10 cms., which will be extruded through the os uteri when the cervix is practically fully dilated.

These bags are made of a fairly heavy, good quality of soft rubber and can be folded within the grasp of a uterine dressing forceps, so that the bag can be introduced through a cervix which will admit the index finger. The quality of the rubber will permit of the attachment of a weight to the extending tube in appropriate cases.

AN UNUSUAL CASE OF EXTRAUTERINE PREGNANCY

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EXTRAUTERINE gestation is such a common condition or disease, that, ordinarily, one might feel like apologizing for presenting this report. However, I feel that this case is so unusual and so atypical, that it is worthy of record.

This patient had the usual signs of pregnancy and felt the fetal movements. These, without the usual evidence that accompanies tubal rupture, suddenly ceased between seven and one-half and eight months of the pregnancy. Outside of the presence of an abdominal tumor, she enjoyed good health, and one year subsequently, gave birth to a full term, living child. Her pregnancy and labor were normal in every way.

She subsequently gave birth to four children, two of whom were born dead. There was no history of any abnormality during these pregnancies or labors.

On admission to the hospital, she complained of frequent urination and the presence of an abdominal tumor. Her menses began when she was thirteen years of age, and had been regular except during her pregnancies. She was married August 9, 1909.

In January, 1912, she had an attack of nausea and vomiting associated with a noticeable weakness. When her family physician arrived, he noticed that she was pulseless and appeared to be in a very weakened condition. A few hours after this, she noticed pain, which radiated to the shoulder, in the left upper abdomen. She was in bed for two months following this experience. She was troubled with cramping pains after eating and felt weak, but recovered from this attack gradually and appeared as well as ever. Her periods up to this time had been perfectly normal in every way. Did the tubal rupture occur at this time?

In February, 1912, she noticed a partial cessation of the menses, the flow at this time being very scant. Experiencing no morning sickness, she thought that she had a normal pregnancy and felt fetal movements in May, 1912. During May, she experienced a rather severe pain in the left upper abdomen. This pain radiated to the shoulder. She thought that she had miscarried, although there had been no flow and no evidence of abortion. Her physician assured her that was not the case, as there were no symptoms of this condition.

These symptoms ceased and the pregnancy proceeded without any complication until August, 1912, when she failed to feel the movements of the child. There were no pains or unusual symptoms at this time. She had observed that the abdomen had increased in size as it would in a normal pregnancy. After the cessa-

tion of the fetal movements, she thought that the child would be born and waited for its birth.

In September, 1912, having been examined by her physician who noted that there were no movements, no fetal heart sounds, no dilatation of the cervix, and thinking she might have a tubal pregnancy, he advised operation, but she did not follow this advice.

She continued to feel well and had no untoward symptoms of any kind. The abdomen did not increase in size to any noticeable extent, and after a year it began to decrease. She experienced some pain in the right lower quadrant, which was more noticeable when she was lying on the right side.

The bowels and urination were normal, except for a slight urinary frequency which she had experienced throughout her life. The abdominal mass was about the size of a double fist, and seemed to be in the right lower quadrant, near the midline.

On August 12, 1913, she gave birth to a normal, living child, weighing six pounds. The labor lasted for two hours and was easy and normal. The pregnancy had been normal with no complications of any kind. There was no laceration. The child was delivered alive and is living at the present time. She was in bed for two weeks following her labor, had no chills or fever, and made an uneventful recovery.

A second living child was born sixteen months later. There was no complication throughout the pregnancy and the labor was normal, lasting three hours. There were no complications, chills or fever following delivery.

Following this, she had one miscarriage at three months with no untoward symptoms.

The third labor was in June, 1919. The child was stillborn at eight months. The mother ceased to feel life two months prior to delivery. The labor was easy, spontaneous, and without laceration. The child appeared normal and the puerperium was normal. She miscarried again at three months.

The fourth child was born in January, 1920, an eight months' baby, born dead. It appeared normal. Life had been felt up to one week prior to delivery. At this labor she experienced more pain than she had in the previous ones. The labor lasted three hours and there was a slight laceration. She had no chills or fever following. She has not been pregnant since.

Her weight at marriage in 1909 was 130 pounds, and in 1919, she weighed 160 pounds. At the time of her examination, October 3, 1921, she weighed 100¾ pounds.

On admission, the patient gave a history of having frequent, painful urination for the past six months, and at the time of the examination, she was urinating every two hours during the day and night. She had noticed no blood or pus in the urine. For the last three or four months she had noticed that every time she voided, the bowels would move, or there would be considerable straining. There were no bloody or abnormal stools and they varied in amount from a small to a normal quantity.

She complained of what she thought was a slight prolapsus of the uterus. One year ago she had a colic-like attack of abdominal pain which subsided after a few days. There was a moderate amount of whitish vaginal discharge which was non-irritating. She had belching and bloating at times, lumbar backache was noticeable in the morning, and pain in the right lower quadrant, which was variable in severity, but never agonizing. She thought there was an obstruction in the rectum, as it troubled her when her bowels moved. She had lost fifty pounds in the last year and a half. She felt weak, but otherwise, the history was negative.

The examination showed a poorly nourished woman with a small amount of subcutaneous fat. The height five feet and six inches, pulse 116, temperature 99.6° F. blood pressure 110-68. The abdomen was distended, the muscle tone increased on the right, no hernia, tympany in both flanks. There was a distinct suprapubic mass, the superior surface of the mass being on a level about midway between the navel and the symphysis. The perineum was relaxed, the vaginal mucous membrane pale, the uterus in anterior position and deviated to the right.

A firm, croquet-ball sized tumor was firmly attached to the left of the uterus, causing considerable pain upon examination. It was fixed and immovable. It was rather irregular and hard like a myoma. No crepitus was elicited. Rectal examination was very painful and the mass felt irregular to the examining finger.

The husband inquired if this tumor could be an extrauterine fetus. I felt that it was not possible for a woman to give birth to four full term children without trouble and have an extrauterine fetus as large as this mass appeared to be, and I believed the tumor to be a myoma. The tubes and ovaries could not be palpated.

The blood Wassermann test was negative, white blood cells, 8,750, polynuclears 82, lymphocytes, 18, urine, negative.

A median suprapubic incision was made, about eight inches long. On opening the abdomen, the peritoneum in front of the bladder and uterus was pulled up and attached to a mass of loops of small bowel and the sigmoid colon. The intraperitoneal space in front of the bladder and uterus was obliterated. At the point where the peritoneum, mass and coils of bowel met, there was a stellate scar appearance, which made one feel as if he might be dealing with a carcinoma of the large bowel. It was possible to introduce the hand behind the uterus and broad ligament on the right side. The culdesac was not obliterated. The right tube and ovary were normal. On the left side, however, the mass and intestines blocked the way for any entrance into the culdesac. The uterus was about the size of a Bartlett pear, and was pushed to the right and backward by the mass in the left broad ligament.

On attempting to dissect the bladder from the mass, it was opened. A finger was introduced and the bladder dissected loose and then sutured. My dissection had opened a cavity from which a very foul odor emanated. I found the cranial bones of a fetus buried slightly below the surface of the capsule of the mass. The abdominal cavity had been completely walled off and the opening into the sac was enlarged and it was found to contain the bones of the fetus and a large amount (several ounces) of foul smelling, milky colored fluid.

The fluid was evacuated, the bones removed and the sac swabbed out with pure phenol followed by alcohol. Several of the bones were embedded in the walls of the sac and had to be dug out. Although there was no evidence of intestinal perforation at this time, this subsequently, appeared to have occurred. The cavity was about the size of a large grape fruit.

On account of the dense adhesions of the bowels and the structures of the pelvis, and the probable presence of infection, the peritoneal cavity was closed above the sac and the cavity of the sac was packed with iodoform gauze and a rubber drainage tube inserted. This brought the packing and whatever discharge might occur, extraperitoneally. At the close of the operation, a catheter was passed into the bladder and the urine was slightly blood streaked.

The patient showed no evidence of shock and was returned to her room in good condition. She was then given one pint of 5 per cent glucose and 5 per cent sodium bicarbonate solutions per rectum.

On removing the iodoform packing, about thirty-six hours after the operation,

fecal matter was observed coming from the cavity. This did not cause any particular trouble, gradually becoming less and less. She had some trouble in emptying her bladder for a few days. She was catheterized and irrigated with one to two thousand silver nitrate solution, and this condition rapidly improved.

A small sinus discharging fecal matter persisted, and on January 14, 1922, the abdomen was reopened and the sinus carefully dissected down to the sac of the previous operation. The sac had contracted to about the size of a lemon. It was thick walled and attached to the bladder, lateral pelvis and the pelvic colon. There were no adhesions except those immediately about the sac. A small opening was

FIG. 1.—Photograph of skeletonized extrauterine fetus, removed nine years after rupture of sac.

found extending from the upper part of the sac into the pelvic colon. This was closed with silk and the abdomen closed with drainage down to the peritoneum. She made a very nice recovery. A recent report shows that she is perfectly well.

The bones of the fetus were entirely clean of all tissue. My colleague, Dr. Kernodle, has made a rather remarkable assembly of them as the accompanying photograph (Fig. 1) will readily show. It measures seventeen inches in height, and apparently represents the size of a fetus at seven and one-half to eight months' pregnancy.

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