The tumor consists of two parts, — a solid, irregular, smooth mass and a cyst wall. The cyst has been incised, but when distended readily admits both fists. In the cyst cavity there is a small amount of yellowish, gelatinous fluid, and communicating with it are other smaller cysts. At one point in the cyst wall there is a small mass of curled-up hair, surrounded by small bits of grayish white, grumous material, which resembles the contents of a sebaceous cyst.

Section through the solid portion of the tumor shows irregular masses of tissue of varying size, form and consistence, separated by connective tissue trabeculae. Everywhere there are small, smooth-walled cysts from three to seven millimeters in diameter. Widely distributed through the tissue are dots and streaks of dark blue-black or intensely black pigment, which, against a grayish background, give a marbled appearance to the mass. In many places there are spicules of bone. In others, cartilage and adipose tissue appear. The entire cut surface has a somewhat gelatinous appearance, and from it can be scraped a sticky, gelatinous material. No large pieces of bone occur, and nowhere is there any symmetry of arrangement.

Clinical Department.

OBSERVATIONS ON THREE CASES OF HYDATIDIFORM MOLE.¹

FRANK A. HIGGINS, M.D., BOSTON,

Instructor in Obstetrics, Harvard Medical School; First Assistant Visiting Physician for Diseases of Women, Boston City Hospital; Senior Physician to Out-Patients, Boston Lying-in Hospital.

It has been my fortune to have seen within a few months three cases of hydatidiform mole. Two of these cases I delivered myself, while the third patient was on my service in the gynecological wards at the City Hospital, where I examined her several times, although the patient was under the direct charge of Dr. Young, who was on duty as my assistant at the time. No one of these three cases exhibited any new or unusual symptoms at any time, and neither in the history nor in the progress of the cases up to the time of delivery was there any indication that we had anything more to deal with than a case of abortion at a corresponding period. In fact, none of the typical symptoms of the disease, as so regarded, were present in either of the cases. There was no serious, or at least what would be considered dangerous, hemorrhage, no rapid or unusual increase in the size of the uterus, and no discharge of the small cysts or vesicles, by which alone a positive diagnosis can be made. Therefore since seeing within a comparatively short time these three cases, of a rather rare disease of pregnancy, and as a result my ideas being somewhat modified with respect to the condition, I have believed that a short description of the cases would be of interest to the Obstetrical Society.

The first case was seen in the latter part of June in consultation with Dr. Boland. The patient, a

young married woman of rather frail physique, with one living child, had been having repeated moderate hemorrhages for a number of days. She believed herself to be about three months pregnant, and the uterus corresponded in size approximately to this period. The cervix was slightly softened as of normal pregnancy and the external os tightly closed. A probable diagnosis of placenta previa was made both by Dr. Boland and myself, although it seemed to us at the time that the cervix was not so soft, and the external os was more tightly closed than it is customary to find in placenta previa. In view of the repeated hemorrhages, the general condition of the patient, the early stage of pregnancy, the danger of repeated and increased hemorrhage, and the small chance of prolonging pregnancy for a sufficient length of time to enable the fetus to be born alive, it was decided that it was safest to empty the uterus. The patient however, declined immediate operation, and also refusing to be removed to a hospital where more careful supervision of her case could be obtained than in her own home, the vagina was packed to prevent further loss of blood. At the end of twenty-four hours, the hemorrhage still continuing and prolongation of pregnancy being considered impossible, the patient was etherized and manual dilatation and removal of the uterine contents was performed. Sufficient dilatation to admit two fingers into the uterus was easily accomplished, after which the diagnosis of Hydatidiform mole became apparent and the whole mass was easily removed by separating it with the finger at its attachments on the upper anterior surface of the uterus. A curette was afterwards passed lightly over the inner surface of the uterus to remove any foreign material which might remain, as the gloved finger is not a perfectly satisfactory curette and the mole is very friable. The uterus was then washed out with weak corrosive solution, the uterus contracted down well, and there was no more hemorrhage than would occur in emptying a uterus for an abortion at this period. The convalescence was uneventful.

The second case was about three months pregnant and was sent into the City Hospital for hemorrhage and threatened abortion. Soon after the patient's entrance, because of persisting hemorrhage, it was decided to empty the uterus, and while she was being put on the table and made ready for operation, there was expelled spontaneously from the uterus a mass containing nearly a pint of hydatidiform material. This mass comprised about two thirds of the whole contents of the uterus, the remainder being easily separated with the gloved finger and with a curette, and the uterus was then washed out. No ether was given. The convalescence was perfectly normal. The contents of the uterus was roughly measured in these two cases, the amount being about a pint and a half in each.

The third case was also seen at the City Hospital, to which place she was sent for pain, hemorrhage, and threatened abortion. She was about four and a half months pregnant, and the uterus was correspondingly enlarged. There had been several hemorrhages of moderate amount before the patient came to the hospital. The patient was kept in bed,

¹ Read before the Obstetrical Society of Boston, Oct. 21, 1902.

having occasional slight hemorrhage and pain, and she was repeatedly examined without the presence of hydatidiform mole in the uterus being disclosed. Finally, after nearly four weeks in the hospital, a hemorrhage of considerable size occurred, and the uterus was emptied with the curette with the patient under ether. Her convalescence also was normal.

The nature and appearance of the hydatidiform growth in all these cases was essentially the same: a large number of vesicles of various size and shape, the largest seen being about three quarters of an inch in diameter. Most of the cysts were of a light, opalescent tint, and contained a thin, light-colored fluid. Many of the cysts, however, contained blood, and consequently were dark colored, and there was also some blood on the outside, as may be seen now in the specimen. The cysts are all attached to an irregular membranous structure, the chorion, either directly or by narrow pedicles, the membrane itself being attached to the uterine surface at the placental site, and this attachment was no larger in area than that of a normal placenta of the same period. There was no evidence of fetus or of placenta in either case.

The blood supply of the growths seemed particularly small, and the hemorrhage during delivery was slight in all the cases. It seems probable that the bleeding which occurred before delivery came from the uterus at the site of the attachment and not from the breaking off of portions of the growth.

The question arises in connection with these cases, Should a positive diagnosis of cystic chorion be made? I do not believe it is possible to do so at three or four months unless some of the cysts are thrown off and are seen. Even if discharged from the uterus they may readily become occluded in clotted blood. The most prominent symptom, then, is hemorrhage, and with continued hemorrhages in the early part of pregnancy, the possibility of the presence of hydatidiform mole should be kept in mind.

In the later months of pregnancy the absence of fetal parts on careful palpation and the unusual size of the uterus, said to be present, would tend to make the diagnosis much more certain.

There is little that need be said with respect to treatment. The uterus should be emptied as soon as the diagnosis is established. Manual or instrumental dilatation to admit one or two fingers, and removal of the uterine contents with the finger, followed by the curette, is safe and efficient.

CASES OF TYPHOID FEVER SIMULATING PUERPERAL SEPSIS.

BY H. T. SWAIN, M.D.

HAVING seen a few cases of typhoid fever following immediately after delivery, which bore a most striking resemblance to cases of puerperal sepsis, it seemed worth while to speak of them, as they are not of frequent occurrence, judging from the literature. I do not mean to say that cases of typhoid developing during the puerperium are rare, but that cases coming on at once, so that a virulent sepsis is simulated, are not frequently reported.

Three cases I have in mind which were so closely

alike that to report one is to report all, and for that reason I will detail only one.

Mrs. N. H. entered the Boston Lying-in Hospital July 10, 1899, in labor. It was her third pregnancy, and she had been feeling, previous to the onset of labor, the same as during her former pregnancies.

She had an easy labor in the early morning of the 10th. That evening her temperature went up to 101.5°, pulse not elevated. The next morning the temperature was 102.5°, pulse 100. That evening the temperature was 104.2° and the pulse 130 of poor quality. During the day a marked diarrhea appeared, stools yellow, of pea-soup consistency, typhoidal odor. There was slight delirium. Tongue was thickly coated in the center, with red edges. There was some distension and general tenderness. Lochia and milk scanty. Inspection of the vagina and cervix negative. It was hard to tell the character of the lochia because of the continual discharges from the bowels and the fecal odor about the patient. There was present a macular eruption, which appeared and disappeared without apparent reason.

The third day there was no change in the patient's general condition except that the temperature was reduced by alcohol sponge baths and the pulse by stimulation. The diarrhea persisted and the delirium at night was present. White count 3400. No Widal. No diazo.

The fourth day rose spots appeared in abundance, the spleen was to be felt. Lochia normal in quantity and character. The diarrhea had disappeared.

The fifth day whites 3000. No Widal. Diazo present. The seventh day whites 3000. No Widal. The case was now a typical mild typhoid, from a clinical point of view. On the tenth day the Widal reaction was negative, and was not again tried for. The mother was discharged well at the end of a month. The babe was discharged well at the same time, not having been put to breast.

It will at once be seen that it was difficult to eliminate sepsis as the cause of this woman's serious condition. The temperature, taking such a sudden rise without any prodromata, is much unlike typhoid but is very like sepsis. The sudden rise of pulse and its rapid loss of character is extremely uncommon in early cases of typhoid, and is just what you would expect in a virulent sepsis. The scanty milk secretion throws no light at all on the diagnosis, because in any febrile condition the flow is diminished, especially when the baby is not put to breast. The lochia is not of help, since they may be unchanged in character and quantity in a virulent sepsis. The general abdominal tenderness with slight distension might be expected in either condition. Absence of pelvic tenderness may or may not exist in sepsis. The spleen is usually enlarged in typhoid and may be in sepsis, but is late in appearing.

Now as to diagnostic points of typhoid. First and by all odds the most important is the low white count, that is, a count way below the normal. It appears early and is certainly not an accompaniment of sepsis. The Widal reaction which appeared late in one of the cases was of no help, as it was a clear case of typhoid before that was found. Diazo reaction is of doubtful value, but may be