SELECT CLINICAL REPORTS.

(Under this heading are recorded, singly or in groups, cases to which a special interest attaches either from their unusual character or from being, in a special sense, typical examples of their class).

I.**On a Case in which Ovariectomy was Performed
During Labour.**

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MRS. E. G., aged 38, residing in Leeds, was admitted into the Leeds Infirmary on June 20th, being in labour. She was sent in by Mr. V. Hackworth, of Leeds, formerly Resident Obstetric Officer in this hospital, who had diagnosed an ovarian cyst obstructing labour, but had found that the cyst could not be pushed up out of the pelvis.

She had had three previous normal labours and was now at full term in her fourth pregnancy. In the third month she had suffered, according to her own account, from "falling of the womb." This she attributed to a strain. The womb had been replaced under anæsthesia and she had then worn a pessary for five weeks. Pregnancy after this had run a normal course, except that she had required the catheter once or twice during the last three weeks.

On June 19th labour began, and early on the 20th the liquor amnii began to escape spontaneously and pains occurred every hour. On admission at 1 p.m., she was observed to be a not unhealthy woman, florid and well-nourished. She was in an excited state, protesting loudly against being brought to the Infirmary. Pulse 108. Tonic uterine spasm was not present, patient somewhat, but not seriously, exhausted. The foetal parts were very easily felt through the abdominal wall, the head being well above the brim in the right inguinal region and the breech above the umbilicus on the left, the face was anterior. On vaginal examination the os could not be reached by the finger nor any presenting part. A tense tumour occupied the pouch of Douglas, and effectively prevented the head from entering the pelvis.

Operation. At about 2 p.m. Aether was administered. I made a median incision about 10 inches in length through the linea alba, and having exposed the uterus drew it gently forwards and to the right out of the abdominal cavity, covering it with a warm towel. An ovarian cyst the size of a melon was then very easily drawn up

out of the pelvis and through the wound. There were no adhesions. It was attached to the left side of the uterus by a well defined pedicle, in which the venous sinuses were extremely large. I tied the pedicle in small sections with cat-gut, closing the peritoneum over the stump. The uterus was next replaced, the head being guided and pressed down into the pelvis. The abdominal wound was closed with two series of continuous cat-gut sutures passed through the deeper layers and twenty interrupted silkworm-gut sutures through the skin and superficial tissues. The abdominal wall was then firmly strapped and bandaged. Immediately after operation the head could be felt *per vaginam* engaging the inlet, the occiput being posterior. The labour proceeded naturally with very little effort on the mother's part, the head rotated easily, and then forceps was applied to bring it through the vulva and save strain on the abdominal muscles. A living child was born at 5-30 p.m. The third stage was short and without complications. Next morning the wound was examined, but nothing had given way. No suppuration. The mother made a perfectly smooth recovery, suckled her child, and was sent home on the 17th day, to Mr. Hackworth's care. The cyst was composed chiefly of one loculus. It ruptured during extraction but was perfectly innocent in nature. The right ovary was normal.

There can, I think, be no doubt that the above was the proper treatment under the circumstances. Had anyone been called to this case after labour had commenced in some place remote from the appliances for the major operation it would have been proper treatment to tap the cyst through the vaginal wall and to postpone ovariectomy till a subsequent date. At the same time it must be remembered that tapping cannot always be relied upon to reduce materially the bulk of an ovarian tumour. Tapping also tends to cause adhesions, and there might in such a case as this be danger of infection of the cyst contents or of the general peritoneal cavity.

It is clearly better to remove the tumour entirely out of the way rather than to leave it, even though partly evacuated, to the danger of injury or infection during labour or the puerperal period.

If the abdominal wall be firmly sutured in separate layers, and if straining during delivery be obviated by timely traction by forceps, there should be little or no danger of the wound giving way during childbirth. There was clearly no indication for Cæsarean section in this case, and it would have been bad practice to open the uterus. I suppose it is possible for cases to occur where impaction or adhesion of the tumour, or its relations to the peritoneum, might present difficulties for the solution of which the preliminary removal of the uterine contents by hysterectomy might be the best expedient. This particular ovariectomy was one of the easiest I have ever undertaken.