

ART. II.—*The Spontaneous Elimination of Uterine Tumours.*

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IN this communication I propose considering the modes by which nature occasionally relieves the uterus of the presence of a solid growth. The very great frequency of such growths in this organ, and the serious consequences which they so constantly entail, invest their history with deep interest for the practical gynecologist.

To study any disease aright we should commence by studying the course which it takes when left to itself, and uninfluenced by the active interposition of art. Of such an investigation there is no more important branch than that which relates to the conservative processes whereby nature removes from the system morbid products constituting the essence or the effects of a disease. This paper I would offer, then, as a contribution towards the natural history of solid tumours of the uterus—an attempt to improve and extend our knowledge concerning the spontaneous elimination of these neoplasms.

From the title of this memoir it will be seen that I do not strictly confine my observations to any one class of tumours, though, in point of fact, the tumours to which it relates were almost entirely of the fibroid or fibro-sarcomatous kind, the occurrence of any other kind being extremely rare in this organ.

Out of all cases of tumour of the uterus, the proportion in which a curative process is set up is comparatively but very small, whilst the number in which nature effects a cure is still smaller. Nevertheless, many cases of spontaneous elimination are recorded, and there are few obstetricians of any considerable experience who have not met with two or more instances. An acquaintance with this subject is, therefore, absolutely necessary, if we would aim at correct diagnosis, or avoid committing gross errors.

It is to be remembered that the processes set up by nature for the destruction of these growths, although conservative in their tendency, sometimes involve considerable danger to life.

The study of a large number of recorded histories, together with the results of my own clinical observation, lead me to believe that there are *five* different modes by which nature may effect the cure

^a Read before the Dublin Obstetrical Society.

of a tumour of the womb. To reduce the number cannot be done, I think, without confounding cases essentially different, whilst to increase it beyond five would be devoid of any real utility. These five modes of elimination are as follows, viz. :—

1. Interstitial absorption.
2. Simple detachment, or separation.
3. Calcareous transformation, or petrification.
4. Sloughing, or disintegration.
5. Expulsion by uterine contractions.

I have arranged them in this order, believing that it represents—approximately at all events—the relative degree of risk attaching to each process, absorption being the least dangerous, expulsion the most so. Were the cases to be arranged according to frequency, the order would be somewhat different. *First* and most frequent would be the cases of sloughing; then the cases of detachment; after them the cases of expulsion; next those of calcareous degeneration; and lastly, those of interstitial absorption. I do not pretend to affirm that this order is strictly correct, for it is not deduced from any minute statistical calculation; still I think it will be found pretty near to the truth.

1. The *absorption* of a solid uterine tumour, even with the aid of medicine and other agencies likely to favour the process, is considered by some an impossibility. It is true, as a general rule, that heterologous formations are not removable by absorption. But is it correct to regard fibrous tumour of the uterus as such? Upon this point I can cite no higher authority than that of Virchow:—"We find, for example," he says, "that the so extremely common form of uterine tumour, which has been designated fibrous or fibroid, has in every respect the same structure that the walls of the 'hypertrophied' uterus have, inasmuch as it consists not only of fibrous connective tissue and vessels, but also of muscular fibre cells. The tumour may, as is well known, become so large as not only to embarrass the uterus in all its functions in an extreme degree, but also to exercise, through pressure, the most injurious influence upon the neighbouring parts. In spite of this, it must always be considered an homologous structure."—*Cellular Pathology*, p. 443.

But again, in cases where a fibrous tumour (or what was supposed to be such) was absorbed, the correctness of the diagnosis has been disputed, and it is urged that the tumour was only an inflammatory

or œdematous swelling, or a chronic hypertrophy, or some tumefaction whose removal we know to be quite probable. Objections of this kind may no doubt be advanced, and the possibility of an error of diagnosis in any particular instance, can very seldom be completely excluded. Still there remains an amount of evidence on this question, from which we cannot escape drawing the conclusion, that nature is capable, on some rare occasions, of entirely removing a solid—it is to be presumed a fibrous—growth by the process of interstitial absorption. This position derives corroboration from the cases—and they are not a few—in which the same result was brought about by the use of therapeutic agents. One such case occurred to myself, and has been published.* I do not here refer merely to cases—common enough—in which the tumour undergoes an apparent reduction of its bulk after treatment, menstruation, or delivery, and which reduction is to be explained by the removal of congestion or œdema. I am speaking now of the actual absorption of the growth itself.

A very striking example of the complete removal of a fibrous tumour by absorption is recorded by Dr. Matthews Duncan, and what enhances the value of this case (besides the thorough competency of the observer) is Dr. Duncan's own acknowledgment that he has been, as it were, forced against his judgment, by the evidence of a single case, to admit the possibility of the complete removal of a large fibrous tumour by absorption. He writes:—“The tumour was as large as the fetal head at the end of pregnancy. It was as easily and as perfectly diagnosed as any case could be. There was no doubt ever thrown upon the nature of the case by any of the experienced practitioners who examined it. It had every character and symptom of a fibrous tumour. The patient was long in the most aggravated state of anemia. *Now*, there is as certainly no uterine tumour, as there was certainly one formerly. The only method of escape for me, in the evidence of this case in favour of complete absorption, is the supposition that the tumour may have become spontaneously enucleated, separated and discharged, without the consciousness of the patient. This alternative, I confess, considering the cleanly habits and truthful character of my patient, seems more unlikely than the other.”

Dr. Routh tells us in his Lettsomian Lectures that he “has met with at least two distinct cases of large fibroid, which, he should say, filled the pelvis, and materially interfered with the functions

* Clinical Memoirs on Diseases of Women, p. 141.

in that cavity, where the tumours have gradually diminished to the size of small apples" (p. 38).

It is worthy of notice, and Dr. Routh pointedly alludes to the fact, that in both these instances, as well as in others, the atrophy of the tumour took place contemporaneously with the change of life, which would seem to imply that it resulted from arrested nutrition.

Whether the structure of the tumour undergoes any degree of softening preparatory to its removal by the absorbents, it is impossible to say. Dr. West thinks that it does, and a case recorded by the late Dr. Rigby rather supports this view, as he states, in the course of its history, that the tumour became *softer* and smaller.

The processes of transformation and absorption going forward with such activity in the uterus after parturition may, perhaps, be extended to a growth standing in close vital relation to the organ, and thus lead to its partial or complete dispersion. Although parturition is likely to produce in the tumour other effects than its simple absorption, still experience shows that this latter is an occasional consequence, and the most fortunate one for the patient. "If," says Scanzoni, "we consider the great vascularity, the hyperemia, the infiltration, and the softening which these tumours present during gestation, it will be seen that if there is any time at which the conditions are favourable to absorption it surely is the puerperal state" (p. 237 of American edition). The same high authority reports a case where "a fibrous body of the size of a man's hand, the diagnosis of which was perfectly sure, disappeared during confinement, in a manner so complete that six weeks after parturition we could no longer discern a trace of this tumour, which had existed for eleven years" (*op. cit.*)

2. *Detachment*.—From the meaning of the term detachment (or severance), it is obvious that only such tumours as are pediculated—polypi in fact—can be the subjects of this mode of elimination; but it matters not whether they spring from the mucous or the serous surface of the womb. There are three ways in which this separation may be effected, and numerous examples of each could be adduced. First, the pedicle may give way from simple atrophy and attenuation; second, when the pedicle is small it may break or snap asunder in the act of extrusion from the uterine cavity, or from the weight of the suspended tumour; and lastly, the pedicle may be destroyed through the constriction exerted

upon it by the os uteri or ostium vaginae. If the detached tumour remain in the genital canal, it will, of course, speedily decompose and become putrid.

CASE I.—In the year 1863 Mr. Richardson asked me to see with him a patient from Drogheda, aged forty-two, who had some uterine symptoms. On examination we found in the vagina a polypus the size of a walnut, in a completely sphacelated state. It had grown from the interior of the womb, and the small stalk had apparently been strangulated by the grasp of the os uteri. The shred of decayed pedicle which remained was broken by a slight effort of torsion.

Should a polypus become detached whilst still within the uterus—a thing not wholly impossible, perhaps—and be retained there till decomposition sets in, it would be very hard to distinguish such a case from one of those to be presently described, in which sloughing or disintegration of a tumour occurs as the primary lesion. This obscurity would have hung over the following case, had I not been made acquainted with the previous history of the patient.

CASE II.—In the month of April, 1859, Dr. Fitzpatrick, then medical attendant of the Moynalty Dispensary, County Meath, but now of Sussex Gardens, London, sent up to the Lying-in Hospital (of which I was at the time Master) a patient, in whom he had ascertained the existence of a smooth pyriform polypus, insensible to the touch, and encircled above, at its neck, by the os uteri. Some days intervened between the dates of his examination and of her arrival at the hospital. I found the uterus low, its orifice considerably dilated, and a firm rough tumour within the os, and partially protruding from it. There was an exceedingly fetid discharge. The surface of the tumour was seen to be of a dark green and brownish colour. I took hold of this tumour with a vulsellum, but on pulling firmly it gave way, and only a small bit was removed, which was evidently in a gangrenous state; but its fibrous structure was still apparent, and it lacerated in a definite direction. In the course of the succeeding week I extracted several fragments of the tumour in a decomposed state, and a good deal more came away in the discharge. During this period her life was seriously threatened, from the amount of irritative fever which was present. She had rigors; a small, rapid pulse; dry tongue; total loss of rest and of appetite. According as portions of the tumour,

day by day, were withdrawn, the os began to close, and the constitutional disturbance to subside, so that by the end of the month she was able to leave the hospital and return home. I should mention that she was a widow, aged sixty, and had borne nine children. For upwards of two years she had been subject to constant hemorrhages, but these had entirely ceased a short time before she came to the hospital, in consequence, we may presume, of the strangulation of the tumour. The *rationale* of this case is plain enough, I think. The polypus was expelled through the os, whilst the pedicle was still insufficiently long for this change of place. Complete strangulation of the tumour now took place, entirely destroying its vitality. Consequent upon this, it diminished in size, so as to permit of retraction within the uterine cavity; and such was the state of things when the woman came under my care.*

Polypoid fibrous tumours, growing by a slender pedicle from the peritoneal surface of the uterus, may become detached by some sudden movement of the body, whereupon the tumour drops into the cavity of the belly; of which Simpson states that he "has seen several instances" (*Obstetric Works*, Vol. i., p. 117), and Dr. Turner has very fully reported another (*Ed. Med. Jour.*, January, 1861). In one sense the tumour is now to be regarded as a foreign body lying within the peritoneal sac, and so far is analogous to the loose cartilaginous bodies found in the knee-joint. It would appear from the reports of cases that the presence of a loose fibroid in the belly is perfectly innocuous, and does not ordinarily excite any irritation in the contiguous viscera or serous membrane. The tumour itself undergoes no change, but presents the same appearance as these tumours are wont to do when still in vital connexion with the womb.

It not uncommonly happens that before its separation the tumour has contracted an adhesion to some adjacent part, and when so circumstanced its severance from the uterus is more apt to occur, especially if the new connexion be to a viscus, such as the bladder or rectum, which is constantly undergoing changes in size and position. Simpson reports the case of a lady who, from her unusual shape after delivery, was supposed to have an extra-uterine fetation. She died of puerperal peritonitis in the second week, and a fibrous tumour was found adhering firmly to the peritoneum lining the anterior wall of the abdomen, while its pedicular

* The full particulars of this case will be found at page 166 of my Clinical Memoirs on Diseases of Women.

attachment had stretched and lacerated during the involution of the organ after delivery (*op. cit.*, 834).

3. *Calcification*.—A much rarer event than either of those we have been considering, is the transformation of a fibrous tumour into a calcareous mass which ceases to grow, and may be partly or entirely discharged. It is a degeneration from animal to inorganic substance. The propriety of regarding this change as a mode of elimination may be disputed. The tumour certainly remains in most cases, but it ceases to hold a vital connexion with the economy, and the symptoms which it had previously produced abate or altogether disappear.

In a very few instances the structure of these calcified or petrified fibroids has a near resemblance to bone, but such cases are quite exceptional. In the vast majority no true bone is formed, but earthy particles, chiefly salts of lime, “are deposited and accumulated in the organic basis of the tumour, so as to make a mass which is sometimes friable and porous, sometimes hard and dense as marble” (Simon). By what process this remarkable conversion or transformation is brought about we cannot tell. Inflammatory action would seem to have no part in it. The appearance of the tumour and of its nidus indicates this. Nay, more, guided by the analogy of the cretaceous transformation of tubercle, and of the so-called ossification of arteries in the aged, we should rather regard it as the result of defective nutrition. “This much at least can, with certainty, be affirmed (writes Virchow, p. 365), that we are as yet acquainted with no stage in these changes which is at all akin to inflammation.” Although we must confess our ignorance of the precise way or mode by which this calcification, or, to use the term proposed by Virchow, “petrification,” of a fibroid is produced, still experience has shown us the circumstances and conditions which favour its production. It is chiefly met with in women advanced in life. It is confined nearly altogether to subperitoneal, or extramural fibroids; and generally to such as are pediculated, but not invariably so, as Dr. Turner would lead us to suppose. In the Museum of the Royal College of Surgeons (Ireland) is a very fine preparation, presented by the late Sir Philip Crampton, which strikingly exemplifies these points. The patient was an elderly woman, who married late in life, and never bore children. The disease was supposed during life to be ovarian dropsy, and did not appear to be the cause of death. The uterus contains several fibroids, the largest of which is about the size of a fetal head, and

has the hardness and density of bone. This tumour lies almost immediately under the peritoneum, but is still imbedded in the uterus, and not in the slightest degree pediculated. In direct apposition with it is a large interstitial fibrous tumour, which contains merely a trace of calcareous deposit.

Again we find that this process of petrification may be limited to the surface of the tumour, or pervade its structure. It "has no necessary connexion with the size of the tumour, and is not commensurate with its growth; but it appears (says Dr. Turner) to be in intimate relation to the size of the peduncle, and to the changes which take place, by obliteration or atrophy, of the vessels which pass from the substance of the uterus through the peduncle to the tumour."

A tumour that has undergone this calcareous transformation ceases to be productive of symptoms, except such as may arise from its mechanical influence. On rare occasions the calcified tumour has fallen from its nidus, and been discharged *per vaginam*.

It does not always prove quite so innocuous, however. Cases have been reported in which these petrifications, by infringing on a neighbouring organ, have caused ulceration and other ill effects. Dr. Turner cites a case where a large calcified tumour, growing from the back of the uterus, caused death by compression and rupture of a fold of the ileum, consequent upon a fall on the pavement.

Dr. Matthews Duncan exhibited, at the Edinburgh Obstetric Society, a calcified fibrous tumour of the uterus, from a patient who had died of peritonitis, and two holes were found in the peritoneum, apparently made by the tilting upwards of two thick scales of the tumour.

Through the kindness of Dr. Fleming, I once had an opportunity of seeing a most singular—indeed, I may say, unique case, in which a calcified tumour, springing from the anterior wall of the uterus, had made its way by ulceration into the bladder, producing all the symptoms of vesical calculus in their most intensely aggravated form. Some fragments of the tumour had been detached, and were found in the cavity of the bladder.

4. *Disintegration or Sloughing* is another change that may take place in a uterine tumour, and lead to its partial or complete extirpation. This process generally gives rise to symptoms of a grave kind, and in many instances the patient has actually sunk under the wasting effects of the discharge and the constitutional irritation.

Suppuration of fibrous tumours is described by some authors, but I see no necessity for making a separate category of such cases. In many of them the discharge was plainly due to softening of the tumour and irritation of the uterine cavity.

The vitality of the tumour having been destroyed—how, we shall presently inquire—it may come away *en masse*, or in broken, irregular fragments, quite putrid, at intervals of days, weeks, or months. All this while there is little or no pain, but a constant puriform discharge of a highly offensive character, and sometimes mixed with blood, is going on. In a few instances the tumour is too dense to melt away, and too large to be expelled spontaneously. Here art must interpose, or the life of the patient will inevitably be lost. Dr. Hall Davis met with two cases in the Middlesex Hospital, which strikingly exemplify the good effects of this timely interference. Very alarming symptoms, viz., fever, delirium, vomiting, &c., were present in each case; but the lives of both patients were saved by dilating the os, and removing the putrid *debris* of the tumours. I may here venture on observing that it was the study of such cases as these that led me soon after its first announcement, to form an unfavourable opinion of the operation of gouging uterine fibroids.

I have said that the coming away of the tumour may extend over a period of many weeks or months. A case will be presently related, in which six weeks were so occupied; and Dr. Churchill has kindly furnished me with the outline of a case where the process extended over a still longer period.

CASE III.—A widow lady, under fifty years of age, had uterine hemorrhages for a long time. Three tumours were ascertained to be present in the uterus, and could even be readily distinguished by external examination. Two of these tumours sloughed, one after the other, and came away per vaginam, at different times, in a softened, putrid state. From first to last the eliminative process occupied several weeks. During this time there was a profuse and very fetid discharge from the vagina; and there was much constitutional disturbance, but no uterine pain. After the second fibroid had passed away she recovered her health. The tumour remaining in the uterus could now be felt by itself. Soon after this the lady died of cholera; had she lived, it is probable the remaining tumour would have been cast off.

A very interesting but difficult question presents itself for solution,

with regard to the cases comprehended in this class, viz., what causes the sphacelation or death of the tumour? Both Dr. West and Dr. M. Duncan maintain that inflammation has nothing to do with it; whilst Cruveilhier, Scanzoni, and Simpson hold an opposite opinion. I am at a loss how to reconcile this latter view with the absence of all local symptoms of inflammation in or around the tumour. No doubt inflammation may arise in the progress of a case, but then it is a consequence, an effect, not the cause, of the death of the tumour: and further, when it does supervene under these circumstances, it is generally peritoneal or phlebotic.

There is yet another way in which, I think, we may very satisfactorily account for the death of the tumour, independently altogether of the influence of inflammatory action, namely, as the result of spontaneous enucleation, whereby its structural connexion with the uterine tissue becomes so limited as to be inadequate to the continued nutrition of the tumour, and, as a consequence, its vitality ceases—it dies, in short.

I am not aware of any fact directly confirming this supposition; but many cases have been recorded—especially by Dr. Matthews Duncan and by Cruveilhier—tending to show that it is not only possible, but highly probable; and so far, the explanation has more to commend it than any other theory that has been put forward to account for the spontaneous dissolution of an intra-uterine tumour.

An admirable example of the particular mode of elimination we are now considering lately fell under my notice, and I trust no apology is needed for presenting an outline of its history.

CASE IV.—The subject of the case was a large corpulent widow lady, aged sixty-eight, the mother of twelve children. She first consulted me in June, 1864, on account of recurring attacks of metrorrhagia, to which she had been liable for six or eight years. After due investigation I made the diagnosis of a large fibroid to the left side of the uterus. This accorded with opinions previously given by the late Professor Montgomery, the late Dr. Charles Johnson, and by Dr. Beatty.

I did not again see this lady till the latter end of last April. She then told me that for some months there had been little or no bleeding; but, that during the three or four weeks preceding my visit, she had suffered extreme annoyance in consequence of a profuse watery discharge from the vagina, of an intolerably fetid odour. Since the occurrence of this discharge the following symptoms had

developed themselves, viz., total disinclination to food; occasional attacks of diarrhea and sickness of stomach; severe rigors on three or four occasions; sleeplessness; a frequent pulse; foul tongue; and œdema of the feet and ankles. The os uteri was healthy, but dilated to the size of sixpence, and within it could be seen a portion of substance, evidently sloughy, which I endeavoured unsuccessfully to remove with a dressing forceps. This discovery led me to suspect the nature of the case, and I explained my views to the late Dr. Banon, who, as the family physician, saw this lady occasionally with me. At next visit (two days afterwards) she complained of a feeling of pressure on the rectum, and of dysuria, when I found a very large, softened tumour filling the whole vagina. The relations of the upper part of this decomposing mass I could not satisfactorily ascertain, in consequence of its enormous size, and the tenderness of the vagina. She had experienced no particular sensation that would have marked the time when the tumour passed out of the uterus; and I may here take occasion to state that at no time, from the beginning of present symptoms, was there any abdominal pain or tenderness whatsoever. Assisted by Dr. Banon, I fixed the points of a strong vulsellum in the tumour, and began rotating it. At first there was some little resistance to the movement, but this soon ceased, and the tumour could be turned round and round—in fact, it was quite free. We now set about extracting it, but our united efforts were required to get it through the vulva; at length it came away with a violent jerk, and was followed by the escape of a large quantity of abominably offensive purulent fluid.

The tumour had the size of a large cocoa nut, but was soft and sloughy. It was in a highly putrid state. The preparation of this tumour is now on the table, and belongs to the Museum of the Royal College of Surgeons. Dr. John Barker was kind enough to examine a section of it under the microscope, and he reports that he “could detect in it no specific characters of a malignant nature: it was very fibrous, with a large quantity of elastic tissue pervading its structure.”

From the time the tumour came away all this lady's symptoms began to subside, so that at the end of a fortnight not one remained. She soon afterwards returned to the country in better health and spirits than she had been for many years.

On many occasions the death and discharge of tumours has followed parturition, either from the effects of some injury which it sustained during the process of labour, or from the vascular supply

to the growth, being diminished by the contraction and subsequent involution of the uterus. Where this dissolution of the tumour has taken place at an early period in childbed, the consequences have generally been fatal to the patient.

Dr. Gardener, the American editor of Scanzoni, suspects that some of the pelvic cellular abscesses occurring after labour may, perhaps, be properly considered as the result of the breaking down of previously unsuspected fibrous tumours; and he adds, that several cases he has seen, while they are not perfectly convincing, force him to give this opinion some consideration. Pelvic abscess is known to be an occasional complication of uterine fibroids. In some of these cases it may be that the abscess depends on the disintegration of the fibroid, as Dr. Gardener describes. Certainly one case of this kind fell under my notice some years ago.

CASE V.—The patient was a middle-aged married woman, never pregnant, who had a large fibroid in the posterior wall of the uterus, for which she had been under my care for nearly three years. An abscess formed behind the uterus, and burst into the rectum. It continued discharging for some months, during which time the tumour underwent a gradual diminution in size, till it was reduced to about one-fourth of its original bulk. Eventually, however, the patient—who was very much anemiated, and had always been of a very delicate and highly scrofulous constitution—sank under the discharge and constant irritation of the rectum.

5. *Expulsion*.—The fifth and last mode of elimination I term expulsion, under which title are comprehended all those cases where uterine contractions—parturient efforts, in fact—form the leading symptom as well as the efficient cause of the separation of the tumour, which is still in vital connexion with the womb when the contractions commence. In the group of cases last considered, expulsive pains were very rarely present, and when they did occur, it was *in consequence of the death of the tumour*, which then acted as a foreign body, and excited parturient efforts on the part of the womb.

As the uterus is endowed with very great contractile power, we might, *a priori*, expect solid growths to be got rid of occasionally by the exercise of this faculty. Experience amply confirms this, but at the same time teaches us what we otherwise should not be quite so prepared for, namely, that the danger arising from this mode of elimination is greater, perhaps, than from any of the preceding.

A good many cases are reported where this species of parturition has been set up, and the tumour has thereby been partially or entirely removed. A large proportion of these cases occurred in the puerperal state, which may go far to account for the large mortality amongst them. But setting aside the puerperal cases, the danger would seem to be greater from *expulsion* than from *sloughing*. This more unfavourable result admits, perhaps, of some explanation. The expulsive process is the more acute: it is often accompanied by prolonged pains of a very severe kind; and lastly, the violent contractions of the diseased organ must powerfully tend to excite inflammation, or other morbid action in it.

Let me now submit the sketch of a very apposite case.

CASE VI.—In July, 1864, I met Dr. Bernard, of Dundrum, in consultation upon the case of a widow lady, aged forty, who four years previously had begun to lose blood in large quantity from the uterus. For the last twelve months, however, there had been no hemorrhage of any serious kind, and the catamenia were moderate. The uterine tumour reached as high as the umbilicus. In the lower part of it a short, loud souffle was audible.

The patient was a small, delicate woman, very ex-sanguine. At the time of my visit, and for some hours previously, she had been complaining of pain, of an intermitting kind, in the tumour, and there was a good deal of watery discharge. I found the os uteri dilated to the size of a shilling; its edges very thin, and the tumour pressing firmly into it. Some days later regular labour pains, of a very violent and expulsive character, set in. When I saw her they had continued for six hours without any abatement, and she was much exhausted, and her distress and weakness were aggravated by a continual nausea or vomiting. The abdominal tumour had undergone a considerable reduction in its size; whilst the vagina was distended down to the perineum with a fleshy mass, rendering it necessary to draw off the urine with the catheter. By the aid of morphia she got a little respite from the severe bearing down pains, but nothing stopped the sickness of stomach. Some hours later I found the tumour protruding from the vagina. Pains were still present, but she was altogether very low and weak, and harassed by incessant vomiting. I succeeded in removing a portion, the size of a large orange, of the tumour. It was of a dark red colour, with a fleshy structure, but admitting of being lacerated with the fingers, in which manner I detached it. No more could be got

away, and she died a few days afterwards, utterly worn out by pain, hemorrhage, vomiting, and loss of sleep. I much regret an autopsy could not be obtained.

In some respects, though certainly not as regards its issue, this case bears a resemblance to one of Dr. Rigby's, in which, by successive operations, he removed 35 lbs. of tumour, which was gradually forced down by regular labour pains.

Dr. Thompson, of Omagh, has furnished me with the particulars of a case, in which the successful removal of a uterine tumour, weighing nearly seven pounds, was effected through the influence of parturient efforts, seconded by surgical treatment.

CASE VII.—The patient was a married woman, aged thirty, who never had borne children. When she came under Dr. Thompson's care she presented all the symptoms of extreme anemia. She was also very weak, and incapable of the least exertion, and for some days previously had retention of urine. On examination he found an enormous tumour filling the vagina, and distending the womb above pubes to the size of a five months' pregnancy. This tumour was so firmly jammed in the pelvis that it was impossible to reach even its greatest circumference. Its surface was smooth, pale, and traversed with large veins. It was not sensitive or painful, though its pressure on the rectum and urethra was productive of much distress.

The bladder was emptied, and an attempt made to pass a ligature round the upper part of the growth, but from the want of a proper instrument, this failed. In the course of the next few days the tumour began to protrude beyond the vulva, and to assume a gangrenous appearance, being flaccid, dark coloured, and fetid. As the fingers could now be passed up the vagina, and beside the tumour, with less difficulty than before, Dr. Thompson applied a tight ligature round the tumour as high up as he could reach, but not to its neck, and ordered a mixture of biborate of soda and strong infusion of ergot of rye. This acted in a most marked and decided manner on the uterus, producing pains similar to those of labour, and unlike anything she had before, and with the effect of bringing down the tumour so low as to expose the ligature. The pains continued until the whole tumour—which nearly equalled a mature fetus in bulk—was expelled, and hanging by a pedicle of about an inch in diameter. By this time she was reduced to a state of alarming prostration, and she was only kept alive by

the unremitting administration of brandy, &c. On the following day, as her condition was very little better, Dr. Thompson determined on the excision of the tumour, and this he effected with the ecraseur, having previously tied the pedicle as tightly as he could, to guard against any hemorrhage. This precaution was very needful, as there were found to be some large vessels traversing the pedicle. The tumour weighed $6\frac{1}{2}$ lbs., and was of a fibro-cellular structure. The patient slowly rallied out of this state of extreme depression, and recovered without a bad symptom.

I would wish to draw attention to two points in the foregoing history: first, that the expulsive contractions of the uterus (without which the removal of the tumour could not, in all probability, have been effected) were artificially induced; and second, that the tumour was apparently of a polypoid nature. Neither—nor both—of these circumstances, however, exclude the case from the class now under consideration.

The following case was communicated to me. It very well exemplifies the danger attendant upon a long continuance of uterine efforts to get rid of a morbid growth.

CASE VIII.—The patient's age was forty-five; though married for twenty years she had never been pregnant. For many months she had been losing large quantities of blood from the uterus, so that she was extremely weak, and anemic to the highest degree. The uterus was enlarged to the size of pregnancy at five months, from the presence of a hard globular tumour, which could be felt through the thin and partially-open os uteri. Latterly she had severe pains in the womb at each menstrual period, and to relieve these she was in the habit of taking opiates pretty freely. To aid in the expulsion of the tumour she was ordered to take at next period one drachm of ergot, infused in a wine glass of hot water, three times a-day; this direction she followed.

Strong uterine action supervened, which so far expelled the tumour that its uterine attachment, which was very extensive, could be reached. No artificial means to detach the tumour, however, were tried, and the woman sank in the course of some days, apparently worn out by the protracted and unavailing uterine efforts.

The similarity between this and Case VI. is very great. They both strongly suggest the propriety of attempting the removal of the tumour by artificial means, under circumstances such as those

described. Gooch relates the history of a case closely resembling these; it occurred in the practice of Mr. Barrett, of Yarmouth. The patient sank under the long-continued fruitless expulsive pains, when a tumour weighing nearly four pounds was found growing by a thick stalk from the os uteri. Had this tumour been excised, as was done in Case VII., the woman's life might, in all probability, have been saved.

It has been already stated that the recorded instances are numerous in which expulsion of a tumour occurred as a sequel of childbirth, and that the danger of the complication was in proportion to its earliness after delivery. Time will not permit of allusion to any of the published cases which might very profitably be adduced to illustrate this part of the subject. One remarkable case I must mention, where the expulsion of a tumour, weighing nearly four pounds, followed six days after a three months' abortion, the patient recovering perfectly, and giving birth to a healthy, mature child, fifteen months subsequently. This remarkable case occurred in the practice of the late Dr. J. Beatty.

I must now bring this very imperfect memoir to a close. I purposely say imperfect, because I have not fully entered on the question of treatment; and also because little or no reference has been made to the researches of others on this subject.* In fact, the observations are based mainly on the results of my own experience.

ART. III.—*Introductory Address at the Opening of the Winter Session of the Medical Society of the College of Physicians.* By FLEETWOOD CHURCHILL, M.D., President of the King and Queen's College of Physicians.

GENTLEMEN,

By the favour of the College of Physicians, it is my privilege to occupy this chair, and it becomes my duty to make a few observations, introductory to the opening of the session of the Medical Society.

I am not ashamed to confess that I feel it a great pleasure to be so honoured, and not the less so that I cannot plead a consciousness of desert.

* Dr. C. West is almost the only English writer who has treated this subject at any length.