

could have been more unfortunate than the application of this term. It has been made free use of and it has served to establish many in their hostility to the medical officers. But are they civilians? They hold commissions in Her Majesty's army, they wear a uniform and carry arms, and in an army they are placed in charge of the thousands of armed men and the transport which go to make up a hospital train. In action they are with the fighting line. Of necessity they are where the fire is heaviest, for their duty is to relieve the wounded on the spot where they fall, and for this reason you will realise why it is that the death-rate of army medical men is nearly twice as great as that of the combatant officers. I looked into the Army List the other day and I found that nearly twenty surgeons who are actually serving or are alive and retired have won the Victoria Cross. And I noted also that they are called "military recipients" of this splendid reward "for valour in battle." If they are "military" they are not "civilian." I press my argument further by pointing out that no civilian can win the decoration. The Victoria Cross warrant expressly declares that the Cross is for the naval and military services only, and that no "other circumstances or condition whatsoever, save the merit of conspicuous bravery, shall be held to establish a sufficient claim to the honour." What, then, becomes of the allegation that army medical officers are only civilians? They are not only in the army, but they are of the army. Every circumstance of their official lives proves it, and there will be no contentment until that fact is established by warrant beyond all cavil.

I have brought these matters before you so that you may understand some of the reasons of the outcry which is raised against the Army Medical Service. Even with these drawbacks many will find it to their interest to go forward for appointments. I by no means blame them. The competition of life is very keen, and I do not advise anyone to hold back. Perhaps I shall be condemned for this statement, but who, I ask, will provide an equally secure position for the young men who follow counsels of another kind? I know of none; and it seems to be asking too much of our students to stand back and thereby perhaps sacrifice a life's career. Each knows his own necessities and desires. We will do all in our power, as we have done, to help forward army medical reforms, but we must not speak hardly of those who in spite of disadvantages seek entrance into the service. At the same time the authorities must know that many brilliant men are looking elsewhere for a career, and that it depends upon an enlightened policy whether the medical department of the army will be again largely recruited from among the most promising of our young surgeons.

I pass from this question of the day to congratulate the prize-winners. Mr. D. A. Fitzgerald and Mr. F. J. Palmer have been awarded the Carmichael and the Mayne Scholarship respectively, and having regard to the extent and severity of the course their success is a brilliant one. In the classes Mr. J. S. P. Stewart has won three firsts and a second, and Mr. E. Glenny two firsts and a second, a result which points to still higher distinction in the future. Then Miss Dreaper and Mrs. Hennessy have each carried off a first and a second prize, and thus illustrated the fervour with which our lady students devote themselves to their work. The rest of the list shows that a large proportion of the class has engaged diligently in the studies of the various years, and it is a special gratification to find that in every instance a candidate has qualified for a first rank. Of the number who just failed in the struggle I have no record, but I wish to encourage them and all others to try again. They must not take defeat to heart too keenly and throw down their hands in despair. I have known some distinguished men who never could win a school prize, although later they earned the highest successes in life; and I trust that some of you who miss your names from the returns will yet achieve that which you have lost to-day. There is much that I should like to say to you now, for next year another President will speak to you from this place; but time is running out and I have already trespassed upon your indulgence. But I should like you always to bear in mind in your work that examinations are not the only things for which you should read. To have in your mind constantly that you must only make up what will get you through the portal is demoralising; it begets the worst of all mental processes—cramming. Prepare for your examination by all means, but let your reading be wide and generous. And, next, I sometimes feel that students do not value as they

ought the work in the hospital wards. Give to this all the time you can spare, not with your hands in your pockets, as I occasionally see, but with your mind keenly set upon the cases which are before you. For, necessary as all teaching in the schools is, and important as it is that you should be highly informed in the subjects taught here, it is with the living sick you will have to deal when you come to practise. No amount of knowledge will avail you unless you can apply it—unless you are able to recognise disease or injury and use your remedies. In a very few years these classes which I now address will have passed away into the world. You will be scattered here and there; some in large cities, but many in places where you will be isolated from the helping mind and hand of a member of your profession. Then you will realise in its fullest extent what responsibility is—what it means to have in your charge a case which you find difficult to read and which you must deal with alone. Nothing will be more distressing to you than this failure to help if after all the fault is your own. I ask you, therefore, to try to realise that responsibility now before the day of humiliation comes, and by your industry to relieve yourself of the possibility of self-censure.

With these words I draw to a close, only waiting to assure you that your teachers will do their part, that we all wish you the highest success, and that we shall look to you with confidence to uphold the reputation of the medical school of this old city of Dublin.

SOME NOTES ON OVARIAN TUMOURS, WITH A FIRST SERIES OF FIFTY OVARIOTOMIES.¹

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THE remarks contained in this paper are mainly founded on a series of fifty cases in which I have performed the operation of ovariectomy. The term "ovariectomy" is used to indicate the operation for the removal through an abdominal incision of cystic and solid tumours of the ovary, and also the operation for the removal of parovarian and other broad ligament cysts. No case is included where the ovaries were removed for the purpose of checking the active growth of fibroid tumours or where the appendages were removed on account of salpingo-cöphoritis.

It is well known, though none the less remarkable, that in many cases no symptoms other than those of enlargement of the abdomen are complained of by women who are the subjects of ovarian or broad ligament tumours, and that it is on account of this enlargement alone that they generally present themselves for treatment. Symptoms are, however, by no means always absent. Among my own series of cases disturbances of menstruation were the commonest of all symptoms and were noted in eleven instances. In three of the cases there was amenorrhœa for a longer or a shorter period, and in eight cases there was menorrhagia or metrorrhagia which appeared in point of time, as far as could be judged, to correspond to the growth of the tumour. It did not seem possible to attribute the alteration in the menstrual function to mere coincidence, but I had previously believed that an ovarian tumour, if it affected the menstrual flow at all, more often led to its cessation than to its increase. The history of the cases here recorded, however, does not support this view.

So far as it is possible to judge there does not appear to be any connexion between the variety of tumour and the nature of the change in the menstrual function. It has been asserted that with fibromatous tumours of the ovary menorrhagia is common, and in the single case of fibroma of the ovary which I have operated on menorrhagia was certainly present. The co-existence of amenorrhœa with the development of an ovarian tumour often leads the patient to believe that she is pregnant and may even mislead the medical attendant unless a careful routine examination is made. One of my patients, who was a single

¹ A paper read before the Harveian Society on Jan. 7th, 1897.

woman, not only believed that she was pregnant, but had even succeeded in identifying the supposed father, and was up to the time of operation in receipt of a weekly allowance which had been granted to her as the result of legal proceedings. It is probably the only case recorded in which an ovarian cyst has proved to be a source of income. It is much more common for a gravid uterus to be mistaken for an ovarian tumour than for an ovarian tumour to be mistaken for a gravid uterus, and although in many cases it is hardly possible to make such an error, yet in some cases the differential diagnosis is not made without a good deal of trouble. If a well-marked fluid thrill is present the idea of pregnancy may practically be put out of court at once, but it is not uncommon for an ovarian tumour to resemble very closely the consistence of a gravid uterus at the fifth or sixth month, and secondary cysts projecting on the surface may easily be mistaken for foetal parts. Foetal parts, however, move away from beneath the fingers of the examining hand, whereas the projecting knobs of the ovarian cyst remain permanently in the same place. Of course, in many cases a careful bimanual examination will reveal the unenlarged uterus lying apart from the tumour, but some broad ligament tumours and tumours which have formed adhesions to the uterus move with the cervix. A careful consideration of the history of the case and a thorough physical examination will rarely leave any real doubt as to the diagnosis. In cases of doubt it is always better to wait for one or two months rather than run the risk of opening a patient's abdomen and finding nothing but a gravid uterus. Menorrhagia and metrorrhagia seem to be about equally common, but it is very rare to see the loss sufficiently profuse to induce any marked degree of anæmia. The removal of the tumour has always led to the disappearance of this trouble, and this supports the view that the occurrence of menorrhagia or metrorrhagia is not a mere matter of coincidence.

Pain is another symptom which is fairly common, and sometimes is very difficult to account for. Twisting of the pedicle or suppuration and inflammation of the cyst, of course, are well-known causes, as is also rapid distension of the cyst from hæmorrhage into it, but in several of the cases recorded very severe pain was complained of and yet at the time of the operation nothing could be discovered to account for it. In one case, a girl, aged twenty-five years (Case 31), who had a parovarian cyst on the right side reaching to two inches above the navel, severe paroxysmal attacks of pain were complained of which were sometimes so acute as to induce fainting, and yet at the time of the operation there were found to be no adhesions nor any evidence that the pedicle had ever undergone torsion. This shows that the occurrence of intense abdominal pain in a woman with an ovarian cyst does not necessarily mean that the pedicle has become twisted, or even that there are necessarily any adhesions between it and adjacent parts. In several other cases symptoms of a very similar nature were observed, for which no very definite cause could be discovered at the time of the operation. It seems probable that these attacks are of a colicky nature, and are due to irregular intestinal contractions caused by the presence of the tumour. Attacks of paroxysmal pain of a similar nature were a prominent symptom in a patient of mine who suffered from fibroid tumours complicating advanced pregnancy, and in her case sickness and some degree of constipation usually accompanied the onset of the pain, thus suggesting its intestinal origin.

Another condition which can hardly be spoken of as a symptom, but which sometimes is associated with the presence of ovarian tumours, is procidentia uteri. Complete procidentia in young virgins is undoubtedly a rare condition, but in six cases of this nature which I have myself seen in three of them ovarian tumours were present. This would certainly seem to indicate that there is some causal relation between ovarian tumours and procidentia, and shows how important it is in all such cases to make a thorough abdominal examination in order to determine if any ovarian new growth exists. In the cases which have come under my own notice the tumours lay above the pelvic brim, so that they could at that time, at any rate, exert no direct pressure on the pelvic floor, although of course when smaller they might have done so. This fact seems to suggest that if the procidentia is more than a coincidence it must be due to altered pressure relations within the abdomen, which would no doubt be more easily produced in young women with firm, resistant abdominal walls than in older women whose abdominal walls had

already been stretched by child-bearing or weakened by the use of corsets. My youngest patient in whom procidentia was associated with the development of an ovarian cyst was fifteen years old. When first seen both anterior and posterior vaginal walls were completely everted, the cervix forming the central portion of the mass which lay outside the body. After ovariectomy she still had to wear a small ring to keep the anterior vaginal wall from bulging downwards, but before the operation no instrument could be retained. The tumour in this case lay in the abdominal cavity above the pelvic brim and did not extend into it.

Suppuration of an ovarian cyst is always the result of infection with pyogenic organisms. The infective agent may reach the interior of the cyst by one of three routes: (1) the lymphatics; (2) the Fallopian tubes; and (3) the intestine or vermiform appendix. Among my series of ovariectomies I met with four cases of suppurating cyst. Some authorities hold that by far the commonest route for the pyogenic microbe to take is the Fallopian tube. But in two of my cases the infection had certainly not reached the interior of the cyst by this way because in one of them the corresponding tube was perfectly healthy and in the other it was converted into a hydrosalpinx, which was not adherent by any part of its surface to the ovarian cyst, but was connected with it by a distinct and healthy mesosalpinx. In both of these cases the intestine was closely adherent to the surface of the cyst, and it seems therefore probable that the micro-organisms had passed from the interior of the bowel to the interior of the cyst, although in one case the suppuration dated from childbirth—or, at any rate, since that time the patient had suffered much pain in her tumour and had emaciated very markedly. No bacteriological examination of the pus was made, and therefore no absolute proof can be offered that the intestines were the source from which the infection was derived. In another case (Case 44) the suppuration was induced by a vaginal operation which had been performed six months before, apparently for the purpose of removing a uterine polypus, the operation being followed, according to the patient's account, by high fever and delirium, which lasted many weeks. In this case the pyogenic microbes probably reached the cyst through the lymphatic vessels or Fallopian tube. It is perhaps worth noting, but probably is a mere coincidence, that all the cysts which had suppurated lay on the right side. In three out of the four cases there was no rise of temperature, but in three of them there was marked emaciation. The pus contained in suppurating ovarian cysts is generally found to be sterile—that is to say, it contains no living micro-organisms, although they may be met with in the walls of the cyst; and this fact is one of considerable importance because it explains, what is well known practically, how if some of the pus escapes and soils the peritoneum there is very little real danger of septic peritonitis developing.

In four cases the cyst had ruptured. In two of them the rupture was the result of direct violence, and in the other two it occurred spontaneously. In the first case the patient, who lived in the country and was known to have had an ovarian tumour for eight years, fell out of a cart and alighted upon her abdomen, which was the most prominent part of her body. When seen by her medical man a few hours later she was found to be suffering from symptoms of collapse and complained of considerable abdominal pain, and the tumour, which was previously a very large one, had become much smaller and less well-defined. She remained in bed for six weeks. The tumour, however, soon began once more to increase in size, and four months later she was sent up to the Royal Hospital for Children and Women, and I removed a large very adherent papillomatous cyst of the right ovary. The omentum had to be extensively resected before the tumour could be drawn out.

In the second case (Case 33) the tumour, a dermoid, was ruptured during delivery. The posterior vaginal vault was also torn through, opening up Douglas's pouch, so that most of the greasy contents escaped externally. The collapsed cyst was removed by abdominal section on the fourth day of the puerperium. Spontaneous rupture of an ovarian cyst was observed twice in the same patient (Cases 39 and 50). On the first occasion a large multilocular cyst of the left ovary was removed, and on opening the abdomen the peritoneal cavity was found to contain a quantity of extremely thick gelatinous material which had escaped from one of the locules. The cyst wall was remarkably friable and tore with great ease. The peritoneum covering the intestines was

found to be deeply reddened and roughened so that it looked like velvet pile. Eight months later a second operation had to be performed owing to the development of a similar tumour in the right ovary, although this organ when examined at the time of the first operation was observed to be in no way enlarged. In this instance also the cyst had ruptured spontaneously and a large quantity of ovarian fluid was present in the peritoneal cavity. On neither occasion were there any special symptoms indicative of the extravasation of the cyst contents. I have already alluded to the question of the differential diagnosis of ovarian tumours from intra uterine pregnancy, but the diagnosis of ovarian tumours from uterine fibroids, though sometimes easy, is, on the other hand, sometimes impossible, and this illustrates the importance of never undertaking to perform an ovariectomy without being prepared to perform abdominal hysterectomy if the tumour turns out to be uterine instead of ovarian. Until lately I had always thought that the presence of a souffle was distinctive of a uterine tumour of some sort, but in one of my cases (Case 42) on which I operated last summer a very highly-marked souffle, identical in character with that which is heard over a gravid uterus, was audible all over the abdominal tumour, and yet when the abdomen was opened it turned out to be an ovarian cyst occupying the left broad ligament. The tumour was not unusually vascular and no great vessels were seen running across its surface, and the only way in which I could account for the presence of the blowing murmur was by supposing that the sound originated in the aorta or iliac vessels owing to their being pressed upon by the tumour and was thus transmitted to the surface of the abdomen. The error in diagnosis—for I believed it to be a fibroid—was rendered more easy to make by the fact that the tumour filled the whole broad ligament and ran close up to the uterus, so that tumour and cervix moved together as one mass. Soft myomata which project from the surface of the uterus to one or other side of the pelvis, whether sessile or pedunculated, may be mistaken for ovarian cysts, and no amount of examination will sometimes prevent an error in diagnosis.

Another condition which may easily be mistaken for an ovarian tumour is extra-uterine gestation. Only a few days ago I operated on a woman who had what I thought was an adherent ovarian cyst lying in the pelvis behind the uterus but found on opening the abdomen that I had to deal with a tubal pregnancy of three months' development. In this case there was nothing in the previous history to suggest the true nature of the tumour which was felt. On another occasion a middle-aged woman presented herself with a hard irregular tumour in the left iliac fossa which was diagnosed as an ovarian dermoid. At the time of the operation it turned out to be an old six months' extra-uterine gestation which was encapsuled, and had evidently long since ceased to develop. The condition of the foetus and sac, and the history subsequently obtained from the patient seemed to show that the gestation must have originated some two or three years before. In most instances, however, a careful consideration of the history and physical signs enable a differential diagnosis to be made; but in some exceptional cases like those above alluded to a correct diagnosis is hardly possible. One case at least (Case 39) merits a more detailed consideration because of certain points of unusual interest connected with it. The patient, who was sixty-three years of age, first came under observation in March, 1896, on account of a lump in the abdomen which had been noticed for five or six months. She had suffered, and was still suffering, from well-marked diabetes accompanied by emaciation. This disease seemed to have started about five years before, and at one time the symptoms were extremely serious, but under the influence of a rigid diabetic diet they became considerably less urgent, although she still continued to pass sugar in the urine. The abdominal tumour was very hard and nearly fixed and reached up to the navel; it was not tender and there was no ascites. It was feared that the tumour was malignant, but an exploratory operation was advised, although the existence of the glycosuria obviously increased the risk of such a procedure. At this time the amount of sugar passed was about eight grains to the ounce. The patient, however, did not come up to town for another two months, and during this interval the tumour grew rapidly, and now reached up to the ribs. The abdomen had become much more prominent, and the patient complained of considerable discomfort, and was only able to get about

with great difficulty. There was at this time distinct evidence of free fluid in the peritoneal cavity. The urine contained sugar as before. Sir John Williams saw the patient in consultation with me, and it was decided to perform an exploratory operation. A week later I therefore operated upon her, and on opening the abdomen found that the peritoneal cavity contained a large quantity of thick colloid fluid which had been poured out into it as the result of the rupture of one of the compartments of a multilocular cyst of the left ovary. The tumour itself was non-adherent, and consisted of a large number of small cystic cavities containing a jelly-like material. This was scooped out and the tumour removed. The peritoneal cavity was cleansed as thoroughly as possible by means of irrigation with hot water. The right ovary was examined, but as it was quite small it was not removed. The patient made a good recovery. During the first week after the operation the urine passed was of very low specific gravity, and no sugar could be detected, but during the second week the sugar reappeared.

The hardness of the tumour was due partly to the extreme thickness of the fluid and partly to the large number of cavities in which it was contained. About four months after the operation the patient noticed another tumour in the right iliac fossa. It continued to grow, and when seen in February of this year there was a firm mass the size of a man's head occupying the right half of the abdomen, lying well above the pelvic brim. On opening the abdomen for a second time (Case 50) a tumour was found originating in the right ovary of a precisely similar nature to that of the left ovary, which had been removed eight and a half months before. The peritoneal cavity on this occasion also contained a quantity of colloid material which had escaped from the tumour, and it was necessary to again resort to irrigation to get rid of it. The patient once more made a perfectly uneventful recovery. I know of no other recorded case where ovariectomy has been twice successfully performed on a patient who was the subject of diabetes. On the second occasion the urine was tested and showed the same amount of sugar as before.

Dr. Halliday Croom, in the "British Gynaecological Journal," February, 1896, relates the case of a woman on whom he performed ovariectomy who at the time of the operation was the subject of glycosuria. According to him very few cases of ovariectomy in patients with diabetes or glycosuria have been reported, and but little is known as to the risks of operating under such circumstances. In Dr. Croom's case there was no thirst, polyuria, or emaciation, and the glycosuria seemed to have developed since the appearance of the tumour, and certainly disappeared a few weeks after its removal, and Dr. Croom believed that the tumour caused the diabetes, possibly from irritation or pressure upon the pancreas. The case which I have related above is interesting, not only on account of the fact that the patient was suffering from diabetes at the time of the operation, but also as an illustration of the difficulty of being sure whether an ovarian tumour is malignant or not. Hardness, lack of mobility, rapid growth, and the presence of ascitic fluid may all prove misleading, so that in every case in which there is the least room for doubt an exploratory operation should always be undertaken. An incision sufficient to admit two fingers is often all that is necessary, and if on examination there is clear evidence of malignancy it is of great importance to avoid handling the tumour unless it is free from adhesions, when, of course, it should be removed in the ordinary way. If, as is often the case, the growth is found to have infiltrated and formed adhesions to the neighbouring parts it is very undesirable to penetrate it with the finger—a thing which is very easy to do when the growth is soft, because it certainly seems to greatly increase the rapidity with which the disease subsequently spreads.

Ovariectomy has nowadays become such a common operation, and so much has been written about it; that it is not necessary for me to speak of it in any detail. The results of the operation have year by year shown a lessening mortality until at the present day it is quite exceptional for it to be followed by a fatal issue. Among my own series of fifty cases, which represents all the ovariectomies performed by me up to the present time, there has been no death, and in the great majority of the cases the convalescence was free from any exciting incident. The success which attends the operation is undoubtedly dependent on a rigid attention to all the details of antiseptic surgery. It is difficult enough to always attain to the ideal, and there will probably still occur from time to time an occasional death from septic infection,

TABLE SHOWING PARTICULARS OF FIFTY CASES OF OVARIOTOMY.

No.	Age.	Date of operation.	Place of operation.	Nature of tumour.	Result.	Remarks.
1	58, widow.	1892 Sept. 15th	Royal Hospital for Women and Children	Mainly solid; some cystic spaces, probably sarcomatous; right.	Recovered	Patient died two years later with recurrent growth in abdomen.
2	26, married.	Nov. 5th	Ditto	Papillomatous; right.	Ditto	Suffered from mitral stenosis.
3	42, married.	1893 Jan. 14th	Ditto	Papillomatous; left.	Ditto	—
4	25, married.	Jan. 20th	Ditto	Suppurating; right.	Ditto	Drainage; sinus formed; subsequent removal of silk ligature followed by closure of sinus.
5	26, married.	Jan. 27th	Ditto	Broad ligament cyst; left.	Ditto	Cyst dipped deeply into the pelvis; enucleation was difficult; cavity drained. A few days later faecal matter came through tube; subsequently healed soundly.
6	50, married.	May 18th	Ditto	Papillomatous; right.	Ditto	Very adherent to bowel and omentum.
7	33, married.	June 20th	Ditto	Multilocular; left.	Ditto	—
8	48, married.	June 27th	Ditto	Solid; soft and friable; probably malignant; left.	Ditto	No adhesions.
9	38, married.	Dec. 22nd	Ditto	Broad ligament cyst; right.	Ditto	Enucleation; drainage of cavity.
10	29, single.	1894 Feb. 6th	Ditto	Sarcoma; right.	Ditto	Large tumour; adherent to under surface of liver; small portion left behind. Left hospital three weeks after operation; subsequent death from recurrence.
11	36, single.	Feb. 20th	Ditto	Fibroma; right.	Ditto	Extensive attachment to back of broad ligament.
12	51, married.	March 13th	Ditto	Broad ligament cyst; right and left.	Ditto	Patient had a large uterine fibroid, which was left untouched. Cysts enucleated; cavity on right side drained.
13	32, married.	July 3rd	Ditto	Papillomatous cyst; left.	Ditto	—
14	24, single.	Aug. 21st	St. Mary's Hospital	Multilocular; right.	Ditto	—
15	45, married.	Sept. 18th	Ditto	Multilocular; right.	Ditto	Twisted pedicle. Tumour contained blood.
16	38, married.	Oct. 9th	Royal Hospital for Women and Children	Multilocular; right.	Ditto	During convalescence had an attack of right lobar pneumonia lasting six days, ending by crisis.
17	29, married.	Oct. 23rd	Ditto	Parovarian; right.	Ditto	—
18	48, married.	Nov. 1st	Ditto	Multilocular.	Ditto	—
19	15½, single.	Dec. 5th	Ditto	Multilocular; right.	Ditto	Suffered from complete procidentia uteri.
20	37, married.	Dec. 14th	Ditto	Multilocular; right.	Ditto	Twisted pedicle very adherent.
21	43, married.	1895 Jan. 17th	Ditto	Unilocular; left.	Ditto	—
22	44, married.	Feb. 22nd	Ditto	Partly solid.	Ditto	Suffers from mitral stenosis.
23	44, married.	Feb. 25th	Ditto	Papillomatous; right.	Ditto	Patient operated on for similar tumour on left side, Jan. 14th, 1893 (see Case 3).
24	21, single.	April 23rd	Ditto	Multilocular; right.	Ditto	Tumour reached to ensiform cartilage.
25	32, married.	May 21st	Ditto	Multilocular; left.	Ditto	—
26	16, single.	June 25th	Paddington Infirmary	Multilocular; right and left.	Ditto	Operated on by request of Dr. Hillier; tumour on left side larger than that on right.
27	41, married.	July 4th	Royal Hospital for Women and Children	Bilateral; right suppurating.	Ditto	Vermiform appendix closely adherent to cyst on right side.
28	29, single.	Aug. 10th	St. Mary's Hospital	Dermoid; right.	Ditto	Procidentia uteri.
29	39, married.	Aug. 23rd	Royal Hospital for Women and Children	Multilocular; right.	Ditto	—
30	32, married.	Aug. 31st	St. Mary's Hospital	Papillomatous cyst; right.	Ditto	—
31	25, single.	Aug. 31st	Royal Hospital for Women and Children	Parovarian; right.	Ditto	—
32	56, married.	Sept. 10th	St. Mary's Hospital	Papillomatous; left.	Ditto	—
33	31, married.	Dec. 21st	Royal Hospital for Women and Children	Dermoid; right.	Ditto	Operation on fourth day of puerperium; tumour ruptured during labour and vagina was lacerated.
34	22, married.	1896 Jan. 7th	Ditto	Multilocular; right.	Ditto	—

TABLE SHOWING PARTICULARS OF FIFTY CASES OF OVARIOTOMY—continued.

No.	Age.	Date of operation.	Place of operation.	Nature of tumour.	Result.	Remarks.
35	31, single.	March 12th	Metropolitan Hospital	Parovarian; left.	Recovered	—
36	64, widow.	March 25th	St. Mary's Hospital	Multilocular; left.	Ditto	—
37	39, married.	April 13th	Royal Hospital for Women and Children	Parovarian; right.	Ditto	—
38	46, married.	June 2nd	Ditto	Bilateral; right suppurating, left dermoid.	Ditto	Much emaciated; tumour on right side, very adherent; drainage for twenty-four hours.
39	63, married.	June 8th	Nursing home	Multilocular; left.	Ditto	Patient suffered from diabetes mellitus; tumour had ruptured, and abdominal cavity contained much colloid material.
40	27, single.	June 29th	Royal Hospital for Women and Children	Multilocular; left.	Ditto	—
41	21, single.	July 14th	Ditto	Parovarian cyst; left.	Ditto	—
42	32, married.	Aug. 24th	St. Mary's Hospital	Papillomatous; left.	Ditto	Cyst was intra-ligamentous.
43	29, single.	Aug. 28th	Metropolitan Hospital	Dermoid; left.	Ditto	—
44	34, married.	Sept. 5th	St. Mary's Hospital	Suppurating cyst; right.	Ditto	Patient very thin and ill; tumour to navel: many adhesions.
45	27, single.	Sept. 8th	Ditto	Multilocular; right.	Ditto	—
46	36, married.	Sept. 29th	Ditto	Multilocular; left.	Ditto	Large amount of ascitic fluid.
47	39, married.	Oct. 27th	Royal Hospital for Women and Children	Broad ligament cyst; right.	Ditto	Tumour very adherent; right Fallopian tube inflamed.
48	56, married.	1897 Jan. 26th	Ditto	Multilocular; left.	Ditto	Twisted pedicle; universally adherent.
49	22, single.	Feb. 9th	Ditto	Parovarian; left.	Ditto	Tumour occupied the whole abdomen.
50	64, married.	Feb. 25th	Nursing home	Multilocular; right.	Ditto	Patient suffers from diabetes; tumour of left ovary removed June 8th, 1896 (see Case 39); tumour had ruptured and abdomen contained much glairy fluid.

but when such a death from such a cause does occur it is somebody's fault and indicates a flaw in the antiseptic precautions adopted. Shock is, perhaps, almost the only cause of death after abdominal operations that we cannot altogether eliminate. There is, however, nothing in the whole range of surgery so difficult as to be consistently clean. Instruments and ligatures are boiled and then transferred to a tray of carbolic lotion, from which the operator takes them as necessity arises, without the intervention of any assistant. Very little time is lost by this arrangement and the risk of infection arising from this source is minimised. The sponges are taken by the operator or his assistant from a bowl of carbolic lotion, and wrung out as required. The operations for the most part were performed in a small theatre which is used for general surgery of all sorts, and the patient was subsequently removed to the general ward.

All operators have their special fads, and personally I lay considerable stress upon a short abdominal incision and the ligature of the pedicle in three or more sections except when it is unusually narrow. A three-inch incision is generally quite long enough unless the abdominal wall is unusually fat or the adhesions are very numerous. Exposure of the intestines is thus avoided and the likelihood of the scar yielding is considerably lessened. By ligaturing the pedicle in more than two sections the chance of secondary hæmorrhage from slipping of ligature is practically eliminated. As to the value of irrigation of the peritoneum with boiled water or saline solution there is much difference of opinion. For my own part I very seldom employ it—only three times in fifty cases of ovariectomy, and in two of these cases it was had recourse to simply as the readiest method of removing large quantities of very tenacious ovarian fluid which had previously escaped into the abdominal cavity from rupture of the cyst. If the peritoneum be soiled by the escape of some of the contents of a suppurating cyst it can be cleansed quite as effectively by sponging as by irrigation, and in such cases it is not by any means always necessary to drain. I have had considerable experience in the operation for the removal of suppurating tubes and ovaries and have never had occasion to regret that

irrigation was not employed. If the results obtained by one who does not irrigate the abdomen are as good as those obtained by one who does, then the claims of irrigation fall to the ground. The abdominal incision is closed by means of silkworm gut sutures and no iodoform is used. The application of iodoform is certainly of no use, though it probably does no harm. The wound is dressed for the first time on the eighth day and half the sutures are then removed, the remaining half being left *in situ* for another five or six days. Of the after-treatment of cases of ovariectomy there is but little to say. If the patient is infected at the time of the operation she will almost certainly die, and if she is not she will almost certainly recover. An aperient is given on the third day, and castor-oil is usually the drug administered because of its reliability, and when the bowels have acted the patient is allowed to have solid food. The amount of misapplied energy that has been expended on patients after ovariectomy is enormous and does not appreciably influence the recovery. It is the precautions that are taken during the operation and not those that are taken afterwards that determine the fate of the patient.

Weymouth-street, W.

WEST OF ENGLAND EYE INFIRMARY, EXETER.—The annual meeting of this institution was held on Oct. 29th under the presidency of Mr. G. Franklin, J.P. The treasurer's statement showed that the ordinary receipts amounted to £1257, as against £1272 last year, and the ordinary expenditure was £1317, as compared with £1239 of the preceding year. The medical report stated that there had been 2780 patients under treatment during the year, of whom 2412 had been discharged (being 603 cured and 1758 benefited), leaving 327 out-patients and 41 in-patients under treatment on Sept. 30th. The daily average number of in-patients had been 41. The chairman expressed regret at the continued inability of the committee to proceed with the new buildings owing to lack of funds, the building fund at present being only £433, and added that although everything had been done that could be done the present institution was seriously defective in many respects,

A CASE OF ANTEVERTED WANDERING LIVER.

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In his "Treatise on Diseases of the Liver" the late Dr. George Harley wrote: "There is yet another possible source of error, though from its extreme rarity an error is unlikely to be committed. But, as the mistake is said to have once occurred, and it is quite possible it may occur again, it is but right that I should call attention to it—namely, the possibility of mistaking an anteverted small liver for an enlarged one." In the case that I record below, history has repeated itself to my own discomfiture. I have appropriated the term "anteverted" rather than "moveable" liver because the condition was rather one of axial rotation than of excessive mobility of the organ. The case will be seen to be one of peculiar interest, both because of the symptom complex and its post-mortem corroboration, and of the histological condition of the liver.

The patient, a woman, aged sixty-five years, attended the out-patient department of the Royal Free Hospital on May, 12th, 1897, and every subsequent week till July 7th, when she was admitted to the wards under my care. The following was the history of the patient when first seen. She complained of progressive weakness and pain all over, and there was yellowness and itching of the skin. The patient was married, but had had only one child, which was stillborn at full term; there was no history of parental tubercle or carcinoma; she had had twelve brothers and sisters, of whom only two were living, one brother having died from phthisis and the rest from unknown causes. When quite a child she had suffered with generalised dropsy; she did not know the cause of it but it was not associated with scarlet fever which she also had in childhood. The patient had had a left inguinal hernia for twenty-three years and hæmorrhoids for some years. Six months previously jaundice had set in insidiously with some abdominal pain but not of any severity. At the time she suffered a good deal from vomiting of a paroxysmal type, and was obliged to call in a medical practitioner, who ordered her to bed. In the course of a week or two the attacks of vomiting gradually subsided, but she lost flesh steadily. The jaundice became more intense; the appetite was completely lost; solids caused immediate nausea, so that only liquids were taken; since the illness commenced she had taken a quart of gin daily, but prior to that she had never exceeded one and a half pints of ale a day. The bowels were at first constipated and the motions whitish and foul-smelling.

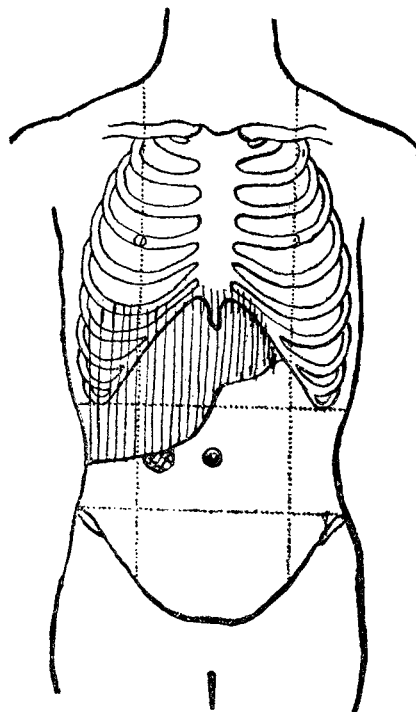
On May 12th she attended the out-patient department and was found to be in the following condition. There was intense obstructive jaundice of four months' duration. Liver dulness commenced at the sixth rib in the right mammary line and at the eighth rib in the mid-axillary line, and the edge could be felt at the level of the umbilicus. The enlargement appeared to be entirely of the right lobe; the surface was smooth; the edge was very hard and blunt; no nodules could be felt; and there was no pain on pressure. The gall-bladder could be clearly felt distended and projecting from beneath the edge of the liver about three inches to the right of the umbilicus.

Cancer of the liver was suspected, although no nodules could be felt and there was no marked tenderness or pain, but a primary seat could not be detected in the uterus or bowel, nor were there any indications of cancer of the stomach or head of the pancreas, so that the distended gall-bladder was fixed upon as the possible primary focus from which the disease had spread directly to the under-surface of the liver. The lungs were emphysematous and dry rhonchi were heard here and there on each side of the chest. For the next two months nothing special occurred beyond gradual emaciation and asthenia, with occasional attacks of acute pain in the right hypochondrium of a colicky nature. The constipation was relieved by a daily morning dose of *mistura alba*.

On admission to the wards on July 7th the patient was found to be much emaciated, and the conjunctivæ and the skin were a deep yellowish green in colour. The patient

expressed herself as much more comfortable in bed than when getting about; she lay chiefly on her back, but could lie in any position. There were complete anorexia and frequent nausea; the mouth was very dry and there was a constantly unpleasant taste; the tongue was coated with a dry and dirty whitish fur; there was no pain and the patient rarely vomited after food. A good deal of troublesome flatulence was present; the bowels were now regular, but the motions were loose and white; the stomach was not distended, and no tumour could be felt there. The superficial abdominal veins on each side were enlarged; there was obvious fulness of the right hypochondriac and lumbar regions, extending into the epigastrium, but the abdomen as a whole was

FIG. 1.



Representing condition on May 12th, 1897.

swagged over to the left, the intestines being apparently pushed *en masse* to this side; there was a large left inguinal hernia. The abdominal walls were very thin and flaccid, and the recti were separated; there was some tenderness on the right side of the epigastrium; a considerable tumour was felt reaching as low as the right iliac region, and extending upwards beneath the ribs. The percussion note was dull from the seventh rib in the mammary line to the lower edge of the tumour, which was felt to be the right lobe of the liver; its features have been already described. The gall-bladder could be felt clearly midway between the pubes and the umbilicus, a little to the right of the median line; the point of the finger could be readily inserted between the gall-bladder and the edge of the liver. The spleen could not be felt and was not enlarged to percussion. There was slight œdema of both legs, and there were some purpuric spots on the shins. The catamenia had ceased at the age of fifty-two years; for three months there had been a yellowish, quite odourless, discharge from the vagina. On examination per vaginam the cervix uteri was found to be atrophied; no induration was present; the fundus could not be felt, and the fornices were free. Per rectum no tumour was felt, but external hæmorrhoids were present. The urine was deep greenish in colour, of specific gravity 1008, and faintly acid; it contained no albumin, sugar, or blood, but bile pigment was abundant. The arteries were slightly thickened; the heart's impulse was feeble, but it was felt in the fifth interspace, just internal to the nipple; and the cardiac area and heart sounds were normal. The pulse was 80. The patient had had a cough for many years on and off; it was especially troublesome in the morning; the expectoration was yellowish and frothy. She was short of breath and her voice was hoarse and weak; the chest wall was much wasted, deeply jaundiced, and moved but little in respiration, though the movements were equal on each side. Behind, the lower ribs on the right side were much more prominent than those on the left; vocal fremitus was normal; there were a few palpable rhonchi. There was general resonance on percussion; the breath sounds were rather harsher over the right side than the left; expiry was