

this projection; the part of the capsule overlying them contained thick cartilaginous plates of various sizes; the larger cyst lay to the left, being about the size of a cricket ball; on cutting into it much pale, watery fluid escaped; the outer wall of the cyst was composed of firm fibrous tissue and condensed liver structure. Lining this internally were the remains of the wall of a parent hydatid cyst, to which numerous minute daughter cysts were adherent; lying free in the interior there was a great number of daughter cysts varying in size from a pigeon's egg to a small pearl. Many of the larger of these had ruptured and collapsed, and these, together, formed a mass of gelatinous material. The smaller cysts from the size of a marble downwards were filled with clear fluid; they had the ordinary structure of hydatid cysts, and on microscopic examination of their inner surface there were found numerous clusters of echinococcus heads, each with a circle of hooklets. The smaller cyst was about half the size of the other and was similar to it; a larger proportion of the daughter cysts had ruptured; there was less free fluid, but a considerable quantity of thick, brown grumous material containing degenerated cysts.

Remarks.—This case presents the following features of interest: 1. Hæmorrhage into the cerebellum is not a very frequent cause of death. In this case the hæmorrhage was very extensive and the effused blood caused severe compression of the medulla and pons, hence the rapidly fatal issue. From the end of 1872 till now there have been 894 deaths in this asylum, and in every case but two there has been a post-mortem examination; in only one other case was cerebellar hæmorrhage the cause of death. Of ninety-six consecutive fatal cases of cerebral hæmorrhage at Guy's Hospital in only one was the cerebellum the seat of hæmorrhage.¹ 2. As is often the case, the hydatid cysts of the liver caused no symptoms or discomfort during life. Hydatid disease seems to be very rare in Cumberland. Of 1144 deaths in this asylum since its opening in 1862 the above is the only case in which this disease has been discovered on post-mortem examination. A case of hydatid disease of the liver treated in the Cumberland Infirmary, Carlisle, by Dr. H. Barnes in 1879 was the first case of this disease recorded in the statistical tables of that infirmary from 1841 till that date; nor had there been any such case under treatment at the Carlisle Dispensary during the same period. The rarity of cerebellar hæmorrhage as a cause of death, as well as the infrequency of hydatid disease in this district, have been my reasons for placing this case on record.

Garlands, Carlisle.

TWO CASES OF OVARIOTOMY DURING PREGNANCY.

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THE following cases of ovariectomy during pregnancy are types of classes presenting well-marked clinical differences. In Case 1 the conditions were exceedingly simple; the tumour was of moderate size and entirely without adhesions, and the operation therefore was easy. The course of the pregnancy was most probably not affected by the operation; for although premature labour came on at the seventh month, this was nearly three months—more precisely, eleven weeks and a day—after the ovariectomy. It seems reasonable to conclude that its occurrence was due to some cause independent of the operation. In Case 2, on the other hand, the conditions were very different. There had been a well-marked attack of peritonitis, laying the patient up for a month some time before she became pregnant; there was also another attack of peritonitis when she was between two and three months pregnant. Again, as regards diagnosis, in the first case it presented no difficulty, the abdomen was lax, and the tumour small and freely movable, so that it was easy to separate it from the uterus, and under chloroform, indeed, to feel the sacral promontory between the uterus and the tumour. In the second case, on the other hand, the abdomen was tense even when the patient was under the influence of an anæsthetic, and though the evidence of pregnancy was clear from the blueness of the vagina and vulva, and from the enlargement and the intense blueness and

softening of the vaginal portion of the cervix, the evidence of the existence of the ovarian tumour was much less definite, as no distinct separation between it and the uterus could be recognised. In favour of the presence of an ovarian tumour were the two well-marked attacks of peritonitis, and the fact that on admission to hospital the upper limit of the abdominal swelling was three fingers' breadth above the umbilicus, although there had only been amenorrhœa for a little more than three months; in addition the upper part of the tumour had a much thinner wall than that of the pregnant uterus, and no evidence of the presence of a foetus could be detected by repeated examination, either by palpation or auscultation in the upper part of the abdominal tumour, nor did the walls of this part of the swelling harden and soften alternately. As regards the operation, the close adhesions between the cyst and the uterus constituted a formidable complication, for the surface of the uterus from which the cyst wall was separated bled freely. Although this was temporarily checked by packing sponges round the uterus, the bleeding evidently soon recommenced, for, on reopening the abdomen two hours after the operation, a considerable quantity of bloody fluid was found in the peritoneum. The use of iodoform gauze packed against the oozing surfaces was strikingly illustrated in this case. It will be seen that one strip of the gauze was left in for ten days without any ill effect. I should consider that the occurrence of the miscarriage on the second day was chiefly due to the irritation of the uterus produced by the pressure of the iodoform gauze. This case also illustrates the importance of early operation in cases of ovarian tumour. No doubt the attack of peritonitis in February (before she became pregnant) was due to the presence of the tumour, and, had the case been thoroughly investigated then, it would no doubt have been discovered, and ovariectomy could have been performed without the serious risk that arose in this case wholly in consequence of the patient having become pregnant.

CASE 1.—*Ovariectomy at the fourth month of pregnancy; no adhesions; uninterrupted recovery; premature labour at the seventh month; a subsequent pregnancy going to full term.*—A woman twenty-five years of age was admitted into the London Hospital under my care on Jan. 25th, 1892. She had been married four years, and had had one child a year and eight months previously. She had had a miscarriage about six months after her marriage; she thought it was due to running to catch a train. She suckled the child for twelve months. At the time of her admission to hospital she thought herself to be three months pregnant, as she had "seen nothing" for that time. Three weeks ago something came down in the front passage; it went back on lying down. When the swelling came down she had difficulty in passing water; at the same time there was a slight show of blood. There has, however, been no hæmorrhage since. On examination under anæsthesia a swelling the size of a child's head was found occupying the umbilical region, and extending up towards the epigastrium as far as three fingers' breadths above the umbilicus. The tumour was freely movable, and evidently contained fluid. It was separated by a distinct depression from a swelling lower down, which rose from the pelvis, and was, in fact, the pregnant uterus. Under anæsthesia it was possible to sink the hand between the tumour and the uterus so as to feel the sacral promontory. The patient went home for a short time, and was readmitted to hospital on Feb. 17th. The uterus then reached to within three fingers' breadths of the umbilicus. On Feb. 29th the abdomen was opened by an incision starting from one inch above the umbilicus to two inches below it. The cyst was tapped and drawn out of the wound in the usual way. There were no adhesions. The pedicle was tied with a Staffordshire knot, then another ligature round the whole pedicle, and the tumour was cut away. It was an ordinary multilocular ovarian cyst. The peritoneum was not washed out, and the wound was completely closed in the ordinary manner. The patient did well, the temperature never rising above normal. She went home on March 27th. The foetal heart was heard for the first time on March 22nd. I heard afterwards that she was confined on May 17th prematurely, at the seventh month—that is to say, about three months after the operation. Recently (last November) I heard from her that she was again pregnant, and, indeed, within a few days of full term. Before she became pregnant this time the intervals between the menstrual periods were from six weeks to two months.

CASE 2.—*Ovariectomy during pregnancy at about the fifth month; tumour closely adherent to uterus; pelvis packed with iodoform gauze to stop bleeding; miscarriage on second day*

¹ Fagge's Principles and Practice of Medicine, second edition, vol. i., p. 562.

after operation; good recovery.—A woman thirty-one years of age was admitted to the London Hospital under my care on Sept. 18th last. She had been married for four years and had had two children, the last in March, 1892. She had had no miscarriages. The last child was suckled for eleven months—i.e., till last February. In December, 1892, she menstruated for the first time since the confinement. She first menstruated at the age of twelve years and was regular every four weeks, the periods lasting for six or seven days and being unattended by pain. When she was seventeen years of age there was amenorrhoea for eighteen months, and after that she again became regular. The family history was good. In February of this year she suffered from “inflammation of the lower part of the stomach.” This lasted for a month; the pain “doubled her up.” During this time she had a slight vaginal discharge of blood. The abdomen was much swollen, and the medical man in attendance told her that she had a tumour; at the end of this illness, however, he told her he thought that he had “dispersed” it. From February to June 4th she menstruated regularly and appears to have been in fairly good health. From June 4th up to the time of her admission to hospital she had not menstruated and considered herself to be pregnant. About the middle of August she became very ill and did not call in the medical man who had attended her in February, but sent for Dr. Downes of Hornsey; he found her to be suffering from peritonitis, with constant vomiting and great prostration. The abdomen was distended and very tender. As the acute symptoms subsided Dr. Downes detected what he believed to be an ovarian tumour, and asked me to admit her to the London Hospital with a view to operation. When admitted to hospital the abdomen was prominent and tense. The umbilicus was level with the skin. A tumour was felt, evidently containing fluid and rising out of the pelvis. Its upper limit was about three fingers’ breadths above the umbilicus. Nothing was at this time heard over the tumour. On vaginal examination the vulva and vagina were found to be distinctly blue and the cervix soft and intensely blue. On Sept. 21st the patient was anaesthetised and examined again. Even then the examination was not completely satisfactory owing to the tense condition of the abdominal walls, but the uterus was found to be retroverted, and there seemed, to the outside hand on the hypogastric region, to be a slight groove between the body of the uterus and the main swelling in the abdomen. At this time a soufflé was heard in the hypogastric region in the middle line. On Oct. 5th the tumour in the abdomen reached a finger’s breadth higher than on admission. On vaginal examination the swelling felt in the posterior fornix had disappeared, and the cervix was pointing in its normal direction, so that the uterus had spontaneously regained its normal position. On the 18th the tumour was a good hand’s breadth above the umbilicus. The upper part of the tumour seemed to be more movable than before, and appeared to have a thinner wall than the lower part, the thicker-walled portion reaching about three fingers’ breadths above the pubes. On vaginal examination ballottement was obtained for the first time. On the 26th the measurements were as follows:—Umbilicus to pubes, 8½ in.; umbilicus to tip of xiphoid cartilage, 6½ in.; maximum girth of the abdomen (at the umbilicus), 32½ in. On Oct. 26th, at 2 P.M., the abdomen was opened in the usual way, except that the lower end of the incision was not carried as low as usual. The swelling was found to be an ovarian tumour, adherent to the abdominal parietes at the lower half of the incision. There were also numerous adhesions to the omentum, which were tied in several pieces and divided. The tumour was adherent on its under and posterior surface to the uterus, which was about the size corresponding to five months’ pregnancy. There were some adhesions between the tumour and the anterior surface of the uterus. The relations of the tumour to the uterus were, in fact, somewhat like a cap fitted over the top of it, and closely adherent to it in several places. The tumour was tapped in the usual way and found to contain a tar-coloured fluid. It grew from the left ovary. The right ovary was healthy. When the tumour had been separated from the uterus the pedicle was transfixed and tied with Bantock’s knot and another ligature round the whole pedicle. Wherever the cyst had been adherent to the pregnant uterus there was a free oozing of blood; the abdomen was repeatedly irrigated with hot water containing a drachm of tincture of iodine to the quart, but it had little effect on the oozing. An attempt was made to check the oozing at one or two places where it was most noticed by passing a fine silk ligature under the site of it. The punctures made by the needle in doing this,

however, bled freely. Sponges were packed around the oozing surface, but it was some time before the bleeding appeared to be sufficiently controlled to allow the wound to be closed. I saw the patient about 6 P.M., and it seemed to me probable that some bleeding was going on internally. I therefore took out two stitches; there was a good deal of bloody fluid in the peritoneum, but no clots were to be felt. A little chloroform was given, and nine strips of iodoform gauze, each measuring six yards in length, were packed into the abdomen round the uterus; the ends of the gauze were left hanging from the lower end of the wound. One fresh deep suture was then inserted above the ends of the gauze and tied. Some of the iodoform gauze was removed in thirty-six hours, and the remainder (as was believed) forty-eight hours after the operation. The pulse before removal of the gauze was 170. The patient miscarried early on the second day after the operation. Two rubber drainage-tubes were put in after removal of the gauze. During the first four days after the operation there was more or less vomiting and the patient was fed by nutrient enemata; during the same time the pulse was very rapid, varying from 120 to 150, but on Oct. 31st it fell to 100. The temperature only once rose to 100·2° F. (on the 28th), and was then normal till Nov. 5th, when it rose to 100°. The wound was dressed at first three times a day, then twice, and afterwards once. One drainage-tube was removed on Oct. 31st and the other on Nov. 2nd. On Nov. 5th—i.e., ten days after the operation—the temperature rose to 100° after having been normal for several days. The wound was explored with a probe, and it was found that a piece of the iodoform gauze had been left in. It was removed and a small drainage-tube was inserted, it being finally removed on Nov. 18th. By Dec. 4th there was no longer any sinus and the patient got up for the first time; she had been kept in bed much longer than usual, and much against her will, so that the sinus might be completely healed. She went home on Dec. 9th. The temperature remained normal after Nov. 5th.

Wimpole-street, W.

A FIRST SERIES OF FIFTY OVARIOTOMIES: A PLEA FOR THE PERFORMANCE OF OVARIOTOMY BY OBSTETRIC PHYSICIANS.¹

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THE publication of a series of cases of ovariectomy at the present day would seem to need some apology. I have three reasons for writing this paper. The first is that I consider it a useful custom for everyone who performs ovariectomy to publish complete lists of his cases, with dates and other means of identification, and with a statement (sufficiently detailed in the fatal cases) of the other abdominal sections which he has performed during the period to which his lists refer. The second reason is that, in the series of cases hitherto published, there has usually been a noteworthy absence of reference to such important points as the number of cases in which the wound failed to unite by first intention or in which stitch-hole abscess occurred, the number of cases in which sinuses existed when the patient was discharged or in which ligatures came away subsequently, hernia at the site of the scar, and the after-history of the cases. In this connexion also I would point out that, while it is often stated that an operation has been performed with antiseptic, with aseptic, or with no special precautions, it has rarely been stated what are the actual precautions which have been taken. Upon these points I give information in the present paper. My third and my chief reason for writing this paper is that I think the time has arrived when the obstetric physicians in London, the men who do the bulk of the teaching of gynaecology, should by their publications show that the operation of ovariectomy, when performed by themselves, is at least as safe in a general as in a special hospital. To University College Hospital, where ovariectomy has been performed by the obstetric physicians for twenty years, the obstetric physicians of London owe a debt of gratitude, for it is

¹ A paper read at a meeting of the Medical Society of London on the 11th inst.