yet, before the final outcome of these treated cases can be known. The difficulty is further increased by the fact that those patients who have subsequent trouble after any form of treatment, operative or otherwise, usually consult other physicians. We get other men's postoperative hernias, rarely our own. It will not do, however, to infer that we never have any.

I desire to put on record as a contribution to the subject, the history of a patient known through conference with her physicians for many years, who finally developed sarcoma in a fibroid tumor, about seven years after Roentgen-ray treatment was begun, and five years after it was stopped.

The patient, Mrs. I. H., now aged 56, married, one child, one miscarriage, underwent at my hands nineteen years ago, in consultation with Dr. John H. Musser, an operation for laceration of the perineum. She then had no tumor. She was not seen again until April, 1914, when she was referred by other physicians for operation, and I removed a large tumor, which proved to be a sarcomatous degeneration of a multiple fibroid of the uterus. The following interesting history was obtained of her experiences and treatment at the hands of various physicians during the intervening years. There had been one attack of gallbladder inflammation and jaundice, in October, 1913.

The menstrual flow had remained normal until early in 1907, when it increased, and also partial suppression of urine occurred. Examination by Dr. Rachel Williams discovered a large fibroma of the uterus, tightly filling the lower abdomen, and pressing on the urinary tract. She was then subjected to electrical treatment for the tumor by an electric specialist, who writes on cataphoresis. This treatment is said to have continued for nearly a year, one or two treatments a week, with no effect observed.

In November, 1907, Roentgen-ray treatments were undertaken by Dr. Newcomet to diminish the size of the growth; the patient being referred to him by Dr. Williams. He writes that she received at this period 54 treatments of ten minutes each at 20 inches distance; spark-gap 4 inches. In spite of leather protection for the skin, considerable reaction was produced, followed by bronzing and local dilatation of vessels; which effects are, by the way, still observable. He further states that the tumor was reduced to about one-fourth of its size, and hemorrhage was controlled by April 1, 1908. Nine months later, in January, 1909, the tumor grew again to the level of the umbilicus and 11 more treatments were given by Dr. Newcomet. In November, 1909, he found the growth just above the pelvic brim. It then apparently remained quiescent until November, 1912, when it began to grow, hemorrhage reappearing in December, 1913. Dr. Newcomet refused to administer the Roentgen ray longer, and advised operation. The patient delayed, seeking other opinion, but as has been stated, finally reached me for operation in April, 1914.

On examination the bleeding was now found very dark brownish or black; there was no odor; no leukorrhea; the systolic blood pressure was 180; the patient was quite stout; the heart sounds good. The abdomen showed a number of hemorrhagic spots in the skin apparently produced by the Roentgen ray, and a number of reddish spots were scattered over the mucous membrane of the cervix and upper vagina. The tumor was round, smooth, moderately fixed, a little irregular in outline, hard, reaching to the umbilicus, no infiltration of surrounding tissue. I advised immediate removal of a growing tumor which at the patient's age of 56 had shown signs of activity and had resumed bleeding after a cessation of five years.

A very smooth recovery followed abdominal hysterectomy. There were no parietal adhesions. Dr. William Evans and Dr. Rachel Williams were present. One year after operation the patient reported herself entirely well.

Dr. Damon B. Pfeiffer, the pathologist of the Presbyterian Hospital, has kindly furnished the following report:

The specimen consists of a large, irregularly shaped uterus measuring roughly 15 by 10 cm. The greater part of the mass consists of a rounded tumor, which on section presents the appearance of a myoma. There is no sharp demarcation between the mass and the uterine wall. Several small sub-peritoneal nodules are also present. The uterine cavity is opened. The endometrium presents no abnormalities. The fallopian tube is distorted and somewhat thickened. The ovary appears normal.

Microscopically, the ovary is normal, the tube is moderately thickened and fibrous, presumably the result of chronic interstitial salpingitis sometime in the past. Sections from the large tumor or mass show, in some places, areas of hyaline degeneration and in other portions the growth is extremely cellular. The cells are relatively large, but vary considerably in size, appearance and nuclear content. Many mitotic figures can be seen, and at the margin of such actively proliferating areas, there can be seen at times evidences of invasion of the older and less cellular portions of the growth. There is no sign of extracapsular invasion or metastasis, but the evidences of rapid atypical proliferation above mentioned warrant the belief that sarcomatous transformation has occurred.

CONCLUSION

It is the complications of fibroid tumors which render them important. Hemorrhage; pressure; intestinal adhesions; stasis, or obstruction; pressure on the uterus or bladder; secondary renal disease; heart lesions; salpingitis; appendicitis; pregnancy, necrosis or other forms of degeneration; associated malignancy may be mentioned.

In the study of end-results time is necessary. That treatment must be advised which best eliminates most complications as well as the tumor, and which preserves, if possible, sexual characteristics by its technic. This treatment in a large proportion of cases is surgical.

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UPPER BRONCHOSCOPY FOR A FOREIGN BODY IN AN INFANT THREE MONTHS OLD

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An infant 3 months of age in some manner introduced a closed safety pin into her mouth. About all the history obtainable was that the accident was followed by the appearance of some frothy secretion, after which the child fell asleep. She was very restless and could not cry aloud. On this account she was taken to a hospital, and an unsuccessful attempt was made to remove the pin. A roentgenogram showed the pin with the closed end downward about the level of the sternal notch. I saw her the next afternoon. There had been no trouble in nursing nor any marked respiratory distress. The temperature was 101 F.

The bronchoscopic tube was passed through the larynx, and the pin was seen at the lower part of the trachea, its lower portion projecting into the right main bronchus. It could not be removed through the small tube, so they were brought out together. No anesthetic was used. The temperature rose to 101.8 F. after the operation, but declined to normal within forty-eight hours. The voice returned the day following the operation.

This case is reported to emphasize the fact that tracheotomy is not necessarily indicated for the removal of foreign bodies from the air passages in infants and young children. A tracheotomy in this instance would have added an unnecessary and serious danger to the recovery of the child.

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