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Reports of the Rotunda Hospital.*

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MATERNITY REPORT, 1907-8.

By the recent death of Sir Arthur Macan our hospital has sustained a severe loss. He was a past Master of the Rotunda Hospital, and occupied a position on our consulting staff.

His Mastership was marked by active advance in gynæcological and obstetric technique. Through his teaching the importance of abdominal palpation and the dangers of vaginal examinations received general recognition throughout the United Kingdom. In perfection of antiseptic methods he was far ahead of the then accepted views, and the success of his practice exercised a powerful influence on the teaching of midwifery between the years 1882 and 1889. It is certain too that general surgery received a great impulse from his practical teaching.

The hospital during Sir Arthur's Mastership was wretchedly equipped, and no one had a keener appreciation of this than he, and it is no secret that he held the gloomiest views as to its future. His forebodings were only saved from fulfilment by the enterprise and untiring energy of his successor, Sir William Smyly, who in reorganising the nursing staff, building labour wards, lavatories, bathrooms, operating theatres, and adding the splendid gynæcological wing, has earned for himself the unfailing gratitude of those who have succeeded to his heritage.

In the year with which our Report deals, 2,882 patients were admitted to the hospital; of these 2,393 entered the maternity hospital, either in labour or suffering from complications of pregnancy, and 2,060 were delivered.

Not since the year 1834 has this number been equalled. At that time there was neither a gynæcological nor an extern maternity department. The latter now is responsible for over 2,000 deliveries

* Abstract from the official reports.

per annum, so that we may proudly claim the past year as the one in which the hospital has achieved its greatest period of activity.

The morbidity shows a further improvement, 5.30 per cent. as compared with 6.41 per cent. by the B. M. A. standard—i.e., a temperature reaching 100° Fahr. on any two occasions between the second and eighth day of bi-daily taking, the mouth temperature to be recorded, abortion cases to be excluded, and deaths to be included in the morbidity list, regardless of temperature. By our own estimate it is 3.64 per cent., as compared with 3.99 per cent. last year.

Our method of estimating the morbidity is as follows:—A patient is considered morbid if her temperature and pulse, taken twice daily, rise above 99°F. and 90 respectively on three consecutive occasions, counting from the beginning of the second day to the time of her discharge, which in normal cases is noon of the eighth day. Abortion cases are included, but deaths without fever are excluded. If patient's temperature and pulse are above the lines indicated she is not permitted to leave the hospital until they fall to normal for three consecutive takings, and should a patient be kept in hospital, after the eighth day, and then show any morbidity, our statistics will show it. Temperatures are always taken in the mouth.

Five patients remained over thirty days in the house. Two had pneumonia, one had white leg, one had continued temperature following version for placenta prævia, and one was the case of pyæmia that died.

Of our 7 deaths, the one due to Cæsarean section requires very particular mention. It is the only death we have to record in our series of 10 cases. The woman was apparently in perfect health, and was operated on at full term before the onset of labour. The uterus, on being opened, displayed an almost bloodless condition, and the placenta was so firmly adherent that its removal was accomplished with the greatest difficulty.

During this manipulation the atonic uterus lay flabby and thin-walled without showing the slightest indication of retracting and thickening. Hæmorrhage was very slight, and we proceeded to stitch the uterus without the least foreboding of disaster. Suddenly the anæsthetist announced that respiration had ceased, and the operation had at once to be interrupted whilst successful means were adopted to revive the patient. The pulse, however, remained quite imperceptible, and was never felt again, though death did not take place until three hours after the completion of the operation.

It may be remembered that in 1905-6 I commented on three labour deaths due, in my opinion, to obstetrical shock apart from hæmorrhage. In these cases the uterus was found flabby and dilated. This condition is frequently the accompaniment of adherent placenta, and the dilated condition of the uterus precedes rather than

follows the general shock. We consider this case one of the same class.

The two cases of ruptured uterus are typical examples of quiet rupture. In both the rent was extensive, involving the lower uterine segment and vaginal vault. The infants, both dead, were delivered through the vagina—one by forceps and one by manual extraction.

Our treatment in each case consisted in plugging the rents with iodoform gauze. Recovery was uneventful in both, and we think this good result largely attributable to the method of plugging. As some confusion appears to exist in regard to the *rationale* of plugging, we think it important to explain our technique.

We plug with a threefold object—(1) To prevent intestines prolapsing into the vagina. (2) To drain away blood already in the abdomen. (3) To arrest further bleeding. Obviously this result cannot be attained if a strip of gauze is pushed through the rent by one ignorant of the result desired. Thus, in such a case we have known a man to push gauze into the abdomen where it was recovered at autopsy lying near the spleen. To fulfil the conditions mentioned it will be seen that a mere strip will be of no avail. A large piece of gauze should be loosely bunched in the hand as a housemaid holds a duster, and introduced *en masse*, so that it firmly fills the rent and exercises pressure on its lips, but does not penetrate into the abdomen to any considerable extent. Within twenty-four hours the edges of the rupture contract and compress the gauze plug. After this, day by day, the plug should be loosened gradually, drawing out a little at a time to permit further retraction of the tear until the last of the gauze may be removed on the fourth or fifth day.

The case of A. C. shows the uncertainty of high forceps and the difficulties that may arise in applying them before the fixation of the head by its largest diameter. The patient fell into labour in the country, Nov. 8, 1907. Several hours later delivery by forceps was attempted although the head was not fixed. After prolonged and vigorous but ineffectual efforts to deliver, during which the perineum was torn into the rectum, the patient was brought to the Rotunda in a cab, a distance of over twenty miles. She was placed on the couch, and delivered herself, unaided, of a $7\frac{3}{4}$ lb. living child, with a depressed fracture of the right parietal bone, due to the forceps blade. This was raised in the following manner:—The pointed end of one blade of a bullet forceps was sunk through the bone about the centre of the depression. The handle was then raised to the perpendicular and the bone lifted by direct traction.

K. S. was sent to us with a diagnosis of incarceration of a retroverted gravid uterus. This diagnosis was confirmed by us and by one of our consultants who kindly saw the case. The tumour was partially pushed out of the pelvis by repeated daily efforts, but this did not relieve the retention of urine. The fifth day after admission

the patient developed a febrile temperature which remained above normal for five days, reaching 101·8°F. on one occasion. On the third day of fever abortion was induced by inserting two bougies. Under the existing circumstances this was deemed safer than cœliotomy. A three and a half months' foetus came away spontaneously, but the placenta had to be removed with the finger and flushing curette. During the removal of the placenta it was found that the cavity of the uterus ran upward and forward, and that the tumour filling the pelvis was a large soft fibroid intimately associated with the posterior wall of the uterus. She was kept in the house until involution was complete. During this time she occasionally exhibited an intermittent temperature without apparent uterine cause. Four weeks after emptying the uterus supravaginal hysterectomy was performed. There were several myomata in the uterus, the large one on the posterior wall being markedly softened and degenerated. Convalescence was rapid and uninterrupted.

A. K. well illustrates the immediate benefit ensuing on the induction of premature labour for pernicious vomiting. This is the first case we have had where induction of labour was necessary, all others having recovered under the recognised treatment of gastric lavage, purgation, and absolute starvation, prohibiting even fluids, including water by mouth, giving by the bowel what fluid is necessary. This patient seemed in such a serious condition that labour was induced twenty-four hours after admission. The cervix was dilated with Frommer's dilator and version performed. Labour started in thirty-six hours, and lasted four hours. The foetus weighed 6¼ lbs., and when turned was found to be macerated. Vomiting ceased as soon as version was done, and it seems more than likely that this was to be attributed to the loss of liquor amnii. In assigning this case to its proper class it may be mentioned that the patient was highly neurasthenic. Vomiting followed excitement caused by a lecture from a fault-finding sister-in-law.

In the case of B. N. we applied forceps because of acute symptoms due to heart disease. The woman was admitted with failure of compensation, extreme dyspnœa, cyanosis, and beginning œdema of the lungs. Pulse, 150; respirations, 52. She was treated symptomatically with oxygen, morphine, whiskey, atropine, strychnine and digitalin. Nevertheless, the symptoms persisted. Thirty-six hours after admission, labour having started and the os being three quarters dilated, a living child was easily extracted with forceps. The cervix apparently did not tear, but examination immediately after delivery showed extensive bilateral tears, which were repaired with catgut and united by first intention. Urgent symptoms abated soon after delivery, and the patient went out on the eleventh day of the puerperium symptomatically cured.

We induced labour for contracted pelvis in A. MacE. We hold

that this is an operation seldom justified in a well equipped hospital. At present our only indication is in the event of receiving a patient up from the country many weeks before full term. Some of these women have never been in a train before, and have been able to get barely enough money for a single ticket to Dublin. Having made a supreme effort to collect sufficient money and nerve to trust themselves in a railway train and reach a city known to them only by tradition, we feel it inhuman to send them back undelivered to their homes in the wilds of Galway or Mayo. On the other hand we cannot afford to keep them in hospital for an indefinite number of weeks.

Our treatment of eclampsia has undergone no change, and of 12 cases treated one died.

It is interesting to note the increased number of cases of eclampsia that have been treated in hospital in recent years. From 1904 to date we have treated 52 cases; to this may be added 2 private cases; 6 died, a mortality of 11·11 per cent. From 1896—1903, inclusive, 26 cases were treated, with 5 deaths, a mortality of 19·23 per cent. From 1889—1895 inclusive, 35 cases were treated, with 11 deaths, a mortality of 31·43 per cent.

Up to this year we have counted as eclampsia every death in which fits occurred. This year we have excluded one case obviously uræmia.

Our number of contracted pelves, as usual, appears comparatively small, and this has given rise to the impression that the condition is very rare in Ireland; but it must be remembered that we do not record as a contracted pelvis any case based on an uncertain diagnosis; in other words, unless careful measurement with Skutsch's pelvimeter shows a true conjugate not more than 9 cm. We do not believe that there is any practicable method which provides certainty in these measurements. It is a troublesome operation, necessitating a great deal of vaginal manipulation, and nearly always a general anæsthetic; therefore we do not feel justified in taking measurements unless we have reason to believe that the head will not fix in the brim spontaneously. Such a case is rarely met with in a pelvis over 9 cm.

We would protest particularly against the assumption of accuracy in estimating the true conjugate from the diagonal conjugate. To the many known liabilities to error must be added one which we hold is the most important, though it has not been mentioned before—namely, the stretching of the skin (or glove) that takes place when the fingers are pushed up forcibly towards the promontory. The indentation beneath the pubes is made on stretched out skin (or glove), which at once retracts to its former position when the fingers are withdrawn. From direct observation we have shown that the error caused by this can be well over a quarter of an inch.

Some surprise has been expressed that we do not estimate *post-*

partum hæmorrhage by the amount of blood lost. We do not do so for the reason that, in our opinion, it is impossible to draw useful conclusions from such data. It is obvious that the loss of a pint of blood will have an altogether different importance in the case of a pale and delicate woman of 6 or 7 stone weight than in that of a plethoric woman of double the weight. In our 1905-06 Report we alluded to three deaths from what we called labour shock. In none of these was there anything like a pint of blood lost, and yet, in criticism of our diagnosis, we have been told that these women died of *post-partum* hæmorrhage. Our diagnosis of *post-partum* hæmorrhage is based on the extent of constitutional symptoms resulting from free bleeding.

Of 749 primiparæ delivered, 330 required perineal repair. Failures to unite primarily amounted to slightly under 5 per cent. In every case in which union did not take place, secondary repair on the tenth day proved successful. Our primary repair is carried out as follows:—

A fully curved needle, $2\frac{1}{2}$ inches from eye to point, is threaded with silk-worm gut and held in a long needle holder. The patient lies on her left side, her hips well out to the edge of the couch, the right leg flexed with the right foot on the left knee and the right thigh abducted. The operator's left hand is passed over the woman's abdomen and between her legs. The thumb and middle finger are used to separate the edges of the tear, enabling the operator to see clearly the extent of the laceration; but we do not rely on sight alone, the index finger is used to determine the extent of the injury to one or both levator muscles, and is then inserted at the apex of the tear beneath the vaginal mucous membrane. The stitch nearest the anus is inserted first. Inserted on the skin surface it is passed along the under side of the tear (taking a deep bite of the tissues), then deep to the vaginal mucous membrane, and beneath the index finger in the apex of the tear; then along the upper side of the tear, again taking a deep bite of the tissues, to the skin surface opposite the starting point; the stitch is buried from start to finish. The subsequent stitches are similarly placed, but may emerge on to the vaginal mucous membrane. When the torn muscles are brought together and united in the median raphe they functionate as perfectly as if they had never been torn.

MATERNAL MORTALITY.

1. *Cæsarean Section*.—A. F., aged thirty-six years, quartipara, 1 abortion, 1 premature, 1 forceps; admitted Dec. 22, operated Dec. 23, 1907. Operated upon before the onset of labour. Placenta firmly adherent, and removed with difficulty. Uterus did not retract and thicken, and during operation patient collapsed. Revived by

artificial respiration and stimulation. Operation finished. Died three hours later.

2. *Pyæmia*.—A. O'B., aged twenty-five years, primipara; admitted Jan. 26, 1908, delivered Jan. 26, 1908. Vaginal discharge with scalding of vulva and groins. One vaginal examination. Temperature irregular, intermittent and remittent from 1st day. Four intra-uterine douches, 3rd, 5th, 15th, and 16th evenings, antistreptococcic serum (polyvalent), 10 cc. on 5th, 24th, 25th, and 26th days. Credé's ointment on 7th day. Blood cultures showed streptococci on the 23rd day. Leucocytes 40,000. Smears from lochia showed staphylococci, streptococci and bacilli on the 3rd day. Abscess on right side of vaginal fornix opened and drained on 27th day. Patient died on 45th day.

3. *Eclampsia*.—S. A. H., aged thirty-two years, primipara, admitted Jan. 29, 1908, delivered Jan. 31, 1908. History of six or seven fits before admission. Had seven fits between admission at 6-25 p.m. and 7-30 a.m. of Jan. 30. Bled 12 oz., and transfused $1\frac{1}{2}$ pints at 10 a.m. Jan. 30. Became conscious in afternoon, and took water freely by mouth. Improvement continued during next day, when labour started, and she delivered herself at 10.30 p.m., Jan. 31. For some hours previous to delivery patient began to show signs of circulatory and respiratory failure, which continued after delivery, becoming progressively worse in spite of free stimulation. Patient died 4 a.m. Feb. 1, 1908, $44\frac{1}{2}$ hours after the last convulsion. Treatment consisted in washing out the stomach and bowel, morphia, purgation, bleeding, transfusion and stimulation. Bowels moved freely several times after purgation. Patient had been married eight years, and was never pregnant until a posterior division of the cervix was performed.

4. *Puerperal Insanity*.—W. C., aged thirty-two years, primipara, admitted Feb. 8, delivered Feb. 9. Normal delivery. Developed puerperal insanity on 5th day, and was violent for about a week. Developed œdema and marked albuminuria on 18th day. Physical examination revealed aortic stenosis and mitral regurgitation. Died on 26th day.

5. *Uræmia—Chronic Heart and Kidney Disease*.—C. C., aged forty years, terdecipara. Œdema of legs and marked dyspnœa. Large amount of albumen in urine. Loud systolic murmur at apex. Patient had three fits on the 4th, 7th and 8th of June respectively. On 5th June attempts were made to induce labour by inserting bougies after a hot vaginal douche. Repeated three times, and finally removed June 8th. Labour started twelve hours later, and a six and a half months—3 lb. dead child—naturally delivered. Condition improved for some days, but on the 18th June, nine days after delivery, patient developed extreme dyspnœa and died in two hours.

6. *General Peritonitis*.—M.C., aged thirty-one years, primipara; admitted, June 14th, delivered June 15th, 1908. Child premature six and a half months. Normal delivery. One vaginal examination before admission. Placenta incomplete. For sixteen days her temperature varied between normal and 101°F., usually about 100°F. Intra-uterine douches on 4th, 8th, 11th, and 15th days. Smears from lochia showed diplococci and staphylococci. Acute general peritonitis suddenly developed on the 16th evening, and was fatal within a few hours.

7. *General Peritonitis*.—K. McH., aged thirty-three years, tertipara; admitted August 7th. Incomplete abortion, foetid, completed with curette. Second and third evening intra-uterine douche. Temperature between 102.4° and 103°F. Third evening vaginal examination revealed hard mass in left fornix. At 7 a.m. next morning developed sudden pain and signs and symptoms of general peritonitis. Posterior colpotomy and drainage; but patient died at 3 p.m. some day. No post mortem.

OTHER CASES MENTIONED ABOVE.

Ruptured Uterus.—K. T., aged twenty-eight years, tertipara, Previous labours normal. Admitted April 15th in normal labour, vertex presentation to palpation and vaginal examination 6 a.m.—pulse and temperature normal; pains regular and strong; head visible at vulva, but not advancing. Manual pressure during pains had been tried; then tight binder applied and patient allowed up. No pains. Put to bed. Contour of abdomen markedly changed, and foetal parts felt immediately under abdominal walls. Pulse rose to 120, but patient never showed any signs of shock. Child and placenta manually through vagina delivered from abdominal cavity. Rent involved vaginal vault and lower uterine segment; packed with gauze, which was gradually removed, the last being taken out on the fifth day. Uninterrupted recovery. Child dead. Caput for first vertex.

Ruptured Uterus.—E. F., aged thirty-seven years, decipara, 5 normal labours, 1 difficult breech, 3 abortions. Uterus ruptured ten hours before admission, after three hours of normal labour. Patient markedly collapsed on admission. Vaginal examination revealed an occipito-posterior presentation. Forceps applied and head delivered. Impacted shoulders freed by bringing down the arms. Placenta removed from among intestines. Large rent in anterior and lateral fornices involving vaginal vault and lower uterine segment. Packed with iodoform gauze. Extreme collapse requiring vigorous stimulation. Last of gauze removed on fourth day. Uninterrupted recovery.

Forceps.—A. C., aged twenty-seven years, primipara; admitted

Nov. 9, 1907, delivered Nov. 9, 1907. Driven in a cab twenty miles to Rotunda after forceps had been unsuccessfully applied. Admitted with complete tear. Delivered herself easily one and a half hours after admission. Baby had a depressed fracture of right parietal bone due to forceps. This was raised with one blade of bullet forceps. Baby lived twenty-four hours. Primary perineal repair failed, but secondary operation successful.

Myoma and Pregnancy.—K.S., aged thirty-eight years, primipara, admitted July 15, 1907, with diagnosis of incarceration of retroverted gravid uterus. Retention of urine; large cystic mass in posterior fornix; cervix up behind symphysis. Attempts to shove tumour out of pelvis were partially successful, but retention of urine persisted. Developed fever four days after admission. Three days later abortion induced by dilatation with Frommer's dilator and insertion of two bougies. Twenty-four hours later foetus came away, but not the placenta, which was removed manually. It was then found that the uterine cavity ran upwards and forwards towards the umbilicus, and was very much stretched out. The pelvis was filled with soft tumour, continuous with posterior uterine wall and encroaching on the cavity of the uterus. There were two other fibroids on the posterior wall near the fundus. On two occasions fever of an irregular type occurred. No demonstrable cause for fever found in uterus, but patient had a mild attack of cystitis. Supravaginal hysterectomy four weeks after delivery. Uninterrupted recovery.

Pernicious Vomiting.—A.R., aged forty-two years, duodecipara, six and a half months pregnant, admitted Sept. 28, delivered Sept. 30. Admitted with history of two days vomiting following a fright. Pulse 140, temperature 99°F. Incessant vomiting in spite of treatment outlined above. Pulse remained above 120. Patient looked extremely ill. The day after admission labour was induced by dilatation of the cervix with Frommer's dilator, followed by bipolar version. Child macerated. Vomiting ceased, and patient began to improve immediately, although delivery did not take place until thirty-six hours later. Uninterrupted recovery.

Chronic Endocarditis. Failure of Compensation.—B. N., aged twenty-eight years, primipara. Admitted with dyspnoea, cyanosis, rapid irregular pulse and fine, moist râles at both bases. Received symptomatic treatment—whiskey, strychnine, atropine, digitalin, morphin, oxygen and purgative. Patient fell in labour, and symptoms became more pronounced. Forceps applied when the os was three-quarters open and child easily extracted. Cervix and perineum both torn. Primary repair with good union. Baby alive. Compensation was restored, and patient went out apparently in good health June 4, 1908.

GYNÆCOLOGICAL REPORT.

During the past year 489 patients were admitted to the Gynæcological Wing of the hospital; about the same number as in the previous year. The vast majority of these were admitted for operation, as those patients on whom palliative measures can be adopted are treated in the Out-patient Department. The lack of accommodation is a serious difficulty, and precludes us from admitting a great number of deserving patients. As in our former Report, we describe operations under the different heads, and many of these which occur in separate tables* are operations performed on the same woman. There has been a gratifying increase in the number of major operations performed, and there is every indication of still greater activity. This increase cannot be viewed without a certain degree of anxiety, on account of the extra expense involved. Our present Gynæcological Wing is worked on uniquely economical principles, and with the aid of only two fully qualified nurses for day work. The sister is not only required to help at all operations, to assist at all dressings, and to look after the welfare of the patients, but is absolutely responsible for the sterilisation of all operating material, and for the management of the theatre, where 119 abdominal sections took place. It can easily be understood that work is carried out by this small staff at high pressure.

Six patients died. In one of these no operation was performed. Of the other five, A. G. was admitted to the hospital in a very enfeebled condition. Tubercular peritonitis was diagnosed; the abdomen was opened. The patient seemed relieved for a few hours, but death ensued the following day; this, we need hardly say, had no connection whatever with the operation. Our only fatality after Wertheim's operation was due to the breaking away of a severed ureter from its attachment to the bladder. A case to which particular attention should be drawn is one in which cancer was found in the pedicle of an ovarian cyst, which had been operated on six months previously; the special interest in the case lies in the fact that the tumour, which was removed in the former operation, when examined was found to be a simple papillary cyst. The fifth fatal case was one in which a very adherent retro-peritoneal lipo-sarcoma had been removed two and a half years previously. When the abdomen was opened the second time, several large tumours were in evidence, extending as far as the under surface of the liver, and involving that organ; it was found impossible to remove the entire tumour, (at the autopsy the liver had to be extirpated before the entire mass could be removed). The portion, which was left, after the autopsy, subsequently sloughed, and death ensued from sepsis ten days later.

* The tables have been omitted from the report given here.

The last fatal case was of a patient who was admitted in a dying state, and in great distress from an abdomen distended with ascitic fluid, the result of alcoholic cirrhosis. Paracentesis had frequently been performed, and this at shorter and shorter intervals. The abdomen was at last opened in the hope that the fixing of the omentum to the under surface of the liver and parietal peritoneum might to some extent alleviate symptoms.

The increase in the number of operations for cancer of the uterus calls for some comment. Our view totally differs from that usually expressed. We hold that the operation is not contraindicated in many cases, though they offer no prospect of a permanent cure. The prospect of a permanent cure in any case of cancer of the uterus must remain for a long time a matter of great uncertainty. The operator who can number many non-recurrences after an interval of four or five years must be considered strangely fortunate in obtaining early cases. On the other hand, experience has impressed us with the great relief obtained by operation in cases absolutely hopeless in respect to non-recurrence. We do not suggest to either the patient or her friends that we can hold out the least prospect of a non-recurrence of the disease. Our desire is rather to relieve distressing symptoms, to cause freedom, and, perhaps, permanent relief from foetid and ill-smelling discharges. It is a well-known fact that cancers not exposed to septic influences are seldom painful, and a patient may die with freedom from pain from the most extensive cancers of the liver or other internal organ. For this reason we would not hesitate to remove a painful or necrotic area, even though secondary deposits were known to be present in the liver. It has been urged against this view that discredit has been thrown on operative work when relief is not permanent and cancer soon recurs. For our own part we can only say that we have not observed this, but, on the contrary, have found unfailing gratitude on the part of the patient for renewed hope and relief given; and the same holds good in respect to the friends. Would any surgeon hesitate to amputate a leg for sarcoma, even though recurrence be bound to follow? and why, therefore, should the rule that holds good in general surgery not also be the same for the gynaecologist? As to the steps of the operation, we endeavour to follow Wertheim in every case, though, obviously, modifications are frequently necessary. We remove enlarged glands, but do not prolong the operation unnecessarily in the search for them. The main object is to remove as much vagina and parametrium as possible.

Three cases may be quoted as illustrating in a most marked manner the ever present difficulties in diagnosis which beset the abdominal surgeon. In the case of B. C. the abdomen was opened for the removal of a myoma, and all present were startled to discover that the uterus closely resembled that of pregnancy. Not without

the greatest hesitation was it decided to make a small exploratory incision, and thus decide the matter. An interstitial myoma, fortunately, came into view. Had the case turned out to be a pregnancy, the wound could hardly, with safety, have been closed without first emptying the uterus. In the case of M. D. an interstitial myoma was diagnosed by bimanual examination, though doubt existed as to whether the case was one of pregnancy, and this doubt received expression in the written diagnosis; through a most lamentable oversight the suspicion of pregnancy was forgotten, and laparotomy was performed, to find once again a uterus presenting all the characters of pregnancy. The abdomen was closed without further manipulations. The woman made an uninterrupted recovery, and departed without aborting. Shortly after this, M. M. was admitted to the hospital, and interstitial myoma was diagnosed. Here again, when the abdomen was opened, the uterus presented so much the appearance of pregnancy that it was decided not to continue the operation. At the expiration of a month it became obvious that the case was not one of pregnancy, and a fibroid uterus was successfully removed per vaginam. These three similar and puzzling cases all occurred within the space of four weeks, and are the first and only cases in which we have experienced this difficulty in diagnosis.

Operations for the cure of backward displacements of the uterus were performed sixty times. Of these Kelly's operation of ventrosuspension was the method adopted on forty occasions; ten of these patients were sterile, and it was interesting to note, especially in these cases, the fact that the tubes were occluded; this alone seems to be a great point in favour of the operation, for this fact can certainly not be diagnosed by even the most experienced gynæcologist. Vaginal fixation was performed fifteen times, and Alexander-Adam's operation five—the former usually in patients who had symptoms of retroversion, and who required other plastic vaginal work; the latter, for what we considered to be a simple retroverted uterus.

The technique is still the same as that which we described in our former reports, and it continues to be satisfactory.

NOTES ON SOME OF THE CASES.

PERINEUM AND VAGINA.

Complete perineorrhaphy was performed once according to the method of Lawson Tait. Incomplete perineorrhaphy was performed sixty-two times by Lawson Tait's method; colpoperineorrhaphy eleven times—nine by the method of Hegar, and twice by that of Martin. A case of cicatrix of the vagina was treated by forcible dilatation and plugging with iodoform gauze. There was one case of vaginal cyst, which was excised; four fistulæ were operated on—one vesicocervical and three vesicovaginal fistulæ. Anterior colpor-

rhaphy was performed on fourteen occasions—eight of these being associated with the operation for vaginal fixation, and six for that of prolapsus uteri. Fifteen cases necessitated anterior colpotomy—fourteen of these being associated with the operation for vaginal fixation. Posterior colpotomy was undertaken six times—four for small ovarian cyst, one for pyosalpinx, and one in connexion with the operation for vaginal fixation.

CERVIX.

A modification of Dudley's posterior division was undertaken on eighteen occasions, and was associated with curettage for sterility or dysmenorrhœa.

UTERUS.

Abdominal Hysterectomies.

L. B. Interstitial and subserous myomata first removed. Excessive hæmorrhage made hysterectomy necessary.

K. R. Large right intraligamentous subserous myoma. A large amount of hæmorrhage from adhesions.

C. R. Uterus riddled with myomata. Hysterectomy by Doyen's method.

Hæmatosalpinx at outer end of right tube—pus at inner end; below this tube was an intraligamentous cyst the size of an orange. Firm adhesions on this side, with an extratubal abscess in the pouch of Douglas. Other side sound. Gauze drain. Complete hysterectomy.

A. Q. Uterus much elongated. Subserous myoma so intimately connected with the cervix that complete hysterectomy had to be performed. Both ovaries left.

M. K. Complained of dysuria; at times had complete retention. A large cystic fibroid, freely movable in Douglas's pouch. Supravaginal hysterectomy was performed, owing to injury to uterus in removal of the myoma.

H. H. Multiple myomata. Hæmorrhage too great to allow myomectomy.

Abdominal Hysterectomies—Malignant Disease.

E. D. Epithelioma of cervix. Uterus very adherent to bladder, which contained cancerous mass. It was impossible to get completely outside the cancer. Wertheim's operation performed.

M. H. Epithelioma of cervix. Uterus very adherent to bladder, which was perforated in attempting separation; the tear was stitched. The abdomen was closed with catgut. Vagina was divided very low down, owing to infiltration. Patient coughed very severely eight days later, and burst open her wound; this was re-united with

through and through silkworm gut sutures. There was a vesico-vaginal fistula, and the abdominal wound became septic. Both these conditions were healed when patient left the hospital six weeks after operation.

M. Q. Uterine wall friable, and perforated in preliminary curettage. Abdominal wound became septic, but was healed before patient's departure from hospital.

L. R. This was a case which was sent to the hospital as one of twin pregnancy. Two solid ovarian tumours were diagnosed. When the abdomen was opened it was found that there were two large masses, each larger than a full term fœtus, and malignant in appearance; these were removed, after which total extirpation of a fibroid uterus was performed.

M. E. This was the only fatal case out of thirteen Wertheim's operations performed during the year. During the operation the ureter was found to be involved in the cancerous process, and two inches had to be resected; the end was implanted in the bladder by means of sutures, and evidently these separated, for signs of peritonitis developed three days after the operation, and death occurred on the following day.

MYOMECTOMY.

The conservative operation of myomectomy is performed whenever possible. In three cases several great myomata were removed and the uterus left.

TUBES AND OVARIES.

The abdomen was opened twenty-three times for operations on the tubes and ovaries, besides which many resections were performed as accessories to other operations. All these recovered. The case of M. M. was very troublesome, the cyst being retroperitoneal and very adherent. It was not possible to remove the entire cyst, although the uterus was extirpated in the endeavour. Drainage, therefore, was carried out through the vagina.

MISCELLANEOUS OPERATIONS.

E. . The chief interest in this case lies in the fact that a year after the operation of cholecystectomy for cholelithiasis, the patient returned with a tumour in her abdomen, which, when removed by Mr. Heuston, turned out to be a malignant ulcer of the pylorus.

A. G. This patient, suffering from tuberculous peritonitis, was moribund on admission, and operation was resorted to as a last resort.

A. M. This was a very large suppurating renal tumour which, when examined, was found to be an hypernephroma. The patient made an uneventful recovery.

M. M. Retroperitoneal sarcoma. This was a case of recurrence

after two and a half years' freedom from the disease. The autopsy revealed marked cirrhosis of the liver and chronic interstitial nephritis.

MORTALITY.

E. C. This was the case of cancer recurring in the pedicle of an ovarian cyst, to which we referred in our opening remarks. When the abdomen was opened on this occasion it was found that nothing could be done. The patient died from shock on the following day.

A general anæsthetic was administered on 317 occasions with no death:—

Ether	248
Chloroform... ..	30
Ether and Chloroform	24
Nitrous Oxide and Ether... ..	15
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Total	317

For the compilation and arrangement of these Reports I am indebted to my two Assistant-Masters.

Dr. Freeland has made himself responsible for the Maternity Report and Dr. Solomons for the Gynæcological Report.

PATHOLOGICAL REPORT.

By ROBERT J. ROWLETTE, M.D., Pathologist.

Seven post mortem examinations were made in the case of adult patients. Brief notes of these are appended:—

CASE 1 (Maternity).—Partial autopsy. Annie F., aged 36, died December 23, 1907, after Cæsarean section. Large quantity of blood-stained fluid in abdominal cavity; saline; no bleeding point discovered. Uterus flabby and soft. All other organs healthy.

CASE 2 (Gynæcological).—Ann G., aged 30, died February 15, 1908. Body emaciated. Abdomen flat; operation wound healthy. On opening the abdomen the parietal peritoneum was found much thickened and hyperæmic, at least quarter of an inch thick. No tubercles visible to the naked eye. Great omentum, ascending and descending colon adherent to anterior abdominal wall. Behind this mass, and in front of the small intestines, which were closely adherent, was a large cavity containing blood-stained serum, with masses of clotted serum. Large miliary tubercles studded over small