

was performed on Nov. 10th, 1902. (Chelsea Hospital for Women.)

CASE 10.—The patient was a married woman, aged 31 years. She was sterile. She had a fibroid of the size of a turkey's egg growing from the anterior wall of the cervix and pressing on the bladder. This filled up the vagina, hindering coitus. Vaginal enucleation was performed on May 18th, 1903. (Chelsea Hospital for Women.)

The largest intracervical fibroid known to me is a specimen (Hunterian) preserved in the Museum of the Royal College of Surgeons of England. It measures 30 centimetres (12 inches) in length by 12·5 centimetres (five inches) in width. Unfortunately it is without history.

A close study of these ten cases brings out some further facts. It will be noticed that in some of them the condition of the mouth of the womb is described in this way: "The os uteri was a mere dimple"; wherever this sentence appears it almost certainly follows that menstruation is described as normal, scanty, or irregular and a closer study of the records shows that the patient is usually a spinster or, if married, sterile. On the other hand, the great majority of the women in whom the intracervical fibroid is a source of menorrhagia have borne children and present a patulous and often widely patulous os uteri. It should also be borne in mind that cervical fibroids of all varieties, though commonly solitary tumours, are occasionally complicated by a submucous fibroid in the body of the uterus and this is, of course, a notorious agent in producing metrorrhagia.

A glance at the brief notes of the ten cases shows that these cervix fibroids do not lend themselves to any routine kind of operation. When of moderate size and associated with a capacious vagina the intracervical kind and those which arise on the anterior aspect of the supravaginal cervix may be easily, expeditiously, and safely enucleated through this channel. Tumours which attain and exceed the bulk of a foetal head at term almost invariably demand treatment by the abdominal route. I have tried a variety of methods. When the uterus with the tumour in its cervix can be raised out of the pelvis far enough to allow the necessary manipulations then panhysterectomy can be performed easily and quickly. Occasionally the tumour is wide and so fixed in the pelvis that it will be necessary to split the uterus longitudinally and to enucleate the fibroid from its bed; then an ordinary supravaginal hysterectomy can be carried out. The enucleation of a large impacted cervix fibroid requires to be conducted carefully without undue display of force or so much shock is produced that the patient's life will be placed in the gravest peril. However, large cervix fibroids can be safely enucleated even when the uterus is gravid, as Case 6 testifies.

Perhaps the acme of difficulty is that met with when the body of the uterus is occupied by a large fibroid and another, even larger, grows from the posterior aspect of the cervix and tightly blocks the pelvis. In this particular condition the fibroid can be enucleated from the cavity of the uterus; the larger tumour is then shelled out of the pelvis and the uterus is removed as in an ordinary supravaginal hysterectomy. The lower extremity of the capsule forms a pouch and the unexpanded vaginal portion of the cervix lies in its anterior wall; before suturing the stump in order to secure free drainage into the vagina I split the cervix longitudinally with scissors. In one instance in which I divided the uterus longitudinally in order to extract a large, tightly impacted intracervical fibroid, instead of removing the uterus I sutured the two halves and left the organ intact. The patient recovered without even a rise of temperature. In conclusion, there is no form of uterine fibroid likely to test the judgment, resources, and common sense of the surgeon to such a degree as a large cervix fibroid tightly incarcerated in the pelvis. The three diagrams used to illustrate this article were drawn by my colleague Dr. A. E. Giles who has assisted me in the removal of many difficult cervix fibroids.

Brook-street, W.

ERRATUM.—In the paper by Dr. Alexander Marmorek on Treatment with Antituberculous Serum, published in our last issue, the words "in which tubercle bacilli were found" (see THE LANCET, March 26th, p. 859, column 1, line 6) were deleted by the author and printed by us in error.

A CASE OF SLOUGHING OF THE CENTRAL PART OF A UTERINE FIBRO-MYOMA SHORTLY AFTER DELIVERY.¹

By JOHN D. MALCOLM, F.R.C.S. EDIN.,
SURGEON TO THE SAMARITAN FREE HOSPITAL.

THE following case is interesting on account of the fact that an acutely formed slough was surrounded by living healthy fibro-myomatous new growth and also because a fibro-myoma touching the mucous membrane and the peritoneum was removed by enucleation without serious hæmorrhage.

The patient's age was 32 years. She married in March, 1902, and miscarried in September of the same year. On Oct. 25th, 1903, she had a still-born child of about seven months' gestation. Her medical attendant was not present but he delivered the placenta an hour later. Much blood was lost for five hours after delivery and many clots were passed during the following four days. On the fifth day the vaginal discharge was very offensive, the patient's temperature was high, and she felt very ill. She gradually got better and the discharge ceased but much pain in the pelvis continued. Her medical man told her that this was caused by a tumour attached to the womb which had been there since her delivery and which would probably get all right. He ceased to attend after about four weeks. The pain increased very much as the patient tried to move about and on Dec. 10th she sent for another practitioner, with whom I saw her seven weeks after delivery, and she was admitted to the Samaritan Free Hospital on the next day. She had then a mass in the pelvis, apparently between four and five inches in diameter, closely attached to the womb, which lay to the right and behind. The swelling was always painful but the slightest manipulation and every movement caused intense suffering. The uterine cavity measured just over two and a half inches in length and there was no vaginal discharge. The temperature was 99·4° F. on admission to hospital but on the next day it was normal and it did not again rise until after the operation. Except for the presence of the mass attached to the uterus and some anæmia the patient seemed to be quite healthy. I thought that possibly there might be an extra-uterine foetation but a diagnosis of inflamed fibro-myoma seemed to explain the conditions better.

On Dec. 18th, 1903, the fifty-fourth day after delivery, as there was no improvement, the abdomen was opened and a tumour which was obviously a uterine fibroid was exposed. The most prominent part seemed to be covered by little, if anything, but peritoneum and the uterus which was well involuted was attached to the back and right side of the growth. The body of the uterus could be seen and felt standing well out from the growth and they seemed to be slightly mobile on each other. The appearances suggested that the tumour was not very deeply buried in the wall of the uterus and it was therefore decided to attempt to remove the fibroma and to leave the uterus. An incision was made through the capsule and enucleation was effected without much difficulty. Only one vessel bled sufficiently to require a ligature, all other hæmorrhages being controlled by sponge pressure. The tumour was placed, however, much more deeply than I thought, and in removing it the cavity of the uterus was laid freely open. A sound passed through the cervix made this quite certain. Nevertheless, hæmorrhage was unimportant and I therefore closed the wound in the uterine wall. The deeper parts were brought together by a continuous catgut suture, but it was impossible to adjust the mucous surfaces accurately and drainage into the uterine cavity was therefore free. The outer walls of the capsule which had contained the tumour were then inverted, but to do so it was necessary to shorten them considerably. This had the advantage of making their edges much thicker and there was no difficulty in inserting Czerny-Lembert sutures so that no part of the silk entered the cavity from which the tumour was removed. The necessary shortening of these flaps caused very little bleeding. Two small pedunculate fibroids of about the size of marbles were also removed from the back of the uterus and no other tumour was detected. The patient

¹ A paper read before the Obstetrical Society of London on Jan. 3rd, 1904.

made an uninterrupted recovery, there being a considerable vaginal discharge for the first few days.

The tumour appeared to be an ordinary fibroid and showed no sign of degeneration until it was incised. Then it was seen that about half an inch all round had the appearance of an ordinary living fibro-myoma, whilst the central part was a whitish-grey slough. There was no possibility of separating the central from the outer part except by using a knife. There was no odour. After being in spirit a few days the colour had all gone, but it was obvious that the external part had contracted more than the central. The appearance was very similar to that shown when a fibroid in the uterine wall has been incised and kept in spirit, but in such a case it is normal uterine tissue that retracts. Mr. W. Sampson Handley kindly made a section of the growth, including part of the central sloughed tissue and part of the unaltered tissue. The surrounding growth stained well with eosin and hæmatoxylin and showed numerous muscular cells with well-stained nuclei. The sloughed part took on little stain and showed hardly any structure, no nuclei being visible. It was apparently in a state of mucoid degeneration. There was a definite line of demarcation between the well-stained and the slightly-stained parts.

These conditions are unique in my experience. It does not seem that there was an ordinary sloughing due to septic influences absorbed from the uterine cavity. The growth was so close to the mucous membrane that contamination from this source must inevitably have induced a putrid slough of the whole tumour, and the death of the patient would probably have followed, because the growth was as near to the peritoneal as to the mucous surface.

The greater contractility of the outer portion of the growth suggested that the central part was more fibroid and less vascular, but probably the difference was due to a degeneration of the sloughed tissue. Nevertheless, the large number of muscular cells must have subjected the central part of the growth to considerable pressure, and this, together with the diminution of the vascular supply caused by the involution of the uterus, seems to afford the most satisfactory explanation of the sloughing of the central part of the growth. According to this view the slough was aseptic and it is probable that if the patient had been kept absolutely quiet sufficiently long the dead tissues would have been very slowly absorbed.

The advantages of enucleating the tumours and of leaving the uterus in a recently married woman, 32 years of age, are obvious. But it should not be forgotten that the surgical completeness of the operation, whilst it gives the patient the opportunity of becoming a mother, exposes her at the same time to the risks involved in the presence of a long scar in the uterine wall, and this condition must give rise to considerable anxiety if the patient should become pregnant again.

Portman-street, W.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

UNIVERSITY COLLEGE HOSPITAL.

A CASE OF TETANUS TREATED WITH ANTITETANIC
SERUM; RECOVERY.

(Under the care of Dr. J. ROSE BRADFORD.)

FOR the notes of the case we are indebted to Mr. W. F. Annand, house physician.

The patient, a well-nourished, healthy-looking woman, aged 70 years, was admitted into University College Hospital on Nov. 25th, 1903, at 2 P.M., said to be suffering from tetanus. The history was that on Nov. 22nd she began to feel cramp-like pains in her right leg, which during the next two days spread to the abdomen and thence up the spine. On the 24th she was said to have had a typical tetanic

spasm. Ten cubic centimetres of antitetanic serum were injected beneath the skin of the abdomen and the patient was sent to the hospital. On admission a large healing ulcer was present on the front of the right leg, measuring six inches by three inches. Its base was firmly fixed to the bone. No other breach of the surface was discoverable anywhere. The temperature was 97·8° F., the pulse was 96, and the respirations were 24 to the minute. There were slight rigidity of the jaw muscles, slight difficulty in swallowing, and inability to protrude the tongue beyond the teeth. There were no other signs of importance. At 4.30 P.M. the patient had an attack of violent spasm. There were intense pain in all the muscles, along the spine particularly, and marked opisthotonos, the body being bent like a bow, resting only on the occiput and the heels. The eyebrows were screwed up, the angles of the mouth were drawn, and the jaws were firmly clenched. The thorax was absolutely fixed and respiration was entirely suspended. The spasm lasted for about a minute and then passed off, leaving the patient very cyanosed and for a short time unconscious. This condition passed away in two or three minutes. From 4.30 P.M. on the 25th to 12.30 P.M. on the 26th there were 11 attacks of spasm at fairly regular intervals, the third, fourth, and fifth being very slight. An enema of 30 grains of chloral had been given after the first attack and another was given after the last. At 2 P.M. on the 26th chloroform was administered, the ulcer was excised and the surface left was scrubbed with peroxide of hydrogen. An injection of 100 cubic centimetres of antitetanic serum was made beneath the skin of the abdomen. On coming round from the anæsthetic two very severe spasms occurred at 6 and 6.45 P.M. The pulse showed signs of failure and brandy was given frequently. She slept well during the night. At 3 P.M. on the 27th a further injection of 90 cubic centimetres of serum was made near the site of the former injection, this time without an anæsthetic. At 4 o'clock there was a severe spasm, resembling in all respects those which had occurred before. Until Dec. 1st the history was uneventful, no further attacks occurring. On that date the temperature rose for the first time, reaching at night 99·8°. During the evening the patient complained of considerable irritation over the front of the abdomen, the lower part of the back, the knees, and the wrists. There was present on examination an urticarial erythematous eruption consisting of minute white papules on a ground of vivid pink. There were slight headache and nausea for from eight to ten hours. On the following day the rash was general. On the afternoon of the 4th the temperature began to rise steadily, reaching 101·8° on the night of the 5th. There was considerable pain in the wrist-joints, the metacarpo-phalangeal joints of the thumbs, and the interphalangeal joints. They were all swollen and excessively tender, the skin over them being red and glossy. On the 5th there was slight laryngitis, with hoarseness and cough. The knee-joints were swollen and fluid was detected in each. By the 7th the rash and the arthritis were lessening and these had gone by the 10th. The temperature continued going up and down until the 14th, the highest rise occurring on the 8th, when the thermometer registered 102·6°. During this time, on the evenings of the 9th and 10th, two syncopal attacks occurred. Another attack occurred on the 14th, when the patient became unconscious, the chest was fixed, and respiration stopped. This lasted a few seconds and then the back arched as in the tetanic spasms at the beginning of the illness. No special measures were taken. From this time onward convalescence progressed uninterruptedly. On the 23rd a Thiersch graft was applied to the ulcer which united perfectly. The patient was discharged well on Jan. 23rd, 1904. Unfortunately the piece of tissue forming the floor of the ulcer which had been excised was lost and no microscopical or other examination was made of it.

Remarks by Mr. ANNAND.—The case seems to me to be interesting as showing the result of the large injections of antitetanic serum now recommended. The patient had in all 200 cubic centimetres of serum subcutaneously; the rash appeared on the seventh day from the time of the first injection of 10 cubic centimetres and on the fifth day from the date of injection of the first large dose of 100 cubic centimetres. The arthritis appeared on the tenth or eighth day, according to whether one reckons from the date of the small or large injection. That the successful issue of the case is due to the use of the serum, which was supplied by the Lister Institute of Preventive Medicine, is, I think, indubitable.