of tissue resembling boiled sago. I could not empty nor get out the growth.

As the uterus was too large to be pulled through the vagina, I decided to do a double operation, and as I did not want to put my hands into the abdomen, after working in the vagina, I asked Dr. Mixer to open the abdomen and remove the tumor, after I had separated its attachments to the bladder and rectum by vaginal hysterectomy. Accordingly I proceeded as if I expected to remove the tumor through the vagina, and when I had separated the uterus from the bladder in front and from the rectum behind, and had clamped the broad ligaments from below, Dr. Mixer opened the abdomen and delivered the tumor, separating what attachments I had been unable to reach, owing to the size of the tumor and the smallness of the vagina. There was but little bleeding.

I think the removal of this tumor in any other way would have been well-nigh impossible.

Dr. Whitney made the following report on the tumor:

"The uterus measured eight centimetres internally, and the walls were four centimetres thick. From the interior hung polypoid projections — the ends of many of these were sloughing. The wall of the uterus could be divided into two layers, an inner, measuring about two centimetres, and filled with numerous small cysts containing a clear fluid. The outer layer, also of equal thickness, represented the muscular wall of the uterus.

"Microscopic examination showed the inner layer to be formed of numerous cysts with smooth walls, separated by a fibrous tissue framework. In this were also to be found tubular glands covered with large cylindrical epithelium.

"As far as the examination has gone, it points to the growth as a malignant lymphangiectatic fibrous adenoma.

"The relations of the cystic to the muscular wall are well seen in the frozen section stained green, and placed in the bottle which accompanies this report."

THE REMAINS OF A BROKEN LEAD-PENCIL (SURROUNDED BY PHOSPHATIC DEPOSITS); AND THE METAL TIP OF THE PENCIL REMOVED FROM THE BLADDER BY PERINEAL SECTION.

BY GEO. H. MONKS, M.D., BOSTON.

LAST spring a patient came under my care in the surgical wards of the Carney Hospital, with a violent cystitis resulting, as he said, from the presence of a lead-pencil in the bladder. He stated that sometime during the preceding October he had pushed a lead-pencil into his urethra for the purpose of "opening the passage for his water to run." He declared that he had suffered with stricture, and that he had introduced the pencil after a vain attempt to urinate. The patient was rather stupid, and he would not or could not give a very satisfactory account of the affair.

The pencil, when introduced, was between three and four inches in length. It was an ordinary lead-pencil, with a piece of rubber attached to one end, while the other was bluntly pointed. The rubber was kept in place by a metal collar.

In some unexplained way the pencil, while in the

* This patient died on the fourth day. There was no autopsy.

urethra, escaped from the patient's grasp, and managed to slip into the bladder: — a circumstance which renders the story of the stricture extremely improbable.

Shortly after this, the patient was obliged to seek surgical assistance on account of the intense pain, violent tenesmus and frequent desire to micturate, which resulted. He said that he had been twice etherized and operated upon, and that he was told after the operations that attempts had been made to remove the pencil through the urethra, that the pencil had been crushed and several fragments removed, including the rubber tip, and that the nickel collar still remained in the bladder, with possibly a few fragments of the pencil itself.¹

Months went by until the patient came to the Carney Hospital. This was in April. He was suffering tortures from pain and tenesmus. The urine was filled with sediment, and its odor was foul. A foreign body, — it seemed like a stone, — was readily detected by the searcher, and it was decided to do perineal section. On April 12th, the patient being under ether, I opened the bladder by the perineal route, the incision being made upon a staff and in the median line.

With my forefinger pushed well into the wound I could feel the foreign body; it was rough on the outside like a stone. Owing to the depth of the perineum I had some difficulty in catching the body with forceps and extracting it.

At last I was successful and it was removed. It was a little over two inches long (see Fig. B), was slightly curved and appeared to consist principally of phosphatic deposit. A considerable piece of macerated wood protruded from one end, while the other end was smooth and was moulded into a blunt point. During further examination of the bladder the metal collar was found and removed. This collar (see Fig. A) was distorted, its shape suggesting that of a cocked-hat; and from one end projected macerated wood. The thread on the collar was quite distinct. The cut represents the two bodies in their actual size.

The bladder was thoroughly washed out, a drainage-tube inserted and a T-bandage applied.

The patient's recovery was rapid and uninterrupted. The bladder was washed out daily with antiseptic so-

¹ I subsequently learned from the surgeon in charge of the case that his intention had been to make an opening into the bladder later, and remove the metal collar, but that the patient would not submit to another operation and had disappeared.

lutions, and all signs of cystitis gradually disappeared. The perineal wound healed rapidly and urine began to flow through the penile urethra. About three weeks after the operation the patient left the hospital with a small perineal opening, through which occasionally escaped a few drops of urine.

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The larger specimen was evidently a heavy phosphate deposit about a nucleus of macerated pencil-wood, part of which I have already mentioned as protruding from one end of the mass. The smooth, blunt point at the other end was of such shape as to suggest that it had rested either in a pocket or in the internal meatus of the urethra.

Prof. E. S. Wood, to whom the specimen was shown, was inclined to think that the body lay on the floor of the bladder with its convexity downwards, and that the blunt-pointed extremity rested in a pouch, probably behind the prostate.

The distorted shape of the metal collar, already referred to, suggested that it had been squeezed and flattened at its two extremities by the powerful jaws of the lithotrite, but that, *unfortunately for extraction*, this flattening had been made in different diameters at the two ends, thus making a body whose smallest diameter was too large to permit its extraction through the ordinary urethral tubes.

It would seem that the operation of crushing and washing should be restricted to the removal of calculi and of such substances as will, when crushed, break up into separate fragments, of a size and shape such as will readily engage the tube and pass through it; and that all other bodies should be removed by an immediate opening into the bladder.

I should not neglect to mention that the bodies, at the time of their removal, were very foul smelling. They were kept for three days in fresh running water, and even at the end of that time, the odor about them was distinctly perceptible.

FIVE CASES OF LAPAROTOMY FOR PELVIC ABSCESS.

PERFORMED BY DR. J. C. WARREN,
Surgeon at the Massachusetts General Hospital.

REPORTED BY HARDY PHIPPEN, M.D.,
Formerly Surgical Internist.

THE following five cases of laparotomy, all occurring during a few months, at the Massachusetts General Hospital, in the service of Dr. John Collins Warren, may be found of interest in showing the obscurity of diagnosis in three cases of tubercular peritonitis, associated with acute pelvic inflammation, and the tendency to cure after operation.

The two cases of simple pelvic inflammation, one with a favorable outcome, the other fatal, are for convenience classed with the others. The successful case making with the three tubercular ones a group of four, in which the sinus formed when drainage was established, continued to discharge for several months after the operation.

The first case is one of tubercular peritonitis, undoubtedly of pelvic origin, and of at least one year's duration. The tubercular element in this case, which was not accompanied by an increased amount of fluid, was not suspected until discovered at the time of an

operation for encysted peritonitis of the right side of the pelvis. The result in this case has been good, the patient being in excellent condition eighteen months after the operation, in spite of the fact that the whole peritoneum, as far as seen, was studded with tubercles, while the history of an attack of pleurisy while the patient was under observation, might point to the extension of the same process through the diaphragm.

R. A., unmarried, twenty-seven years old, entered the hospital February 10, 1888. Her family showed no tubercular tendency. Her own health had been always good with no unusual abdominal or pelvic symptoms. For two years she had been slowly losing weight and strength, but without any localizing symptoms. This had finally culminated in two attacks of very profuse menstruation, the second of which brought her to the hospital.

A poorly developed, poorly nourished woman was found. The chest was normal, the abdomen somewhat distended, but containing no free fluid. There was some diarrhoea. A well-defined area of dulness, very tender on pressure, was found in the right iliac region. The uterus was not movable, and there could be felt at the right of the uterus a thickening. The temperature was 102° F., the pulse 112.

The patient remained under medical treatment for two months. The urine at first comparatively clear, later contained large quantities of pus, accompanied by a fall in the temperature and a gradual improvement in the general condition. The patient was at the end of this time discharged in fair condition, with normal temperature and pulse, perfectly clear urine and no abdominal tenderness, but with a thickened mass still to be felt at the right of the uterus. During this time there had been no symptoms pointing to the general abdominal cavity, but there had been an intercurrent attack of pleurisy of the lower left chest.

The same patient was admitted eight months later. There had been pain in the former seat at every menstruation since her discharge. The condition now was bad. The temperature 102.8°, the pulse 112. Fluctuation in the right iliac region was very clear, and there was some general abdominal distention. The patient was operated on December 15, 1888. An incision in the median line showed the intestines everywhere matted together and thickly studded with gray and yellowish tubercles, varying in size from miliary tubercles to those more cheesy in appearance, as large as peas. A few of these removed, showed the characteristic appearance of tubercles. There was no excess in the amount of free fluid. On separating the adhesions between a few coils of small intestines of the right side, a cavity containing about a pint of very foul pus was directly opened into. This cavity was cleaned with warm water, and a drainage-tube put in; the general peritoneal cavity was closed.

The recovery in this case was excellent. The discharge, at first profuse, soon diminished. The tube was removed at the end of a month, but the sinus still discharged.

Eighteen months from the time of the operation the woman was seen. She was in excellent condition, had married, but not been pregnant. The chest was normal. There were no symptoms whatever of any abdominal or pelvic trouble. The old sinus continued to discharge for ten months after the operation. Just above this sinus there was now a small ventral hernia.

The second case is one in which symptoms were