regulated rest and exercise and copious draughts of water is beyond dispute; but it is surely a pity when, instead of rational explanation of a "cure" treatment, we suffer our patients to be deceived by unscientific and more or less untruthful statements.

Is it not a mistake for so many of us to prescribe the made-up drugs offered us by wholesale manufacturers instead of our own combinations? It leads our patients to ascribe their recovery not to our skill, but to this or that pill or tablet. It would be an excellent task for this great association to set some of our skilled analytical chemists to strip the veil from mysterious remedies and tell us the exact composition of the many patent medicines, some of which are inert and some injurious.

RATIONAL MEDICINE AND ITS WAGES.

Lastly, we may ask whether our profession obtains the recognition that is due at the hands of the public. I believe that on the whole it does, or if in any degree it fails, that the failure is due to ourselves. We cannot expect that any but the most educated and enlightened should look at our science or our art from a rational point of view. The popular notion of a doctor among our patients is a man who has got some wonderful cure in a bottle which will make them well. The more educated patients suppose that, knowing what is the matter with them, or, as we say, having made their diagnosis for themselves, their next business is to choose the doctor who has devoted his exclusive attention to the malady of which they suppose they are the subjects, or if they chance to suffer from what they call a complication of diseases they will consult a heart specialist to cure palpitation, a throat doctor to cure hoarseness, and a rising young surgeon to "a special hospital for diseases of the knee," to cure weakness in that joint. If they should find no relief after these consultations—*Plectere si nequeo superos, Acheronta movebo*—they denounce legitimate medicines as useless and go to the lowest impostor, and will afterwards tell their friends that after being "given up by the faculty" they found instant and miraculous relief in a single box of wind pills, a galvanic belt, or a pad of "oriental herbs" worn on the pit of the stomach. Among the more enlightened the rule seems to be that they believe in surgery, they believe in nursing, in change of air, in tonics, and in stimulants, but they have long since given up faith in doctors or in medicine.

The fact is that we cannot expect our patients should understand the scientific basis of medicine, the meaning of etiology, or the possible degree of efficiency of treatment. What they frequently ask of us is to allow them to continue the very course of life to which we have laboriously traced their symptoms, and to give them some medicine which, as if by a charm, will break the inevitable sequence of cause and effect. They are slow to understand that this world gives nothing for nothing, and that we can only subdue Nature by obeying her laws.

There is, in fact, only one way in which we can obtain what we call our just recognition. Our services, however great, are services to the individual, not to the community. It is therefore absurd for us to expect the honorific or more solid rewards justly assigned to statesmen, to generals, or to judges, but from individuals we may expect—and I venture to say that as a rule we receive—the trust, the honor, and the grati-

tude which we have earned. Few of our patients will ever understand our principles or our methods, the reason for our successes, or the explanation of our failures; what they do understand is personal character, honesty and sense, kindness and sympathy, liberality and benevolence to rich and poor. These are the qualities which have always gained and still gain the respect of our fellow men; and I venture to say there is not a town in the three kingdoms where such respect is not widely and deservedly earned. In every cathedral, in almost every parish church, we see tablets bearing witness to the esteem in which the local practitioner lived and died. He spent his life in the constant exercise of his best faculties, intellectual and benevolent—a sure path to happiness; every day brought fresh interest and left no time for melancholy; he earned not only money but money's worth, in respect and influence; and when the practitioner became the patient—as we all must one day be—he had pleasant memories of a life spent in the service of God and man. He lives in the hearts of those who knew him,

"And there sepulchred in such pomp doth lie
That kings for such a tomb might wish to die."

Original Articles.

REPEATED ECTOPIC GESTATION IN THE SAME PATIENT, WITH OPERATION IN EACH CASE.¹

BY MALCOLM STORER, M.D., AND M. T. THURBER, M.D., BOSTON.

I. PREVIOUS HISTORY OF THE CASE, BY DR. THURBER.

In bringing to your notice this evening the interesting features of the following case I will endeavor to give only a brief clinical picture from the commencement of the abnormal conditions up to the time of the patient's entrance to the hospital. I am indebted to Dr. Joyce, of Kingston, N. H., (formerly of Dorchester) who had the patient under his charge during her first illness, for many particulars of the case.

A young woman, twenty-three years of age, small in stature, weight 110 pounds, of a nervous temperament; born in Canada, of the physical development characteristic of the French-Canadian girl, and married three years; never pregnant; ceased to menstruate October 20, 1898, having begun on the 17th. Her period was expected again November 14th, but was missed and, as she had always been on time, she concluded she was pregnant. She had nausea during the morning at different times, which was quite unusual for her, and this confirmed her belief.

Aside from "morning sickness" she felt as usual up to the early morning of November 26th, when immediately after coition she began to flow profusely. Soon severe pains began, located low in the pelvic region. She feared she was about to miscarry and at eight o'clock she was seen and examined by Dr. Joyce about half an hour after the hemorrhage began. Believing that a miscarriage was threatened, he administered remedies with the hope of checking the flow and to continue if possible the pregnancy. One visit only was made, as the above conditions soon passed away and the patient was as well as before.

¹ Read before the Suffolk District Medical Society, Section for Obstetrics and Diseases of Women, March 28, 1900.

The doctor was again called December 7th for pain, but no hemorrhage. Relief was soon obtained by morphia given hypodermically.

Five days after this visit, December 12th, Dr. Joyce was called for the third time and as he was out of town the husband asked me to see her. When I arrived I found the patient, to use her own words, "suffering agony." Her temperature was 99½° F. and her pulse 104. Hemorrhage was profuse. There was marked tenderness over the lower part of the abdomen, especially on the left side of the median line, where the slightest pressure produced sharp, cutting pain. She had had several chills, each leaving her in a more nervous condition than the preceding one. For three days previous to my visit she had had a bloody discharge which had an offensive odor. In attempting to pass my finger into the vagina the rectum was found to be loaded with a hard fecal mass, which was removed by a copious enema. Proceeding with the examination I found the parts very hot and exceedingly painful to the touch. The uterus seemed to be unusually low in the pelvis and was somewhat enlarged. The os was not dilated at all. In the cul-de-sac an oval, painful mass could be felt. This mass was soft and seemed to fluctuate like pus in an abscess. Rational signs of pregnancy were present. I could not satisfy myself with a positive diagnosis.

I gave an anodyne, ordered absolute rest in bed, with liquid diet. On the following day I found her quite comfortable.

Two days later her condition was worse than ever. I thoroughly sterilized a sound and carefully explored the uterine cavity, finding nothing. Dr. Joyce returned in the afternoon, and in consultation with him, everything was ruled out excepting ectopic gestation, which we believed must be the true condition, and operative interference the proper way to treat the case. She was sent to the Carney Hospital, December 19, 1898, just nine weeks from the date of her last menstruation.

REPORT OF FIRST OPERATION, BY DR. STORER.

On December 17, 1898, I was asked by Dr. F. L. Johnson to see at the Carney Hospital Mrs. J. L. Examination under ether showed the posterior pelvis filled by an apparently solid mass, with only one small area of doubtful fluctuation, the size of a ten-cent piece, directly behind the cervix. In the left pelvis a harder mass was to be felt that was adherent, while to the right was a movable tumor, rounded and somewhat smaller. The mass was so densely adherent to the uterus that it was extremely difficult, without the sound, to be sure that the fundus lay forward. The uterus was only slightly enlarged.

My diagnosis from the pelvic examination—not having heard the clinical history, and not seeing the patient until she was under ether—was that it was a case of old salpingitis with much exudate. Examination without ether must in this case have been quite hopeless. As at that time I was trying to persuade myself that the vaginal route offered advantages over the abdominal, and also perhaps because I did not have the patient's consent to a laparotomy, I determined to attack the mass by the vagina. On incising the posterior vaginal wall I came at once upon black, shining peritoneum, which when opened gave vent to several ounces of sweet blood. The finger then came upon a hematocoele nearly filling the pelvis, and a

rounded mass that was apparently the gestation sac. I met great difficulty in bringing this down, as the patient's vagina was extremely small and the hematocoele very much in the way, and as now manipulations were causing free hemorrhage and the patient beginning to be in very poor condition, I packed the pelvis with gauze and opened the abdomen. A large amount of fresh and old clots were turned out and the left tube, which was somewhat adherent, was found to be ruptured and bleeding freely though not alarmingly. The tube and ovary were removed. The fetus was not found. In spite of the entire lack of previous preparation for an abdominal operation, and in spite of the immediate preparation being of the most superficial nature owing to the probability of active hemorrhage being present, convalescence was as uneventful as if the most elaborate aseptic precautions had been observed.

I regret very much that I cannot show you the specimen of this pregnancy, but as I had no reason to suppose that the case would be one of especial interest it was not preserved. As I remember it the sac was about the size of a walnut, situated near the middle of the tube. I examined the other tube and ovary very carefully, having in mind a paper I had read a few days previously in which the writer advised that the other ovary should always be removed to avoid the possibility of an ectopic pregnancy on the other side. But as the right appendages were apparently perfectly healthy, except that the large old blood clot was adherent to the ovary, I decided to leave them for two reasons. I felt that being a young woman recently married she was entitled to at least the chance of giving birth to a child, and furthermore, I did not have her permission to sacrifice both ovaries.

HISTORY OF SECOND ECTOPIC PREGNANCY, BY DR. THURBER.

Mrs. L. came to my office on the 20th day of May, 1899. She informed me that menstruation had been regular after the operation, but that she had now passed her period about one week and thought she must be again pregnant. Presumptive signs of pregnancy were present, morning sickness, etc. She was feeling well and had no complaints to make, but wished to place herself under my care as soon as she found herself to be in an interesting condition. I felt quite sure I could make out Hegar's sign, and ventured a positive opinion that she was pregnant, and asked her to notify me at once if anything went wrong. Two days after her visit to the office, the 22d, she sent for me. She had a slight pelvic pain which soon passed off after administering an opiate.

On May 24th I received another call. At this time there was a slight hemorrhage but no pain, although there was some tenderness over the lower part of the abdomen, and, as in her previous illness, the left side was the more tender to pressure. I could make out nothing satisfactorily. She stayed in bed, and by the next day the hemorrhage had ceased. She was comfortable on the following day.

My next visit was in the early morning of the 27th, and I tried again to find the cause of the trouble. Her temperature and pulse were normal. In the cul-de-sac there could be found a small mass, very tender when pressed. This mass was soft and oval, and did not feel much unlike the fundus of a retroflexed uterus. I presume my previous experience with similar condi-

tions in this patient led me to believe that ectopic gestation was repeated.

The next day, the 28th, Dr. Storer, in consultation, confirmed my diagnosis and advised her immediate removal to the hospital for operation. She was admitted to the Carney Hospital that afternoon, six weeks from the date of her last menstruation.

REPORT OF SECOND OPERATION, BY DR. STORER.

On May, 1899, five and one-half months after the previous operation, Dr. Thurber asked me to see Mrs. L. again, as she thought that she had another extra-uterine pregnancy. Examination now showed a somewhat enlarged, retroflexed and rather soft uterus with a prolapsed and somewhat thickened tube. There was no exudate or boggy mass. The diagnosis of an extra-uterine pregnancy was made more from the history of the previous attack, the recent symptoms and the foul flow rather than from what I felt in the pelvis, which without the history to guide us suggested a retroflexed gravid uterus as much as anything. I have often noticed a similar hardness of the cervix in gravid retroflexions, from disturbances with the blood supply probably. I advised immediate removal to the Carney Hospital. After my previous experience with the vaginal route in this patient I had no desire to try it again, and so opened the abdomen at once. The uterus was found retroflexed and adherent with rather fresh adhesions, and the prolapsed tube showed a fusiform enlargement at about its middle. A considerable amount (half a basinful) of free blood and clots was found in the pelvis, all of which was perfectly sweet. The tube was found to be practically unadherent, and on bringing it up carefully it was found to be intact, but blood was coming from the ostium in rapid drops. I removed the tube, but left most of the ovary stitched close to the stump of the tube, not wishing needlessly to remove the only remaining ovary in so young a woman. Although there was in my mind some question as to its subsequent nutrition, Nature had no trouble in attending to that. I tied this tube off with chromicized catgut; and the many cases in which tubes have become patulous, no matter how carefully they have been tied off, will naturally cause me to ask Dr. Thurber to watch this case with great care to see whether a third pregnancy ever takes place. There is really no great reason why she should not become pregnant again, and from the shortness of the tubal stump the chances are that another pregnancy would be uterine rather than interstitial. Menstruation, I may say, took place after the patient left the hospital in normal amount, and has continued as usual and without pain, although she has no tubes.

According to Dr. Whitney's report upon this second specimen, it will be seen that he is unable to state with any certainty that he found any evidences of an extra-uterine pregnancy, but the clinical picture of the case given by Dr. Thurber fits in so perfectly with the gross conditions present in the abdominal cavity that I think we are justified in regarding it as one, especially as some cells were found recalling very strongly decidua cells, and as there were no symptoms of any previous inflammatory condition in the pelvis. Dr. Whitney's report was as follows:

MARCH 25, 1900.

DEAR DR. STORER:—The specimen of the tube and portion of the ovary consisted of the fimbriated end of the tube for about 4 or 5 centimetres, which was opened and

to the inner surface was adherent a small, firm clot of blood about 5 millimetres in diameter. The outer surface was also roughened and a few clots adherent. Microscopical examination through the wall and attached clot showed the papillary folds of the tube of about normal size, but with enlarged lymph spaces, prominent blood vessels and here and there a little hemorrhagic extravasation. The blood clot seemed to be in the outer part of the fold and looked as if it could have originated from the rupture of some of these vessels. At one place on the wall, just beneath the adherent clot, was a little clump of large mononucleated cells with rather clear protoplasm, recalling very strongly decidua cells. But this was the only place that pointed to a change that could have been produced by pregnancy. Nowhere was there the slightest trace of chorionic villi, nor were the folds of the tubal mucosa infiltrated with small cells, as is frequently the case. A rather loosely attached piece of hemorrhagic tissue proved to be full of very many thin-walled blood vessels, which were also present in the adhesions on the outer surface. Aside from the one little group of large, decidua-like cells, there is nothing which proves the condition of pregnancy. The hemorrhage can be explained by the rupture of the enlarged vessels in the folds of the tube and from the thin-walled ones associated with the chronic inflammatory process of the peritoneum.

Yours very sincerely,

W. F. WHITNEY.

That repeated extra-uterine pregnancy is of more frequent occurrence than was formerly thought is attested by the cases reported in recent years, but authentic ones are still sufficiently rare. Zangenmeister in a paper published last year has gathered together some 40 cases. A careful examination of the literature shows, however, that in only 17 was the condition proved by actual operation [J. Veit, 1889, Olhausen, Hermann, Abel, Beck, Harrington, Bennington, Frankenthal, Ross, Brosin, Kokman, Schoolfield, Falk, Dührssen, Zangenmeister (2 cases), Thomson]. To these may be added the cases of Winckel, who in 1888 demonstrated the specimens from a patient in whom he had destroyed an extra-uterine fetus in 1885 and again in 1888, and the case of Tait in which an operation for extra-uterine pregnancy was followed three years later by the death of the patient from the rupture of another extra-uterine sac. The number of surgeons to whose lot it has fallen to have had an opportunity to operate twice upon the same patient for this interesting condition is naturally extremely small, limited as far as I can find to the following: Veit, Olhausen, Hermann, Harrington [1893 (the first, and with the exception of Ross the only one in this country)], Ross, Brosin, Dührssen, Zangenmeister (twice), Thomson and myself. My case is also noteworthy in that she was in each case under the care of the same physician as well as of the same surgeon. In this case the diagnosis was naturally easy with the history of the first ectopic gestation to aid us, and I would emphasize the importance of a previous extra-uterine pregnancy as rendering more probable the recurrence of the condition should in a second suspicious attack any or most of the classical symptoms be wanting.

A patient who has been operated upon for extra-uterine pregnancy and in whom the other ovary has not been removed should be carefully warned of the extreme importance of reporting herself to her medical attendant should she go a single day over her normal period. The earlier the diagnosis can be made the better are the chances for the patient, and in a case in which extra-uterine pregnancy is suspected before rupture has occurred, the fact that the patient

had previously been operated upon for this condition would with me turn the scale in favor of immediate operation. I feel that nothing is gained by waiting for symptoms to develop. The removal of a tubal pregnancy before rupture of the sac offers no dangers in comparison to an operation after rupture has taken place with probable inflammatory results.

With the history of this case in view we are met with the question of whether or no it is the surgeon's duty in operating upon an extra-uterine pregnancy to remove the other tube or not, lest it later become the seat of another ectopic gestation. This question cannot be answered offhand, as many writers have done, that the other tube should be removed. Of course it by no means follows that pregnancy will ever take place in the other tube, although it is probable that the same conditions that produced a tubal pregnancy in the one tube also exist in the other. Any greater degree of mutilation than is necessary should be avoided. Should the woman be a nullipara (which is the case in about 1 case in 5 of extra-uterine pregnancies), and children be greatly desired, we should at least leave her to decide (should she be in condition to do so) whether she is willing to run the risks of a second extra-uterine pregnancy on the bare chance of giving birth to a living child. We can encourage her by citing the cases of Tait and Kokman, in each of which a normal pregnancy intervened between two tubal ones, and that of Dührssen, who reports 2 cases of normal pregnancy after operation for extra-uterine.²

It is, of course, possible that should the extra-uterine pregnancy be due to kinks, etc., in the tube, caused by inflammatory adhesions, as, according to most writers (Virchow, etc.), is generally the case, they may exist only on one side, or if bilateral they may in the course of the manipulations incident to the removal of the one tube be so broken up as to permit the free passage of ova from the ovary to the uterus. Our willingness to leave the other tube may, however, be modified by other considerations. Inflammatory bands which we may possibly break up satisfactorily are not the only causes of extra-uterine pregnancy. It may also be caused, according to Freund, by the persistence of the infantile convolutions, or by diverticula in the tube, or, according to Klob, in a failure in the normal peristaltic wave towards the uterus, or even in default of other cause upon which we can lay our finger, to a failure in the proper working of the cilia lining the tube due possibly to a catarrhal salpingitis. To be sure Webster argues very ingeniously that the site at which pregnancy takes place in these cases is determined by its being the seat of greatest receptivity—showing the greatest decidua reaction—probably because of some fault in development, but I think most observers still cling to mechanical causes as the most plausible explanation of ectopic gestation. Such cause may or may not be amenable to treatment; the tube may possibly be laid open and curetted and straightened out if necessary or diseased portions resected. A case of mine shows well to what an extent plastic operations upon the tube are feasible:

R. G., twenty-two, one child two years previously; ill since then. In June, 1898, I resected a cyst the size of a small orange from the left ovary, together with about a third of that organ, and after removing the outer half of the catarrhal and cystic left tube

built a new ostium for it by suturing its mucous membrane to the peritoneum and divided the various peritoneal bands that bound it down so as to leave what was left of it a straight tube instead of being much twisted and kinked. The remnant of the ovary was stitched close to the ostium. On the other side the tube was apparently perfectly normal at its two extremities, but in its middle for the distance of an inch and one-half it was much thickened, convoluted and entirely impervious. This impervious portion was excised and the small proximal end of the cut tube introduced into the lumen of the larger distal part, and the peritoneal coats stitched together with two anchoring sutures from the proximal end running up through the wall of the distal part of the tube from within. Five small cysts of the right ovary were punctured with the cautery, and a ventrosuspension completed the operation. About a year later she became pregnant and last month gave birth to a child at St. Elizabeth's Hospital.

The question of the treatment of the other appendages, then, must in each case stand by itself, and the surgeon must decide from the conditions present whether he is willing to allow the patient, even knowingly, to run the risks of another extra-uterine pregnancy. In my case the tube that I left in the first operation had certainly no macroscopical appearances that would have suggested its likelihood to become the seat of another ectopic gestation. Should, however, it seem best to remove the other tube I would urge that at least one ovary be preserved, or a part of it, to avoid the discomforts of the premature menopause.

This case is also I think of some interest as bearing upon the vexed question of whether to approach an ectopic pregnancy in the early weeks from below or from above. In the first operation I had to abandon the vaginal route on account of free hemorrhage, stirred up by possibly unskillful manipulations. Be that as it may, I found I had to open the abdomen to stop the bleeding. In general terms I would confine the vaginal operation to women with a large pelvis, yet even in them should there be urgent symptoms of active hemorrhage I should personally prefer the abdominal route, being confident that with the aid of the eye I should be able to find the source of the bleeding and control it much sooner than if working in the dark. Under some conditions every drop of blood saved is of value. When the diagnosis has been made before rupture the vaginal route may have its advantages, and after rupture, when actual suppuration has taken place, it lessens the risk of sepsis and therefore may be preferable, especially as in such late cases the danger of active hemorrhage is not so very great, but even then I think that in every case of extra-uterine pregnancy in which the operator prefers to begin by the vaginal route he will be extremely wise to have everything ready for a celiotomy in case he should find it necessary to abandon the vagina in a hurry, and a celiotomy without proper preparation is not conducive to a surgeon's peace of mind.

REFERENCES.

- Abel. *Arch. f. Gyn.*, 1893, xlv, 35.
Beck. *American Journal of Obstetrics*, 1893, xxvii, 570.
Bennington. *Medical Press and Circular*, 1884, N. S., lxi, 303.
Brosin. *Centrl. f. Gyn.*, 1896, 807.
Dührssen. *Arch. f. Gyn.*, 1897, 259.
Falk. *Zeitschr. f. Geb.*, 1898, 404.
Ferguson. *Edinburgh Medical Journal*, 1899, 145.

² Cf. Schroder: *Lehrb. f. Geb.*, 1891, S. 61.

Frankenthal. *American Gynecological and Obstetrical Journal*, 1896, ix, 297.
 Harrington. *Boston Medical and Surgical Journal*, 1894, cxxx, 6.
 Hermann. *British Medical Journal*, 1888, i, 1152; 1890, ii, 722.
 Kokman. *Centrbl. f. Gyn.*, 1897, 1221.
 Olhausen. *Deutsch. med. Woch.*, 1890, 174.
 Ross. *American Journal of Obstetrics*, 1896, 234.
 Schoolfield. *Loc. cit.*, 1898, 270.
 Tait. *British Medical Journal*, 1888, 1001.
 Thomson. *Centrbl. f. Gyn.*, 1900, 189.
 Winckel. *Verhandl. d. deutsch. Gesellsch. f. Gyn.*, 1888, ii, 82.
 Zangenmeister. *Zeitschr. f. Geb.*, 1898, 404.

THE MORTALITY OF HYSTERECTOMY FOR FIBROIDS.¹

BY F. H. DAVENPORT, M.D., BOSTON.

THE question of the mortality of any operative procedure has an important bearing upon the advice we give a patient who consults us for the relief of disease. It modifies very materially the advice given. How important it is, depends upon the character of the disease present, as, for instance, in the case of ovarian tumors, where the outlook, if nothing is done for the patient, is absolutely unfavorable. In such cases we are therefore justified in taking great risks for the sake of cure. That was the state of affairs from twenty-five to fifty years ago, when abdominal operations were in their infancy. Then, even though the physician could not assure his patient that the operation was practically without risk, as he can today, he could still urge it, knowing that the risk of the operation was less than from the disease left untreated. The same is true of cancer today. Any operative measure, however severe, which holds out the least chance of success is to be advised.

The case stands differently with fibroid tumors. In themselves they are benign, that is, they do not necessarily endanger life. In their early stages they rarely give rise to any serious symptoms except hemorrhage, and even when they attain considerable size the symptoms may be unimportant. The frequency of their occurrence, their slow growth and the fact that in a large proportion of them hemorrhage is not an essential feature, has, in my opinion, led the profession to put too light an estimate upon their importance. The fact, too, that the operative measures for their removal were in the early stages of operative work accompanied by a considerable mortality has led to a very conservative course of action on the part of a good many surgeons. It could not fail to have a marked effect upon the opinion of the profession when so prominent an abdominal surgeon as Dr. Keith, of Edinburgh, only ten or eleven years ago, made the following statement: "Hysterectomy is a hazardous operation for the removal of a tumor that of itself rarely shortens life. For myself I have always had grave doubts if I were justified in performing such operations at all, especially hysterectomy, for the mortality attending this operation is out of all proportion to the natural history mortality of uterine tumors, and the results of it are out of all proportion to the benefits received by the few." These sentiments expressed the grounds which led Dr. Keith to abandon all operative treatment of fibroids in favor of the electrical treatment after the method of Apostoli, of Paris. There is no question but that the technique of hysterectomy has made great strides in the last de-

cade, and yet the mortality even then must have been, in the hands of Dr. Keith, a comparatively small one. He speaks of a fibroid tumor as one that of itself rarely shortens life. It seems strange that an observer of so large an experience could look upon fibroid tumors as such innocent affairs. In a series of cases, such as would naturally fall under the observation of a practising gynecologist, there must occur a certain number which would clearly demonstrate that fibroid tumors bring with them distinct dangers and not infrequently threaten life.

Before discussing the question of the mortality of hysterectomy for fibroid tumors, I desire to point out causes of danger which are operative in case the tumor is left alone. These are, first, hemorrhage. This may become a source of danger no matter what the size of the tumor, and it not infrequently happens that insidiously, and almost unconsciously on the part of the patient, a condition of anemia is produced which may affect the prognosis in case of operation, or exceptionally may be fatal. The second cause is the size of the tumor. A large tumor may so press upon the other abdominal organs as to induce serious disease. A third cause is death of a part of the tumor, from what is known as anemic necrosis. A fourth cause is the development of malignant disease in connection with the fibroid. It may be said that these are rare conditions, so rare that they need not really enter into the calculation in considering the prognosis of these tumors, yet, as will be seen later, they are found too often to be ignored. In the light of the occurrence of these various conditions, it seems almost absurd to speak of a fibroid as almost never shortening life. Such being the case with regard to these tumors if left to themselves, is it not our duty to revise our opinions with regard to their early removal? It is just here that the question of the mortality of operative measures is of importance. If, with the improved methods of operating now at our command, it can be shown that the mortality, if the operation is done in the early stages and at a time which the operator can select, is practically nil, should not we advise our patients to submit to such operation, and get rid of a condition which has such very serious possibilities if left to itself? In order to see what bearing my own statistics have upon this question, I have looked over the cases of hysterectomy for fibroids occurring in the last 100 abdominal operations which I have done for all conditions. I find that they number 19. This comprises both small and large tumors, and of these 19 cases 2 died. Both of these cases were large tumors which had existed for a great many years, and which presumably could have been successfully removed if taken earlier. The histories of these cases show some very interesting points.

CASE I. Mrs. A., fifty-two years old, married, two children, consulted me in July, 1898, for an abdominal tumor which began on the right side about twenty years ago. It grew slowly, but about six years previous to my seeing her had become so large as to occasion her a great deal of annoyance from its size and weight. She then placed herself under the care of an irregular practitioner, who promised her that he could cure her by such simple measures as massage, electricity and tampons. For six years she faithfully continued the treatment advised, all the time being buoyed up with the hope of relief which was always promised, yet all the time conscious that the tumor

¹ Read before the Suffolk District Medical Society, Section for Obstetrics and Diseases of Women, March 28, 1900.