

The patient was sent to St. Elizabeth's Hospital, where she was put to bed in a quiet room. Extra feeding, in the shape of raw eggs, was started. Hydrochlorate of hydrastrin was given every four hours in one-eighth-grain doses.

On March 18th I examined her under ether, to see how much the mass filled up the uterus. It filled the whole space with the exception of a small canal, too small to allow passage of finger, running up behind the mass farther than the finger could reach. No sound was passed, as it was not desirable to start any bleeding. The tumor itself felt rather soft, almost giving a sense of fluctuation.

Flowing began two days later, and she was then put on doses of gallic acid as well as the hydrastrin. The flow was at no time profuse and lasted about a week. She was then put on quite large doses of Gude's Pepto-Mangan, was allowed to get up every day and sent out for a drive. Her color and general condition improved quite rapidly, and she was in such an improved condition by the end of the first week in April that on the 8th the operation was performed.

There were present Dr. Faunce, who had very kindly sent the patient to me; Dr. Burrage, who assisted me during a part of the operation, and Dr. Kingman part of the time; Dr. Hinckley, senior house physician, assisted me through most of the operation. The vagina was thoroughly scrubbed with soap and hot water, then with corrosive solution. The external genitalia had previously been shaved and an antiseptic poultice put on abdomen. The uterine cavity was next washed out with a corrosive solution. The abdomen was now uncovered and washed with soap and water, ether, alcohol and corrosive solution.

Incision was made in the median line. On opening the abdomen the rounded mass was immediately in view, with the fundus of the uterus perched on top of it (like a small hat on a large head), the tubes and ovaries extending from either horn. The left ovary was considerably enlarged and cystic.

On account of the youth of the patient it had been decided to try to preserve the uterus. The inside attachment of the tumor was so extensive that I did not wish to risk removal by morcellation, and it was determined to deliver the tumor through the abdominal incision. A cut was made in the anterior wall of the uterus, extending from the fundus to the fold of peritoneum, just as it goes over the bladder. When the capsule of the tumor was reached, it was peeled off from the uterus by the finger as far as it could reach. The uterine opening being too small to deliver the tumor, two lateral incisions were made at right angles to the first cut. The tumor was now seized with vulsellum forceps and drawn up strongly, so that the remaining portion could be peeled off, and a mass about as large as two fists removed. There was hardly any bleeding up to this time. Now, however, there was much oozing from the extensive raw surface. A strip of sterile gauze was passed down into the vagina, one end remaining in the uterus. With No. 2 chromicized St. J. Leaven's catgut, the slack of the uterus, or the oozing blind spaces, was taken up. A new cavity was made for the uterus, preserving the space covered with mucous membrane. The left horn was apparently obliterated, but the right was pervious into the tube. The uterine muscle was brought together by deep sutures. A superficial layer of continuous suture united the seroserosal surfaces. No. 2 St. J. Leaven's

chromicized catgut was used in all uterine sutures. The left tube and ovary were now tied off and removed, the ligatures being placed at either end of the broad ligament, the two peritoneal surfaces between being sewed with a continuous silk suture. The abdominal wall was closed in four layers; the peritoneum, muscle and fascia being united with Leaven's chromicized catgut, and the skin and fat by interrupted wormgut suture. Hypodermic of aseptic ergot (P. D. & Co.), one-half drachm, given.

The patient was put back to bed in good condition; head elevated. The gauze was removed from the uterus in forty-eight hours, and an intra-uterine douche of one-per-cent. creolin solution given. There was very little vaginal discharge. A daily intra-uterine douche was given for a week. The temperature has at no time been over 100.5°. There has been very little pain after the first night. Abdominal wormgut stitches removed April 17th; perfect union.

Patient is now eating well, improving in color, and said to-day she felt like sitting up.

I have reported this case so fully, because this operation has not been done many times here, I think, and I believe it is deserving of consideration. In a young woman it does not seem right to mutilate by doing a hysterectomy, and trying to remove so large a tumor by morcellation through a virgin vagina seems to me a more dangerous operation than this, if feasible at all. There are also certain definite advantages in the way of having the field of operation open to inspection; hemorrhage is more easily controlled where it exists. The appendages may be inspected and treated if necessary.

To sum up, the operation is not very difficult; hemorrhage can be more readily controlled; the conditions in the pelvis are open to inspection, and, above all, mutilation of the patient is avoided, and what may be a useful organ is saved.

A CASE OF OVARIAN CYST WITH TWISTED AND STRANGULATED PEDICLE.¹

BY W. L. BURRAGE, M.D., BOSTON.

ANN C., age sixty years, widow, the mother of twelve children, entered the Carney Hospital, August 2, 1897. She was an Irishwoman, of large frame, and had always enjoyed rugged health. Her labors had been normal, and she had had the menopause fifteen years before. About a year ago she noticed that her abdomen was larger than formerly, but it gave her no special discomfort. Three weeks before entrance, early one morning while getting ready for mass, she felt a sudden sharp pain in the lower abdomen. The pain was very severe, and, as she expressed it, it seemed to her as if her insides were being torn out. It continued throughout the day, and she had had a dull pain across the abdomen, with exacerbations of sharp pains, ever since; for two weeks had had vomiting and loss of appetite and complete stoppage of the bowels.

On entrance to the hospital the patient had a temperature of 100° and a feeble pulse of 80. She was emaciated, especially about the arms and chest, and she had conjunctivitis and a poor color. The abdomen was universally distended, bulging in the flanks;

¹ Read before the Obstetrical Society of Boston, December 21, 1898.

tympanitic everywhere above the level of the umbilicus and flat below that level. In the lower half of the abdomen, reaching to the umbilicus, could be felt a hard, immovable tumor of smooth contour, that was not in any respect tender to manipulation. By vaginal examination could be made out a senile uterus, retroverted and on the pelvic floor underneath the tumor.

An attempt was made to move the bowels by enemata without much success. Vomiting of a fecal character was almost constant and was excited by swallowing. In the next three days the temperature fell to 98.9° and the pulse became more rapid, 118. In spite of rectal alimentation and stimulation the patient's strength failed.

Operation, August 5th, under ether. The cyst wall, thickened and necrotic, was found closely adherent to the parietal peritoneum. When the cyst was punctured it gave exit to about a quart of dark blood and flakes of lymph, having a slight musty odor. The cyst filled the pelvis and was intimately adherent to the pelvic wall, bladder, omentum and intestines. It was shelled off with moderate ease and there was little oozing. The cyst wall, yellowish gray in color on the outside and deep red on the inside, was four millimetres thick and its interior was trabeculated. The pedicle, three centimetres broad, and from right broad ligament, was twisted on itself tightly, one and one-half times from left to right, like a corkscrew with its handle in the pelvis and its point at the position of the cyst. There was no circulation in the pedicle, which was white and friable. The pedicle was ligated and the tumor removed. When the loops of the intestines, which were much injected and pretty generally adherent, were freed from one another, a distinct noise of pent-up gas and fluid could be heard passing along. The peritoneal cavity was irrigated with salt solution, a pint being left inside, and the wound was closed without drainage. The postural method of draining the peritoneal cavity was employed for twenty-four hours after the operation.

The patient reacted well; the nausea ceased at once and did not return, and the bowels moved three times on the third day after calomel. The temperature was not above 99° and the pulse about 104. The remaining convalescence was uneventful.

Reports of Societies.

MASSACHUSETTS MEDICO-LEGAL SOCIETY.

J. A. MEAD, M.D., SECRETARY.

The Society met, with a full attendance of members, June 13, 1899.

The business of the annual meeting having been transacted, including the re-election of the board of officers who had served the previous year, Dr. F. W. DRAPER read a paper entitled

CRIMINAL ABORTION, WITH A DYING DECLARATION.¹

DR. HOUGH: Although dying declarations are considered with sanctity by not only people in general but the medical fraternity as well, the statements made by persons with full knowledge that they are

about to die are not necessarily true. I have had, as medical examiner, one experience of that kind. A man who had been stabbed, having been informed by the Catholic priest in "extreme unction," as well as by myself, and I think two other physicians, that he would die, stated who had inflicted the wounds upon him, and also stated that the attack was entirely unprovoked. Yet it was unquestionably proven in the police court that the homicide had been done in self-defence; that the dead man had assaulted the other fellow with a heavy iron bar or some such weapon, had knocked him down, and that the victim of this assault had stabbed the man who had assaulted him, and that the stabber was about five feet six inches, and the man whom he killed was over six feet. There was no question but that this man said what was not true in the dying declaration.

DR. MEAD: I was much interested in Dr. Draper's case, because conviction came so quickly. My experience has been that, even with dying declarations and confessions, somehow or other the jury pronounce a verdict of not guilty. I had a case where a dying declaration was taken by a physician in a Newton hospital. The man who had performed the operation was brought to the hospital, confronted by the woman and identified, and after that experience and confession the jury acquitted this man, who undoubtedly did the operation. I think that we more often have this experience than that of Dr. Draper in his case.

DR. CANEDY: I have nothing to say in the matter of dying declarations, as I have had no experience in that matter. But the difficulty of prosecuting abortionists is as apparent to medical examiners in the northwestern part of the State as in Boston and vicinity. Near the town in which I live has been a noted abortionist, who has carried on her notorious trade for many years, and it has been known by many citizens that she has carried on this business, and she must have got a great deal of money in that way. The district attorney heard of her, and declared that she should be brought to justice; but it was impossible when the time for the case came to get her to court. She said that she was sick and had to stay at home in bed, and some physicians, members of the medical society, gave certificates of illness, saying that she was not able to attend court. She succeeded in playing this game for a considerable time. In the meantime, a petition was circulated and signed by one-half of the reputable business men of the village in her favor, asking that she be dealt with leniently. This was enough to discourage any district attorney, and it is generally the way that public opinion runs in all such cases. The authorities, however, finally succeeded in getting this woman into court, and compromised by giving her about a year in jail.

DR. ADAMS: I think that the last gentleman's remarks have struck the real key to the difficulty. A law is not good for much that is not backed up by public opinion and public sympathy, and however people may talk, I fear that that is what the execution of this law lacks — backing of public sympathy.

DR. PRESBURY: I have known a medical examiner to return a case of criminal abortion, and wait in vain for it to appear in court for trial. There is another instance: when we speak of dying declarations I think that we ought to remember that it is not accepted in the court as truth; it is viewed as other evi-

¹ See page 461 of the Journal.