

was wrong to consider the size of passage without further investigation as to changes of the size. Many eminent men doubted the reality of so-called cures of sterility, and he had no doubt that most cases were mere lucky coincidences. He was not convinced of the reality of any cures except in these cases of combined dysmenorrhœa and sterility discussed in Dr. Godson's paper. One evidence in favour of the reality of the cures was that all were done by substantially the same method—namely, dilatation of the cervix. Among the various means of dilatation, he held a well-known opinion in favour of that recommended in the paper just read.

Dr. GODSON, in reply, said that his dilators were not curved any more than an ordinary uterine sound, and not so much as those used by the president. It seemed almost certain that the patient upon whom Dr. Rogers had passed the dilators was suffering from congestive dysmenorrhœa, and was not a fit subject for the treatment. It was most important that a proper diagnosis should be first arrived at, and that dilatation should be only practised where there was absence of congestion, otherwise there was great fear of inflammatory mischief ensuing. His paper treated only of spasmodic dysmenorrhœa associated with sterility, and therefore Dr. Priestley's remarks with respect to the treatment of young girls were outside the scope of the paper, but he entirely accorded with them.—*Lancet*, February 11, 1882.

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The Elastic Ligature in the Abdominal Extirpation of Uterine Fibroids.

One of the chief difficulties in the extirpation by laparotomy of uterine fibroids has been to find some trustworthy method of securing the stump. The pedicle, being formed of muscular tissue, contracts, so that the clamp or ligature, a few hours after it has been applied, will have become loose. In a recent number of the *Archiv für Gynäkologie* a case is recorded in which the elastic ligature was successfully employed. It occurred in the clinique of Professor Olshausen, and is reported by Dr. E. Schwarz. The tumour, before operation, was supposed to be ovarian; its smoothness, the sense of pseudo-fluctuation which was felt over it, and the facts that it pressed down the uterus (which could thus be palpated per vaginam apparently throughout its whole length) and that a rounded elastic segment of the tumour could be felt behind the uterus, being the features which led to this error. An incision having been made, and the tumour exposed, a trocar was thrust into it, but nothing escaped. The opening was then enlarged with the knife, and a quantity of opaque, reddish-brown, thin fluid, and a mass of decolorized blood-clot as big as two fists (in all, weighing about thirty pounds) was removed. The incision having been prolonged upwards, and thus the bulk of the tumour (which was found to grow from the upper and posterior part of the uterus) got outside of the abdomen, a piece of India-rubber drainage-tube was made fast round its pedicle to control hemorrhage. Then the tumour, the solid part of which weighed twelve pounds and a half, was excised, the pedicle being left of a funnel shape; the arteries visible were separately taken up and tied, and the sides of the hollowed-out pedicle were brought together by superficial and deep sutures. The India-rubber tubing was then taken off; but blood welled up from the pedicle in such quantity as to call for some mode of stopping it which would not involve delay. A piece of India-rubber tubing about the thickness of a goose-quill was therefore put twice round the pedicle and tied. Between the two bands of tubing the stump was transfixed with a long needle, and it was then made fast to the abdominal walls, drainage-tubes were inserted, and antiseptic dressings applied. The part outside the ligature was nearly as big as the fist. The operation lasted one hour and three-quarters. In the evening the dressings were found soaked through, and on removing them, it was discovered that the

needle had broken, and the stump dropped into the abdominal cavity. The ends of the elastic ligatures were still outside. As there were no bad symptoms, it was not thought necessary to interfere further. The drainage-tubes were removed on the fourth day. The elastic ligature and the detached part of the pedicle came away on the seventeenth day. The patient did well. Dr. Schwarz suggests some ingenious modifications in the mode of applying the elastic ligature; and Professor Olshausen (who adds some comments) expresses himself as without doubt that the elastic ligature is destined to play a large part in the treatment of cases similar to the one described. We may add that a volume of *Beiträge* recently published to commemorate the jubilee of Professor Credé's occupation of his chair, contains a communication by Dr. Leopold, of Leipzig, bearing on the same subject.—*Med. Times and Gaz.*, Dec. 17, 1881.

— *Diagnosis of Ovarian Tumours.*

Dr. A. MACDONALD mentions the following points as assistance in the differential diagnosis of ovarian tumours:—

1. *Pregnancy*.—The possibility of pregnancy, the signs and symptoms of pregnancy, and waiting if in doubt, place the diagnosis beyond possible mistake with a fair measure of care.

2. *Fibroid*.—A large fibroid with solid walls, leading to general enlargement of the uterus, is easily diagnosed. The increased length which the sound enters, the fact that the uterus moves with the sound, the peculiar feel of the uterus, and the nearly constant menorrhagia, suffice to keep the diagnosis correct. It is quite common to hear a bruit in a case of uterine fibroid; only in vascular sarcomata is such audible if the tumour is ovarian. But much greater difficulty is experienced in cases of fibro-cystic tumours connected to the uterus with or without pedicle. In that case we must try to ascertain whether the tumour is connected or disconnected with the uterus. Then the cyst of a fibro-cystic tumour may be tapped, when we expect to find only a thin fluid of great density, with some blood-corpuscles, and possibly some non-striated muscular fibres. But in those cases it is often found that only an exploratory incision can determine the diagnosis with accuracy.

3. *Renal cysts* begin below the false ribs and extend downwards and forwards. They have a line of resonance between them and the liver due to the transverse colon, which is of value as showing they are not of hepatic origin, and when aspirated they contain urea. Usually accompanying such there are urinary symptoms, but not always.

4. *Ascites* exhibits the characters of free motion of fluid in an imperfectly filled cavity. Accordingly, when the patient lies on her back the abdomen is flattened anteriorly, the flanks give a dull note, and there is clearness round and above the umbilicus. With change of the patient's position the areas of resonance alter. Thus if the patient is turned on her left side, the right flank gives a clear note, and *vice versa*. In case of tapping an ascites the thick gelatinous fluid characteristic of ovarian tumour is never obtained.

5. *Hydatid Cyst of the Liver*.—In this case the tumour grows from the liver, distending first the distance between the ensiform cartilage and the umbilicus, the reverse of an ovarian cyst. Again tapping and discovering acephalocysts in the fluid is convincing evidence of the true nature of the tumour.

6. *Hysterical abdominal distension*, commonly known as spurious pregnancy, need deceive no one, as the percussion is uniformly resonant, and the tumour disappears under chloroform.—*Edinburgh Med. Journ.*, Nov. 1881.