belief substantially true. The worst that can be said of the therapeutic inoculation of bacterial vaccines controlled by the opsonic index is that the methods are laborious, but what of that if good results, not to be got otherwise, are obtained? In estimating the merits of this method of treating infectious disease it must be remembered that we are striving after an ideal effect, and that the nearer we approximate thereto the better will be our results. Also that this ideal, which is to keep the blood and body fluids continuously supplied with an increased amount of protective substances, cannot be even approximately reached without conscientious care and much labour. As our experience increases and our knowledge of disease and immunity grows greater, improvement in method with lessening of labour must come. It may be that an easier plan of following the immunising process will be devised, but the essential principle of the treatment will remain and be in the years to come a powerful factor in Practical Medicine.

ART. VII.—*Report of the Rotunda Hospital.* By E. HASTINGS TWEEDY, F.R.C.P.I. (Master); ARTHUR HOLMES, M.B., B.Ch., B.A.O.; and ROBERT J. ROWLETTE, M.D.

(Continued from page 110.)

TABLE NO. V.—*Continued.*

Name	Age and Para	Date	Variety	Treatment	Result to Mother	Result to Child	REMARKS
S. M.	21, I.	1906 May 21	External	Plugged	Recovery	Dead	8 months' child. Delivery followed plugging 3½ hours. Adherent placenta. Manual removal.
A. L.	26, III.	July 1	„	Rupture of membranes	„	„	Patient in strong labour. Free hæmorrhage. Membranes tough and very protruding.
M. R.	24, III.	„ 15	„	Tight binder and forceps	„	„	Patient admitted blanched and with air-hunger. Full term.
M.E.M.	35, XI.	Aug. 8	Concealed	Plugged and tight binder	Death	„	Vide mortality table (Maternal). No. VI.

TABLE NO. VI.—*Placenta Prævia.*

Name	Age and Para	Variety	Period	Result to Mother	Result to Child	Presentation	REMARKS
M. K.	37, X.	Marginal	8th month	Recovery	D.	Vertex	Version. Delivery in 19 mins.
M. M.	25, II.	Central	Term	„	„	„	Version. Irregular hæmorrhage for four weeks.
E. C.	40, II.	„	„	Death	„	„	Version. Vide mortality (maternal) No. II.
J. C.	32, V.	Marginal	8th month	Recovery	A.	„	Patient in strong labour. Portion of placenta in vagina. Nothing done.
L. G.	23, II.	Lateral?	Term	„	D.	„	Portion of placenta in front of head at birth. In strong labour. Nothing done.
M. M.	23, I.	Central	7th month	„	A.	„	Admitted plugged; the plugs removed; no hæmorrhage. Version performed. Delivery in five hours. Placenta battledore.

TABLE NO. VII.—*Contracted Pelves.*

Name	Age	Para	Pelvic Measurements				Mode of Delivery	Result to Child	REMARKS
			C. V.	Trans.	Ext. C.	I.-C.			
M. H.	30	II.	8	13	15	28	25	Alive	Second operation.
S. F.	34	III.	7	11.5	20	27	28	Dead	Induction at 36th week; second time.
M. K.	43	XI.	6	11.5	18	31	29	Alive	Induction, 37th week; 8th time.
M. G.	22	II.	8	13	—	—	—	Alive	Symphysiotomy performed previously.
E. K.	27	III.	9	11.5	18.5	29	27	Dead	Induction, 39th week; 3rd induction.
M. W.	27	II.	7.2	—	18	28	26	Alive	Labour prolonged for 20 hours; previous confinement normal.
S. M.	23	III.	7.2	13	18	31	31	Dead	Labour induced, 37th week; head did not fix, so podalic version was done.
T. M.	28	III.	7	12	17	27	27	Dead	Induction, 28th week; breach presentation. Previous labours, 1st term, forceps; 2nd term, version.
J. F.	24	III.	7.7	11.2	20.5	28	27	Alive	Induction, 38th week; prolapse of cord. Previous labours, term, forceps; both children dead.
M. P.	16	I.	8	11.5	19	25	25	Alive	Face presentation.
L. K.	21	I.	6.8	—	15.5	26	24.5	Alive	Prolonged labour; small head, which moulded well.
G. L.	27	I.	7	11	20	27	26.5	Alive	Induction, 32nd week; compound presentation, head and hand. Small child; weight, 4½ lbs.
M. T.	30	III.	7.5	10	17.5	24	24	Alive	Term, occipito-posterior. Dorsal curvature.

TABLE No. VIII.—*Forceps.*

Indication	No.	Dead Children	REMARKS
Delay in second stage, with danger to mother or child	34	3	One of the children was macerated.
Prolapse of cord	4	—	
Contracted pelvis	3	—	
Occipito-posterior	3	—	<i>Vide</i> contracted pelvis, Table No. VII.
Eclampsia	2	1	Os fully dilated, and head low down in both cases.
Induced labour	1	1	<i>Vide</i> E. K., contracted pelvis, Table No. VII.
Accidental hæmorrhage	2	1	<i>Vide</i> accidental hæmorrhage, Table No. V., K. C. & B. G.
Face presentation	1	—	Patient admitted from outside with a history of having been 68 hours in labour. <i>Vide</i> "Eclampsia" case No. 7, M. O'D.
Brow presentation	1	1	
Total	51	7	

SUB-TABLE A.—*Showing No. of Pregnancy.*

I.-para	-	-	-	36
II.-para	-	-	-	4
III.-para	-	-	-	4
IV.-para	-	-	-	1
V.-para and over	-	-	-	6
Total				51

SUB-TABLE B.—*Showing Ages of Patients.*

17-25	-	22
26-30	-	17
31-35	-	7
36 and over	-	5
Total	-	51

TABLE NO. IX. A.—*Morbidity.*

Estimation proposed by British Medical Association.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Total
Temp. was twice 100° or over, counting from the end of first 24 hours of the puerperium to 8th day, inclusive.	4.44	5.19	8.17	10.79	11.87	8.84	6.62	14.10	8.23	8.13	4.57	10.25	
Total percentage ...													8.43

TABLE NO. IX. B.—*Morbidity.*

Rotunda Estimation.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Total.
Temp. and Pulse over 99° and 90 for three consecutive takings between 2nd and 8th day.	2.22	3.25	5.72	3.52	5.00	6.80	6.07	5.76	4.11	4.06	1.71	3.84	
Total ...													4.33

TABLE NO. IX. C. — *Morbidity.*

	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Total.
Percentage of cases in which both estimations existed.	2.22	2.59	5.03	3.52	3.75	6.80	4.41	5.76	3.52	3.90	1.71	3.84	3.92

TABLE NO. IX. D.—*Comparison of Morbidities.*

PRIMIPARA.

	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Total
Percentage of morbidity occurring with primiparæ.	3.92	12.19	18.96	17.54	22.40	14.03	13.88	26.53	16.39	13.33	6.55	18.03	15.31

MULTIPARA.

	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Total
Percentage of morbidity occurring with X-para.	4.76	3.53	2.97	6.09	7.84	5.55	3.66	9.34	4.49	6.18	2.63	5.26	5.19

TABLE NO. IX. E.—*Causes of Morbidity other than Uterine.*

Breast abscess	...	...	...	2
„ inflamed	...	...	...	2
Constipation	...	...	...	7
Eclampsia	...	...	...	4
Influenza	...	...	...	5
Pneumonia	...	...	...	1
Puerperal ulcer	...	...	...	3
Hæmorrhoids	...	...	...	2
Typhoid	...	...	...	1
Urticaria Herpetiformis		...	...	1
Phlegmasia alba dolens		...	...	3
Alveolar Abscess	...	...	...	2
Total				34

TABLE NO IX. F.

Number of Lacerated Perinæums Showing Morbidity for Year.

English estimation	-	-	-	-	-	-	-	33
Rotunda	„	-	-	-	-	-	-	10
Both	„	-	-	-	-	-	-	23
Total,								71

Operative Cases Showing Morbidity.

Forceps (English, 3 ; Rotunda, 2 ; Both, 8)	-	-	-	-	-	13
Manual removals (English, 2 ; Rotunda, 1 ; Both 5)	-	-	-	-	-	8
Induction of labour (English, 1)	-	-	-	-	-	1
Abortion removal (English, 1)	-	-	-	-	-	1
Breech (English, 1 ; Both, 1)	-	-	-	-	-	2
Plugging for P.P.H. (Both, 1)	-	-	-	-	-	1
Total,						26

Of these morbid operative cases 8 were associated with lacerated perinæum.

TABLE NO. X.—*Maternal Mortality.*

Name	Admitted	Delivered	Died	Cause of death	Notes
A. H.	Mar. 3	Mar. 3	Mar. 4	Labour Shock	Placenta Prævia
E. C.	Mar. 16	Mar. 16	Mar. 16	Hæmorrhage	
E. N.	May 19	May 20	June 25	Pyæmia	
M. O'N.	June 24	June 25	July 13	Typhoid	Admitted with disease
M. K.	July 20	July 22	July 22	Labour Shock	Concealed Accidental
M. M.	Aug. 8	Aug. 8	Aug. 8	Hæmorrhage	
M. G.	Oct. 14	—	Oct. 14	Eclampsia	
E. H.	Oct. 27	Oct. 27	Oct. 27	Labour Shock	Post-partum

PATHOLOGICAL REPORT.

By ROBERT J. ROWLETTE, M.D.

THE work of the Pathological Laboratory has been, as heretofore, almost entirely in the field of clinical pathology, subservient to the ordinary work of the Hospital. It is concerned with both the Maternity and Gynæcological Wards, but chiefly with the latter. The number of specimens submitted for examination during the year is considerably in advance of that during the previous year. This increase is most marked in the specimens, such as curettings, submitted to obtain aid in diagnosis—eighty-four this year as compared with forty-four in nine months and a half of last year—and so, I believe, due to a growing recognition of the importance of microscopic examination in the diagnosis of morbid conditions.

The museum is gradually increasing, and will form, I hope, the nucleus of a collection of importance in the special field of gynæcological pathology.

Eight *post-mortem* examinations were made on the bodies of adult patients. Brief notes of these are appended :—

CASE I. (Gynæcological).—Eliza d'A. Death twenty-four hours after operation for carcinoma uteri. Autopsy partial. Only abnormal condition found—quantity of blood in peritoneal cavity.

CASE II. (Gynæcological).—Kathleen J., aged twenty years; died May 31, 1906, one week after exploratory operation on tumour of abdomen. Operation had revealed an inoperable mass adherent to the anterior abdominal wall from the umbilicus to the pubes. As it was impossible to attempt removal, the abdomen was closed.

At the autopsy, which was partial, the tumour was found to be the stomach, still adherent to the anterior abdominal wall and to the bladder. Its wall was thick, soft, pulpy, and white, the entire wall being affected. Internally, large flat ulcers were discovered. Secondary masses were present in the omentum.

Microscopically the tumour was found to be a columnar-celled carcinoma.

CASE III. (Maternity).—E. N., aged twenty-eight years. Death seven weeks after labour.

Heart normal.

Lungs.—Advanced phthisis in both lungs. Large hæmorrhagic infarcts in both lungs.

Spleen.—One large hæmorrhagic infarct.

Uterus firm, small, without any sign of inflammation. Small fragment of placenta in left cornu. Right uterine veins enlarged and thrombosed, thrombus stretching into right iliac vein.

Other organs healthy.

A pure culture of *B. coli* was obtained from the uterus and spleen, and *B. coli* and a diplococcus were separated from the lungs.

CASE IV. (Maternity).—O'N., aged twenty-one years. Died of typhoid fever (Widal test positive) three weeks after delivery.

Heart.—Small and pale.

Lungs.—Hypostatic congestion; slight broncho-pneumonia; old tubercle at left apex.

Liver.—Normal.

Spleen.—Normal, neither enlarged nor congested.

Intestines, Small.—Slight ulceration of Peyer's patches near ileo-cæcal valve.

Intestines, Large.—Extensive ulceration of cæcum and descending colon.

Mesenteric Glands.—Large and soft.

Uterus.—Firm and healthy, although containing a few shreds of adherent placenta.

CASE V. (Maternity).—Mary Ellen M., aged thirty-five years. Died immediately after delivery. Examination of brain only—entirely negative.

CASE VI. (Gynæcological).—Anna Maria M., aged sixty-three, observed August 24, 1906, while awaiting operation for myoma.

Lungs.—Healthy. A few old tubercles at both apices.

Heart.—Covered with fat. Muscle apparently healthy.

Abdomen.—Very marked effusion, nearly a gallon of fluid being present. Fluid is turbid and white.

Peritoneum.—Thick and leathery, with fibrinous exudate. Scattered adhesions.

Bladder.—Adherent to uterus.

Mesenteric Glands.—Enlarged.

Appendix.—Enlarged; internally red and ulcerating.

Spleen.—Small and pale.

Liver.—Pale.

Kidneys.—Healthy.

Uterus contains globular fibroid, five inches in diameter, in anterior wall. Cavity contains semi-purulent fluid.

Culture of *Diplococcus pneumoniae* from peritoneal fluid.

CASE VII. (Gynæcological).—M. B., aged thirty-six years, observed September 3, 1906, four days after myomectomy. *Post-mortem* four hours after death.

Heart.—Healthy.

Lungs.—Posterior bases congested. Otherwise healthy.

Abdomen.—Wound healthy and healing. A few ounces of blood-stained fluid in peritoneum. Blood clot size of fist at stump of uterus. Concretion in appendix.

No peritonitis.

Cultures from peritoneal fluid, from appendix, and from heart blood negative.

CASE VIII. (Maternity).—M. K., aged thirty years, primipara, died four and a half hours after the birth of child. Only pathological condition discovered—a slight rent, one and a half inches

long, in peritoneum covering back of uterus; the rent did not go deeper than the peritoneum.

For clinical references to Cases III., IV., V., VIII., see Clinical Report.

Curettings or other fragments were examined for purposes of diagnosis on 84 occasions :—

TABLE I.—EXAMINATIONS OF CURETTINGS OR OTHER
FRAGMENTS FOR PURPOSES OF DIAGNOSIS.

Endometritis	-	-	-	-	51
Congested endometrium	-	-	-	-	1
Placental remains	-	-	-	-	7
Squamous-celled carcinoma of cervix	-	-	-	-	2
„ „ vagina	-	-	-	-	1
„ „ vulva	-	-	-	-	1
Adeno-carcinoma of uterus	-	-	-	-	4
„ „ vagina (secondary)	-	-	-	-	1
Mucous polypus	-	-	-	-	1
Erosion of cervix	-	-	-	-	2
Syphilitic ulcer of vulva	-	-	-	-	1
Urethral caruncle	-	-	-	-	1
Tubercular peritonitis	-	-	-	-	1
Blood clot, debris, normal tissue, &c.	-	-	-	-	10
Total	-	-	-	-	84

In the above table all forms of endometritis have been grouped together. In attempting to classify them one is met by two great difficulties, one indeed dependent on the other. First, although many principles of classification have been put forward, there is none which has received general acceptance. Secondly, morbid conditions of the uterine mucous membrane do not fall into separate classes, distinct like watertight compartments. The same specimen presents most commonly several distinct variations from the normal, which it is impossible to sum under one descriptive title. In consequence, different observers, even when attempting to classify on the same principle, would furnish different tables of results from an examination of any given series of slides.

I therefore have to content myself with certain descriptive terms, recognising that as a principle of classification they would be logically inadmissible, since they are neither exhaustive nor inclusive. The name in each case merely states the most striking feature of the specimen :—

TABLE II.—CASES OF ENDOMETRITIS.

Hypertrophic or glandular (including cystic)	-	30
Interstitial	- - - - -	4
Simple	- - - - -	15
Polypoid	- - - - -	1
Hæmorrhagic	- - - - -	1
		—
Total	- - - - -	51

The term “*hypertrophic*” or “*glandular*” is applied to those specimens which show an undoubted increase of glandular tissue, whether the glands show dilatation or not. It will be seen that three-fifths of all the specimens fall under this head. Naturally, they present great variety. In some of them the glands are merely increased in number, but are quite normal in appearance. In others, there is a distinct proliferation of epithelium, forming tufts, protruding into the glands. In others, again, the glands show marked dilatation as if by the collection of secreted material.

These various forms have all been illustrated in Dr. Purefoy’s Clinical Report of the Hospital for 1902–3. In certain of the cases—three in number during the present year—the dilatation of the glands was of such a degree as to merit the classification “cystic endometritis.” This condition has been regarded by some as a distinct form of disease, and even as an intermediate stage between endometritis and malignant disease. It is true that the clinical features are somewhat distinctive, and in particular, recurrent hæmorrhage is a marked symptom. On the clinical side, therefore, there is often a suggestion of malignancy, and in the three cases under review, as well as in some other cases which have come under my notice, the question of malignancy was prominent in the mind of the physician in charge of the case. I do not at all

agree, however, that the condition is a step in a change towards malignancy. Malignant changes in the endometrium are marked by excessive epithelial proliferation and diminished function, whereas in cystic endometritis the epithelial growth rather lags behind in comparison to the amount of secretion. That the dilatation is due to an excessive secretion or to a blockage of the duct of the gland is suggested by the fact that the larger the cyst the flatter are the cells lining it. In the same section one finds all the stages between normal glands lined with columnar epithelium and cystic spaces lined with almost flat cells. In very few cases of genuine adenocarcinoma of the uterus have I seen any tendency towards cystic forms of gland.

The term "*interstitial*" has been applied to those specimens in which increase of the connective tissue was marked and change in the glands inconspicuous. The number of cases falling under this head was relatively small.

Fifteen cases are described as "*simple*," though the term is open to objection. The terms "*septic*" and "*diphtheritic*" have been applied by others to this condition. The noticeable feature is the inflammation varying greatly in degree, but unaccompanied by productive changes either in the glands or in the connective tissue. In some cases there is merely congestion of the part with some degree of leucocytic infiltration. In others the change is so severe as to produce necrosis, and the curetting may be a mass of necrotic material mixed with cellular exudate. All stages between these extremes are to be found.

One case is described as "*polypoid*." In it there was a marked increase of the superficial epithelium forming tufted polypoid projections. The epithelium, however, was so regular in its arrangement as to prohibit any thought of malignancy.

One case is described as "*hæmorrhagic*." In it no change was to be observed except the marked congestion and great infiltration of the tissues with blood. Of course, in many of the cases hæmorrhagic infiltration was noticeable, but in this case it was practically the only pathological condition present.

The diagnosis of adeno-carcinoma of the uterus from endometritis by examination of curettings is not always easy. The great majority of cases of endometritis, of course, convey no suggestion of malignancy. On the other hand, where a doubt rises, the condition is probably malignant. In two cases during the year from an examination of the curettings I could not go further than to say that there was a suggestion of cancer. Relying on the clinical signs the uterus was removed, and showed undoubted evidence of carcinoma. It is to be remembered that the change may be much more advanced at one part than another, and that even a careful curetting may fail to bring down fragments showing an advanced condition of disease.

Tumours and operation specimens were examined in ninety-one cases, as follows :—

TABLE III.—EXAMINATION OF TUMOURS AND OPERATION SPECIMENS.

Epithelioma of vulva	-	-	-	-	2
Adeno-carcinoma of vulva	-	-	-	-	1
Epithelioma of cervix	-	-	-	-	8
Adeno-carcinoma of uterus	-	-	-	-	5
Endothelioma of uterus	-	-	-	-	1
Fibro-myoma of uterus	-	-	-	-	26
Mucous polypus	-	-	-	-	6
Extra-uterine pregnancy	-	-	-	-	6
Pyosalpinx and salpingitis	-	-	-	-	8
Dermoid of ovary	-	-	-	-	3
Cyst of ovary	-	-	-	-	15
Carcinoma of ovary	-	-	-	-	2
Endothelioma of ovary	-	-	-	-	1
Fibroma of ovary	-	-	-	-	1
Cast from bladder	-	-	-	-	1
Abortion	-	-	-	-	1
Fibroma of groin	-	-	-	-	1
Fistulous tract	-	-	-	-	2
Adeno-carcinoma of breast	-	-	-	-	1
Total	-	-	-	-	91

There were some points of interest in the early history of one of the cases of epithelioma of the vulva. On the first occasion in which the patient presented herself there was a small, hard-based ulcer on the labium. Part of it was excised and examined. No evidence of epithelial infiltration could be found, but relying on the fibrosis and endarteritis which were present, I suggested that the ulcer might be syphilitic in origin. Under iodide treatment it disappeared, but seven months later the patient returned with a larger ulcer. Microscopic examination showed typical squamous cancer. I am at a loss to know whether this was a case of cancer developing in a syphilitic ulcer or if it was malignant from the beginning.

Adeno-carcinoma of the vulva, of which one case occurred, is by no means a common disease. It is supposed to originate in Bartholin's glands. The present tumour was about the size of an egg, occupying one labium. Microscopically it consisted of masses of epithelial cells, separated into groups by thin fibrous bands, the groups in some places being glandular in appearance. A secondary tumour, exactly similar in structure, was removed from the groin.

One of the cases of carcinoma of the uterus presented certain peculiarities. There was a definite patch of ulcerous growth on the wall of the vagina, which naturally attracted notice. A fragment submitted for examination revealed adeno-carcinomatous structure. A curettage fragment from the uterus showing similar pathological changes, the uterus and vagina were removed. The uterus was found to be extensively diseased, and some small nodular subserous fibroids were infiltrated. The case presents, therefore, three points of interest :—(1) The occurrence of adeno-carcinoma in a fibroid uterus ; (2) the infiltration of the fibroids by the disease ; (3) the implantation of the growth on the vaginal wall. A case exactly similar in the last particular is recorded by Cullen,^a and the picture he gives exactly represents the condition as we saw it.

In two of the five cases of adeno-carcinoma of the uterus

^a Cancer of the Uterus, London, 1900, p. 415, *et seq.*

there were fibroids present, whereas in none of the cases of epithelioma of the cervix were there fibroids. This proportion between adeno-carcinoma and fibroid is almost identical with that observed by Mr. Bland-Sutton, who in twenty-three cases of adeno-carcinoma found fibroids present in eight.^a

The specimen of endothelioma or perithelioma of the uterus showed the organ uniformly enlarged with some fibroid induration. Sections of the endometrium revealed nothing abnormal. Certain small nodules under the peritoneum, however, attracted attention. Microscopic examination of these, and of the serous surface generally, showed masses of fairly large flat cells, arranged in a somewhat columnar manner, and infiltrating the muscle bundles. This condition was quite general over the whole fundus, and can hardly be explained otherwise than as a malignant growth originating in the peritoneum.

Among the 26 fibroids met with, seven had undergone marked secondary changes. In several others there were minor degrees of œdema or slight cystic changes. Of the seven, five had undergone softening—grey necrobiosis, one red degeneration, and one sarcomatous metamorphosis.

Red degeneration is a comparatively rare condition, usually associated with pregnancy. In it the tissue turns a pink or deep red in colour, often presenting a close resemblance to raw beef-steak. The pigment is derived from broken-down blood corpuscles, and the change is probably due to a sudden stoppage of a rich blood-supply. In the present case the red coloration was slight. A much more extreme case was exhibited to the Obstetrical Section last December by Dr. Kinkead and myself.

The case of sarcomatous change in fibroids is of special interest, since the possibility of this condition has often been denied. In the present specimen several fibroids are to be seen. Some of them show no change except ordinary necrobiosis. The larger tumour at the fundus, however, was bright red in colour, and microscopically showed little trace of muscle or fibrous tissue. It consisted of mixed cells. The growth was infiltrating one broad ligament.

^a *Journal of Gynæcology of Obstetrics of the British Empire*, July, 1907.

Only three dermoids came under notice. In none of them was there other structure than skin, with an appended mass of hair and grease.

Two cases of carcinoma of the ovary occurred, differing considerably in type. One specimen (A. H.) is very large, some ten inches in diameter, and semi-solid. Part of it is like an ordinary multilocular ovarian cyst in appearance, but part presents a solid, though soft, mass. It is in this part that the malignancy is best marked; microscopically it consists of masses of irregular epithelial cells with little glandular arrangement.

In the other case (J. K.) the disease is bilateral and the specimens are much smaller, four or five inches in diameter. The tumours are quite solid, and microscopically have a close resemblance to the first case. The occurrence of two cases of carcinoma of the ovary out of eighteen tumours of the ovary is in support of recent researches in the pathology of the organ, and is an interesting comment on the view still held by some teachers on the rarity of the disease. In the new edition of his book on *Tumours* (p. 515), Mr. Bland-Sutton starts the discussion of carcinoma of the ovary with the remark—"Primary cancer of the ovary is a rare disease." This is not our experience at the Rotunda. Moreover, Norris, Leopold, and others have shown, by careful examination of ovarian cysts, that a much larger proportion of them than is generally supposed are, at any rate potentially, malignant.

Endothelioma of Ovary.—These specimens were from a girl of twenty-one, treated some weeks previously in a general hospital for ascites, regarded as due to tubercular peritonitis. The abdomen was opened in the Rotunda Hospital, and the peritoneum was found studded everywhere with small white nodules, not unlike tubercles. The ovaries, which were removed, presented a curious appearance. Each ovary was the site of origin of a papillomatous growth, somewhat resembling a bunch of grapes. The nodules varied in size from that of a pea to that of a grape, and each of them contained in the middle a small cyst-like cavity. Microscopically, the tissue was found to consist of large flat cells, with slight thread-like

stroma, the cells being indistinguishable from those of the peritoneum covering the tumours. The nodules scattered over the general peritoneal surface were of exactly similar structure. The tumours were regarded as endotheliomata, originating in the peritoneum. Their resemblance, microscopically, to the case described as "endothelioma of the uterus" was very marked.

TABLE IV.—BACTERIOLOGICAL EXAMINATION OF UTERINE LOCHIA IN TWENTY-FIVE MORBID CASES, SHOWING THE ORGANISMS ISOLATED OR OBSERVED.

Diplococcus A	-	-	-	-	-	10
„ B	-	-	-	-	-	10
Streptococcus	-	-	-	-	-	2
Bacillus coli	-	-	-	-	-	5
Unrecognised bacilli	-	-	-	-	-	5
„ cocci	-	-	-	-	-	2
Saprophytes	-	-	-	-	-	2
Negative	-	-	-	-	-	5

The lochia were obtained in every case by Döderlein's method. In the laboratory they were examined by smears and by cultures. In ten cases, where organisms were seen in the smear, they failed to grow. In these cases it cannot be claimed that the organism was identified.

The organism "diplococcus A" was described briefly in last year's report. It closely resembles the gonococcus in appearance, and in its tendency to be situated in the cells, but, unlike the gonococcus, it varies in its reaction to Gram's stain. I have had great difficulty in getting it to grow. In the two or three instances, where primary cultures were obtained, attempts at sub-culture entirely failed.

Diplococcus B is probably the pneumococcus.

The absence of all staphylococci from the list is interesting.

One of the cases of streptococcal infection was very severe, ending fatally; the other recovered after an illness of some four weeks' duration.

Pus or other infective material was examined as follows:—

(a) Stitch abscess in perineum—*St. aureus*.

(b) Abscess of abdominal wall—*St. aureus* ; *Diplococcus pneumoniae*.

(c) Abscess of abdominal wall—*B. coli* ; an unknown coccus.

(d) Abscess of abdominal wall—*St. albus*.

(e) Necrotic tissue from epithelioma of the cervix—*Streptococcus* ; *St. aureus* ; *St. albus*, &c.

(f) Abdominal wound—*St. albus*.

(g) Vaginal discharge—*Streptococcus* ; *Diplococcus pneumoniae*.

(h) Abdominal wound—*St. albus*.

(i) Vaginal abscess—*St. albus*.

These results may be tabulated as follows :—

TABLE V.—BACTERIOLOGICAL EXAMINATION OF PUS OR OTHER INFECTIVE MATERIAL SHOWING ORGANISMS ISOLATED.

<i>St. aureus</i>	-	-	-	-	-	3
<i>St. albus</i>	-	-	-	-	-	5
<i>Streptococcus</i>	-	-	-	-	-	2
<i>Diplococcus pneumoniae</i>	-	-	-	-	-	2
<i>B. coli</i>	-	-	-	-	-	1
Unrecognised	-	-	-	-	-	2

One patient suffering from tuberculosis of the bladder was for some weeks under vaccine treatment, controlled by observations of the opsonic index. She reacted excellently to the treatment, her index rising from .6 to 1.2, and after a temporary fall remaining about that figure. At the same time her health improved, and the pain, which had been very troublesome, disappeared. The urine, which at the beginning of treatment contained much pus and plentiful tubercle bacilli, became much cleaner, and we failed to find any tubercle bacilli. Unfortunately, the patient left hospital before anything more than alleviation could have taken place. In several cases an estimation of the opsonic index was made as an aid to diagnosis of tubercular conditions.

During the year the following specimens have been added to, or have been put in preparation for, the Hospital Museum :—

(1) *Adeno-carcinoma of vulva*, described above.

(2) *Endothelioma of uterus*, described above.

(3) *Fibromyoma of uterus*, undergoing sarcomatous degeneration.

(4) *Tubal pregnancy*, showing embryo *in situ*.

(5) *Carcinoma of ovary*.

(6) *Endothelioma of ovary*.

(7) *Sarcoma of vagina* (lent by Dr. Jellett). Fully described to the Academy in 1904 (Proceedings, 1906).

(8) *Red degeneration of fibroid*. A description of this specimen was given to the Obstetric Section of the Academy, December 14, 1906.

ART. VIII.—*Epidemic Cerebro-Spinal Fever : its Earliest History, and its most recent Scientific Investigation*. By R. B. BRYAN, Clk., M.A., M.D., Ch.B., & B.A.O. (UNIV. DUB.).

THIS very peculiar and very interesting form of epidemic disease has recently been again displaying its activity in our Irish metropolis, as well as in other large cities of this and the neighbouring island. Our capital had already been noted for the repeated favours of its visitations ; and it is, I believe, to Dublin physicians of the past generation that we owe the best clinical descriptions of epidemic cerebro-spinal fever which have hitherto appeared in the English, or indeed in any, language. The English literature of this fertile subject also first dawned here—at one of the darkest periods, too, of Ireland's troubled history. An Irish provincial—perhaps I had better say suburban—practitioner, Dr. Darby, gave the first definite notice of its appearance in this country (and in the British Islands) in the early part of the year 1846. That year also derived a dismal celebrity in our annals from the fact that its autumn displayed the full development of the ravages of the fell “potato blight,” which soon consigned tens of thousands of the inhabitants of the “congested districts” to the horrors of death from complete starvation. And in August of the same year, Dr. Mayne, of Dublin, published his classical description of the symptoms of *cerebro-spinal arachnitis*, as the disease was then named. It was afterwards