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PART I.

ORIGINAL COMMUNICATIONS.

ART VI.—*Clinical Report of the Gynæcological Department of the Dublin (Rotunda) Hospital for Poor Lying-in Women, for the Year ending November 1st, 1903.* By R. D. PUREFOY, M.D. Univ. Dubl., F.R.C.S.I., Master. (Illustrated.)

DURING the year with which this Report deals the number of patients was somewhat smaller than usual. Amongst the cases of exceptional interest were two of inversion of the uterus, both successfully treated—one by amputation and one by reposition; two examples of pancreatic disease, in one of which the symptoms for many days strongly suggested disease of the gall-bladder, and in the other suppuration occurred in a thin-walled cyst; some of the rarer forms of endometritis, including two examples of the variety termed cystic endometritis. Thanks to the labours of our distinguished Pathologist, Dr. W. C. Neville, I have been enabled to secure illustrations of several of these cases. Our eight cases of tubal pregnancy all ended in recovery; in only six of them was laparotomy deemed necessary.

* Read before the Section of Obstetrics in the Royal Academy of Medicine in Ireland, on Friday, May 20, 1904.

TABLE I.—LIST OF CASES TREATED.

DISEASE	Total	Cured	Relieved	Not Relieved	Died	REMARKS
VULVA—						
Vulvitis - - -	8	8	-	-	-	
Epithelioma - - -	1	1	-	-	-	
Eczema - - -	5	5	-	-	-	
Labial cyst - - -	4	4	-	-	-	
Chancroids - - -	1	1	-	-	-	
Labial abscess - - -	1	1	-	-	-	
PERINEUM—						
Laceration, simple - -	48	48	-	-	-	
„ complete - - -	5	5	-	-	-	
URETHRA AND BLADDER—						
Caruncle - - -	5	5	-	-	-	
Calculus - - -	1	1	-	-	-	
Cystitis - - -	1	1	-	-	-	
Urethrocele - - -	1	1	-	-	-	
VAGINA—						
V. V. fistula - - -	2	1	1	-	-	
Vaginitis - - -	15	15	-	-	-	
Cysts - - -	3	3	-	-	-	
Cystocele - - -	20	20	-	-	-	
Rectocele - - -	15	15	-	-	-	
Ischio-rectal abscess - -	1	1	-	-	-	
Prolapsed rectum - - -	1	-	1	-	-	
CERVIX—						
Polypus - - -	8	8	-	-	-	
Erosions - - -	12	12	-	-	-	
Carcinoma - - -	3	3	-	-	-	
Cysts - - -	7	7	-	-	-	
Hypertrophy - - -	11	11	-	-	-	
Lacerations - - -	28	28	-	-	-	
CORPUS UTERI—						
Metritis - - -	1	1	-	-	-	
Endometritis - - -	88	70	-	-	-	{ 1 membranous, 2 cystic, 1 polypoid
Infantile uterus - - -	1	1	-	-	-	
Incomplete abortion - -	24	24	-	-	-	
Inversion - - -	2	2	-	-	-	
Carcinoma - - -	9	2	4	3	-	
Sarcoma - - -	1	-	-	-	1	

TABLE I.—LIST OF CASES TREATED.—*con.*

DISEASE	Total	Cured	Relieved	Not Relieved	Died	REMARKS
CORPUS UTERI— <i>con.</i>						
Pathological antelexion	18	18	-	-	-	
Retro-displacement	34	20	14	-	-	
Procidentia	8	7	1	-	-	
„ with preg- nancy	1	1	-	-	-	
Fixed retroversion	10	-	-	-	-	
Gravid retroversion	1	7	-	-	-	
Subinvolution	16	16	-	-	-	
Hyperinvolution	1	-	1	-	-	
Pyometra	1	1	-	-	-	
Polypus	4	4	-	-	-	
FALLOPIAN TUBES—						
Pyosalpinx	6	5	-	-	1	{ In one instance pus escaped through the uterus
Salpingitis	3	-	3	-	-	
Tubal pregnancy	8	8	-	-	-	
OVARIES—						
Cyst	16	16	-	-	-	
Dermoid	2	2	-	-	-	
Parovarian	1	1	-	-	-	
Carcinoma	3	3	-	-	-	
Ovaritis	3	-	3	-	-	
MISCELLANEOUS—						
Hernia	2	2	-	-	-	
Mastitis	1	1	-	-	-	
Cystic kidney	1	-	-	1	-	
Pancreatic cyst	1	1	-	-	-	
Sapremia	1	1	-	-	-	
Tubercular peritonitis	1	-	1	-	-	
Perimetritis	13	-	13	-	-	
Parametritis	3	3	-	-	-	
Malignant disease of pancreas	1	-	-	-	1	

VAGINAL HYSTERECTOMY.

CASE I.—A. B., multipara, aged forty-eight. Patient had been in the Rotunda about one year previously suffering from superficial ulceration of cervix, apparently of a benign type, though attended with unusual pain and loss of general health. Local treatment was followed by such improvement that I believed her complete

recovery was simply a question of time, and when leaving the Hospital very little disease was discernible. On re-admission we found that the ulceration had extended so much over the anterior vaginal fornix that radical treatment was obviously necessary; its slow advance, the scanty discharge present, and the continuous distressing pain, recalled the cases formerly described as "Rodent Ulcer." My first step in the proceeding for the removal of the uterus was to sear the diseased surface with the thermo-cautery. Owing to the spread of the ulceration towards the anterior lip, the safe separation of the bladder was a matter of some difficulty; in securing the broad ligaments ligatures were used. For two days after the operation blood-stained fluid escaped from the vagina in considerable quantity. Excellent convalescence.

CASE II.—M. S., aged sixty-three, multipara, suffering from bleeding and offensive discharge; anterior lip nearly quite destroyed by ulceration; vaginal roof involved. Uterus movable; on passing a curette into it, pus flowed away in considerable quantity. At time of operation I passed strong silk ligatures through edges of os to close it as much as possible, and to serve as a means of drawing down the uterus. I divided the vaginal walls anteriorly and posteriorly with cautery, and secured the broad ligaments with silk ligatures, which were afterwards cut short. Excellent convalescence.

In connection with these cases of malignant disease I desire to add the following notes on a case (E. C., aged thirty-eight, 17 years married) in my Report of last year. Dr. Neville writes:—"This case is specially interesting, as showing two types of malignant disease in the same uterus. Clinically, it was diagnosticated, and correctly so, as a case of squamous carcinoma affecting the cervix and involving the vaginal vault. The appearances of this cervical carcinoma were peculiar, however, in that they closely simulated in some respects those which are found in syneytioma malignum (*vide* Micro-photograph, No. 1). But the body of the uterus—apparently evenly enlarged to about twice its normal size—was found also to be the seat of an adeno-carcinoma (Micro-photograph, No. 2), in which the glandular tubes, though similar in form to those of the uterine mucosa, were found to own an entirely inde-

pendent growth." An exact parallel for this case is to be found in the history of H. F., aged fifty-eight, mentioned in my last Report, from which I quote the following:—
 "The thickened corporeal endometrium is found to consist entirely of a malignant adeno-papillomatous growth, which shows very characteristically the typical form of that cancer. The cervical canal appears healthy; there is nowhere any superficial roughening or loss of substance; but sections through the breadth of the cervical tissue show that here we have an unsuspected—and in no way outwardly evidenced—adeno-carcinoma, occupying the depths of its muscular tissue. The specimen is, therefore, of pathological interest, as presenting two typical forms of cancer: (1) an adeno-papilloma, confined strictly to the endometrium of the body, and (2) an adeno-carcinoma, confined equally strictly to the muscular portion of the cervix."

TABLE II.—OPERATIONS.

Abdominal Fixation	-	-	-	-	-	-	-	2
Colporrhaphy	-	-	-	-	-	-	-	30
Colpoperineorrhaphy	-	-	-	-	-	-	-	12
Emmet's Trachelorrhaphy	-	-	-	-	-	-	-	19
Schröder's	-	-	-	-	-	-	-	13
Removal of Caruncle	-	-	-	-	-	-	-	5
„ Cervical Polypi	-	-	-	-	-	-	-	8
„ „ Cysts	-	-	-	-	-	-	-	7
Posterior Division	-	-	-	-	-	-	-	11
Perineorrhaphy	-	-	-	-	-	-	-	53
Panhysterectomy	-	-	-	-	-	-	-	2
Vaginal Hysterectomy	-	-	-	-	-	-	-	2
Abdominal „ (for Fibroids)	-	-	-	-	-	-	-	12
Laparotomy for Tubal Pregnancy	-	-	-	-	-	-	-	6
Salpingostomy	-	-	-	-	-	-	-	1
Ovariectomy	-	-	-	-	-	-	-	18
Salpingo-oöphorectomy	-	-	-	-	-	-	-	8
Exploratory Laparotomy	-	-	-	-	-	-	-	7
Vesico-vaginal Fistula	-	-	-	-	-	-	-	2
Circular Amputation of Cervix	-	-	-	-	-	-	-	1
Amputation of Uterus for Inversion	-	-	-	-	-	-	-	1
Reposition „ „ „	-	-	-	-	-	-	-	1
Herniotomy	-	-	-	-	-	-	-	2

TABLE II.—*continued.*

Colpotomy	-	-	-	-	-	-	-	-	2
Cæsarean Section	-	-	-	-	-	-	-	-	1
Cystotomy	-	-	-	-	-	-	-	-	1
Removal of Calculus	-	-	-	-	-	-	-	-	1

TABLE III.—SALPINGO-OÖPHORECTOMY.

No.	Name	Age	Disease	Operation	Result	REMARKS
1	A. R.	30	Pyosalpinx -	Right	R.	Tubercular salpingitis. Three years previously underwent laparotomy for ruptured tubal pregnancy
2	E. J. R.	42	"	"	R.	
3	L. B.	28	"	Left	R.	
4	S. B.	27	"	"	R.	
5	A. W.	26	"	Double	D.	
6	M. G.	24	Tubo-ovarian abscess	"	R.	
7	M. D.	30	Intralig. cyst and double hæmato-salpinx	Left	R.	
8	M. J. B.	38	Intralig. cyst and salpingitis	"	R.	

CASE III.—In the case of L. B., the patient's aspect and condition generally suggested excellent health, and it was with considerable surprise I found what Dr. Neville considered evidence of tubercular disease on both tubes. Both were much contorted, the abdominal ostia closed; the larger swelling on the left side consisted of tube and ovary inseparably bound together. They were removed.

CASE IV.—S. B., aged twenty-seven, presents many points of interest. Two years previous to her admission a ruptured tubal pregnancy was diagnosed, and as it was feared that the accompanying hæmatocele had suppurated, the vaginal wall was incised, giving exit, not to pus, but to a four months' foetus. Abdominal section was then performed, and the ruptured tube removed.

On the present occasion she was suddenly seized with severe pain in belly and faintness, and presented on admission most of the signs and symptoms of peritonitis. In a few days the trouble was at an end, and pulse and temperature were normal. On making a vaginal examination, a tender lump was felt on the left side, which I suspected to be a distended tube. That evening alarming conditions were again present; rigors, faintness, vomiting, and rapid pulse; and on the following day laparotomy was urgently indicated. I made my incision near the old one, and, only with much anxious care, succeeded in avoiding injury to the coils of intestine which, as I anticipated, were adherent along the old cicatrix. There was ample evidence of intense recent peritonitis, and on separating some adhesions a quantity of turbid fluid and flaky lymph floated up into view. With a little more searching I was able to find a large unruptured pus-tube, which was removed, leaving the corresponding ovary. With a long curved forceps I made an opening in the posterior vaginal fornix, through which a gauze drain was passed into Douglas' space, and finally removed in forty-eight hours. Perfect convalescence followed.

CASE V.—A. W., aged twenty-six, had been under our observation for many months. In the beginning double pyosalpinx was easily diagnosticated, but the patient refused operation, especially as the palliative treatment she had undergone had been followed by entire relief from pain, and great improvement in her condition in every respect. After several months she returned in a worse condition than ever, and consented to undergo operation. I made one unsuccessful attempt to reach the pus by colpotomy, so the next time I chose the abdominal route. The intestinal adhesions on both sides were numerous and dense, especially involving the rectum, but I could not at the time detect the point of communication between the left sac and the intestine, through which pus had leaked into the bowel for some time. I passed a gauze drain from Douglas' space into vagina, but all my efforts were unavailing to ward off the sepsis of which she died in a few days.

CASE VI.—E. J. R., aged forty-two, presented much difficulty in diagnosis, and for some weeks I regarded it as a case of fibroid uterus, complicated with perimetritis. When she had lain some weeks under observation and palliative treatment, a sudden and marked aggravation of all her symptoms led me to open the

abdominal cavity. The omentum was widely adherent to the bladder, and when it had been tied and divided a deep red globular mass, elastic to touch, came into view, occupying a mesial position. The uterus was nowhere visible. What looked very like the appendix was connected with the tumour on the right side, but, on examination, this proved to be the right tube, its expanded abdominal extremity lying adherent in Douglas' space. While separating some of the numerous intestinal and omental adhesions which invested the tumour, it gave way, and pus flowed up freely. I immediately applied a ligature to the left broad ligament, and with much difficulty extricated the now collapsed sac from its adhesions in Douglas' space and separated it from the uterus, which had been completely invested by it. The mesosalpinx was tied and divided, the right tube was similarly dealt with and a drainage bag inserted. Recovery was uninterrupted.

OVARIOTOMY.

CASE III.—In the case of A. M., aged thirty-three, the tumour lay so low in the pelvis and so close to uterus that I was unable to determine before operation whether it was uterine or ovarian. This is the fourth case of primary malignant tumour of ovary which has come under my observation. Bland Sutton avers such cases are of great rarity. This patient is at present (Dec. 16) in rude health. In the other instances recurrence was observed in a few months, and in one in a few weeks.

CASE V.—A. T., aged forty, had been for some years troubled with attacks of severe pain, attended with vomiting and prostration, and suffered thus a few days before admission. The cyst was small, invested by adhesions between it and the intestines and omentum, and the pedicle was twisted on itself three times.

CASE IX.—R. G., aged thirty-two, 3-para, was very interesting owing to the difficulty of making a satisfactory diagnosis. Physical signs were :—Vulva and vagina normal ; cervix large and soft, lying immediately behind symphysis ; uterus thrust forward by a hard mass in Douglas' space, quite fixed. Though the patient's aspect suggested perfect health, I suspected this swelling was a malignant growth. Some hours after being examined, her suffering became so great that I determined to operate the next day. On opening the cœlom the uterus came prominently into view, being pushed up by the mass behind. The latter, however, was so covered over by firmly adherent intestine, that I made no

attempt to remove it. The left appendages, quite healthy, lay extended considerably above the uterus. The right ovary also lay some distance above the uterus; it was as large as a golf ball,

TABLE IV.—OVARICTOMY.

No.	Name	Age	DISEASE	Operation	Result	REMARKS
1	R. F.	27	Small cyst	L. side	Recovered	
2	H. L.	33	"	Parovarian	"	
3	A. M.	33	Large malignant tumour of ovary	L. side	"	Carcinoma. Had been operated on some years ago for pyosalpinx
4	H. F.	25	Small cyst	"	"	
5	A. T.	40	Moderate sized cyst	"	"	Pedicle twisted three times; cyst partially emptied before operation
6	A. G.	68	Parovarian	"	"	
7	R. H.	30	"	"	"	
8	L. W.	38	Dermoid	"	"	
9	R. G.	32?	Papillomatous	R. Side	"	Sago-like bodies on parietal peritoneum and intestines
10	M. D.	37	Very large unilocular cyst	"	"	
11	L. B.	32	Parovarian	L. side	"	
12	A. C.	90	Unilocular cyst	R. side	"	
13	F. H.	30	Intraligamentous	"	"	
14	A. R.	35	Dermoid	"	"	
15	M. G.	24	Small cyst	"	"	
16	J. M. P.	44	"	"	"	
17	M. D.	39	"	"	"	
18	M. J. B.	—	Small intralig. cyst	—	"	

of firm consistence, and studded with warty patches. On the intestines and parietes I observed numerous small, hard, translucent bodies.

CASE XIV.—A. R., aged thirty-five, 1-para, was admitted two months after a very difficult labour, suffering from complete perineal laceration; there was also a smooth globular swelling filling up Douglas' space, and elevating the uterus so much that the cervix could not be easily reached. The contents were manifestly fluid, and in order to determine their nature the swelling was aspirated with a hypodermic syringe. As pus cells were present in abundance, I incised the vaginal wall, giving free exit to the fluid, which presently was shown to come from a dermoid by the presence of a coil of hair. The cyst cavity was washed out and packed with iodoform gauze. In about ten days later I opened the belly, broke down some recent thread-like adhesions, and lifted out the cyst, which was firmly adherent to back of uterus and to the edges of the opening in vaginal wall. Through these I passed two silk ligatures, the ends of which were drawn into the vagina, and in the opening I placed a small drain of iodoform gauze; an excellent recovery ensued, though it was retarded for a few days by either a small localised cellulitis, or a hæmatocele.

In last year's Report there is an interesting account of a case in our Maternity in which labour was obstructed by a tumour in the pelvis, which at the time I regarded as a uterine fibroid. When it was pushed out of the pelvis, delivery was easily effected. I allowed the patient home to recruit a little before attempting its removal, but unfortunately she did not return till she was in a moribund condition from suppuration in what proved to be an ovarian dermoid, and general peritonitis. She survived laparotomy and vaginal drainage only two months.

In another similar case, where labour (which took place in the patient's home) was obstructed by a dermoid, a rapidly growing sarcoma developed in the remains of the cyst. In another case, which had been treated in America by posterior colpotomy and drainage, we found on passing a Bozeman catheter into the vaginal openings that some locks of hair were washed out, and the patient was soon able to leave the Hospital quite convalescent. It will always be a difficult

point to determine in such cases whether immediate or deferred removal is the safer course to follow; but personally I am in favour of the latter.

TABLE V.—VENTRAL CCELIOTOMY; HYSTERECTOMY.

No.	Name	Age	DISEASE	OPERATION	Result	REMARKS
1	M. S.	45	Fibroid reaching to navel	Supravaginal amputation	Recovered	
2	A. M.	34	Sub serous fibroid	Myomectomy	"	
3	C. G.	29	Fibroid reaching above navel	Supravaginal amputation	"	
4	M. T.	39	Fibroid and sarcoma	Panhysterectomy	Died	
5	J. C.	22	Fibroid reaching to navel	Supravaginal amputation	Recovered	
6	M. T.	40	Fibroid reaching nearly to navel	"	"	
7	R. H.	42	Fibroid uterus	"	"	
8	L. K.	32	"	"	"	
9	S. P.	46	"	"	"	
10	E. H.	42	"	"	Died	Died of broncho-pneumonia, of which she had several attacks
11	K. R.	40	"	"	Recovered	
12	A. P.	49	"	Panhysterectomy	"	
13	M. B.	39	"	Supravaginal amputation	Died	

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CASE I.—In this case a large number of varicose veins in right broad ligament attracted our attention ; and when the operation was over a swelling of some size had formed here, and, on pressure, blood flowed from it freely ; this was effectually checked by passing a silk ligature through the swelling.

CASE II. was jaundiced 48 hours after operation, but her convalescence was uneventful.

CASE IV.—M. T., aged thirty-nine, presented many rare points of interest. When first admitted to hospital she was moribund from sepsis ; a gangrenous mass, the size and shape of a foetal head, protruded between labia ; her pulse, scarcely to be felt, was 135, her temperature 103.5°, and her aspect generally suggested that no interference could save life. However, I proceeded by morcellation to remove the sloughing tissue and found, when a large portion had been excised, that the growth was a direct continuation of the uterus ; this was especially manifest anteriorly where nothing representing a cervix could be made out. A little to the right of the mesian line the glass nozzle of the douche could be introduced behind the pubes to a distance of several inches, but for many days it was impossible to determine whether it entered a greatly elongated vagina or the cervical canal. The tissue removed on this occasion appeared to be that of an ordinary myoma. To our great surprise the patient rallied. During the ensuing four months several similar morcellations were effected, the tissue, however, in these later removals showing plainly sarcomatous characters. Posteriorly for the most part the growth was continuous with the vaginal wall, and any attempt with the finger to separate them disclosed the presence of what might be termed cavernous tissue, traversed by large veins, and bleeding furiously when disturbed. At length I determined, though with little hope of ultimate success, to attempt its entire removal by coeliotomy. The upper portion of the broad ligament on each side was secured without much difficulty, but neither uterine artery could be seen nor felt, though the bleeding was controlled by passing several ligatures with a curved needle in the position usually occupied by the vessels. The uterus was finally transfixed and removed, when it was found that the vaginal canal extended far above the symphysis, and, as had been observed before, the posterior vaginal wall was merged in the diseased mass. The patient only survived the operation a few days.

CASE VII.—R. H., aged forty-two, sought advice because of dragging pain and swelling in left side. In performing supra-vaginal amputation in this instance I left the right ovary and tube; two uterine arteries on each side required ligature. I allowed an interval of a few minutes to elapse between the tightening of the two knots on the silk ligature encircling the cervical stump. The compressibility of uterine tissue renders this a wise procedure.

CASE VIII.—In the case of L. K., aged thirty-two, one tube was furnished with a supernumerary ostium, and on both tubes several small growths were observed.

CASE X.—E. H., aged forty-two. During the eight years preceding admission had more than once nearly died of bronchopneumonia, and had troublesome cough at time of admission. She suffered much from abdominal pains, menorrhagia and frequent micturition, and was anxious for operation. The parietes were very thick, and the bladder extended very high up. There was slight elevation of temperature during the first few days after operation, but the pulse was good, and she was able to take abundant nourishment. Towards the end of the week respiration became hurried and laboured, and grew gradually worse, death taking place on the 11th day, evidently from recrudescence of old lung trouble.

CASE XII.—A. P., was admitted suffering from complete laceration of perineum, also severe menorrhagia, which two conditions had greatly impaired her health, and her aspect at times was most unfavourable. The perineum and sphincter were restored, and the patient allowed home to recruit her health. In performing the panhysterectomy, it was found impossible to eviscerate the uterus till the upper margin of broad ligament on each side had been tied and divided.

TUBAL PREGNANCY.

CASE I.—R. O., aged twenty-eight, 2-para, was wanting in many of the signs and symptoms of ectopic gestation, but tubal abortion appeared to me the easiest, if not the most likely, explanation of the cyst containing blood lying in Douglas' space.

CASE II.—M. L., 3-para, after several weeks' amenorrhœa was attacked with hæmorrhage and pain, followed by pain on micturition and defæcation, connected with a considerable swelling

behind uterus. At the time of operation the right appendages were found imbedded in this, but the exact site of rupture was not determined.

CASE III.—M. K., aged thirty-seven, 6-para. The uterus lay right in line of incision, thrust forward against parietes, having omentum, which was very redundant, adherent on anterior surface and fundus, thus roofing over a very large mass of coagula. When this was partially removed I had an easy view of large rupture in right tube and the ovum, which had escaped from it, lying close by. The tube and ovary (which was very small) were tied and removed. The condition of the left tube interested me considerably; it was very œdematous, but not being otherwise unhealthy, it was not removed.

CASE IV.—E. O'N., aged twenty-five, 2-para, admitted on July 2, 1903. Amenorrhœa since April. Near the end of May began to suffer from pains and bleeding, with attacks of faintness; these troubles are still present, also pain with defæcation and occasional nausea. The belly is very tender, and the uterus is pushed forwards by a soft mass in Douglas' space, reaching two inches above pubes, and everywhere adherent. Operation, July 10. On making incision uterus and appendages were not in view, being pushed to the left by a smooth swelling, lying under and closely adherent to right broad ligament. A large quantity of encysted blood-clot was lifted out of Douglas' space, and with much trouble the tumour connected with broad ligament was detached and tied off at its base; it proved to be a thin-walled cyst, with clear fluid contents. Below it a smaller firm lump was found and shelled out of closely adherent, semi-organised blood-clot. In its outer two-thirds the tube was so incorporated with old adhesions that its outline became unrecognisable. The peritoneum was washed out and dried, the omentum drawn down, and the belly closed.

CASE V.—J. M'P., aged forty-four, 2-para, admitted complaining of pains in belly and back, and in right iliac region. The uterus is erect, and lying in front of it is an elastic mass, size of a Tangerine orange. The case was regarded as a ruptured tubal pregnancy. Operation, Sept., 23. Parietes very thick; on opening cœlom free blood was observed; firm adhesion between omentum and parietes in middle line, close to bladder, uterus and appendages entirely covered by intestines. Omentum detached with difficulty

and intestinal adhesions separated, disclosing on the left side a considerable mass of a greyish-green colour. On the right side the finger could be passed into Douglas' space, which contained fluid blood, and the right ovary was converted into a cyst the size of a thrush's egg. The uterus was incorporated with posterior surface of mass situated on the left side, and in trying to lift the latter out of the pelvis, the cyst wall broke in several places, giving exit to a large amount of black coagula. I tied and removed as much as possible of the cyst wall, also the ovarian cyst on right side, and washed out *cœlom* before closing it. The cyst wall in this instance was undoubtedly the posterior layer of broad ligament; in other words, the extravasation was partially, at any rate, sub-peritoneo-pelvic.

CASE VI.—M. R., aged thirty-nine, 1-para, two years since last pregnancy. During the past few weeks patient has had intermittent bleeding, sometimes considerable in amount, attended with pain in lower belly, continuous and sometimes severe. On admission patient complained of weakness, temperature 100.8°; pulse, 115. The os is gaping, uterus enlarged, pushed to the left. Lying on the posterior fornix, extending some distance to the right side, and half way to umbilicus, and a little to the left of mesian line, there is a mass of elastic consistence, which, in places, is tender to the touch. This mass is distinctly larger than it was when the patient was examined two days before admission. It is closely applied to the uterus on the posterior and lateral aspects. Operation, Oct. 5. Parietal peritoneum distinguished with much difficulty, owing to the presence of a layer of blood-clot, immediately underneath, and so adherent to intestines that it could be detached only in places. The uterus was concealed by a large quantity of coagula, and when these were being removed I found an embryo, one and a half inches in length, which had escaped through a rupture in the right tube. Its uterine end was secured, and then the remainder of the tube was tied and removed. The *cæcum* was adherent to broad ligament, close to outer side of sac. Handfuls of clots were then removed from Douglas' space and elsewhere; the *cœlom* was douched, the fluid sponged out, and the wound closed. As no radial pulse could be felt, I injected 25 ounces of saline solution, which restored the pulse in the wrist. The patient had no sickness after the operation, and convalescence was uninterrupted.

INVERSION OF UTERUS.

CASE I.—*Inversion caused by two Fibroids growing from Fundus.*—The patient, K. M., unmarried, aged forty, for three years had suffered from menorrhagia, almost continuous, though variable in amount. Much pain in back and belly was also experienced, aggravated during defæcation, and accompanied by the sensation of a swelling in the vagina. On the 13th of February a large mass, nearly six inches in length, was suddenly extruded from the vagina, and micturition became impossible. Two days later, on her admission to the Rotunda, we found this to be the uterus completely inverted—the endometrium already showing several patches of superficial necrosis, and two fibroids, each the size of a large walnut, projecting from the fundus. The patient's aspect, as well as her pulse and temperature, showed plainly that a dangerous degree of sepsis was already present; while the local conditions were such as to render operative measures full of risk. I determined, in the first instance, to try the effect of liberal diet and stimulants internally; externally antiseptics of various kinds were applied, and a tardy improvement in the condition of the endometrium followed their use. Retention of urine often occurred, requiring the use of the catheter, and a copious offensive vaginal discharge added much to the risk of this proceeding. When some weeks had elapsed sufficient local improvement was observable to warrant an attempt for the removal of the uterus, which was carried out as follows:—I encircled the organ at a point where the endometrium was healthy with a few turns of an elastic ligature, and at a short distance below this made a circular amputation in such manner that the cut surface was somewhat concave. The incision passed through the cervix a little below the os internum. Numerous silk ligatures were then passed; first, one running in purse-string fashion around the canal, and then several in a radiating direction from within outwards. When the elastic ligature was loosened several other bleeding points, including a couple of vessels, were separately tied. Convalescence, as might be expected, was slow, but entirely satisfactory; and I observed with much interest a few weeks afterwards that the remaining portion of cervix became re-inverted, allowing the original os externum again to appear in the vagina.

It will be remembered that in the cases reported by the late Dr. Denham, and by Spiegelberg, the same incident was observed.

In the *Dublin Medical Journal*, 1866, Dr. Denham writes :—
“A primipara, aged twenty-three, suffered inversion from pulling on the cord and pressure on the fundus uteri. She was admitted to the Hospital eleven days afterwards. Under steady pressure the uterus gradually diminished, and was felt to yield, so that the fundus alone remained unreduced; no amount of force, compatible with the safety of the organ, could enable us to complete the operation. On the third morning we were agreeably surprised to find that the fundus had spontaneously returned.” In Spiegelberg’s case efforts at replacement were tried with partial success, but were interrupted by an attack of diarrhoea. A fortnight later examination showed that in the interval complete reduction had taken place.

CASE II.—*Inversion, complicating Childbed, in a Case where Manual Removal of the Placenta had been found necessary.*—
In April, 1903, a primipara, aged twenty-five, was admitted to the Auxiliary Ward suffering from metrorrhagia. Her pregnancy had terminated somewhat precipitately five weeks previously, and a midwife, who was in attendance, had removed the placenta manually. A physician arrived shortly afterwards, and finding the uterus inverted, replaced it, as he believed. At the time of her admission to Hospital her anæmic aspect testified to the loss of blood in considerable quantity, and the local signs and conditions rendered the diagnosis of inversion a very easy matter. I specially noticed that, so complete was the inversion, only a very narrow rim of cervix could be felt. When her strength had been somewhat restored by rest, food and tonics, I proceeded to attempt reposition in the manner which proved successful in a similar case narrated in a former Report. Four bullet forceps were inserted at equi-distant points in the very narrow rim of cervix, and my repositor was applied to the fundus; at the same time an assistant kept a hand firmly placed on the parietes. Our efforts for a few minutes did not appear to avail much, especially as a bullet forceps now and then lost its hold on the slender portion of cervix which was within reach, and its readjustment was sometimes difficult; but steady perseverance in the details already mentioned, aided by the application of the fingers to the sides of the uterus, effected the complete replacement of the fundus in about twenty minutes. A gauze drain

was placed in the uterine cavity and left there till next day. Convalescence was in every respect satisfactory, and on measuring the uterus just before patient left the Hospital the cavity was something less than two and a half inches.

These two cases may be profitably considered in connection with two similar ones recorded in a former Report; like them they illustrate the two commonest causes of this most serious uterine displacement—viz., the presence of a polypus springing from the fundus and injudicious management of the third stage. In the former case the propriety of amputating the organ can seldom be questioned, though the proceeding is by no means free from risk, and one of my patients had considerable pyrexia for some days. In the latter case the possibility of replacement should be seriously considered; and the number and variety of operations and mechanical devices which have been described show how much attention has been given to the matter. In my opinion sufficient attention has not been given to the importance of fixing the cervix before applying pressure to the fundus, and our success in the above-noted cases appeared to be mainly attributable to this detail.

EXPLORATORY LAPAROTOMY.

CASE I.—J. B., aged thirty-two. Patient states that at one period each menstruation was attended by the passage of a “fleshy membrane,” and that this continued for three years and then ceased. Very numerous firm adhesions, concealing uterus and left appendages; right tube much thickened and inseparably united with cystic ovary on same side. Owing to firmness of adhesions removal was not attempted. Patient improved.

CASE II.—M. C., aged twenty-three, suffering with fixed retroversion. Slightest attempt to move uterus followed by severe pain. Some hours after examination rigors, vomiting and elevation of temperature; laparotomy deemed advisable. Ample evidence of recent peritonitis; flaky lymph at various points on intestine; also on fundus, to which right tube was adherent by abdominal end. Coelom washed out; uterus brought into position and wound closed; perfect convalescence; uterus in normal position.

CASE III.—K. D., aged fifty. Patient suffering from offensive watery, discoloured discharge; much pain. Uterus enlarged and irregular; cavity four and a half inches. Curette removed large quantity of soft, greyish matter, attended with free bleeding. Laparotomy revealed the presence, on the left side, of a large deep-red tumour, lying beside uterus, arising by a broad base from pelvic brim, and involving sigmoid flexure. Inoperable. Some months subsequently patient writes saying she is troubled with flatulence, but not making any other complaint.

CASE IV.—M. B., aged forty-four. Fibroid uterus reaching nearly to navel. Incision in usual position, led directly into bladder, which extended upwards nearly as high as navel. Opening in bladder closed with catgut, and parietal incision in usual manner with silkworm gut. Operation followed by relief to bladder trouble, which patient had before experienced.

CASE V.—Patient, S. F., aged twenty-four, admitted moribund. History of obscure typhoid symptoms lasting for some days before admission. Incision gave exit to foetid gas and quarts of bowel matter. Extraordinary improvement for three days, when patient suddenly expired.

CASE VI.—S. O'B., aged thirty-six, nullipara, admitted on account of a small pelvic tumour lying close to uterus, but, I think, more probably ovarian than uterine. Patient had, on more than one occasion, suffered from severe attacks of vomiting, but at time of admission did not appear ill, and is well nourished. On Nov. 4 patient had several attacks of severe pain followed by bilious vomiting. Pain referred to epigastrium and also to the right side, extending back towards scapula. On the 6th her condition was so much worse, owing to continued vomiting and pain, that I performed an exploratory laparotomy in the epigastrium. The tissues in abdominal wall were deeply bile-stained, and the viscera so universally adherent that exploration was most difficult. In separating deep adhesions blood was found extravasated in considerable quantity; the head of the pancreas was indurated and much enlarged. No perforation of stomach or gall-bladder could be found. The patient died twelve hours after the operation.

ABDOMINAL FIXATION.

CASE I.—E. B., aged thirty-two; childless; marked hyper-

trophy of cervix, which protruded from vulva. Uterine body small. Circular amputation of cervix, followed by abdominal fixation.

CASE II.—A. C., aged eighty. Complete procidentia uteri, accompanying an ovarian cyst. When ovariectomy was performed, abdominal fixation was also secured by passing two of the abdominal stitches through anterior surface of uterus.

SPLENIC ABSCESS.

E. M., aged twenty-four, 1-para, admitted July, 1903; had been confined ten weeks previously, and was in bed for fifteen days, probably owing to some pyrexia. When out walking about four weeks after confinement she was seized with severe abdominal pain, and remained very ill for some weeks, when she was sent to the Rotunda from Athlone. Her prostration was such that it was feared she would not survive the journey to Dublin. Her pulse was so feeble that I could not count it; extreme emaciation had occurred; the belly manifestly contained fluid, encysted, situated between epigastrium and navel; lower down, the belly is flat, and two doughy swellings are noticeable. I regarded the condition as due to tubercular peritonitis. Under treatment, chiefly symptomatic, slow but steady improvement was observable, and coincident with this all evidence of fluid in the belly disappeared. After a few weeks, however, the temperature, which had become normal, began to show marked evening elevation, and some rigidity of the abdominal wall below the navel being observable, I determined to make an exploratory incision in this region. The parietes were very tense and vascular, and peritoneum undistinguishable. Presently very stinking pus began to flow in considerable quantity from a cyst, or space shut in by very thin walls. This was washed out, and a gauze drain inserted. Slow but satisfactory convalescence ensued.

It will be seen that, though this trouble originated in or shortly after childbed, the situation of the pus and some other points in the history suggest that there was suppuration in a pancreatic cyst.