the stitching is done in layers) when blood began to pour up from the pelvis. It was difficult to pull up the stump as there was so little left to get hold of. The bleeding seemed at first to come from one side, but in dragging up the pelvic floor I evidently pulled off a ligature from the uterine artery on the other side, so there were the two uterine arteries with open mouths. My brother, who was assisting me, had once seen this accident happen and the patient died on the table, so he was even more uncomfortable than I was for what seemed a good many minutes, until I obtained a firm hold of the stump, and it is difficult to realise what an awkward thing this is to do when there is no broad ligament on either side to get hold of. The tumour weighed a little over 13 pounds. The patient did not seem to suffer much from the loss of blood and the convalescence was uneventful. Now rather more than 18 months have passed and she says that while she can do more than a great many, she still looks forward to be able to "tear about" more.

The third patient, also unmarried, was 47 years of age at the time of the operation. Her first visit to me was paid in June, 1897. She said that she had a hard lump in the abdomen but that in every other respect she felt quite well. On examination a specially hard fibroid tumour was to be felt. It reached to within two fingers' breadth of the ribs on the left and three on the right side. No vaginal or rectal examination was made. As there were no symptoms the patient was advised to have nothing done. The estimated weight was about 8 pounds. She paid me a second visit three and a half years after the first. There were still no symptoms; the tumour had grown but one finger's breadth higher. At one spot, however, it had become soft and, as the patient reminded me afterwards, I told her that it was possible that the growth might not cease with the menopause. The estimated weight was about 10 pounds. When the patient came back to me for the third time, 18 months after the second visit, her appearance had changed completely. She had the aspect seen commonly enough at one time and known as the facies ovariana. The abdomen was distended by a soft, non-fluctuating tumour of a weight guessed at from 22 to 24 pounds. It turned out to be a little over 23 pounds.

The operation was one of the most formidable I have ever seen and as I had not made any vaginal examination, which could only have been done with the help of an anæsthetic, I was not prepared for its magnitude, though I expected to meet with extensive splitting up of the broad ligaments. A long incision was made and this showed the anterior uterine wall projecting from the surface of the tumour, the fundus being situated at the level of the umbilicus. The masses of veins on both sides were enormous. On putting the hand into the abdomen I found that on the right side there was no cavity, the colon being raised and pushed over to the left side, the peritoneum from the tumour being reflected on to the posterior abdominal wall at the level of the ribs. What

the exact relations were on the left side I did not waste time to determine as it was evident that there was a long operation to be faced. I began by tying and clamping the two masses of veins and then took a circular sweep through the peritoneum. It was found afterwards that about one-quarter of the tumour had peritoneum attached. Then I separated, first on one side and then on the other, the intestines coming close up on the back. Eventually I was able to put a pair of forceps on the right uterine artery and as the size of the growth complicated matters, the upper half of the tumour was cut off, my brother catching the artery on the left side as it spouted. The enucleation was continued to the very bottom of the pelvis, the lower part of the tumour having pushed its way down between the vagina and rectum well below the cervix, so that part of the posterior wall of the vagina and the whole of the cervix had to be removed. The vagina was closely stitched up after having been thoroughly cleansed and then the peritoneum was loosely brought together. It is wonderful how it falls together, leaving little evidence of the amount of injury. The operation lasted close on one and a half hours, nearly half an hour longer than I believe should be the maximum time for almost any operation, but not a moment had been wasted; it had been hard work from start to finish. Neither ureter was seen and it is difficult to understand why they escaped injury unless it was that I always keep closely to the tumour when enucleating and am very careful not to get off it and into the cellular tissue. At first the patient progressed slowly, the immediate convalescence being retarded by fever and much irritation in the abdomen, due presumably to the injury sustained by the cellular tissue and its contents. As soon as all danger was over the patient gained strength very rapidly and well within six months said that she felt as strong as she ever remembered to have done.

The fourth patient was married, 32 years of age, and the case is the most interesting of the four. Between four and five years before this operation I performed in the ordinary way a supravaginal hysterectomy, leaving one ovary. The patient never regained health and complained of pain in the left side, aggravated at the monthly periods, which did not cease, though the loss was not great. Examination showed that there was a mass connected with the cervix of the size of an eight or ten weeks pregnancy, but hard and remarkably tender to the touch. On opening up the old scar the omentum was found to be adherent to the abdominal wall, strangely enough not to the wound but to the peritoneum on the right side. The intestine was matted together and adherent to the left side and to the upper part of the tumour so firmly that at first it seemed impossible to reach the growth. However, it was eventually got down to and gradually, though slowly and very carefully, cleared from the adherent intestines. The vagina was opened all round and the whole of the uterus was removed. The ovary was not seen. The specimen was interesting in many ways; it measured five inches in length and as the depth of the uterine cavity was barely five-eighths of an inch the monthly flow must have come entirely, or almost entirely, from the cervix. Above the canal there was a rounded fibroid and above that again another one, with several small ones at the sides and in front. Though this operation was fully as difficult to perform as the preceding one the patient had no trouble at all afterwards—a good illustration of what a patient can stand when the amount of injury is small and how much more danger there is when the injury is extensive. It was a case where the Trendelenburg position added to the safety of the operation, as the adhesions to the intestines were so firm that they could not be broken down with the fingers but all had to be dissected off with scissors. The patient had practically no convalescence: she was well and strong all through.

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A CASE OF MELÆNA NEONATORUM; RECOVERY.

By EDWARD FORTREY HEAP, M.R.C.S. ENG.,
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ON Oct. 27th I attended a woman at the birth of her second child. The delivery was normal and the progress of the mother was uneventful. The child, a male, strong, well-developed, and in every way healthy so far as one could