ONE HUNDRED GYNAECOLOGICAL CASES.

A CLINICAL STUDY.

Being a GRADUATION THESIS for THE DEGREE OF M.D.

of THE UNIVERSITY OF EDINBURGH.

BY

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T A B L E O F C O N T E N T S .

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I N T R O D U C T I O N.

During the twelve months from October 1895 to October 1896, I had the privilege of acting as Clinical Assistant under Dr. Halliday Croom, in the Extra Mural Gynaecological Department of the Royal Infirmary, and had thus many opportunities of studying the various forms of Gynaecological Disease, which are met with in Hospital practice. During my term of office I was in the habit of keeping a careful record, for my own use, of all the patients that were admitted into the Wards for treatment; and in the following Thesis I have attempted to summarise the experience I have gained from a detailed study of these cases.

With a view to ascertaining the relative frequency of the various Gynaecological diseases met with in Hospital practice, I have contented myself with taking only one hundred of these cases. These, however, have not been chosen because of any special interest they may have possessed, but have been taken consecutively from my list of cases.

To facilitate reference I have added a short abstract of each of these cases at the end of the Thesis. The relative frequency of these diseases, as shown by an analysis of the one hundred cases, is

not, of course, an accurate indication of the frequency with which these diseases are met with, even in Hospital, far less in General practice, because all of these cases were admitted into the Wards for treatment, while a large number, of the less serious cases, were treated in the Out-Patient department, and, also, it must be borne in mind, that it is only, as a rule, the more serious cases come into Hospital at all.

This statement will be readily borne out, by a glance at the Analysis of these one hundred cases, where the number of Ovarian tumours, and Extra Uterine Pregnancies, are, of course, out of all proportion to other Gynaecological diseases, taken as a whole. Apart from this, however, I think that the Analysis is of considerable interest, and of some value as showing which cases are met with in the Intern Department of a Gynaecological Clinique.

In the following pages I have arranged the various diseases into groups, following, as nearly as possible, an Anatomical classification, and have very briefly discussed the various points of Symptomatology, Diagnosis and Treatment. In doing so, I have, of course, been largely influenced by the teaching I received as an undergraduate; but wherever the teaching has not been in accord with my own experience, I have not hesitated to say so.

Some original observations I made in regard to the preparation of patients for operation (particularly vaginal), the sterilization of dressings, and the antiseptic treatment of wounds generally, are embodied in this Thesis. This was a subject, I may state, to which I devoted special attention, and the results I obtained after several experiments on the after-treatment of the external wounds in abdominal operations were eminently satisfactory.

This Thesis professes to be a Clinical Study, and ~~the~~ to give the results of my own personal experience, hence no attempt at reference to the extensive Gynaecological literature has been made.

I gladly avail myself of this opportunity of acknowledging my great indebtedness to Dr Halliday Croom, and to Dr Freeland Barbour, his Assistant in Ward 28, for their unvarying kindness, for their invaluable instruction and advice and encouragement with my work, during the time I acted as Clinical Assistant in the Royal Infirmary.

ANALYSIS OF ONE HUNDRED GYNAECOLOGICAL CASES.

External Genitals	Ruptured Perinaeum		2%
	Diseases of the Vulva		1%
	Carcinoma of Labia	1%	
	Diseasesof the Vagina		2%
	Bartholinian Abscess	2%	
Uterus	Displacements of the Uterus		14%
	Downward	3%	
	Backward	9%	
	Forward	2%	
	Diseases of the Uterus		17%
	Inflammations	11%	
	Retention of Placenta and Blood Clot	1%	
	Ectropion of Cervix and Hypertrophy	1%	
	Malignant	4%	
	Tumours of the Uterus		18%
	Fibroid		
	Interstitial	12%	
	Subperitoneal	6%	
	Submucous	9%	

ANALYSIS OF ONE HUNDRED GYNAECOLOGICAL CASES
(Continued).

Appendages	Diseases of the Ovaries		24%
	Inflammations	4%	
	Displacements	3%	
	Tumours		
	Cystic	14%	
	Solid	1%	
	Semi Solid (Dermoids)	3%	
	Malignant (Sarcoma)	1%	
	Diseases of the Tubes		2%
	Salpingitis	2%	
	Diseases of the Broad Ligament		2%
	Simple Cyst	1%	
	Malignant Cyst	1%	
	Diseases of the Par Ovarian		1%
	Cystic Tumour	1%	
Diseases of the Urethra, Bladder and Ureters.	Diseases of Urethra		2%
	Urethral Caruncles	2%	
	Diseases of the Bladder		3%
	Vesico Vaginal Fistula	1%	
	Cervico Vesical Fistula	1%	
	Cystitis	1%	
	Diseases of the Ureters		1%
	Uretric Fistula	1%	

ANALYSIS OF ONE HUNDRED GYNAECOLOGICAL CASES (Continued).

Diseases of Menstruation	Amenorrhoea	7%
	Menorrhagia	12%
	Metrorrhagia	11%
	Dysmenorrhoea	18%
	Premenstrual (Extra Uterine)	11%
	During the flow (Uterine)	12%
Pelvic Inflammations.	Utero Sacral Cellulitis	2%
	Parametritis	4%
	Parametritis Tubercular	1%
Extra Uterine Gestation	Extra Peritoneal	4%
	Intra Peritoneal	1%
Diseases of Omentum Peritoneum and Intestines	Omental Tumour Malignant	1%
	Tubercular Peritonitis	1%
	Carcinoma of Caecum	1%
Pregnancy	Haemorrhages (Raynaud's)	1%
	Haemorrhages	1%
Absence of Organs of Generation		1%
Thrombosis of Femoral Vein		1%

E X T E R N A L G E N I T A L S.

RUPTURED PERINAEUM.

From the Analysis of the 100 Cases, it will be seen that there are only two cases of Ruptured Perinaeum. This by no means conveys the frequency with which tears of the Perinaeum occur in Gynaecological practice, but it so happens that only these two occurred in the hundred Consecutive Cases.

In both cases (Case 25, page 140 & Case 54, p.163) the symptoms complained of were Prolapse of the Uterus. Both had trouble on micturition and both, menorrhagia and metrorrhagia. The vaginal examination revealed in addition to the torn perinaeum, procidentia, cystocele, and Rectocele.

The Uterus was enlarged and there was a considerable amount of hypertrophy.

From the above symptoms it would appear that the rupture was one of considerable extent, as a matter of fact, both were of the incomplete variety, viz:- Neither involving the sphincter ani. They were both of some duration, in the one case as long as 6 years (Case 25) the other (Case 54) 9 months.

On comparing these cases it will be found that although they present such a degree of prolapse, the tear in both was really one which should not have been the cause of this prominent symptom.

Speaking generally one has to take into account other factors which might tend to produce the degree of prolapse amounting in both cases to complete Procid-

Procid-)
entia, and to ascertain whether the laceration was really the only cause of the prolapse.

Although perhaps not the immediate cause it certainly was predisposing, as these patients were both women accustomed to heavy work, such as weight lifting etc., it is only natural to suppose that with a weakened pelvic floor plus their heavy work, would certainly conduce to this one outstanding feature.

In tears of the perinaeum the symptoms vary according to the degree of laceration so that in different patients we expect entirely different symptoms.

Take those in which the tear is Complete, the outstanding feature is of course the incontinence of faeces and flatus. On the other hand patients with a small tear such as has been quoted in Case 25 and 54 would in patients of easy circumstances in all probability give rise to practically no symptoms at all.

The other symptoms noted in these cases, 25 and 54 viz:- Menorrhagia, Metrorrhagia and Bladder troubles, are not directly caused by the ruptured perinaeum so need not be taken into account when speaking generally.

TREATMENT.

The treatment varies according to the degree of laceration and to the amount of suffering and discomfort borne by the patient. In tears such as has been described, the treatment, provided that there was no great degree of prolapse, would probably not call for operative interference. (It is not the intention here to go into the details or describe any of the well known operations for repair of the Perinaeum, but rather to record the treatment both preparatory, operative and after treatment in the cases under observation). If, however, there is any accompanying prolapse with its train of symptoms, then operative interference (after having tried the use of Mechanical supports, i.e. pessaries) will be nearly always necessary.

In those cases where there is Complete rupture there is no question as to what should be done, here operative treatment is the only remedy.

PREPARATION OF PATIENT FOR PERINAEL OPERATIONS.

The following plan was adopted in the two cases recorded (and others), and it is equally suitable for all cases of ruptured Perinaeum. The patient has her usual bath every morning, and for at least a week beforehand the Vagina should be thoroughly douched morning and evening with Perchloride of Mercury 1 - 8000, the bowels should be kept well opened, and for two days preceding the operation the douching of the Vagina should be done at more frequent intervals during the day, and

the Vagina swabbed out with sterilized gauze.

The night preceding the operation, the bowels having been thoroughly attended to, it is better that the parts be shaved. The vagina again douched out and swabbed with strong perchloride, and finally packed with tampons (sterilized) and soaked in a very weak solution 1 in 12,000 of perchloride. A carbolic soaking is applied to the external genitals (after these have been thoroughly washed and scrubbed) and left on till the time of operation. The tampons are removed from the Vagina when the patient is on the table and the canal is then thoroughly douched with hot sterilized water.

This plan of treatment was carried out in the two cases recorded, and in many others, in all it was entirely successful.

The operative treatment need not be described in detail, but was in each case the flap splitting operation.

AFTER TREATMENT.

At the close of the operation it was found that benefit resulted by the introduction into the Vagina of a light plug of Iodoform gauze; the wound dusted over with Iodoform powder and a T shaped bandage applied. If there should be any vomiting, care should be taken that the patient should not be allowed to strain too much, or if this is impossible, then support should be applied to the perinaeum. It is better that the urine should be drawn off at regular intervals as there is less risk of contamination to the wound, the

value of the plug of iodoform gauze is recognized here, for if by any chance Urine should escape, the gauze would absorb it, and could be frequently changed; this leads one to think that there would be no necessity for catheterisation, but that the patient might pass her urine herself, and so lessen the risk of infection from catheter. As regards food, she should get nothing for the first twelve hours, and then after that, sips of milk and soda water. The first twenty-four hours food is entirely fluid, later farinaceous till the sixth day, then after the bowels have moved, which is generally secured by the aid of castor oil on the night of the sixth day, followed later by an enema of olive oil, the diet is of a light nature.

It has been urged by some writers that the bowels should be moved earlier than the sixth day, as by so doing the motions are not nearly so scybalous, but no untoward result was found by leaving them until the sixth day, especially by the use of the enema of olive oil. The sutures are removed on the seventh day, and diurnal douching with a weak antiseptic, usually closes the after treatment.

DISEASES OF THE VULVA & VAGINA,

CARCINOMA OF THE LABIA.

Malignant disease of the external genitals is rare primarily, when it does occur it usually shows itself in connection with the Labia Majora, or in the cleft between the Labia, Majora and Minora - Carcinoma is not nearly so frequent as epithelioma which usually develops on the lower and inner surface of the labia majora and in the form of hard warty nodules.

In case 84,p.188 the disease extended from the junction of the labia majora and minora along the vestibule, and Half an inch along the anterior vaginal wall, then spread down on either side of the nymphae. The mass was thickened, nodular, fungating, bleeding and with a very foul odour. The Clitoris was not involved.

The inguinal glands on both sides were thickened and hard. This case is rather typical of carcinoma of the external genitals. It will be seen that from the site it differs greatly from epithelioma and did not present at all, both in appearance and symptoms, anything like the latter disease. Unlike epithelioma the pain complained of by the patient was very severe. This in itself forms a very useful point of differential diagnosis. Pruritus, which is present in both, is a very much more marked symptom in the carcinomatous condition.

There is not the same ulceration that one finds in the epitheliomatous, and the secretion is a much more prominent symptom - if any doubt exists as to whether

the case is one of epithelioma or carcinoma (not that it matters very much for the treatment is practically the same in both) removal of a portion of the diseased tissue, examined microscopically will soon settle matters. Haemorrhages, when they do occur, are not very severe, but their continuation acts as a drain on the strength of the patient, as a rule the mental condition, which is not a little affected by the unbearable odour causes rapid decline. This, in conjunction with the probability of metastasis to the internal organs, soon puts an end to the patient's life,

TREATMENT

The question arises, can this disease be cured ? If seen sufficiently early there is a remote possibility of a cure, but, as is too often the case, unfortunately, the disease is one which does not come under notice, until the growth has become rather extensive and the lymphatic system involved.

Suppose that a case presents itself in which the disease is not very extensive, and there is no involvement of the lymphatic glands; free removal is the best, in fact, the only treatment, preferably by the thermo cautery. If, on the other hand, the disease is too far advanced and the glands are affected, then of course palliative treatment ═══ is all that we can do.

This is best carried out by removing with the aid of the cautery, the more putrid and ulcerative parts ,

and to control the odour as much as possible. This may perhaps best be done by large pledgets of cotton wool steeped in a saturated solution of potassium chlorate, which should be frequently changed; and opium freely exhibited to relieve the pain and make the patient's last days as comfortable as possible.

In case 84, it will be seen that the disease was of so extensive a nature, even to the involvement of the inguinal glands, that treatment just described was all that could be done.

BARTHOLINIAN ABSCESS.

Abscesses of the glands of Bartholini are of common occurrence, although only two are here recorded. They are, of course, easily recognised from their situation. They usually begin as an inflammation round the mouth of the duct leading to the gland itself. This causes an increase of secretion and the duct generally becoming blocked, the secretion finds no exit, and the abscess formation results. It usually shows itself as a distinct globular tumour, situated in the lower part of one or both labia, they are as a rule, if not of specific origin, single, but, when gonorrhoeal they are nearly always bilateral.

The Causation of Bartholinian Abscesses is not hard to explain. They generally result from an extension of either purulent vulvitis or vaginitis. They may, however, be brought about by direct inquiry, and they are not infrequently seen in the newly marr-

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-ied. The symptoms, in addition to the presence of a tumour, are acute pain of a burning character, radiating along the vulva and down the inner side of the thigh. There may be discharge from the Abscess, which discharge, as a rule, gives temporary relief.

Not infrequently there is pain during micturition.

In the cases quoted 23 page, 139 (It will be noted here that Case 23 contains no reference to Bartholinian abscesses, these developing shortly after admission into Hospital, were not noted in the case at the time of admission), and 63 page, 171 only one of the cases, viz:- 63, had no trouble during micturition, in the other case 23, painful micturition was due to urethral caruncles, so that neither of the cases bear out the statement, which is made by some authorities that these abscesses have as an accompanying symptom painful micturition. There is one point alluded to, viz :- that where specific in origin the abscesses are always bilateral. This is well exemplified in both cases 23 and 63. The former, when admitted to the hospital, had none but developed the first one two days after admission. In case 63 the patient came in with an abscess on the right side, and two days later one on the left side appeared. In both of these cases a specific history was obtainable.

TREATMENT.

With simple inflammation of the glands we do not here concern ourselves, as both cases under observation were of abscess formation. Treatment where an abscess is present admits of only one Course, that is free incision. The abscess should be laid open to the very bottom and scraped. If possible it is better to dissect out the gland, but as a rule the free incision, scraping, and the application of some strong antiseptic such as pure carbolic acid, to the abscess wall. irrigating and packing with iodoform gauze generally suffice. A pad of iodoform gauze is placed over the wound, the vagina is douched the following morning, a frsh piece of gauze is put in the wound so as to keep the mouth of the abscess open, and allow it to heal from the bottom. Usually a piece of moist gauze should be placed between the labia to keep them apart.

U T E R U S.

DISPLACEMENTS OF THE UTERUS.

Upward Displacement.

Has not been taken into account when making up the Analysis, as no case presented itself in which this was a definite and distinct condition, of course a great many of the cases recorded showed upward displacement of the Uterus, notably some of the larger fibroids; in pregnancy; (Cases 59 & 66); some of the extra uterine cases (Cases 39 & 100); and in some of the larger Ovarian tumours. Nothing further therefore will be said about this condition.

Downward Displacements.

This is a very much more common condition than would be supposed from the paucity of cases here recorded, viz:- 3. However these three cases are typical.

Prolapse of the Uterus may be of any degree from simple displacement so that the fundus of the Uterus may be just below the brim of the pelvis, to complete extrusion. The former may be only secondary to, or accompanying a backward displacement; a still further degree, where the uterus sinks lower and the cervix is directed backwards, and comes to rest on the perinaeum, or perhaps appearing at the vulva. In the latter degree where the uterus projects completely beyond the vulva, the cervix has an altered position, and now looks downwards and forwards and the fundus backwards, often too the body is retroflexed. An accompanying condition of the complete variety is prolapse of the

anterior and posterior vaginal walls, (Cystocele and rectocele). In some cases the prolapse of the vaginal walls is so marked that the cervix is hidden. Later when complete extrusion takes place, the condition of the uterus is much more evident. Accompanying this prolapse, changes take place both in the cervix and vaginal walls; the former becomes swollen, smooth, hypertrophied, and of a pinkish hue, and if untreated may be covered with patches of ulceration due to irritation from the patient's clothes. The Vaginal Walls loose their rugosity, are pale and shining, and the epithelium becomes thickened. The condition is comparable to a hernia. The sac being the peritoneum, its coverings the ant and post vaginal walls and uterus, and its contents small intestine. The displacement of the uterus is accompanied by displacement of the appendages which are dragged down by the uterus in virtue of their attachments to the Broad Ligaments.

When Cystocele accompanies the prolapse of the uterus, it must be remembered that the direction of the bladder is thus considerably altered, and if a sound be passed into the bladder in this condition the point of the sound will be felt low down on the cervix.

In all the three cases recorded, (55 page 164) 91 p.195), the prolapse was complete and in each instance was accompanied by Cystocele and rectocele.

Two of these cases (25 and 51) have already been mentioned in connection with Tears of the Perinaeum.

This leads us to ask what then are the commonest causes of Prolapse ? By far the greater number are

due to faults in the perinaeum, and in the three cases quoted, laceration of the perinaeum was the exciting cause. The question of tears in the Perinaeum has already been discussed.

Are there any causes in the uterus itself which may tend towards Prolapse ? normally in Pregnancy, in the early periods, the uterus is slightly prolapsed and again during the process of involution. Both these causes are however physiological; should however involution not go on properly, then the condition known as subinvolution might readily act as a cause of prolapse; so too in most cases of enlarged and heavy uteri, this condition may be brought about.

Other causes may be found in the relaxation of the ligaments supporting the uterus, viz:- the broad, round, and utero-sacral ligaments. Another cause, and this is one which is not uncommon in the nulliparous, viz:- the absorption of the fatty padding, which often occurs in wasting diseases, and at the menopause. External causes may be factors in the production of prolapse, e.g. tight lacing, and such causes as heavy and constant strains, this latter is perhaps the most common cause in the lower classes, who rise too early after parturition when the parts are in a state of relaxation and the uterus in an enlarged condition. Abdominal tumours, even ascites may be looked upon as probable causes.

SYMPTOMS.

In the moderate degrees of prolapse we may only get slight pelvic discomfort, bearing down pain and vesical troubles; as there is usually endometritis

associated, we not infrequently see menorrhagia.

In complete prolapse symptoms are more marked, the patient usually complains of a "something coming down". Menorrhagia, Metrorrhagia, and if the Uterus is protruding very far, discomfort in walking is complained of.

DIFFERENTIAL DIAGNOSIS.

We may have to diagnose prolapse from such conditions as hypertrophy of the cervix, Fibroid Polypi, inversion of the Uterus, and tumours of the Vagina. Careful Vaginal and Bi manual examinations, aided by the use of the sound will, as a rule, easily distinguish between them.

TREATMENT.

First reduce the displacement which should be done, the patient lying down, and it is important to bear in mind that the part which came down last should be reduced first; as a rule this is the posterior wall of the vagina; pressure is made on this first, then the uterus, then the anterior vaginal wall. Suppose the case is one in which the parts are swollen and congested; before reduction is attempted, the patient must be kept at rest, and the parts must be thoroughly douched, and even scarification may become necessary before reduction can be effected. After the displacement is reduced, and all inflammation has subsided, the next thing to do is to keep the prolapse in place.

As a rule, where the prolapse has been of any size, it will be necessary to introduce some form of support, and of all the many pessaries in use, two, need only be

mentioned, the ring, and the stem and cup; if support fail to give relief, operative treatment must be next considered. Firstly, where there has been rupture of the perinaeum, this must be repaired. This often results in a cure, secondly, repairing the perinaeum, and anterior and posterior colporraphy. It has even been suggested, especially when the patients are past the menopause, that complete closure of the vagina should be adopted. Ventral fixation has been done, shortening the round ligaments, and latterly vaginal hysterectomy has been tried.

In the cases recorded, the first two, (25 and 51) had repair of the perinaeum, the third case (91) had repair of the perinaeum, and anterior colporraphy, all the three cases did well.

BACKWARD DISPLACEMENTS:

Backward displacements are divided into two conditions, the first in which the uterus is turned back as a whole, and the other where the body is bent backwards. As the two only differ in degree they will be discussed together.

Backward displacements are sometimes congenital. With this we need not here concern ourselves as the cases quoted (37 page 149, 57 page 166, 62 page 170, 76 page 182, 79 page 186, 83 page 189, 87 page 192, 88 page 193, and 89 page 193), were all acquired. One of the commonest causes is subinvolution, chronic metritis, especially associated with trauma, then again inflammatory action of the utero vesical ligaments, which becoming shortened, and pulling the cervix forward allows the

heavy uterus to fall back; if the utero sacral ligaments are in a state of undue laxity giving free play to the utero sacrals, the same thing may happen. It has been stated that over distension of the bladder is a cause.

SYMPTOMS.

Down bearing pain, menorrhagia, sometimes metrorrhagia, leucorrhoea, dysmenorrhoea, Sterility, vesical and rectal troubles, sometimes dyspareunia. In Case 37 there was pain in the back, menorrhagia, and metrorrhagia. In Case 57, pain in the left iliac region and metrorrhagia. In Case 68 , pain in back and a feeling of "Something" in the vagina; this patient had a retroverted gravid uterus. This sometimes happens (see also Case 79) but, it is perhaps more frequent that impregnation occurs first and the displacement afterwards. In Case 76 metrorrhagia pain and sterility. Case 83 downbearing pain, Metrorrhagia. Case 87 Metrorrhagia and pain. Case 88 pain and persistent leucorrhoea. Case 89 pain, premenstrual dysmenorrhoea during the flow and persistent leucorrhoea. From the above it will be seen that the majority of these cases bear special reference to menstrual disorders.

TREATMENT.

The first thing to make sure, is the exact condition. The next, to see if there is any accompanying inflammatory conditions. Should this latter complication exist, then it must be treated before any attempt at reposition is made; this is best done by hot douches,

absolute rest, use of ichthyol in the form of plugs.

When the inflammatory products have been absorbed then replacement can be effected. This may be done firstly by posturing the patient viz:- the genu pectoral position aided by either, fingers pushing the fundus forwards, or better still by grasping the anterior lip of the cervix with a volsella, and pulling cervix downwards and outwards. Or the reposition can be made bimanually, but perhaps the best of all, if posturing and the aid of the volsella are ineffectual, is the use of the sound. This, so long as the uterus is not bound down by adhesions, is the simplest and quickest way of replacement.

Having replaced the Uterus the next thing is to keep it in position, for retroflexions, the soft rubber ring pessary is the best; for retroversions the "Hodge" or "Hodge Smith" is the best. In the gravid condition, provided there are no adhesions, replacement and retention by pessary until after the fourth month, when the uterus is well out of the pelvis is always successful. In Case 62 this treatment was adopted and the patient has since given birth to a living child, and had an easy and natural labour

Forward Displacements

If an analysis were made of those patients who complained, or who were the subject, of Backward displacement, it would be found that by far the larger proportion are married women, or women who have borne children, a like analysis of those who are the subject of Forward displacement, would reveal the fact, that the

bulk of these women, are either unmarried, or if married are sterile.

It might therefore be stated as a fact, that the Backward Displacement, is a Disease of the married and parous; and the forward, a disease of the Unmarried or Nulliparous. This deduction has not been made from the cases recorded, but from observations during a year's work in one of the Gynaecological Wards of the Royal Infirmary.

In the 100 Consecutive cases, it so happens that only four cases of Forward displacement have occurred, so that the aforesaid statement is not based on these four cases.

Little need be said of Anteversion, as none of a pathological nature came under notice, that is to say there were no abnormal Anteversions per se, some there were, markedly anteverted, but these were due to such causes, as Ovarian Tumours, and the presence of Fibroid Tumours in the anterior wall of the uterus etc.

With Anteflexions on the other hand we have more to do.

Anteflexion of the Uterus occurs normally in early life, this condition may, and often does, persist throughout life, one such case occurred in my experience, but does not come in the recorded cases, in addition to the Anteflexion, the uterus was much smaller than normal, and was of the type known as infantile Uterus. One of the recorded cases (Case 86 page191), might be classed as congenital, as there were no signs pointing to an acquired condition, the uterus was

normal in size, the cavity measuring 2½ inches, and there was no inflammatory thickening in the pelvis, nor any other obvious morbid condition which could be said to have caused the displacement.

This leads us to ask what are the causes of anteflexion ? First, as above mentioned, Congenital, a persistence of the foetal condition, next, pressure on the fundus from behind, constipation has been said to have caused this. The most frequent cause is inflammation of the utero sacral ligaments, and consequent shortening of these bands; which by drawing the cervix backwards, allows the fundus to tilt forwards, this portion of the uterus, which next becomes flexed, aided to a great extent by the weight of the viscera above. In Case No. 11. page 127, the actual cause is probably an inflammatory process of the uterus, about the region of the isthmus, as there was no sign of utero sacral cellulitis, there was however well marked ovaritis and salpingitis and it is quite possible that inflammation in the region above referred to might be the cause of anteflexion in this case. In Case No. 5 page 121, and Case No 20 page 137, there was a well marked utero sacral cellulitis, and here, of course, the cause is evident.

Of the causes mentioned it will be seen that one is congenital (?) and one inflammatory of the isthmus, and two due to utero sacral cellulitis.

As regards symptoms, the most prominent one is Dysmenorrhoea, usually the first day of flow, spasmodic in type. Three out of the four cases recorded

complained of this symptom. The cause of dysmenorrhoea is not far to seek, in the first place the uterus being so acutely anteflexed, the uterine Canal is narrowed and does not allow of a free passage of the normal discharge. This causes a considerable amount of congestion, the discharge accumulates in the form of a clot , the uterus is then trhown into a state of contraction in order to expel this clot. This would account for the pain occurring on the first day of flow, because so soon as the blood comes into the uterus and accumulates, then the pain starts, and is only relieved when the flow is established. This is very well exemplified in Case No. 86 page 191

Leucorrhoea is very often present and was complained of in cases Nos. 5 and 11. Dysuria is also an occasional symptom, present in Cases Nos. 11 and 86. Dyspareunia is seen in those cases of utero sacral cellulitis. It was not however present in any of the recorded cases..

Next to Dysmenorrhoea perhaps sterility is most frequently complained of. In only one of the four cases was this present (Case No. 86 page 191). In Case No. 11 page 127, the patient had had one abortion, but no living children. In Case No 5 page 121, there had been one child, eight years before admission into Hospital. In Case No. 20 page 137, there had been five pregnancies out of which there had only been one living child. In the last three cases the sterility was present after the anteflexion had appeared.

Treatment.

If there is inflammation such as utero sacral cellulitis, this must be treated first before any other measures are adopted.

What was done in the Cases recorded, which were of inflammatory origin, was constant hot douching, nightly plugging with tampons soaked in ichthyol 10% with glycerine, and saline purges. Once all traces of inflammation disappeared, a pessary was introduced.

In three of the Cases a soft rubber ring, in one case a stem pessary was tried with very beneficial results.

This was the case in which there was no inflammation however, so that there was no contra indication to the use of a stem pessary as there was in the other three.

It should have been mentioned that in Case No. 86 page 191, Dilatation of the uterine Canal with graduated bougies was tried on two occasions. The period which followed this was quite free of pain, and before the patient left Hospital, a stem pessary was introduced.

It was worn for a fortnight then removed and cleaned, and was worn for a further period of a fortnight.

It is satisfatory to learn that this patient became pregnant two months after leaving Hospital.

DISEASES OF THE UTERUS.

Inflammations.

Of Inflammations of the uterus, only endometritis will be considered, as the cases recorded showed this as the chief symptom. Of Course in many, there was a good deal of Metritis notably in Case 27 page 141.

Endometritis occurs chiefly in married of parous women. The only unmarried woman in which it occurred was in Case No. 24 page 139, and in this patient it followed an incomplete abortion. Two of the cases had specific history, Cases No. 33 page 146, and 61 page 169,, the former with a syphilitic taint, the other gonorrhoeal. No less than four cases (Case 24, 36, 68, and 99) were following abortions; one Case (94) following full time labour; Case 60 was one in which the patient was nulliparous. In this Case the cause was due to displacement. In Case 93 the cause seems to have been a subinvolution. One Case (No. 9) was one of senile uterine catarrh.

It will thus be seen that the causation of endometritis is rather varied.

Symptoms.

Menorrhagia, Metrorrhagia, leucorrhoea, dysmenorrhoea, dyspareunia, and pain in the pelvic region, form the chief symptoms; frequent abortions, too, must be taken into consideration. In Case No. 9 pain and brownish discharge were the chief symptoms, this patient had passed the menopause twenty years before she came under observation. Six of the Cases showed Menorrhagia, while two showed menorrhagia and metrorrhagia: two complained of frequent abortions; four of incomplete abortions; one following full time labour, and one of dyspareunia; four complained of dysmenorrhoea and three of indefinite pelvic pain. In nearly all Cases on examination the uterus was found to be

enlarged, in two cases the cavity measured as much as five inches; the endometrium tender and bleeding.

Treatment.

Of treatment in the Cases complaining of incomplete abortions there can be no question viz:- curretage, and while speaking of this operation, the points to be attended to are, that the patient should be thoroughly prepared for the operation, the vagina should be cleansed daily, and a hot antiseptic douche night and morning for a few days preceding the operation. I would even go as far as to suggest that the hairs about the labia should be shaved, this might quite well be done after the patient is anaesthetised. My reason for suggesting this is, that I have not infrequently seen hairs caught from the external pudenda and dragged in with the dressing to be applied to the uterus. It is a small chance of infection, but if it is a chance, then the little extra precaution that is recommended will not be amiss. I need not go into details as regards the actual operation but a word as to the immediate after treatment. The uterus should be well washed out with very hot water, 118°, and a dry dressed sound applied to the interior of the uterus, followed by two dressed sounds dipped in either pure carbolic acid or iodised phenol. A special sound has been devised for this purpose viz:- a straight flexible piece of metal with a spiral running from about two and a half to three inches from the top: the drawback to this is that the end of the sound is sharp or square pointed.

I think that it would be an advantage to have the

ends bulbous, as in the ordinary uterine sound, as there is less danger of the end of the sound coming through the dressing, as often happens in the sound first mentioned. If the bulbous sound should protrude to the dressings, no harm would be done, whereas the sharper pointed one might cause serious damage. I had two of these sounds with the bulbous points made for me, and they answer the purpose very well.

In the treatment of ordinary endometritis, beyond those following abortions and labour, expectant treatment should first be tried viz:- regular diurnal hot douching, the administration of saline purges, and ergot internally. Ichthyol plugs. Even scarification of the cervix should be resorted to, and finally if these measures fail, curetting the uterus should be done.

Retention of Placenta and Blood Clot.

This condition can hardly be called a disease of the uterus, but for convenience sake it has been included here. The history of the patient is rather remarkable, she was a married woman, her youngest child being a year and eight months old on the date of her admission into hospital. She complained of a constant haemorrhagic discharge, feeling of weakness, and general debility, lasting five months. A curious fact was elicited in the history. She had nursed her last child fifteen months, and during this period she had no discharge whatever. She dates the first appearance of the discharge from the day she weaned the baby, and it had continued from that day to the time of her seeking admission to the ward, that is to say five months. Inquiry as to her last labour showed that it had been a natural one. She stated that during the puerperium she lost no more, than after her first labor.

On vaginal examination, a large mass could be felt bulging the anterior fornix; the Uterus could not be separated from the mass, which was thought to be the uterus anteverted and, considerably enlarged. The cervix was very high up and directed backwards. The patient was chloroformed, the cervix pulled down with a volsella, and the uterus explored. It was found to be filled with a firm dark material like old blood clot.

A smallmetal basinful was scraped away. The uterus was then thoroughly scraped with a curette, thoroughly douched with boracic 120° and the uterine cavity packed with iodoform gauze. Six days later, after progress-

progress-)

-ing favourably she had a rise of temperature 103° with slight rigors. An inter uterine douche of corrosive 1 - 4000, followed by one of sterilized water, was given. The temperature came down the same evening to normal, and from this time on she made an uninterrupted recovery. The tissue on being examined microscopically, was found to contain portions of placental tissue and organised blood clot. What was the cause of this condition ? To my mind the idea occurred that a portion of placenta, (not necessarily very large) was retained in the uterus, haemorrhage naturally was bound to occur, but probably little escaped, and a clot would form on this roughened area of the uterus; given this as the starting point, one can quite imagine such a thing happening as the succession of clots being laid down one on top of the other. That this was really so, was proved by microscopical examination, which revealed these clots to be of different formations; that the haemorrhage could not have been severe is shown by the fact that the patient had no external signs for fifteen months. One can readily understand that the clot would soon become organised. The impression conveyed by microscopical examination was that, assuming that the uterus could be split mesially, the appearance that the clot would present would be somewhat like an onion cut in section.

It is a significant fact that while the patient was nursing her child there was no bleeding, or at least no external evidence of bleeding, but so soon as

she stopped nursing, the bleeding commenced. This important fact clearly proves how close are the relations between the mammae and the uterus ; of course it is well known, how the placing of the child to the breast immediately after parturition has a marked effect upon haemorrhages from the uterus, and it is quite within bounds to make the analogy go a little further, and advance the statement that the fact that lactation was sufficient to check any undue amount of haemorrhage.

If this does not account for the prevention of the haemorrhage then it would be difficult to say what did, for it is well known that any foreign body, even the smallest fragment of placental tissue, keeps up a constant haemorrhagic discharge, until it is removed.

Treatment has already been discussed and all that need be further said that in prophyllaxis we have a remedy; that is to say that after the expulsion of the placenta, this organ should be thoroughly examined, and if it is suspected that the placenta is not complete, then the uterus should be explored with the finger and all adherent portions removed.

Ectropion of Cervix and Hypertrophy of Anterior lip.

It would perhaps have been better to have discussed this case (No 22 page 138) when speaking of "Inflammations of the Uterus", but it is thought better to take it by itself. It had some points which were rather peculiar, especially as regards symptomatology. The only symptoms were, bearing down pain and premenstrual dysmenorrhoea. What one would have expected, was, an abundant leucorrhoea, that is to say judging from

the condition of the cervix.

The Pain had lasted eight years, that is to say two years after the date of the birth of patient's last child.

She had no menorrhagia, the dysmenorrhoea before mentioned, was due to a tender left ovary. The condition of the cervix is noted in this case. All that need be mentioned here, is the ectropion and a large tear in the left side.

There was not in this case, as in many, the difficulty of diagnosing this condition from that of malignant disease of the cervix, as there were no symptoms simulating this latter disease, it will not be further discussed in this respect.

What is the best line of treatment in these Cases? Firstly the patient's general health must be attended to. Tonics and careful regulation of diet and of bowels are of greatest value. A change to some of the Mineral Waters e.g. Kreuznach is, if patient can afford it, to be recommended. This last, often ensures sexual rest, which is an important part of the treatment in all chronic Gynaecological diseases. Locally we must have recourse to the hot corrosive douche 1 - 2000 - 3000. The effect of the corrosive douching if done properly i.e. regularly night and morning, for not less than 10 minutes or ½ of an hour at a time, with the patient in horizontal position is very marked. I am sure that much of the want of success in the treatment of out patients in a Gynaecological clinique is due to the imperfect way the douching is done. The amount of water used is too small, rarely hot enough, and prob-

prob-)
-ably in many cases never enters vagina. I think it is of greatest importance that very explicit directions should be given regarding douching. It will be better if possible that a nurse do the douching if patient can afford it, if not she should at any rate be carefully instructed in the proper use of the douche.

I have noticed patients who stated they had been douching regularly for weeks out of hospital without any improvement, improve rapidly on coming into hospital. I think, too, that after douching rest in the horizontal position for ½ of an hour should be enjoined.

In many of the class of cases under consideration, douching will however only be preparatory to some operative interference. The liability of a long standing ectropion passing into malignant disease must always be kept in mind. In the case under notice the thickening of the cervix and the ectropion, indicated the possibility of a malignant development at a later date. Accordingly amputation of the Anterior, posterior lips of the cervix was performed.

Had there not been hypertrophy in this case, but only the cervical catarrh with the accompanying Ectropion, then Schroeder's operation for excising the mucous membrane would be the best line of treatment.

Malignant Disease.

Cancer of the Uterus is perhaps the most formidable disease that the Gynaecologist is called upon to treat, though happily if seen early enough is not so deadly as it once was.

Unfortunately, however patients seldom come under observation until the disease has made rapid progress they are so seldom troubled by pain; and practically the only symptom which draws their attention, is haemorrhage; this even, they may allow to go on for some time before seeking advice. Cancer occurring as it often does at, or about the menopause, leads these women to think that the irregular haemorrhage from which they are suffering are only preparatory signs of the menopause, and often it is, only when they find the bleeding continues and they are suffering from the drain on the system that they consult a medical man.

In the four cases recorded here, three of the patients were not near the menopause, and one was three years past the climacteric. Of the other three one was 39 years of age, the next was 30, and the remaining one was 29. With the exception of the patient aged 30 (Case 21 page 138), and the patient aged 58 (Case 41 page 154) there was no pain complained of, only in Case 21 was pain, a symptom and it was of the nature of dysmenorrhoea from which she had suffered nearly all her menstrual life.

Cases 21, 82, and 97, were cervical cancer (Epithelioma), and Case 41 was Fundal Malignant disease (Sarcoma). We will take the three cervical cases first.

All three complained of irregular Haemorrhagic discharge, (Case 21 had Dysmenorrhoea also).

In none was pain an outstanding symptom. On vaginal examination all three presented an exactly

similar condition as regards the state of the cervix, hard, indurated, and excavated, one might almost use the term "Crater like", in the first case the vaginal roof was also affected and the disease was far more advanced than in the two subsequent cases. Cases 82 and 97 were practically identical, the cervix in each case was pretty extensively affected, but the uterus was freely moveable , and there was no extension to neighbouring parts, the importance of this will be seen later.

All three had borne children, six, three, and five respectively. The Case of Fundal Sarcoma (Case 41 page 153) was an unmarried woman, nulliparous aged 58. Menopause at 55 years of age, but for the past 4 months had had haemorrhagic discharge, at intervals; she came to hospital complaining of these haemorrhages, and pain shooting across the lower part of the abdomen, and what is very interesting, and I think important, is, that the pain was periodic, viz :- occurring <u>regularly</u> at 12 noon each day.

Taking the cases collectively it will be seen that all complained of haemorrhagic discharge, but there is in this symptom a point not before mentioned, and to which I attach some importance, it is this, :- In the cases of cervical cancer the discharge was extremely malodorous, while that from the Uterine affection was perfectly sweet; the reason is obvious :- the one (cervical) is exposed to the external air, and the vagina being not over clean, organisms abound, and the cause of the odour is thus easily explained. On the other hand, the Uterus being closed as regards the

external air there is less likelihood of putrefactive organisms finding entrance, more especially as the uterus was a virginal one.

The Diagnosis of malignant disease is not difficult, at a stage so late, as the cases quoted presented themselves. It is only in the earlier conditions that Diagnosis becomes difficult, and especially so, in differentiating between chronic Endocervicitis and early cancer; provided that there is no thickening in the fornices, I see no harm in expectant treatment, treat the case as one of chronic cervical catarrh, viz:- withlhot douches, plugging with Ichthyol; and Glycerine; if at the end of a fortnight there are no signs of improvement, then microscopical aid should be called in; this will usually clear up the diagnosis.

It might be suggested that a scraping should be taken to begin with, but my objection to this is, that in making an exposed surface we run the risk of setting up secondary growths.

As regards the diagnosis of the Fundal condition, one must be guided more by symptoms, and on no account should scrapings of the uterus be taken for microscopical examination, unless one is prepared to go on with further treatment; for once the uterine cavity is opened, the disease spreads with great rapidity.

What then is the treatment of the Cancer, be it cervical or uterine.? Certainly total extirpation of the disease, if there is no infiltration of surrounding parts.

If the cervix be not too deeply invaded, amputat-

amput-)

-ation may suffice, but my own feeling is, that in view of a recurrence, Hysterectomy is the safest procedure. In the Uterine affection this admits of no question. Many operations have been devised, but that suggested by Doyen of ~~Paris~~ Rheims, and introduced to this country by Professor A. R. Simpson, offers the best results. The operation need not be described, it is one of the "Clamp" operations. Preparation of the patient must be thorough, the treatment suggested, is that described under the operation for tears in the perinaeum. Cases 82 and 97 were operated on by this method, and in each with complete success.

Little need be said of the after treatment, after the removal of the large clamps the second day after the operation, gentle douching with sterilised Boracic solution and repacking the vagina lightly with Iodoform gauze; after this douching every second day and repacked for the period of five days, after this antiseptic douches night and morning. Recovery is very rapid. In Case 97, before the operation, the patient was losing flesh rapidly, afterwards she gained in weight every week.

I was much struck with the absence of shock after Vaginal Hysterectomy, as compared with older abdominal operations.

TUMOURS OF THE UTERUS.

Fibroid Tumours.

Are the only tumours of the Uterus to be discussed here. They have been subdivided in the

analysis into Interstitial, subperitoneal and submucous. As many of the patients were the subjects of more than one variety. Sometimes of the whole three.

It will be seen therefore that the total analysis is more than the number of cases recorded.

It will be better perhaps to discuss the varieties together. The analysis shows that the interstitial variety are in excess of the others.

Next in frequency are the Submucous.

There are few diseases which present such anomalies, as Fibroid Tumours of the Uterus.

By far the greater majority of patients who are the subjects of Fibroid Tumours have as the most prominent symptom menorrhagia. This of course applies more to the submucous and interstitial variety and not so much to the subperitoneal. In the Cases recorded, it will be seen that this statement is well founded. In the submucous variety not only is there menorrhagia, but frequently metrorrhagia. Pain is not necessarily a marked symptom, and it is only when the tumours are of any size that as a rule, discomfort is felt. However, this symptom is a very varying one, for some patients may have tumours of very large size without being aware of their presence in regard to this symptom. On the other hand, a tumour of a very small size may give rise to a great deal of pain.

Pain of this kind is chiefly due to pressure symptoms. If of the submucous variety then pain is usually due to the expansion of the Uterus. If of

the Interstitial and subperitoneal then the mechanical weight, which causes pain of a down bearing character.

Pressure on the surrounding parts, if the tumour is of any size, causes also a considerable amount of pain.

In many cases Dysmenorrhoea is a prominent symptom (Cases No. 2 page 118, No. 7 page 123, No. 35 page 148, No. 50 page 160, No. 70 page 177 No. 74 page 180, and Case No 89 page 193).

Those cases in which the submucous variety is present, the pain is due, as a rule to the mechanical obstruction to the flow of blood from the uterus, and the Dysmenorrhoea is usually throughout the menstrual period. In the interstitial and subperitoneal variety (Cases Nos. 7 page 123, 35 page 148, 50 page 160, and 74 page 180), the dysmenorrhoea is due, in the interstitial variety to congestion; in the subperitoneal, if the tumour is of any size, mechanical pressure is quite sufficient to account for the pain. Leucorrhoea is more or less present. Trouble on micturition is not uncommon. In Case No. 2 page 118, pain before the act was complained of. Cases Nos. 3, 7, 10, 43, 95, frequency was complained of. In Case 8 pain during the act. In Case No. 10 pain after the act. In Case No. 50, No. 74, and No. 80 retention was complained of. In Cases Nos. 50 & 80, retention had to be relieved by catheter. Case No. 74 relief of this symptom was obtained by posturing the patient. What is the cause od derangements in micturition ? In all the cases quoted, mechanical, from the direct pressure of the tumour. Constipation is frequently seen, and

was well marked in Cases 3, 43, & 70.

Diagnosis, (Submucous).

The haemorrhages, increase in size of uterus, digital examination, bimanual examination, and examination by the uterine sound. Should these fail, it may even be found necessary to dilate and examine the uterine cavity. Polypi of the uterus have to be diagnosed from inversion of the uterus and prolapse; this has already been mentioned when discussing prolapse. (Interstitial and subperitoneal) Unless the subperitoneal variety are pediculated, diagnosis between interstitial and subperitoneal is impossible, so they are taken together here. Haemorrhage, the presence of the tumour, usually the enlargement of the uterine cavity, and if the tumour be of large size and close to the abdominal wall a souffle can usually be heard. On the other hand diagnosis is often very difficult. A tumour which is pediculated by a long stalk may simulate an ovarian tumour, and may give rise to no symptoms such as have been described.

The diagnosis from pregnancy must also be borne in mind, but unless pregnancy coexist, with ordinary care no mistake should be made.

Pregnancy.

The mention of the differential diagnosis between Fibroid Tumours and pregnancy leads us to ask the question as to how Fibroid tumours affect pregnancy?

In the eighteen cases recorded it will be seen that the disease (in those patients who have borne

children) or at least the symptoms have developed subsequent to the pregnancies. In only one case is there an exception, this is Case No. 70, in which the patient had a large tumour of four years standing, and two and a half months previous to admission into hospital she was delivered of a full term child, which was still born. In all the rest, it will be seen that there is great disparity between the development of symptomsand the last pregnancy. In six patients there had been no pregnancies, two only of these were married.

It is probable that the disease was present long before the patients were aware of it, and that therefore the statement about the disparity of years between the last pregnancy and the first appearance of symptoms was not so great; be this as it may, it cartainly points to the fact that in the majority of a cases pregnancy and fibroids do not go together; this with one exception, (Case No. 70) is fully borne out in all the cases noted. That Pregnancy and Fibroids do occur together, I have no doubt, because in two cases (not here recorded), I have seen pregnancy and a subsequent operation for removal of fibroid tumour.

If patients do conceive they generally abort.

I have no doubt that in some of the cases under observation, this occurred without the patient's being aware of the fact; the abortion taking place so early that they would probably think they had a little more discharge than usual.

Treatment (Submucous).

Where pediculated they should be twisted off, where there is a broad base a chain ecraseur, or a wire serre-noeud, or galvano caustic wire. If the polypus has a very broad attachment, and provided the patient is in a condition to stand it, expectant treatment should be adopted viz:- continual hot douching night and morning, and administration of ergot by the mouth, this tends to produce uterine contractions and so an effort is made to expel the tumour; in course of time the tumour becomes pediculated and can then be twisted off.

In Cases Nos. 65 and 89 torsion alone was sufficient. Case No. 57 was an interestingcase, in that a pediculated polypus was in the act of being expelled when it became gripped by the external os. The outer portion of the tumour sloughed owing to the blood supply being cut off. The patient was chloroformed, the tumour grasped by forceps, traction was made, and after the external os was dilated, it was found that the polypus was pediculated and was easily twisted off; the uterus was then plugged with iodoform gauze after an anteseptic douche had been given. The next day the gauze was removed and a daily anteseptic douche closed the treatment.

In Case No. 65 it is of interest to mention that the polypus in this case was not of great size, but there was profound anaemia, and well marked haemic murmurs could be heard over the heart, and specially

over the great veins of the neck. After the polypus was removed, and the patient, was treated constitutionally for the anaemia, a speedy cure was effected.

Case No. 80 the submucous tumour was an exceedingly large one, filling up the vaginal cavity. In this case a chain ecraseur was applied, and the base of the tumour cut through. The tumour had to be then cut piecemeal before it could be delivered.

Case No. 70 will be discussed later.

Case No. 3 presents rather peculiar features. The tumour occupied the whole of the uterine space and vaginal cavity and protruded through the vulva to the extent of eleven inches. There was in addition a large subperitoneal fibroid reaching as high as the umbilicus. This patient was frequently in hospital. The only treatment available was excising, by cautery, or with an ecraseur, large portions. During my tenure of office this patient presented herself on four different occasions, and although when she left the hospital, each preceding time with the mass quite removed externally, she invariably returned at intervals of three months with a large portion extruding. Could any other treatment be adopted for this patient ?

I am inclined to think not. Owing to the large size, both of the submucous and subperitoneal growths, pan-hysterectomy was not possible. This operation was performed on Case No. 70 which had not nearly the same size of tumour (submucous or subperitoneal) and with bad result, and I am of the opinion that operation on this patient (Case No. 3) beyond what I have already described , is out of the question.

The subperitoneal varity, if not too large and not causing any distressing symptoms, are best left alone.

In the cases recorded, the only one operated upon was Case No. 74 where oophorectomy was performed, but as much really for the interstitial variety.

Case No. 10 nothing but constitutional treatment was required. Case No 43 will be discussed presently.

Cases Nos. 3, 70, & 80 have been discussed.

Interstitial.

Without going into any discussion as to treatment I would first quote what was done in the following cases:-

Nos. 1, 2, 30, 35, & 74, Oopherectomy was performed.

Nos. 7, 8, & 12, Curretage was performed together with continual hot douching and administration of ergot.

As regards oopherectomy, I am not so convinced that this is the best treatment, as in two out of the five had no benefit as regards the haemorrhage; indeed in the Case of the patient (Case No. 30) she was brought some months later to the hospital in a moribund condition, of waxy whiteness, and pulseless from the haemorrhage she had been having. It is pleasing to be able to record that under treatment this patient subsequently recovered from this profound anaemia, and at the present time is quite well.

Quite recently Vaginal Hysterectomy has been performed for Fibroid Tumours, and where the neoplasm is of large size it is cut away piecemeal and removed.

My own opinion in regard to this operation is that

it should only be undertaken when the condition menaces the patient's life, and this is only in rare instances.

Electrical Treatment.

I have not mentioned this treatment before as it was not tried in any of the cases under discussion.

I have however tried it in two other cases but with no very great result, it did certainly check the haemorrhage but when the treatment was discontinued the haemorrhage was just as bad. There is one point in connection with electrical treatment that I would like to draw attention to, if care be not taken with the external electrode, the skin is apt to be burnt and small areas of ulceration are produced which are difficult to heal; the electrode should fit the skin surface accurately and should be kept in position by firm pressure. I mention this as in one of the cases, the electrode did not fit accurately and three burns were produced. There is one form of interstitial fibroid that I have not previously mentioned, it is that known as "incarcerated", Cases 43 and 50, were such, they had burrowed between the layers of the broad ligament and had grown down into the pelvis, and part of their bulk was situated behind the posterior vaginal walls; they also extended high up into the abdominal cavity and were too high up to permit of oopherectomy.

If oopherectomy is to be performed then it should be done before the tumour reaches the size of a five months pregnancy, as after they grow bigger the

ovaries, by reason of the stretching of the broad ligaments, become closely applied to the surface of the tumour, and are extremely difficult of removal.

THE APPENDAGES.

INFLAMMATIONS.

Inflammations of the Ovary are acute and chronic, but it is not often, in hospital at all events, that one gets the opportunity of seeing the acute variety, as patients delay so long before obtaining medical advice. Thus it is that in the cases recorded all are of the chronic class.

Symptoms. Vary very much with different patients, but all complain of pain, aggravated just before (a day or two) menstruation commences.

Pain is usually referred to the region of the ovary, the iliac region, and "small of the back".

Those who are married, complain of Dyspareunia, Leucorrhoea, some Menorrhagia, and as in Case 85, Metrorrhagia, though this symptom is usually caused by some other accompanying condition.

In a great number of the cases the inflammation is of specific origin, as was found in Cases 18, page 135, 20 page 137 and 75 page 182.

In others, extension of inflammation from surrounding parts, vide Case 5 page 121.

Sterility is often a sign of diseased ovaries, but of course this is only the case when both glands are affected.

Diagnosis is not as a rule difficult where the disease is well marked, nor is it in the acute stage.

On vaginal examination we usually find the ovary enlarged, (except where a marked cirrhotic charge has

taken place), tender, and sometimes, if there is any cystic formation irregularities on the surface of the gland, often too, we may find the ovary bound down by adhesions, the result of a perioophoritis.

Treatment. First and foremost, Rest absolutely, physical and sexual., Hot antiseptic douches at frequent intervals during the day, plugging at night time with tampons soaked in a 10% solution of Ichthyol and glycerine, if the pain is too severe to admit this Ichthyol pessaries might be substituted. Free purgation with salines is essential. In Cases 5, 18, 20, 85, and 88, this was the treatment carried out and in all it was effectual in affording relief.

Should this treatment fail, is there anything that can be done to cure the condition.?

Removal of the diseased gland either per vaginam, or through the abdomen, the former operation (both anterior colpotomy and posterior colpotomy) is greatly in favour just now, its advocates urging that a great point in the safety of the operation is the ease with which the gland can be reached even though bound down by adhesions, and another point is, that if necessary a very efficient drain is afforded through the vaginal roof, as the operation has not been tried in any of the cases under observation, further mention will not be made. Operation through the abdomen will be discussed under the next heading.

Prolapsed Ovary.

The three cases recorded have also been included under ovaritis and with one exception, Case 75, the treatment referred to under that heading relieved the patients. Still they will be discussed here more in relation to the displacement.

In Cases 18 & 20, there was inflammation of neighbouring organs well marked in 18, a salpingitis, and in 20, a utero sacral cellulitis, in both these cases the uterus was to the front. I mention this point in contra distinction to the third case, 75, where the uterus was retroposed. All three had a gonorrhoeal history.

What was the cause of the prolapse in these cases? I think not a sudden one as sometimes happens through a jar, a fall, or jump, but rather due to inflammation of the gland and consequent enlargement so that the ovary would prolapse gradually by its own weight. In Case 75, the Retroflexion is a distinct cause, I think it is less likely to follow, or accompany a forward displacement; with downward displacements I am inclined to think that it always occurs to a greater or less extent.

The Symptoms are usually very marked. In all three cases pain was a prominent symptom; in one Dyspareunia, and I think that the latter was present in all, but was not a cause of complaint, pain on defoecation was complained of. These two conditions, viz :- Dyspareunia, and pain on defoecation are easily understood

from the position in which the displaced gland lies.

One patient complained, that after coitus the pain was so intense that she vomited.

Diagnosis. presents no difficulty the gland can usually be felt lying in the pouch of Douglas, if free it can be felt to be of the shape of the ovary though much enlarged, exceedingly tender and movable, if fixed by adhesions diagnosis is a little more difficult.

In Case 75, the right ovary could be palpated, but subsequently at operation the left was found bound down by adhesions, this condition of the prolapsed ovary on the left side was thus undiagnosed, not from carelessness but from the indefinitness of the structures.

TREATMENT, In those cases where there is accompanying displacement of the Uterus, the replacing of the uterus and its retention in the forward position by means of a suitable pessary, often also raises the prolapsed ovary. The soft rubber ring pessary will be found the most suitable, for the pressure of a hard vulcanite causes so much pain that the patient's sufferings are increased instead of relieved.

More difficult are those cases where the ovary and uterus are fixed by adhesions. Here douching and plugging must be used till the adhesions are absorbed and replacement possible.

In severe and protracted cases where the symptoms are not relieved by these means, the question of oophorectomy has to be decided on. My own experience is

of course somewhat limited, but I am led to believe that much may be done by medicinal and local treatment to cure the condition and that only a small per cent of the cases call for operative interference; Colpotomy has already been referred to, but as abdominal Section was the operation performed, it only will be noted.

The operation itself will not be described nor mention made in regard to preparation and after treatment of the patient this will be dealt with, when treating with Ovarian Tumours.

Case 75 Abdominal Section was performed and the right prolapsed ovary was easily removed, not so the left, this was found deep down in the pouch of Douglas closely adherent to the retroverted uterus, which was also fixed; the ovary was after considerable difficulty removed, both ovaries were found to be in a very diseased condition. I believe that operation from the vagina for the removal of the adherent ovary would have proved the easier way of freeing the gland.

The patient made a very good recovery and when she left the hospital was entirely free of pain.

TUMOURS.

Cystic By far the greater number of cases recorded of Ovarian Tumours, as will be seen by the Analysis, are cystic. In all these cases the cystic tumours were multilocular. In all except two, Case 13 and Case 71, the fluid was the usual viscid fluid which we are accustomed to find in these tumours.

While speaking of the fluid, reference was made to two which differed from the rest. In these two cases 13 page 129, and 71 page 178. The contents of the tumours were of a whitish colloid material. Itwould be as well when speaking of these cases to detail them now. Case 13 came into Hospital complaining of a large Abdominal swelling with slight pain, of 8 months duration. Patient objected to operation and left hospital; she returned a fortnight later having made up her mind for operation. The operation was performed and a large multilocular Ovarian Tumour was found, with a rent in the capsule, and thick whitish pink colloid material escaping into the abdominal cavity, this was washed out as well as possible and drainage tubes put in, the patient died two days later.

Case 71. This was exactly similar, except that the patient was a much younger woman, aged 28; the Tumour had been aspirated before the patient was admitted to Hospital, and at operation it was found that a considerable quantity of the colloid material had escaped into the peritoneal cavity. Both cases were complicated by numerous adhesions, many of which required ligaturing. One Case, 38, had, before she came into Hospital on this occasion two ovarian tumours removed which contained this colloid material, but in her case the tumours, on opening into the peritoneal cavity, were found intact, and care was taken that none of the material escaped into the peritoneal cavity, she made a good recovery.

That the two Cases 13 and 71 are not unique I know as cases of a similar nature occurred the same year in other wards in the Royal Infirmary and with equally disastrous results, except in one notable case which I believed recovered.

That this colloid material has an irritating effect upon the peritoneum there can be no doubt, but I am inclined to think that there is even a toxic effect, as the end in each case was so rapid; I do not for one moment believe that the complications of the numerous adhesions were the cause of death, though they certainly added to the dangers of the operation, still many of the cystic cases (to be presently quoted) had many more formidable adhesions and yet did well.

I am therefore constrained to believe that the presence of this colloid material in the peritoneal cavity was the real cause of death. In order to make the reference easier, I append the following table of the remaining 12 cystic cases.

Case.	Symptoms.	Complications at Operation.	Result.
4	Swelling of Abdomen & pain.	None.	Cure.
5	Do.....	Adhesions	Cure.
31	Do..... and haemorrhagic vaginal discharge	Adhesions	Cure.
42	Swelling of abdomen	None.	Cure.
44	Do..... & Pain	None	Death.
53	Do.....	None	Cure.
64	Do..... and Breathlessness.	Numerous Adhesions	Cure.
69	Swelling of abdomen & pain.	None.	Cure.
73	Do.....	Adhesions	Cure.
79	Do.....& pain	Retroverted Gravid Uterus	Cure.
81	Do.....& pain	None.	Cure.
98	Do... & swelling of left leg.	Numerous adhesions.	Cure.

It will be seen from the above Table that in regard to symptoms, all complained of the swelling in the abdomen, even in Case 81 where the tumour was found to be a small one, this symptom was noticed by the patient. Out of the twelve cases, six only complained of pain, one of vaginal discharge, one of breathlessness, and one of swelling of the left leg.

The Swelling as a cause of complaint is easily accounted for, no further reference need be made to this as a symptom.

Pain is due to pressure on surrounding structures.

Vaginal discharge, probably due to uterine affection, in this particular case (31) the Tumour was first thought to be a Fibroid, both from the Symptoms, and the physical examination; it is quite possible that there was also a fibroid condition of the Uterus.

Breathlessness, due to the enormous distention of the abdomen, the tumour pressing on the diaphragm, thus interfering with respiration. The Swelling of the left leg noted in Case 98 was due to pressure on the iliac veins of the left side preventing the return of blood to a proper degree; this symptom disappeared after operation. It will be seen by these symptoms that very little help is obtained with a view to diagnosis. How then are we to make our diagnosis?

If we take the swelling first and recognise that we have a tumour of some kind or other to deal with, then I think that the best plan is to arrive at a diagnosis by means of exclusion. First and foremost the bladder should be emptied by means of the catheter. I mention this particularly, as I have seen cases which

have been sent into Hospital diagnosed as Ovarian Tumours which proved to be over distended bladders.

Nextexclude pregnancy and distended rectum.

After having decided that it is not any of the above mentioned conditions, we have to diagnose from ascites, fibroid tumours, parovarian tumours, tumours of the tube and broad ligament, tumours of the kidney and liver, Pseudocyesis, Ascites. The abdominal walls are usually less vascular in appearance, the outline of the tumour is different and alters with the position of the patient. Percussion - note, with the patient lying on her back, yields in the flanks, dulness, and unless the fluid be very excessive the note is resonant on the upper and anterior surface of the abdomen. If the patient is turned on her side, the uppermost side will be found to have a resonant, where there was formerly a dull note. This is of course easily explained by the fluid gravitating to the most dependent part, Diagnosis however, is not so easy where there is an encysted collection of fluid.

These are as a rule however due to a chronic tubercular peritonitis, and here we must be guided by the temperature. On vaginal examination of Ascites, the result is negative.

Fibroid Tumours are usually more central. They may however be on one side. They are solid, more nodulated and on auscultation a bruit is usually present. On vaginal examination the uterus is found continuous with the tumour and moves with it; if the sound is passed, it will be found, if the tumour is

a fibroid, that the uterine cavity is enlarged and usually in fibroids, there is menorrhagia, or even metrorrhagia, while ovarian tumours, the menstrual flow is often lessened.

Parovarian tumours are always unilocular, they grow slowly, and in comparison with ovarian tumours the fluctuation is more marked. On vaginal examination, the surface of the tumour is smooth because there are no smaller cysts to cause any irregularities such as one usually finds in the case of Ovarian Tumours. Again there is nothing solid to be felt in Parovarian Tumours.

Tumours of the Tube. Here the growth is quicker, they are usually more tender and generally there is an antecedent inflammatory history.

In these last two cases the Diagnosis does not matter so much, as the treatment is the same.

Tumours of the Broad Ligament are difficult to diagnose. One should try and make out the ovary on the same side as the tumour.

Tumours of the kidney. Hydronephrosis, the lower border of the kidney can usually be felt, and there is a long history, floating kidney may be mistaken; careful palpation and percussion will eliminate this.

Tumours of the Liver. Hydatids have sometimes been mistaken. If these are numerous diagnosis may be difficult.

Pseudocyesis, - percussion note is tympanitic all over abdomen; give chloroform and the tumour will disappear.

Extra Uterine pregnancy comes under the heading "Diseases of the Tubes".

Before discussing treatment, I would like to draw attention to one case (No. 79), which was complicated by pregnancy. More in relation to the course of treatment to be pursued. Should the operation of ovariotomy be performed,? or should the pregnancy be allowed to proceed, and the operation performed later,? or should the uterus be emptied before the operation is begun.? I think we might certainly throw out of account the second question for there is always the danger of the presence of the tumour causing grave complications during labour. Most surgeons are agreed that the operation should be performed even while pregnancy is progressing, as pregnancy is little affected. For my own part, I am inclined to think that provided the tumour is not causing grave complications, it is better to have the uterus emptied first, before proceeding to operative treatment. My reason is this, often abortion does occur, and I think it easier to attend to this, before the patient has been operated upon, than to run the risk of abortion occurring after the operation, for it is manifest that we cannot attend to the condition of the uterus shortly after abdominal operation, as well as before.

It so happened that Case No. 79 aborted two days after operation, and it was this fact that led me to think had anything happened, in the way of haemorrhage for instance, it would have been a difficult matter to have manipulated the uterus with the

patient in the condition in which they are usually in so soon after operation. I am inclined to think, therefore, that unless the tumour be causing urgent symptoms, operation should be delayed until the uterus is emptied.

Treatment. There can be no question as to the treatment of Ovarian Tumours, once they are diagnosed their removal should be effected. The preparation of the patient for operation need only be mentioned in a word. The strictest antiseptic precautions should be taken; the abdomen prepared in the usual way and a carbolic soakage put on in the early morning and left there till the patient is on the table.

The operation need not be described, but mention may be made of two cases which presented an unusual number of adhesions. In both these cases (Nos. 64 & 98) the tumours were of an enormous size, and had frequently been aspirated before admission to the hospital. In Case 64 everything was adherent to the tumour; intestines had to be sponged off; several numbers of adhesions required ligaturing; and the cyst wall was so intimately attached to the capsule on the under surface of the liver (in Case 64) that on removal of the tumour, this latter was stripped from the liver: the oozing of blood from this torn surface was very free. It was however ultimately controlled, two drainage tubes were inserted in the abdominal cavity, and the patient put back to bed in an apparently moribund condition. She however eventually recovered. The other case No 98, the adhesions were very similar and

had to be ligatured in several places; the interesting fact about this patient was that the wound healed up well by first intention, but eighteen days after the operation, the upper edges of the wound burst asunder and left the bowels exposed; this was first noticed by a soakage appearing on the binder; when the patient was examined, the above condition was discovered; she was immediately conveyed to the operating room; the edges of the wound were pared and the wound resutured; she did very well after this, and was dismissed cured.

Case No. 81 was of interest in as much as the tumour was found lying in the utero vesical pouch, a rather rare occurrence. Case No. 53 was interesting from the point of view that the patient was so young, aged 16, she was very much emaciated, the tumour was almost as big as the patient; after the operation she improved very much, and left the hospital quite strong and well.

A word here as to the dressings of the abdominal wound may not be out of place.

First, I had grave doubts as to the advisability of using iodoform as a dusting powder. I took two of the bottles, which were in the ward, and succeeded in making cultures from them. I wondered then, if this iodoform powder could not be sterilized and I took a sterilized test tube and half filled it with iodoform, closed the mouth of the tube with a plug of sterilized wool and boiled the tube for half an hour. The result was far from satisfactory as I found that free iodine was given off and the powder was reduced

to a hard gritty form. I made a second attempt, and this time kept shaking the tube at intervals so that the different layers might come in contact with the outside part of the glass tube. This was more satisfactory, and no cultures could be obtained from this specimen. The only question was, could the iodoform be sterilized on a large scale ? I had no means of doing this, so contented myself by preparing a fresh specimen for each operation, and dusting it on to the wound through a piece of sterilized gauze.

Where there was no sterilizer it was a vexed question, how best to prepare the dressings ? the following methods were tried in turn, and the last one was adopted :-

Ordinary dressing gauze was boiled and kept in a glass jar in a 5% solution of carbolic. This was wrung out in a solution of Boracic, and squeezed as dry as possible, powdered with the sterilized Iodoform and put on the wound; I know that this method is commonly adopted where there are no sterilizers, but I do not think that it is a good one. First, I think that the moist gauze with all the wool and bandage on top acts very much like a poultice, and does not therefore favor primary healing. Secondly, moisture favours the growth of organisms and I doubt very much if the soaking even in a 5% carbolic would have much effect upon certain of the Bacteria which are found in the skin; this method was tried and was not found very effective. I next tried the following :-

The same kind of gauze was boiled for an hour in

soda solution, it was removed from the boiling solution with a pair of sterilized forceps and put in a clean glass jar filled with 1 - 1000 corrosive sublimate, and left to soak for 24 hours, from this it was taken and fastened up in a towel, which had just been boiled in soda solution, this parcel was then put into a clean sheet, and the whole placed on the steam pipes and left for 24 hours to dry, when this was effected, a glass jar was sterilized, and the gauze put into the jar, with a pair of sterilized forceps, this was found to answer admirably and every wound on which this dressing was placed, healed by "first intention".

Of course all this preparation is unnecessary where steam sterilizers are in use, but at that time there was nothing of the kind to be had. These dressings were freshly prepared on each occasion when laparotomies were to be performed, and it can readily be understood that it meant a good deal of extra work, still the results justified the extra amount of time and trouble expended. I have since had experience with steam sterilisers and am of the opinion that they are invaluable, in as much as <u>everything</u> which comes near the patient can be sterilized by their aid.

Solid. This will be discussed under the heading "Malignant".

Semi-solid. Under this heading will be included the Dermoid Tumours. The other semi-solid tumour 53, has already been discussed under the head cystic tumours, so is no further mention need be made here. Of the Dermoid Tumours, Case No. 34, page 147, 55, page 164, 96, page 198, were typical. In Case 34 each ovary was the seat of a dermoid tumour. Both were removed. Seven months after operation this patient returned and complained that she menstruated as regularly as before the operation, except that she now lost a great deal more than formerly. The ovaries on either side were quite diseased and removal was thorough, as far as could be ascertained. What was the reason for the continuance of menstruation ? Was it due to the possibility of a small portion of the ovarian tissue being left in the pedicle, or could it be put down to "habit" not being overcome. There is of course the possibility that menstruation might have ceased by the end of the year after operation, but the patient in this instance had not returned a second time, so that this point could not be ascertained. I am inclined to think that "habit" or mental impression had not little to do with the return of the periods, because this patient was given a prescription and was told that the medicine would probably cause a cessation of the menstrual flow. She was also advised that if the menses did return, she should come back for further advice, and up to the time of my leaving the

wards, viz :- two months, she had not put in an appearance. I have however since heard of the patient, and she has not, up to the present time, had a recurrence of the periods.

Case No. 55, nothing special to note. In Case 96 perhaps one of the most interesting points is the complaint for which this patient sought advice viz :- constant vomiting. She was kept under close observation and it was found that she vomited everything she took. If reference be made to the Case, it will be noted that a large mass could be felt bulging into the left and posterior fornices : the uterus was pushed to the right and separable from the mass. Everything was tried medicinally to check the vomiting. The stomach was washed out before every meal, but all without effect. Next, Rectal feeding was tried, and was successful. After five or six days of this treatment, a return was made to feeding by the mouth, but again the vomiting was as bad as ever. It was determined to operate, laparotomy was accordingly performed and a large dermoid ovarian tumour was, with very great difficulty removed; the intestines had to be removed from the abdomen, and wrapped in warm towels during the greater part of the operation; special mention is made of this, because after the operation there was a good deal of pain, distention and tympanites. The pain was excessive and the patient tossed about very uncomfortably. Large turpentine enemeta were administered with good result. In connection with this distention and tympanites follow-

following abdominal section. I have found that these turpentine enemeta act in a very effectual manner. I have also found good result from the use of the belladonna in the form of the ointment rubbed into the flexures of the thigh and elbow. After the removal of the dermoid tumour and subsequent recovery from the operation, the patient had no return of vomiting.

It is evident from the above case that the vomiting was due entirely to the presence of the tumour, as on its removal, this symptom quite disappeared.

Malignant. Case No.58 page 167, is the only one showing the variety classified as solid ovarian tumour, and as this tumour happened also to be malignant it will be discussed under this heading. The only symptom was the swelling of the abdomen. It will be noted in the abdominal examination that the tumour was a very large one reaching as high as 2" above the umbilicus. The duration was only four months. The operation was an easy and uncomplicated one. The tumour was as large as a melon, and on microscopical examination, proved to be a spindle-celled sarcoma. The only event of note was the rapid healing of the wound and quick recovery of the patient, as regards the operation. I have not since heard if there has been any recurrence, or metastatic growth. I have noted the rapidity with which the wound healed. It is now a well known fact that in those cases, where there is malignant disease it is rare to find suppuration, and this case is quoted in evidence.

DISEASES OF THE TUBES.

Salpingitis. Neither of the cases recorded, presented any very marked degree of Salpingitis in regard to symptoms.

Both were Gonorrhoeal, and had accompanying Endometritis and ovaritis, both had prolapsed ovaries, Case 18, the right ovary was the gland displaced, but the tube on the left side was the seat of inflammation. In Case 20, the left ovary was prolapsed and Salpingitis on the same side, this latter case had well marked utero sacral cellulitis. The symptoms in both these cases were very vague, as regards the tubal condition; both referred pain to the left side, Case 18 complained of Dyspareunia, and Case 20, Leucorrhoea; it will readily seen that these symptoms might quite well be due to the other conditions, present, and not to the salpingitis.

The Inflammation of the tube was certainly chronic for in Case 18, the enlarged thickened, not sensitive, duct could be readily palpated per vaginam, this with an antecedent history of Gonorrhoea justified the diagnosis quite apart from the symptoms.

What one would have expected to find, especially in Case 18, was dysmenorrhoea, and possibly menorrhagia, but on reference to the Case it will be seen that neither of these conditions were present.

Treatment. adopted in both cases was - Rest in bed, Hot douching, counter irritation over brim of pelvis and the ichthyol glycerine tampons, together with saline purges, improvement was marked in both cases. In connection with Gonnorrhoeal Salpingitis the idea has occurred to me, whether or not the Surgeon would be justified in removing the diseased tube, even though it were giving rise to no distressing symptoms. Take the cases which have just been discussed, and I think that they are the very cases which would raise the question which I now put forward.

The diseased tubes in these cases were not in themselves the cause, at least not the immediate cause, of the patients' suffering, but that they were diseased and irremediably so, from the specific taint , I have no doubt. Now the presence of these tubes, is to my mind a source of great danger to the patients, as they predispose to Tubal Gestations, the dangers of which need not be discussed here. If then the Surgeon believes that he has to deal with a chronically inflamed tube, especially with a Gonorrhoeal history, then I maintain that it is his duty to remove an organ, which is both useless and a source of Danger.

DISEASES OF THE BROAD LIGAMENTS.

Simple Cyst. It is extremely difficult to say whether these cyst originate from the ovary, or whether they actually begin in the layers of the Broad ligament itself; or as some authorities state they may begin in the parovarium. It is unfortunate that in the Case 92, here recorded, the cyst had split the

layers of the broad ligament and was so intimately attached to it, and in addition the adhesions were so numerous, binding the tumour to the pelvic wall and adjacent viscera, that removal was impossible, the ovary too was displaced and its relation to the cyst wall could not properly be made out, the cause therefore could not be determined. Whatever the causation of these cysts, be they from ovarian, parovarian, tissue, or in the broad ligament itself, the treatment remains the same, viz:- removal where possible.

That this is not always possible is well exemplified by the case in question, the only thing left to do then is to open and drain the cyst, which was done in the case quoted. They usually take a long time to heal, and I think that perhaps even a better plan is to keep the cyst packed with Iodoform gauze in the hope that an adhesive inflammation might be set up and the cyst become obliterated, I have no experience of this; but it appears possible that this line of treatment might be effectual, the idea occurred to me, from the treatment of the sac of an extra uterine gestation (to be discussed later) not that this latter had the same characters as the cyst wall, but that the mechanical action of the gauze might act upon the secreting cells of the cyst.

To carry out this treatment it would be necessary to stitch the cyst wall, as much as possible to the abdominal wound in order to shut off the peritoneal cavity, the outside wound too would have to be left pretty large so as to allow access in the packing of the cyst with gauze.

While the cyst was secreting, the gauze would act as a drain and so carry off the fluid. Its presence as a foreign body would tend to cause inflammatory action, and if it were shortened gradually, in all probability, the cyst would heal from below by adhesive inflammation. The Case in question drained for a considerable length of time, and the patient was kept a prisoner in bed for a much longer period, than would have been the case I believe if the cyst had been treated as I suggest.

Malignant Cyst. This was irremoveable, but the diagnosis was arrived at from the fact that there were secondary growths in the peritoneum and omentum; the cyst was filled with thick curdy, and extremely offensive fluid, in parts it was of the consistency of soft cheese; the attachments of the cyst by adhesions to the surrounding viscera were so numerous that its removal was impossible. Symptoms were - swelling of abdomen, with pains radiating from the epigrastrium. If reference be made to the Case No. 72 page 178, it will be seen that the abdominal examination revealed a hard nodular moveable mass, and that there was also a considerable amount of ascitic fluid. There was marked cachexia so that the diagnosis, before operation, as to the malignant character of the tumour was not difficult. Malignant cysts of the broad ligament are usually papillomatous so that the condition here noted is not a common one. The prognosis in these cases is very bad. The case in question died the second day after operation.

DISEASES OF THE PAROVARIAN

Cystic Tumour. No mention need be made here of the causation of these tumours, but attention is mainly drawn from a clinical point of view. The Diagnosis or rather the differential Diagnosis is of importance, especially with a view to prognosis, not so much as regards treatment for when diagnosed they should be removed. They are most likely to be confounded with O varian Tumours, especially if these latter are unilocular, when such be the case, diagnosis between the two is extremely difficult. Of course if an ovary can be felt on the same side of the tumour, it makes the diagnosis of the par ovarian practically certain. In the Case (No. 49 page 159), here recorded, abdominal examination revealed a large cystic uniform swelling with well marked fluctuation; this latter point is almost diagnostic, for the surface of the tumour being smooth, due to the fact that they are unilocular, allows the wave on percussion to travel freely. Vaginal Examination in this case was negative. Treatment; laparotomy and removal. These tumours rarely give trouble in operating.

In one Case, which is not recorded, a par-ovarian tumour was diagnosed, and the physical examination was very much like this last case, when two nights before operation the tumour suddenly subsided and all that the patient complained of was frequency of micturition, and greatly increased quantity of urine.
It will be seen from this that such a thing happening as the bursting of a par ovarian tumour is not so

grave an occurrence as the bursting of an ovarian tumour, vide Cases Nos. 13 & 71. For the fluid in the par-ovarian tumour is an unirritating clear bland solution, which, in the event of escaping into the peritoneal cavity, is quickly absorbed and no harm is done.

U R E T H R A, B L A D D E R A N D U R E T E R S.

DISEASES OF THE URETHRA.

Urethral Caruncles.

These Cases (Nos. 23page 139 and 90 page 194), were very typical of the disease. In both, the meatus urinarius was surrounded by little pinkish bodies about the size of a millet seed, exquisitely painful on the slightest touch. In the first case, painful micturition and pain on walking were the symptoms complained of. In the second case, painful micturition and dyspareunia were complained of. The chief clinical significance is the extreme sensitiveness, the exact cause of which is hard to determine, for they merely consist of dilated capillaries and a possible superabundance. of superficial nerves, although this has never been clearly demonstrated. The site of occurrence is usually posteriorly to the orifice of the urethra, and in both my cases this occurred. In Case 23, however, they were also within the urethra.

Treatment, Practically the only treatment is free removal. This is best done with the cautery, care

being taken to go deep down as they recur, if not thoroughly removed, a pad should be placed over the wound and pressure applied, to obviate a tendency to haemorrhage. This treatment was adopted in both cases, and was successful.

DISEASES OF THE BLADDER.

Vesico Vaginal Fistula. Case No. 32 page 145, was one which presented all the symptoms of the tear from the bladder into the vagina. The tear in this case was very considerable. By far the most frequent cause of Vesico Vaginal fistula is injury during parturition, therefore the antecedent parturient history is of importance. The fistula may be noticed soon after parturition. In the former case the tear will have been produced immediately, in the latter a slough has formed as the result of bruising, from long continued pressure. Case No 32 comes under the second category, and if reference be made to the case it will be seen that the history of her last labour was a very severe one. The incontinence was only noticed two days after labour.

The operation for repair of the fistula need not be discussed, but all important is the preparatory and after treatment. The former should be carried out as suggested in "Tears of the Perinaeum". In addition the bladder should be washed out at frequent intervals during the day, as regards after-treatment I think there can be no question as to the advisability of placing a permanent catheter in the bladder for the

first five or six days at least. Gentle washing of the bladder with antiseptic solution is also advisable.

Cervico Vesical Fistula . Case No. 29. As in the last case, the fistula followed parturition. No definite history could be obtained in regard to the labour, but, the patient had had one previous child still born and she stated that in both her labours she had chloroform, and that they lasted a long time. It is therefore safe to assume that the labour was probably an instrumental one. Diagnosis was not before mentioned in regard to the other case, as the lesion was very evident both on digital and visual examination. In this case however, exact diagnosis was not so easy. The bladder was filled with milk solution but no escape was seen. At a subsequent examination under chloroform the milk solution was seen trickling from the cervix. It was evident therefore that the fistula opened into the cervical canal. The Treatment in this case, as regards the operation, was, apart from the repair of the fistula, that the anterior vaginal wall, which contained the bladder, was dissected off the cervix. The fistulous openings thus exposed on the anterior vaginal wall and cervix were closed. The preparatory and after-treatment were the same as in the first case. In both of these cases the treatment adopted was successful.

Cystitis. This disease is by no means uncommon among women. As to the causation in general, we do not here concern ourselves, as in the case No. 40 page 152, here recorded the cause was evident viz :-

Gonorrhoeal. The Symptoms in this case, were frequency of micturition, pain of a scalding nature during the act, and a sharp stabbing pain at intervals. The patient had had in addition some "growths" removed from the meatus shortly before admission to the hospital. These were, in all probability, urethral caruncles. There is no doubt that in this case, that the cystitis was gonorrhoeal as a distinct history was obtained . The diagnosis of cystitis is not difficult, the symptoms are quite sufficient to astablish the diagnosis. In addition, the appearance of a patient suffering from cystitis is characteristic : the sallow complexion, sunken eyes, distressed, wearied and worried look, are very distinctive of cystitis. The constant desire to micturate, amounting almost to incontinence, which causes the patient to be continually up, soon tells on the general health. It might almost be said that a pretty good idea as to how bad the disease really is, may be obtained by asking the question "how often do you have to rise during the night to pass your water?" In very bad cases the answer will be "every half hour or so." If the bladder sound be passed, it will be found that the bladder is extremely sensitive and usually contracted. The cystoscope is valuable, as it gives a very good idea as to the extent of the inflammation. Prognosis must be guarded in cystitis, as it depends upon the stage of the inflammation and the constitution of the patient. If chronic, and the patient is tubercular, prognosis is bad.

Treatment. If acid, the urine must be made alkaline. Diuretics and suitable medicines, nothing better than the the benzoates, and washing out, at frequent intervals, the bladder. Both boracic and salicylic acid were used in this case with very good results. It occasionally does good to just slightly over distend the bladder, but care must be taken that the patient be not in too low a condition of health. I found great relief given to patients by very hot vaginal douches and the use of ichthyol plugs.

DISEASES OF THE URETERS.

Ureteric Fistula. These cases are not very common; when they do occur, the complaint usually made is incontinence of urine, not to a very great extent as the patients can usually pass a fair amount of urine voluntarily, so it is really more a dribbling of urine. As a rule these conditions are either congenital or secondary to pelvic suppuration. In Case No. 17 page 133, it was of the former class and duration was given since childhood, in other words, all the patient's life. The diagnosis of the condition is not always easy, but no great difficulty was encountered in the case here recorded, for on vaginal examination a small fistulous-like opening could be seen on the anterior vaginal wall, a probe was passed into this opening but could not be pushed on further than half an inch. The bladder, which measured 3½", was filled with 10ozs. of milk solution but none was seen to escape either through the fistulous opening or by the urethra. Fluid was seen to exude from the opening

at a later period, clear, and on being tested was found to be acid. If reference be made to the case page 133, it will be seen that the fluid collected from the fistula was undoubtedly urine. Note is also taken as to further examination of the bladder, and it will be seen that both direct examination by the aid of Kelly's specula and with the cystoscope. With the former after dilating the urethra with the combined specula and dilators, and the bladder wall examined visually, efforts were made to pass Kelly's ureteric searcher and catheter, but with this method it could not be definitely ascertained if both ureters opened into the bladder. On the other hand, with the aid of the cystoscope, it was found that there was the appearance of two ureters on the right side, and one on the left. If this were really the case, for one is apt to err in cystoscopic examinations, then it is quite possible that a fourth ureter opened into the vagina; of course one might theorise to any extent on this point, as confirmation of diagnosis would be extremely difficult.

To leave theory, and to come to practice the condition of "ureteric fistula" existed, what then would be the best thing to do for the patient. First the question arises as to how much discomfort the patient is suffering, if not a great deal, then I am strongly of opinion that no operative interference should be undertaken. I do not think that the discomfort (I refer to the case quoted) is such as to justify the plastic operation for implanting the ureter into the bladder.

D I S O R D E R S O F M E N S T R U A T I O N.

AMENORRHOEA.

The majority of the cases recorded were those of physiological amenorrhoea. Case No 53, before puberty, and Cases Nos. 4, 13, 15, 38, 48, and 64. Amenorr-hoea of the Menopause. The other cases were amenorrhoea of pregnancy. So, as there was no case of pathological amenorrhoea, this subject will not be further discussed.

MENORRHAGIA.

Is a symptom associated with a good many diseases of the uterus and uterine appendages, and it will be seen by the cases recorded that a good many different conditions come into play. Perhaps the commonest causes of menorrhagia are, displacements and fibroid tumours. In Cases Nos. 27, 50, 56, 65, 74, 80, and 95 are all due to fibroid tumours. In Cases Nos. 37, 61, 76, 81, 83 and 91 are due to displacements. Ovarian tumours are also a cause, and this is seen in Cases Nos. 55, 92, and 96 - malignant disease. Nos. 82 and in one case (No. 83) no cause could be found beyond an ovaritis. Little may be said of symptoms. The patient complains of losing an excessive amount at her periods, but treatment is of more importance. In every case seek to remove the cause. In fibroid tumours it is usually the polypoidal form, and the interstitial variety. The treatment of the former has already been discussed, but mention has not been made so much in regard to the interstitial variety.

Here in this condition the tumour may be only of very small size, but quite sufficiently large to set up an endometritis which will cause the menorrhagia. In these cases frequent curettings, the internal administration of ergotine and Hydrastis etc., with hot douching night and morning often effect a cure.

Where the tumour is bigger and giving rise to more trouble in regard to menorrhagia, myomectomy has been suggested, but usually the symptoms are not so grave as to warrant so serious an operation.

Menorrhagia is rarely ever so bad as to necessitate the extirpation of these tumours, but oopherctomy has been suggested, but I think that unless the Case has other complications this should not be called for. Of course rest in bed at the time of the flow is essential. Displacements if rectified and the attending inflammation treated, the disease as a rule yields readily to treatment. Case No. 85 was one of very unusual type, although there was menorrhagia, the real cause of complaint was metrorrhagia - As the treatment of Metrorrhagia is the same as menorrhagia, they are best discussed together. The causes of metrorrhagia are really the same as menorrhagia, merely the one passing into the other; that is to say the patient with menorrhagia untreated often goes on to metrorrhagia, of course metrorrhagia is more closely associated with fibroid tumours and malignant diseases. To return to Case No. 85, the complaint as before stated was metrorrhagia, and if reference be made to the case it will be seen that the uterus was normal in size and in

every other respect, the only condition being a slight ovaritis. This patient resisted all treatment. She was given hot douches regularly, styptics were applied to the uterine cavity, curretage, but all without avail At last plugging the vagina was tried and so long as this was done the haemorrhage ceased. This patient was a long time in the hospital, but eventually, from the effects of the plugging, occasional curretting and suitable medicines, she ultimately recovered. The plugging is useful in this respect, that it checked the haemorrhage which was sapping the patient's strength; it thus gave time to build up the patient and put her in such a condition as to resist the drain. The occasional currettings also were of service, in as much as the uterus was packed with iodoform gauze for a period of 36 hours. This seemed to stimulate the uterus to better contraction. At one time this patient was so bad from the loss of blood, that it was seriously considered as to whether or not oopherectomy should be performed; fortunately the above treatment eventually effected a cure.

DYSMENORRHOEA.

It will be seen in the analysis that by far the greater number of the cases in the disorders of menstruation are classified under the heading. I have classified them into those occurring before the flow was established,(premenstrual extra uterine;) and during the flow (uterine.) Extra Uterine or premenstrual. This is without doubt as the classification shows, due to diseases of the uterine appendages,

it is marked in Cases Nos. 50, 55, 61, 67, 68, 74, 81, & 92. In all these, with the exception of Case No. 61 the cause was due to ovarian or fibroid tumours. In Case No 61 there was a gonnorrhoeal salpingitis. In Case No. 74 there was marked ovaritis.

This form of dysmenorrhoea is always shown as the name suggests by pain preceding the actual flow, perhaps two or three days before. If there is no accompanying inflammation of the uterus, relief is experienced when the flow is once established, because as a rule the tubes and ovaries are in a state of chronic congestion, and when the flow does commence considerable relief is experienced, from this blood letting as it were.

Of all forms of dysmenorrhoea the premenstrual is the hardest to treat, of course where it is due to the presence of neoplasms, their removal will cure the condition. As regard the inflammatory conditions, much can be done if the patient will give herself time Hot douching regularly, ichthyol and glycerine tampons and occasional blisters over the brim of the pelvis, and the use of saline purges. If this does not do, then as a last resource, removal of the ovary should be adopted.

Uterine, during the flow. Cases Nos. 47, 33, 60, 61, 67, 68, 74, 76, 83, 86, 87 and 91 were almost with-out exception due to displacements of the uterus. The exceptions were Cases 61, & 68. In these the Dysmenorrhoea was due to Endometritis. I append a table which shows more clearly the causation, and the time when the pain occurred.

Case.	Cause.	Time of occurrence of pain
33	Anteversion and Specific Endometritis.	First day of flow.
47	Retroversion.	First day of flow.
60	Anteflexion.	First day of flow.
61	Specific Endometritis.	During whole time of flow
67	----------	During whole time of flow
68	Endometritis from Subinvolution.	During whole time of flow
74	Fibroid Tumour	During whole time of flow
76	Retroversion	During whole time of flow
83	Retroflexion	During whole time of flow
86	Anteflexion	First day of flow.
87	Retroversion.	During whole time of flow
91	Prolapse	During whole time of flow

It will be seen then, that in four of the cases, the pain was only on the first day of the flow, and of these four, three were due to Forward displacements of the Uterus, the remaining one was a Backward displacement. I have frequently observed that in the Forward displacement, the Dysmenorrhoea is, almost without exception, during the first twenty-four hours, and is always relieved when once the flow is established, this is especially the case in congenital anteflexions and to my mind is conclusive proof of the mechanical theory of Dysmenorrhoea; one can quite easily imagine the menses collecting at the seat of the flexion ; or to speak more correctly just above it, the uterus in a state of congestion; thrown into action and

expelling the retained menses in the form of a clot, the whole action is analogous to a miniature labour, then the flow once established the pain ceases. In Case 86 there was in addition a marked stenosis of the os uteri, giving the condition known as "pin hole" os.

In the remaining eight cases the pain was during the whole time of the flow. As to causation, three were backward displacements, one downward displacement, one Fibroid Tumour, one Specific Endometritis one Subinvolution with accompanyingvEndometritis, one the cause is not noted as no pelvic condition could be found on examination to account for the Dysmenorrhoea. I have stated that, in these cases the cause is the Displacement, this is of course not the immediate cause, but only that in all, Endometritis was the actual condition (resulting from the displacement) which was responsible for the Dysmenorrhoea.

Treatment. plainly where there is a displacement this must be rectified first, and the accompanying Endometritis treated, before any hope of cure will be realised. In regard to the Anterior displacement. In Case 86, Hot douches were used, and the introduction of graduated Bougies was tried, the period following this treatment was absolutely free from pain, this dilating the uterine canal would require to be done frequently before a cure could be effected. In Case 47, a Retroversion, the same treatment was tried with a like success. In all the other cases, with the exception of Case 67, hot douching regularly, currettage, and afterwards replacement (where necessary) was the treatment adopted, and in most, was successful.

As regards medicinal treatment, Saline purges are necessary; and in these cases where the spasm is marked I have seen good result from the use of the Liquor Caulophyllin and Pulsatillae Co. In those cases with specific taint, in addition to the local measures taken to afford relief, constitutional treatment should not be forgotten.

P E L V I C I N F L A M M A T I O N S.

UTERO SACRAL CELLULITIS.

The symptoms of this disease are usually so well marked that diagnosis can almost be made at once. Chief among the symptoms are pain, either of a dragging character located to the back; pain in the side; dysmenorrhoea and dyspareunia.

In the cases under observation viz;- Nos. 5 & 20, the utero sacral cellulitis was associated with additional disease, so that the symptoms in Case No. 5 were really due, to a greater extent, to the accompanying condition of ovaritis. In Case No. 20 there was also an accompanying condition of prolapse of the ovary. Dysmenorrhoea was present in Case No. 5, but, contrary to what might have been expected the pain complained of, was before the flow commenced, this of course was due to the ovaritis, but had there been, as is nearly always the case, in utero sacral cellulitis.

Anteflexion of the uterus, there is no doubt that pain during the flow would have been complained of. Although in Case No. 21 there was this condition of the uterus present, and no menstrual pain; still in a number of Cases (not recorded) I have been much Struck

with this Dysmenorrhoea during the flow.

I note with interest a paper by Dr. Fordyce read before the Obstetrical Scoiety in Jan.1895, that the cases quoted by him coincide, both in regard to symptoms and the physical examination to many of the cases which were in the Ward during my term of office. I refer mainly to those cases in which utero sacral cellulitis is the only condition present.

That anteflexion of the uterus is not always present is exemplified in Case No.5. Here as a matter of fact, the ligaments were tense, hard and tender, and were in such a condition that the forward dislocation of the uterus would have certainly have been expected. Examination with the aid of the sound,however,showed that the uterus, though lying to the front, was not flexed upon itself.

In case No.20, the uterus was anteflexed. There is another point to which I would like to draw attention, that is the question of sterility; there are few pelvic conditions which are so commonly associated with sterility as utero sacral cellulitis. In case No.5 it will be seen that the patient had not borne children,at all events since she had contracted the disease. In case No.20 it is rather remarkable that there is a history of five pregnancies, the last one being only three months previous to admission, and yet the disease, according to

the patient, had been present for three years. I certainly do not think that the utero sacral cellulitis in this case could have been present for more than a few weeks, and it is quite possible that the cellulitis was due to a recent abortion.

Dyspareunia, for obvious reasons, is not often complained of, that is to say where it is not specially marked, but there are cases in which this symptom is so outstanding that patients make this the sole source of complaint.

On vaginal examination the utero sacral ligaments are found to be tense and inflamed, usually very tender. The Cervix was found dragged upwards and backwards and the body of the uterus acutely anteflexed. The ligaments are felt like tense fibrous bands with a sharp edge, and there can be no mistake in regard to diagnosis when these are once felt on vaginal examination, especially if associated with the accompanying anteflexion.

Treatment. First, rest in bed with careful attention to the bowels. Here again the use of saline purges is extremely valuable. The following prescription was always given in cases such as the above and with marked benefit :-

℞ Mag Sulph ℥ iii
Quin Sulph gr: 32
Ferr Sulph gr: 48
Acid Sulph dil ♏ iii
Aqu. Menth pip ad ℥ viii

Half an ounce of this taken three times a day. This not only acts upon the bowels in lessening the constipation but also depletes the pelvis. Hot douching as described on page 41, should be carried out, also ichthyol plugs, and of course it need hardly be said that sexual intercourse is quite inadmissable, if benefit is to be hoped for.

If the utero sacral cellulitis is cured, then the accompanying anteflexion can be treated later, this has already been referred to.

PARAMETRITIS.

This disease is so common that it is not surprising to find four cases occurring among the hundred recorded. In three of them viz:- Cases Nos. 26, 28, 45 the condition followed upon parturition. These three cases were exactly similar, especially in regard to symptoms and physical examination. The pathology need not here be discussed.

The Causation is undoubtedly always due to septic absorption and in all three of these cases it will be seen that the cause of infection was from some complication during parturition. In all, pain is the most prominent symptom, chiefly referred to the iliac regions; pain on micturition was complained of in Cases Nos. 26, 28, and 45. Vaginal Examination in all revealed a hard boardy mass in one or other fornix. On bimanual examination the mass could be felt extending well up the iliac regions, and in Case No. 45 was as high up as the iliac crest.

Treatment in these cases is long and tedious. Rest, attention to the bowels, frequent hot douching; ichthyol plugging; hot fomentations over the area of swelling and pain, and occasional blistering are about the best lines to go on. Mercury and Iodide of Potash have been recommended and sometimes do good. I do not think, as is too often the case, that the diet should be a low one. (Irefer, of course, to those cases in which there is no great pyrexia) for very often

good feeding, helps not a little towards the recovery of the patient.

Constipation is often quoted as being a constant source of annoyance in this disease, but my experience has been the very opposite, for in Cases Nos. 26, 28, and 45, the diarrhoea resisted all treatment for a long time. Do these Cases ever permanently recover ? Yes! if properly attended to and the patient will take time. In Case No. 45 as unfortunately sometimes happens, abscess formation took place. This patient had previously been discharged from hospital, after having been there for a considerable time, very greatly improved, but three weeks later she was sent into hospital with a large abscess about the size of a big melon, pointing just above, Poupart's ligament.. This was opened and drained; dressings had to be changed frequently through the day for a considerable period. Treatment of various kinds was tried in regard to the abscess cavity, but with no very great result; eventually a second abscess formed over the buttock, but fortunately did not communicate with the joint; this was incised and treated in the same manner, but many months elapsed before improvement took place. I have noted all this in regard to these abscesses in order that I might state what I think to be the best line of treatment; firstly, watch carefully, pulse and temperature for indication of pus formation, directly this latter has occurred, the abscess should be freely incised immediately and drained carefully. The cavity , if large, should be thoroughly washed out with a week solution of Iodine and drainage carried on for at

least a few days, by means of rubber tubing; this may be substituted later by Iodoform gauze, the abscess cavity thoroughly packed with this material, and the gauze shortened day by day. Care must be taken that the wound be not allowed to close too early otherwise the pus will collect at the bottom of the abscess cavity. Given time, patience (above all) strict antiseptic precautions, for although the abscess is already in a septic condition, it is quite possible that, unless care be taken, fresh sepsis may occur again. The iodine washing should be repeated every two or three days; it not only acts as a stimulant to the tissues, but is also a powerful germicide.

Perhaps it would have been better when discussing treatment to have mentioned before anything else prophylaxis, especially during parturition, for undoubtedly the greater majority of these cases are due to injuries received during parturition. Case No. 46 This patient was not mentioned with the other three for the reason that she came into hospital with abscess formation. The Case is an interesting one, in as much as the abscess was in a peculiar position, viz:- lying between the bladder and the uterus. The history was indefinite and did not coincide at all with the history generally received in cases of Parametritis. On vaginal examination the cystic mass could be felt in the position indicated, the swelling in the vagina was incised, and a teacupful of pus was drawn off; the cavity was afterwards packed with Iodoform gauze; the following day the gauze was removed and the abscess

daily until the cavity healed up and the patient was eventually dismissed cured. I think that the rapid progress made by this patient was due in a great measure to the position of the abscess and that when opened, drainage was very efficient.

Tubercular Parametritis. This was really a tubercular infiltration of the cellular tissue of the pelvis prognosis is bad in a case like this, more especially as there was evidence of tubercular affection elsewhere in the body. Local treatment is not of much use, constitutional being of more importance; this need not be discussed here, no further mention will be made of this case.

E X T R A U T E R I N E G E S T A T I O N .

This subject is far too large to be dealt with justice in a treatise such as this.

The cases will only be discussed in regard to the symptomatology, physical examination and treatment. Case No.49, page 159, 52, page 162, and 78, page 184, will be discussed first, as the diagnosis of Extra Uterine Gestation was not proved by operative treatment. The symptoms and physical examination, however, were strongly presumptive of Ectopic Gestation. Reference to the following table will give a clearer idea, both of symptoms as regards complaint from patient, menstrual history and physical examination.

(See Table on Pages following).

Case	Nature of Complaint.	Menstruation.	Abdominal Examination.	Vaginal Examination
39.	Swelling of Abdomen and occasional attacks of severe pain.	Regular till after the birth of last child 9 years ago. Since then almost daily slight haemorrhagic discharge till 6 months ago, then amenorrhoea for 4 months and for the last 6 weeks irregular haemorrhages.	A large tumour reaching as high as the Umbilicus lying a little to the left of the middle line, hard, irregular, and apparently connected with the Uterus.	Uterus enlarged 5" and empty. A large mass can be felt per left fornix and apparently continuous with the Uterus.
49.	General Pelvic Pain, Constant haemorrhagic discharge.	Regular till 4 months ago. Amenorrhoea for 2 months, after that constant haemorrhagic discharge.	Nil.	Uterus slightly enlarged, soft and to the front, behind can be felt a fluctuating tumour which is not separable from the Uterus.

ase.	Nature of Complaint.	Menstruation.	Abdominal Examination.	Vaginal Examination
52.	Pain in back and lower part of abdomen and haemorrhagic discharge	Regular until present attack, when patient went 2 weeks past her time, then began to bleed the same amount as at period. This gradually became less, until a spot or two. 16 days before admission it returned freely, ceased for 2 days and has returned again.	Nil.	Uterus to the front. A mass can be felt in the posterior fornix, fluctuating and tender.
78.	Pain in lower abdomen and lower part of back.	Amenorrhoea for the last 7 weeks, previously was very irregular, sometimes once in three weeks, once in a fortnight with menorrhagia.	Nil.	A large mass about the size of an orange can be felt bulging into the posterior fornix. Uterus to the front 3½".

Case.	Nature of Complaint.	Menstruation.	Abdominal Examination.	Vaginal Examination.
100.	Swelling of Abdomen and pain in the right leg.	Always regular until January 23rd. 1896. From this date till the end of June 1896, Amenorrhoea, when she menstruated, but not like the usual, there being pieces of tissue, like pale skin passed with clots of blood. Nothing after this till 2nd August, when she was unwell till 8th Aug. On this occasion she passed more pieces of pale skin and clots. Nothing until August 14th. and then only a few drops.	A large tumour, irregular in outline, reaching within an inch of the Umbilicus; it extends on the left side to the extent of 3" from the middle line. On the right side it fills up the iliac fossa. There is a well marked linea nigra. On percussion it is dull all over, on palpation it is solid in parts and cystic in others.	A large mass can be felt bulging into the posterior fornix. In the right fornix a small body about the size of a hazel nut can be felt. The uterus is to the front and feels continuous with the tumour.

It will be seen in these three cases quoted, 49, 52 & 78, that the menstrual history is suggestive of Extra Uterine Disease.

Diagnosis of Early Extra Uterine Gestation is not always easy, and it will always remain a difficult question which is the best method of treatment in these cases. I do not feel quite certain that in all cases where an Ectopic Gestation is suspected, it is the surgeon's duty to cut down. Before the second month I should be inclined to adopt expectant treatment. So many cases of haematocele and haematoma are met with in gynaecological practice, which slowly but surely resolve, that if it is the case, as I believe it to be, that these originate in rupture of early Tubal Gestations, I think the risk of exposing the patient to a serious abdominal operation is perhaps greater than leaving the case alone, at any rate, till about the third month. By this time the diagnosis of the condition will be pretty certain if the case has been carefully watched, and if the swelling is steadily increasing then I think operation is certainly called for, as rupture then is a much more serious affair than at the second month. Case 49 is an instance of what I refer to. Operation was performed here, and all that was found was a small organ-

ised blod-clot, but nothing to indicate that the patient would not have slowly and completely recovered without operation.

As to the causation of Extra Uterine Disease, it is probably, in the majority of cases, due to antecedent inflammation of the tubes, a desquamative salpingitis, this being very frequently due to a gonorrheal infection.

It will be seen on reference to the cases 39, page151, 49, page159, 52, page162, and 100, page201, that there had been, before the disease developed, a long interval of sterility. This in itself I consider a great point in diagnosis.

Turning now to cases No.39, page151, and 100 page201, it will be seen that the disease in these two patients was more advanced, and in them the diagnosis was established, in the one case by passage per rectum of foetal parts, and in the other on removal, by Abdominal Section, of the foetus, etc. Case 39 was complicated by the presence of a fibroid tumour of the uterus, but the history (vide table) was so definite, that little doubt could be entertained of the accompanying condition of Extra Uterine Gestation. The patient left hospital against advice and a month or two later, a foetal arm and leg together with a

large quantity of pus were passed per rectum, thus confirming the diagnosis of Extra Uterine Pregnancy.

Case 100 was a very much more satisfactory one to deal with, the history is absolutely typical of the disease, and there could be little doubt as to the nature of the condition. Laparotomy was performed, and I consider that, in this particular operation, there were special points of interest. The first is - that on opening the abdomen and the gestation sac being exposed the sac wall was stitched with interrupted sutures to the edges of the abdominal incision; the sac was then incised, and the contents extracted, which were - a foetus 10 inches in length, shrivelled, mummified, and covered with a yellowish vernix caseosa; some old and some recent blood clots. The second point of interest is - that the sac was partly extra - peritoneal and partly intra-peritoneal. The third point of interest was the after treatment.

As regards the stitching of the sac to the abdominal incision before opening into it, there is some difference of opinion. I think the advantage of doing this is obvious for, firstly, it is undoubtedly easier to stitch a tense bulging sac wall accurately to the incision, than a flaccid empty cyst, and, second, by so doing, the peritoneum is shut off from the contents of the sac, which are often septic if the foetus has

been dead some time. Should it be found at a later stage that the sac is removable, it is a comparatively easy matter to cut through the stitches.

The second point of interest in this case was the double sac, one part intra, the other extra-peritoneal. The lower sac was full of blot clot and placenta, and was clearly extra peritoneal, while the upper, which communicated with the lower, was intra-peritoneal and contained the foetus. A double rupture had probably occurred, first through the lower part of the tube into the broad ligament, (sub peritoneo pelvic) and the placenta remaining attached, the gestation had proceeded till a second rupture had occurred, and the foetus had escaped into the peritoneal cavity (tubo peritoneal). No trace of membranes was discovered in the upper sac, and the condition therefore seemed to confirm what has been pointed out before, that if the foetus escapes into the peritoneal cavity, not enclosed in its membranes, it cannot live, - and that, in those cases of tubo peritoneal gestation which go on to full time, the foetus has escaped along with the Liquor Amnii and membranes into the peritoneal cavity.

The third point of interest in this case was the after treatment. After removal of the foetus and blood clot, the cavity was carefully packed with iodoform gauze. This was removed on the third day, and

then the cavity was washed out daily with antiseptic solution and a drainage tube inserted. The washing out, owing to the careful isolation of the cyst from the peritoneum, could be very thoroughly done without any fear of fluid finding its way into the peritoneal cavity.

The wound slowly healed and the patient was eventually dismissed cured.

D I S E A S E S O F O M E N T U M ,
P E R I T O N E U M A N D I N T E S T I N E S.

MALIGNANT OMENTAL TUMOUR.

This and the following cases, viz., diseases of the peritoneum, intestines, the two cases of pregnancy and thrombosis of the femoral vein, hardly come within the scope, strictly speaking, of Gynaecological cases, but as the hundred cases were taken consecutively and were treated in the Ward, I have been forced to include them.

This case of omental disease(Case 38,page 150) is interesting in as much as the patient had been the subject of Ovarian Disease, and had on a former occasion two large cystic (colloid) tumours of the ovary removed; it has already been referred to under the heading of Ovarian Tumours.

On admission there was found on abdominal examination a large sharply defined swelling, nodular and about the size of a melon, situated a little to the left of the middle line, just below the old laparotomy wound. The swelling was freely moveable and was painful on pressure.

As was the case when this patient was in hospital

before, she had Glycosuria.

On operating, a large mass adherent to the intestines was found, which owing to the intimate relations of the adhesions could not be removed, a small portion was excised, for microscopical examination, which proved to be malignant.

It is worthy of note that the patient left hospital after her operation for the removal of the ovarian tumour with no trace of the malignant condition, and within four months the malignant disease showed itself. Another noteworthy point, already referred to, is exemplified in this case, the rapid and clean healing of the abdominal incision.

TUBERCULAR PERITONITIS.

The diagnosis of this condition, as a rule, unless encysted, is not attended with much difficulty.

The case (case 67, page 174) under observation was typical of the disease. There was emaciation, swelling of the abdomen, the evening rise and morning fall of temperature indicative of tubercular disease, and evidence of tuberculosis elsewhere.

An important diagnostic point in regard to the abdominal swelling is gained on percussion, namely with the patient lying on her back, there is dulness in the flanks and resonance over the anterior part of the abdomen (unless the fluid be present in very large

quantity), this is reversed if the position of the patient be changed.

The difficulty of diagnosis can well be imagined, when the fluid is encysted; here the temperature, presence of tubercle elsewhere and general condition of the patient, must be one's guide.

The patient here referred to, had Laparotomy performed and the fluid removed, the peritoneum was found studded with miliary tubercle, like grains of sand, the feeling of the intestines and pelvic viscera was much as if the hand were gently drawn over fine sand paper.

A good recovery from the operation was made, but before dismissal there was a slight re-accumulation of the fluid.

Is operative treatment the best thing for this disease? I am not so sure that it always is, and the younger the patient the less inclined I would be to operate, at all events until all other measures had failed.

Often, however, operation is followed by a cure, whether this is due to removal of the fluid, which probably acts as an irritant, or the admission of light and air into the abdominal cavity, as suggested by some, I am unable to say.

Although I have here only one case recorded,

I have had experience in several others, and in few, have I seen actual cure by operation; another point to be borne in mind is that often operation, on these cases, is followed by the appearance of tubercle elsewhere, in one case, the patient whose lungs were apparently healthy as far as could be ascertained from the physical signs, after operation developed rapid phthisis.

It is quite conceivable that a patient undergoing an operation such as abdominal section, would be very much depressed in regard to her general health, and being already tubercular is less able to resist the further encroachment of the tubercle bacillus.

In the case of children I have seen this disease cured by attention to general health, the application of Mercury, either the Iodide or Oleate, and massage; if there is a great deal of fluid an occasional paracentesis will relieve, and I do not see why the same treatment should not be successful in adults, or at all events, young adults.

I would urge therefore that treatment such as I have suggested should be practised before operative procedure is resolved upon.

CARCINOMA OF CAECUM.

Very little need be said about this condition, the only interest from a gynaecological point of view being the question of diagnosis, which in this partic-

ular instance did not occasion much difficulty, but one can quite see had there been a little further extension of the disease; diagnosis might not have been so simple.

On abdominal examination, the tumour was found to be situated low down in the right iliac fossa, hard, nodular, and quite movable, on vaginal examination, the mass could be felt quite distinct from the uterus and its appendages. Rectal examination gave no more information than was found on vaginal examination.

As the patient did not remain in the ward for treatment, no further remarks need be made.

P R E G N A N C Y .

HAEMORRHAGES.

These two cases are interesting in that neither of them came to hospital complaining of pregnancy; as a matter of fact they were not conscious of being in that condition. Case No.59, came complaining of a swelling of abdomen which she thought was a tumour, and case No.66 complained of constant haemorrhagic discharge. On reference to Case No.59, page 168, it will be seen that the menstrual history is rather peculiar, and the vaginal examination, as with the abdominal, gave every evidence of normal pregnancy. It is interesting to note that in this case, No.59, patient

had well marked Raynaud's Disease. In case No.66, page 173, the menstrual history shows amenorrhoea of four months, metrorrhagia for two months; on abdominal and vaginal examination nothing abnormal from what would have been expected was found, except that, in addition, on vaginal examination the cervix was found to be very granular and with numerous distended Neibothian Follicles; these bled freely on being touched, no other abnormality was noted. Case No.59 was kept in hospital for a few weeks, and was eventually sent home very much improved as regards haemorrhage; about a fortnight after her arriving home she aborted. Case No.66 eleven days after admission gave birth to a six-month's foetus; the placenta being expelled half an hour later, but portions were retained in utero along with the membranes. It was found impossible to pass the hand into the uterus, as the canals were so small and undilated, any attempt causing the patient acute suffering; she was chloroformed, and the retained portions scraped away. There was considerable post partum haemorrhage which could not be checked by hot douches 120° , applications of Ferri Perchlor. and other styptics; the uterus was then packed with iodoform gauze, and the plugging was continued in the vagina. A hypodermic of Ergotin was administered. At 11.30 p.m. the uterus was found to be well contracted. The guaze

was not removed till the second day, when a corrosive inter uterine douche was given, and from this date on the patient made an uninterrupted recovery.

In regard to treatment of these cases, rest in bed and tonic treatment was practically all that could be done, but I am inclined to think that these cases might have been benefitted by the use of Calcium Chloride, as suggested by Dr. Wright of Netley. If, as is suggested, haemorrhages (without any obvious cause) are due to a deficiency of the coagulability of the blood, the administration of Calcium Chloride will restore the coagulable point to normal. I am inclined to think, therefore, especially in the case complicated with Raynaud's Disease, this drug would have acted efficiently, and I see no reason why that it might not have had a like good effect in the other case. Of course, Dr. Wright's researches have only been published since these cases were discharged from hospital, but if as, Dr Wright shows by cases quoted, that the drug acts beneficially in certain conditions of defective coagulability of the blood. I think it is highly probable that if an examination of the blood of patients subject to a like disease and the blood found, as I think it would be, with the coagulable point below normal, that this drug would cause a cessation of the haemorrhages.

Of course, had the haemorrhages been of very grave nature, then more active measures would probably have to be taken, e.g. empyting the uterus of its contents. In both of these cases, this is what nature did.

A B S E N C E O F O R G A N S O F G E N E R A T I O N .

Case No.14, page130, This condition is extremely rare. That there was complete absence of all the organs cannot be definitely proved without post-mortem examination. This of course did not take place in my patient. The physical examination, which was conducted under chloroform, both visual, rectal and recto abdominal, gave no trace of uterus or appendages. In appearance, she was a well proportioned, well nourished and healthy looking girl, her mammae were exceedingly well developed, the mons veneris was covered with crisp curly hair, the labia majora were present, and on separating them one found nothing but a membrane with the urethral opening situated about its upper third; the sound on being passed into the urethra was found to go directly downwards and forwards, the point of the sound being distinctly felt per rectum. What this patient sought advice for, was occasional attacks of pain in the abdomen, not the amenorrhoea

as would have been supposed. On close questioning it could not be elicited that the pain was periodic in character, that is to say, occurring at monthly or three weekly intervals, but only as the patient herself expressed "now and again".

Cases of malformations of the female genital organs have frequently been recorded, but although cases such as I here record have been mentioned, it is stated that those in which post-mortem examinations had been obtained, revealed the fact that there were very rudimentary organs; it is also stated that by far the greater majority of such cases are usually ill-developed in regard to the mammae, and that the hair is either absent, or long and straight over the pubis. It will be noted that in my case that to all appearance the girl was perfectly formed and it was only when the labia were separated that the defect was seen. The mammae in this instance were rather larger than is usual for a girl of her age; they were virginal in appearance and not pendulous. The only point of doubt is perhaps, the nature of complaint. Could the pain complained of be associated with any change in the pelvis? I think that the duration, viz., six months, is against this. As the girl was kept in for one month and carefully observed, and during this period there was no return of the pain, I am inclined to think that

this symptom has no significance. In regard to treatment of such cases, unless it can be absolutely determined that there are internal organs of generation present, and developed, I do not think any operative procedure is justifiable. The patient's mother had matters explained to her, and was informed that no operation would be advisable.

T H R O M B O S I S O F T H E F E M O R A L V E I N .

This should have been more properly placed under Pelvic Inflammations, but the condition complained of was so outstanding that it has been put under the above heading. On admission, the left leg was swollen, terse, white and shining, in fact, similar to the "white leg of pregnancy". On vaginal examination the cause was soon evident. There was found an extensive cellulitis among the muscles on the left side of the true pelvis, spreading over the brim and setting up phlebitis and thrombosis of the femoral vein. This condition so frequently follows parturition, that it comes as a surprise that this patient had neither been recently confined, nor had she recently aborted. On examination the parts were virginal. There was no history of injury, nor anything else likely to cause

disease.

As cellulitis has already been discussed no further mention will be made of it. Treatment need only be mentioned. The foot of the bed was elevated, the swollen limb carefully bandaged, opium fomentations had occasionally to be applied owing to the pain, and later, as the swelling reduced, massage was employed. Iron and arsenic were given internally. The patient was eventually dismissed cured.

ABSTRACT OF CASES.

No. 1.

Name Mrs. A. J.

Age 35

Address Hawick

Admitted 30th August 1895.

Complaint Pain in lower abdominal region almost constant. Haemorrhagic discharge.

Duration. One year.

Family. One child 14 years ago, no abortions.

Menstruation. $\frac{4}{28}$ Always regular till one year ago, since then as above and abundant Leucorrhoea.

Micturition. Normal.

Abdominal Examination. Reveals a large mass reaching almost as high as the Umbilicus, hard, moveable, regular in outline. Auscultation - bruit.

Vaginal Examination. Uterus enlarged, fibroid tumour in anterior wall, also submucous fibroid.

Diagnosis. Fibroid Tumour.

No. 2.

Name Mrs.B. F.

Age 37

Address Dundee.

Admitted 4th October 1895.

Complaint Dysmenorrhoea menorrhagia severe constant pelvic pain.

Duration 2 years. Had a polypus removed 3½ years ago.

Family None. No miscarriages. Married 7½ years. Widow for 6 years.

Menstruation $\frac{7\text{-}8}{28}$ Regular. Menorrhagia, premenstrual dysmenorrhoea for 2 days. Pain also bad on second day of flow.

Micturition Slightly painful before the act.

Vaginal Examination. Uterus to front enlarged 3" pushed up against pubis by a hard mass in pouch of Douglas.

Diagnosis Fibroid Tumour.

No. 3.

Name Mrs. M. A. W.

Age 33.

Address Perth

Admitted 10th October 1895.

Complaint Swelling of abdomen, great haemorrhagic discharge and protrusion of a mass through vulva.

Duration 4 years.

Family One child 7 years ago.

Menstruation $\frac{8}{28}$ Regular but menorrhagia.

Micturition Frequency.

Abdominal Examination. A large tumour irregular in outline reaching 3" above the umbilicus Auscultation reveals a well marked bruit.

Vaginal Examination. A large mass protruding from vulva, gangrenous foul smelling discharge.

Diagnosis. Submucous Fibroid.

No. 4.

Name. Mrs.H. D.

Age 61.

Address Edinburgh.

Admitted 14th October 1895.

Complaint Swelling of Abdomen with occasional slight pain.

Duration Six months.

Family Seven children, the last 18 years ago. No abortions.

Menstruation. Menopause at 48.

Micturition Two years ago had an attack of retention which lasted for 3 days and catheter had to be used 4 times, since then patient has been troubled with great frequency of micturition.

Abdominal Examination. A large swelling, uniform in size, tense, fluctuating, dull on percussion, resonent in flanks.

Vaginal Examination Vagina large and roomy, cervix high up and small. Posterior fornix bulged by the tumour in the abdomen.

Diagnosis. Ovarian Tumour.

No. 5.

Name Mrs. E. H.

Age 40.

Address Edinburgh.

Admitted 15th October 1895.

Complaint Pain in right Iliac region.

Duration 5 years.

Family One child 8 years ago.

No abortions.

Menstruation $\frac{2}{28}$ Regular, slight premenstrual dysmenorrhoea. Leucorrhoea.

Micturition Normal.

Vaginal Examination Right ovary enlarged and tender. Utero sacral ligaments, tense, and inflamed.

Diagnosis. Ovaritis, Utero sacral cellulitis.

No. 6.

Name J. W.

Age 28.

Address Edinburgh

Admitted 15th October 1895.

Complaint Pain in region of pelvis running down the left leg.

Duration Three weeks.

Family None. Unmarried.

Menstruation $\frac{3-4}{28}$ Regular. Slight dysmenorrhoea.

Micturition Normal.

Vaginal Examination. Cellulitis among the muscles on left side of the true pelvis, spreading over the brim and setting up phlebitis and thrombosis in the femoral vein. The left leg is swollen, tense, white and shiny.

Diagnosis. Thrombosis of Femoral Vein.

No.	7.
Name	J. W.
Age	45.
Address	Kinross.
Admitted	16th October
Complaint	Slight plain in left side and menorrhagia.
Duration	4 years.
Family	None. Unmarried.
Menstruation	Regular till 4 years ago, since then menstruates once a month lasting a fortnight. Menorrhagia as above. Marked dysmenorrhoea.
Micturition	Nocturnal Frequency.
Vaginal Examination	Interstitial fibroid.
Diagnosis.	Fibroid Tumour.

No. 8.

Name Mrs. C. McC.

Age 42.

Address Dalkeith.

Admitted 17th October 1895.

Complaint Swelling of abdomen with pain and menorrhagia.

Duration The swelling for six years; the pain and menorrhagia for 10 months.

Family 3 children, youngest 20 years. No abortions.

Menstruation $\frac{5-6}{28}$ Regular till 10 months ago, since then menstruates for a fortnight every month with menorrhagia as above.

Micturition Occasional pain during the act.

Vaginal Examination Fibroid interstitial, uterus measures $3\frac{1}{2}$".

Diagnosis. Fibroid (Interstitial).

No. 9.

Name Mrs. M. H.

Age 62.

Address Blairadam.

Admitted 19th October 1895.

Complaint Swelling of abdomen, pain in back, and an offensive brownish vaginal discharge.

Duration 3 months.

Family 12, last, 24 years ago still born, one abortion the third month.

Menstruation Menopause at 40, since then no discharge of any sort till 3 months ago.

Mistruition Normal

Vaginal Examination Uterus retroverted 2¾", senile uterine Catarrh.

Diagnosis. Senile uterine Catarrh.

No. 10.

Name Mrs. J. R.

Age 37.

Address Hawick.

Admitted 21st October

Complaint Pain in both iliac regions and back.

Duration. 2 months.

Family One child 13 years ago, one abortion the second month.

Menstruation. $\frac{3}{28}$ Regular and normal till the last two periods which were very profuse. Abundant leucorrhoea lately.

Micturition. Frequency, and painful after the act.

Vaginal Examination. Fibroid Tumour about the size of a small foetal head affecting posterior wall of uterus.

Diagnosis. Fibroid Tumour.

No. 11.

Name Mrs. M. R.

Age. 27.

Address Perth

Admitted 22nd October 1895.

Complaint Pain in right iliac region.

Duration 12 months

Family None, one abortion the fifth month.

Menstruation $\frac{2}{28}$ Regular, always preceded by an acute pain for 2 or 3 days which decreases with onset of flow, slight leucorrhoea.

Micturition Frequent and painful.

Vaginal Examination Uterus 2½" acutely anteflexed; tender tubes and ovaries.

Diagnosis. Anteflexion of Uterus.

No. 12.

Name Mrs. M. A. M.

Age 45.

Address Auchterarder

Admitted 24th October 1895.

Complaint Pelvic Pain and profuse vaginal hemorrhagic discharge, both intermittent.

Duration 14 years

Family Six. The youngest 16 years ago. No abortions.

Menstruation Irregular. Menorrhagia.

Micturition Normal.

Vaginal Examination Uterus 5", a soft fibroid can be felt 2" above pubis and 2 small cervical, mucous, polypi.

Diagnosis. Fibroid Tumour and small cervical mucous Polypi.

No. 13.

Name Mrs. A. W.

Age 55.

Address St. Andrews.

Admitted 22nd October 1895.

Complaint Swelling of abdomen with slight pain.

Duration 8 months.

Family None. One abortion about fifth month.

Menstruation Menopause 8 years ago.

Micturition Normal.

Abdominal Examination The abdomen is occupied by a large tumour reaching almost to the xyphistermun, tense and firm.

Vaginal Examination Uterus to the front, posterior fornix bulged by mass in abdomen.

Diagnosis. Ovarian Tumour.

No. 14.

Name J. S.

Age 20.

Address Penicuik.

Admitted 30th October 1895.

Complaint Occasional Attacks of pain in abdomen.

Duration. Six months.

Family None. Unmarried.

Menstruation Patient has never menstruated.

Micturition Normal.

Vaginal Examination Complete atresia vaginae. The bladder was found lying backwards, small 3½". There is no vagina, and on examining per rectum there is no uterus and no appendages to be felt.

Diagnosis. Absence of organs of generation.

No. 15.

Name Mrs. M.G.

Age 56.

Address Edinburgh.

Admitted 19th October 1895.

Complaint. Swelling of abdomen with occas-ional severe pain.

Duration 2 to 3 months.

Family None. No abortions.

Menstruation Menopause 9 years ago.

Micturition Normal.

Abdominal Examination The abdomen was occupied by a large tumour, tense, hard in parts, and fluctuating in others.

Vaginal Examination Nil.

Diagnosis. Ovarian Tumour.

No. 16.

Name Mrs. J.W.

Age 33.

Address Falkirk.

Admitted 8th November 1895.

Complaint Swelling in right iliac region and pain in left side.

Duration 2 months.

Family Two. Youngest 6 years old. One abortion at 5½ months 3 years ago.

Menstruation Last five months has been regular but scanty in amount, before this she was irregular, missing two months at a time.

Abdominal Examination A large circumscribed swelling can be made out in the right iliac region, nodular and hard. It extends to just above the symphysis pubis.

Vaginal Examination. All fornices are filled up with a hard nodular mass, the uterus cannot be determined as it is embedded in the mass which is of an inflammatory nature. On passing the sound the uterus measures 3" and is pushed to the left side. Apex of right lung attacked by tubercle, breathing bronchial, with numerous moist sounds.

Diagnosis. Tubercular Deposit in Pelvis.

No. 17.

Name J.L.

Age 18.

Address Armadale.

Admitted 8th November 1895.

Complaint Incontinence of urine.

Duration Since childhood.

Family None. Unmarried.

Menstruation $\frac{2}{28}$ Regular.

Micturition Incontinence as before stated no pain.

Vaginal Examination A small fistulous-like opening can be seen on the anterior vaginal wall, a probe passed but could not be got in more than ½". The bladder measures 3½". On being filled with milk solution ℥ X none escaped either per urethram or per vaginam. Dr Barbour passed the sound into the bladder 3½", filled it with milk solution ℥ viii which was retained, passed a probe into the fistulous opening but for no more than half an inch. Later, fluid was seen exuding from the small opening, and on this being tested was found to be acid. A plug of cotton wool was put in the vagina and this was examined for urine together with the urine drawn off for 24 hours. The quantity of urine coll-

CASE NO 17 (CONTD:)

Continuation of

Vaginal Examination (coll-) ected was 62 ozs. faintly alkaline. Sp. G. 1018. copious white deposit consisting of pus corpuscles, with some crystals of triple phosphate: distinct trace of albumen. Urea - 1-3%. Of this fluid collected in the vagina the quantity amounted to 2 ozs. Yellow milky white deposit consisting of epithelial squames, some pus corpuscles micro organisms, faintly alkaline: Sp. G. 1012.9, trace of albumose, no albumen, Urea = 1.0% This fluid is undoubtedly urine. Dr Barbour introduced Kelly's speculum and passed a searcher, but it could not be definitely determined if both ureters were present. Dr Barbour had patient's bladder examined with the aid of the cystoscope. The impression obtained on this examination was that there are three ureters opening into the bladder, two on the right side and one on the left, it is thought then that the fistula in the vagina is due to the misplacement of a fourth ureter.

Diagnosis. Incontinence of urine from abnormal number of ureters, one of which opens into vagina.

No. 18.

Name Mrs. F.T.

Age 23.

Address Broxburn.

Admitted 11th November 1895.

Complaint Pain in left side.

Dyspareunia.

Duration 3 weeks.

Family One, four years ago.

Menstruation $\frac{7}{28}$ Regular.

Micturition Normal.

Vaginal Examination Uterus lying forward 2½"; right ovary prolapsed and tender; tenderness in left fornix, left tube inflamed and enlarged.

Diagnosis. Prolapsed ovary and salpingitis.

No. 19.

Name Mrs. J.F.

Age 25.

Address Edinburgh.

Admitted 11th November 1895.

Complaint Haemorrhagic discharge, and a feeling of weakness.

Duration 5 months.

Family Two. The youngest 1 year and 8 months old.

Menstruation. $\frac{6\text{-}7}{28}$ Before present attack always regular, but for the past five months has had a continuous discharge.

Micturition Normal.

Vaginal Examination A large mass can be felt bulging the anterior fornix; the uterus is not separable from the mass which indeed seems to be the uterus lying forward, considerably enlarged and containing a foreign body. The cervix is very high up and directed backwards.

Diagnosis. Retained portions of Placenta and Organised Blood Clot.

No. 20.

Name Mrs. J.M.

Age 34.

Address

Admitted 13th November 1895.

Complaint Pain in left side and leucorrhoea.

Duration Three years.

Family One living child ten years ago, next full term child still born, 7 months child still born, 6 months abortion, 5 months abortion, this last three months ago.

Menstruation $\frac{3-4}{28}$ Regular.

Micturition Normal.

Vaginal Examination Uterus anteflexed, utero sacral cellulitis; left ovary prolapsed.

Diagnosis. Utero Sacral cellulitis, Prolapsed Ovary, specific taint.

No. 21.

Name Mrs. M. P.

Age 30.

Address Hamilton.

Admitted 16th November 1895.

Complaint Dysmenorrhoea and constant hemorrhagic discharge.

Duration Ten months.

Family Six, youngest eighteen months.

Menstruation Metrorrhagia as above and dysmenorrhoea.

Micturition Normal.

Vaginal Examination Cervix markedly thickened and indurated and craterlike.

Diagnosis Epithelioma of Cervix.

No. 22.

Name Mrs. A. A.

Age 38.

Address Pathead.

Admitted 16th November 1895.

Complaint Bearing down pain.

Duration Eight years.

Family Two. Youngest 10 years.

One abortion at third month.

do. fifth "

do. seventh "

Menstruation $\frac{3}{21}$ Premenstrual dysmenorrhoea

Micturition Normal.

Vaginal Examination Anterior lip of Cervix elongated, hypertrophied and the mucous

Continuation of

Case No. 22.

Vaginal Examination, Contd: membrane everted. Posterior lip somewhat thickened. Uterus to the front 4½". Left ovary tender.

Diagnosis. Ectropion of cervix, Hyper - trophy of Anterior lip of Cervix.

No. 23.

Name J. J.

Age 19.

Address Edinburgh.

Admitted 18th November 1895.

Complaint Painful micturition and pain on walking.

Duration Three weeks.

Family None. Unmarried.

Menstruation 3-4/28 Regular.

Micturition Pain during the act and lasting a little time afterwards.

Vaginal Examination Urethral Caruncle.

Diagnosis Urethral Caruncle.

No. 24.

Name J. N.

Age 25.

Address Edinburgh.

Admitted 25th November 1895.

Complaint Haemorrhagic discharge and pain in back.

Continuation of

Case No. 24.

Duration Three weeks.

Family None. Unmarried.

Menstruation $\frac{2}{28}$ Regular.

Micturition Normal.

Vaginal Examination Uterus anteverted, enlarged, endometrium roughened and bleeding.

Diagnosis. Incomplete abortion.

No. 25.

Name Mrs. M. A. C.

Age 36.

Address

Admitted 28th November 1895.

Complaint Prolapse of Uterus, and pain in right side.

Duration Six years.

Family Six. Youngest 2 years old 2 abortions 12 years ago.

Menstruation $\frac{8}{28}$ Menorrhagia and Metrorrhagia.

Micturition Has frequent desire to micturate.

Vaginal Examination. Rectocele Cystocele and and complete prolapse of uterus. Perinaeum absent.

Diagnosis. Torm Perinaeum Rectocele Cystocele and Prolapse of Uterus.

No. 26.

Name Mrs E. B.

Age 34.

Address Leith.

Admitted 29th November 1895.

Complaint Pain in both Iliac regions.

Duration Six weeks.

Family Four. 3 living. Youngest 6 weeks and four days old. 1 abortion 7 yèars ago.

Menstruation. $\frac{4-5}{28}$ Patient has not menstruated since her last confinement.

Micturition Frequent and painful.

Abdominal Examination Hard boardy mass can be felt in the left Iliac fossa extending almost to the symphysis pubis.

Vaginal Examination Left Parametric deposit about the size of a large cocoa nut fills up the left fornix, hard and boardy. Uterus seems to be embedded in the mass and is lateroverted to the right side.

Diagnosis. Parametritis.

No. 27.

Name Mrs M. A.

Age 41.

Address Balta-Sound.

Admitted 12th December 1895.

Continuation of

Case No. 27.

Complaint Throbbing pain in both Iliac regions and in back; profuse haemorrhagic discharge.

Duration 8 months.

Family 5. Youngest 9 months.

Menstruation $\frac{4}{28}$ Quite Regular until 8 months ago, since which time has had profuse irregular haemorrhagic discharge.

Micturition Pain and scanty in quantity.

Vaginal Examination Uterus retroverted, 5" Endometrium roughened.

Diagnosis Subinvolution and Endometritis,

No. 28.

Name Mrs. M. R.

Age 24.

Address Leith.

Admitted 17th December 1895.

Complaint Pain in left Iliac region and pain on Micturition.

Duration 2 weeks.

Family One. 4 weeks ago.

Menstruation $\frac{2\text{-}3}{28}$ Has not menstruated since confinement.

Micturition Painful and frequent.

Vaginal Examination Right fornix filled up with hard plaster-of-paris-like material. Uterus lateroverted to left side.

Diagnosis. Parametritis.

No. 29.

Name Mrs A. P.

Age 27.

Address Leven.

Admitted 20th December 1895.

Complaint Incontinence of Urine.

Duration Six weeks.

Family Two, dead. Last six weeks ago.

Menstruation $\frac{3}{28}$ Regular.

Micturition Whilst sitting can retain her urine, but on rising and on lying down she loses complete control of her bladder so that there is a constant dribbling of urine.

Vaginal Examination Examined under chloroform a small Cervico Vesical Fistula. was found.

Diagnosis. Cervico Vesical Fistula.

No. 30.

Name E. L.

Age 38.

Address Edinburgh.

Admitted 24th December 1895.

Complaint Almost constant haemorrhagic discharge and swelling, and swelling of legs.

Duration Three years.

Continuation of

Case No. 30.

Family. None. Unmarried.

Menstruation $\frac{1}{28}$ Quite regular and very scanty till 3 years ago, since then menorrhagia and metrorrhagia.

Micturition Normal.

History 14 months ago a polypus, the size of a large egg came away after 1½ hours of very severe pain, after this patient kept pretty well for 3 months. The vaginal discharge almost ceased and her periods were regular, but afterwards she became as bad as ever, and has more or less haemorrhage every day.

Vaginal Examination Uterus to the front, 5" and Interstitial Fibroid.

Diagnosis. Fibroid Tumour.

No. 31.

Name E. M.

Age 35.

Address Balta-Sound.

Admitted 2nd January 1896.

Complaint Pain in side and swelling of abdomen with almost constant haemorrhagic vaginal discharge.

Duration 3 years.

Family None. Unmarried.

Menstruation. $\frac{8}{28}$ Regular and Menorrhagia.

Continuation of

Case No. 31.

Micturition Difficult and painful.

Abdominal Examination A solid tumour can be felt reaching 3" above Pubis.

Vaginal Examination Uterus lying to the back and evidently connected with the tumour. Sound could not be passed.

Diagnosis. Ovarian Tumour.

No. 32.

Name Mrs. C. B.

Age 34.

Address New Lanark.

Admitted 4th January 1896.

Complaint Incontinence of Urine.

Duration 10 weeks.

Family 8 Children, the last 10 weeks ago, one abortion at the 4th month., 5 years ago.

Menstruation. $\frac{3}{28}$ Regular and normal.

Micturition As above.

History Patient was delivered of her last child with Forceps (R.M.P. Case), and Embryulcia was performed; she first noticed the incontinence 2 days after the delivery.

Vaginal Examination A large vesico-vaginal fistula reaching almost as high as the cervix.

Diagnosis. Vesico-Vaginal Fistula.

No. 33.

Name Mrs. E. R.

Age 28.

Address Piershill.

Admitted 6th January 1896.

Complaint Pain in abdomen and constant thick yellowish discharge.

Duration 2 years.

Family 1 child at full term living 8 years ago, since then 6 abortions

2 at the 2nd month.

3 " 3rd " and

1 " 5th ", this latter 2 years ago.

Menstruation $\frac{4}{28}$ Slight pain for a day before the flow.

Micturition Normal.

Vaginal Examination Uterus anteverted, enlarged $3\frac{1}{2}$" and somewhat hard.

Diagnosis. Frequent abortions.

No. 34.

Name F. B.

Address Edinburgh.

Admitted 10th January 1896.

Complaint Pain in back and left side and swelling in left side.

Duration 4½ years.

Family One. 4 years ago.

Menstruation $\frac{5\text{-}6}{28}$ Normal.

Micturition Burning pain occasionally.

Abdominal Examination A tumour about the size of a large cocoa nut can be palpated in the right Iliac region, extending towards the middle line. The tumour is hard and tense.

Vaginal Examination The Uterus is lateroverted and measures 3".

Diagnosis. Ovarian (Dermoid) Tumour.

No. 35.

Name Mrs. C. P.

Age 36.

Address Langholm.

Admitted 13th January 1896.

Complaint Haemorrhage.

Duration 18 months.

Family 3, youngest 7. No abortions.

Menstruation $\frac{6\text{-}7}{28}$ Regular till last 18 months, slight dysmenorrhoea and slight leucorrhoea.

Vaginal Examination Large submucous fibroid extending 2" above symphysis attached along tumour wall. Sound passes along posterior wall 5". Since admission to Hospital in July 1895, the tumour has increased and now measures $3\frac{1}{2}$".

Diagnosis. Submucous Fibroid. -

No. 36.

Name Mrs. A. W.

Age 31.

Address Edinburgh.

Admitted 18th January 1896.

Complaint Pain over lower part of abdomen, and haemorrhagic discharge.

Duration The pain one week, discharge four weeks.

Family Three. One living, the youngest 3 years old. One abortion 4 weeks ago.

Menstruation $\frac{2}{28}$ Regular until the abortion.

Micturition Very painful during the act.

Vaginal Examination. Uterus enlarged 4", tender and bleeding.

Diagnosis Incomplete abortion.

No. 37.

Name Mrs. E. M.

Age 25.

Address Leith.

Admitted 18th January 1896.

Complaint Pain in back passing round to lower part of abdomen and haemorrhagic. vaginal discharge.

Family One full term still born 7 months ago.

Menstruation $\frac{3}{28}$ Menorrhagia and Metrorrhagia.

Continuation of

Case No. 37.

Micturition Normal.

Vaginal Examination. Uterus enlarged 5", Bleeding and retroverted.

Diagnosis. Retroversion and subinvolution.

No. 38.

Name Mrs. M. W.

Age 54.

Address Ayton.

Admitted 18th January 1896.

Complaint Swelling and a hard lump in the abdomen just below umbilicus.

Duration 8 months.

Family One, 14 years ago. No abortions.

Menstruation Menopause 18 months ago.

Micturition No pain, no discomfort, no frequency, no polyuria, and no abnormal constituents.

Abdominal Examination Reveals a large solid tumour sharply defined, nodular and about the size of a melon, situated a little to the left of the middle line just beneath the laparotomy wound, it is freely moveable, does not change with the position of the patient. It is painful on pressure.

Vaginal Examination Nil.

Continuation of

Case No. 38.

Previous History Patient came to Hospital on 24th November 1894, and had at that time Glycosuria. She had removed on the 12th December 1894, 2 large colloid ovarian tumours, which together weighed 58½lbs. She made a good recovery from the operation and remained quite well until 8 months ago.

Diagnosis. Omental Tumour (Malignant).

No. 39.

Name Mrs. R. S.

Age 40.

Address Latheron.

Admitted 19th January 1896.

Complaint Swelling of abdomen and occasional attacks of severe pain.

Duration Six months.

Family Six, Youngest 9 years old. One abortion before the birth of last child.

Menstruation Regular, till after the birth of last child, since then had almost daily slight haemorrhagic discharge till 6 months ago, then amenorrhoea for 4 months, and for the last six weeks irregular haemorrhage.

Continuation of

Case No. 39.

Abdominal Examination A large tumour reaching as high as the umbilicus lying a little to the left of the middle line, hard, irregular in outline, and apparently connected with the uterus. Patient examined under chloroform and on

Vaginal Examination the sound being passed with difficulty the uterus was found to measure 5" and empty. Patient again examined; the tumour seems much as before., auscultation revealed nothing.

Further History Sometime after leaving Hospital (two months) patient had an Influenzal attack, and again after this patient passed per rectum a large quantity of pus which was found to contain a foetal leg and a foetal arm in a state of maceration; this was all that was secured by the friends.

Diagnosis Extra-Uterine Gestation.

No. 40.

Name Mrs. W. T.

Age 36.

Address Edinburgh.

Admitted 22nd January 1896.

Complaint Frequency of micturition, pain of a scalding nature during the

Continuation of

Case No. 40.

Complaint (contd:) act, and a sharp stabbing pain at intervals.

Duration Eight weeks.

Family None. NoAbortions.

Menstruation 2/21 Amenorrhoea for 8 weeks, previously quite regular.

Micturition Painful and frequeht, and at intervals a sharp stabbing pain above referred to. Patient had a yellowish discharge which disappeared 5 weeks ago; almost at the same time she noticed the presence of 1 or 2 small red growths about the size and like in appearance to red currants near to the meatus (probably caruncles), These were removed at the Deaconess Hospital.

Diagnosis . Cystitis (Gonorrhoeal).

No. 41.

Name I. S.

Age 58.

Address Anstruther.

Admitted 5th February 1896.

Complaint Pain shooting across the lower part of the abdomen. Periodic in character occurring every day about 12 noon. Haemorrhagic vaginal discharge.

Duration 4 months.

Continuation of Case

No. 41.

Family None. Unmarried.

Menstruation Menopause at 55. Haemorrhagic discharge at intervals for the past 4 months.

Micturition Normal.

Vaginal Examination Uterus enlarged, cervix smooth Fundal cancer.

Diagnosis. Sarcoma Uteri.

No. 42.

Name E. P.

Age 34.

Address Alnwick.

Admitted 12th February 1896.

Complaint Swelling of abdomen.

Duration 10 months.

Family .One, dead. 9 years ago.

Menstruation 2-3/28 Regular until this last month when patient has gone a week past her time.

Micturition Normal.

Abdominal Examination A large tumour reaching midway between umbilicus and ensiform cartilage; fluctuating, dull on percussion, which dulness does not change with the position of the patient.

Vaginal Examination Uterus forward, enlarged 4"

Continuation of

Case No. 42.

Cont: of

Vaginal Examination posterior fornix bulged by tumour.

Diagnosis. Ovarian Tumour.

No. 43.

Name Mrs. E. W.

Age 34.

Address Leslie, Fife.

Admitted 12th February 1896.

Complaint A hard swelling in the lower part of the abdomen.

Duration 6 weeks.

Family 3, youngest 3 years old.

Menstruation $\frac{4}{28}$ Regular about 7 or 8 days after cessation of menstruation., has a slight haemorrhagic discharge (this only for the past 3 months).

Micturition Occasional Frequency.

Abdominal Examination A well defined swelling can be palpated on the right side, attached to a larger swelling in the middle line and extending to the left side.

Vaginal Examination A large mass can be felt bulging all the fornices, cervix dilated and occupied by a large tumour; the sound was passed along the anterior aspect of the tumour and was arrested at $8\frac{1}{2}$".

Continuation of

Case No. 43.

Diagnosis. Fibroid Tumour ? (Large soft).

No. 44.

Name Mrs. J. M.

Age 44.

Address Perth.

Admitted 29th February 1896.

Complaint Pain in right Iliac region and swelling of abdomen.

Duration The pain one week, the swelling one year.

Family, 3, 2 living, the youngest 7 years.

Memstruation Has not been regular for the past few months, and lately has scarcely had any discharge.

Micturition Normal.

Abdominal Examination A large swelling extending nearly to the ensiform cartilage, dull on percussion which does not change with the position of the patient, fluctuating. Auscultation - Nil.

Vaginal Examination Posterior fornix bulged by a cystic mass.

Diagnosis. Ovarian Tumour.

No. 45.

Name Mrs. J. B.

Age 34.

Address Musselburgh.

Admitted 5th March 1896.

Complaint Pain in right Iliac region passing down right leg.

Duration 4 months.

Family Five. 4 living, youngest 4 months, and one abortion 2 years ago.

Menstruation Before birth of last child quite regular, has had no sign since.

Micturition A fortnight ago had frequency and pain.

Abdominal Examination A hard boardy mass can be felt in the right Iliac region, up to the level of the crest of the ilium, it is hard, firm, unyielding, and can be traced to the brim of the pelvis.

Vaginal Examination The uterus is pushed forward and lateroverted, the right fornix is filled up with a deposit of a boardy nature, the uterus seems to be embedded in the mass; a smaller deposit can be made out in the left fornix.

Diagnosis. Parametritis.

No. 46.

Name Mrs. Mc.D.

Age 38.

Address Edinburgh.

Admitted 10th March. 1896.

Complaint Pain in lower abdomen, pain in the back and painful micturition.

Duration 5 weeks.

Family Nine. One dead 2 years ago, youngest living child 10 months, 3 abortions; one 17 years ago, one 7 years ago, one 19 months ago. All these took place at 2½ months.

Menstruation Quite regular, but has not menstruated since birth of last child 10 months ago.

Micturition Very painful, though not very frequent.

Vaginal Examination A cystic mass lying between the bladder and the uterus - about the size of a small orange.

Diagnosis. Parametric abscess.

No. 47.

Name J. J.

Age 30.

Address Selkirk.

Admitted 14th March 1896.

Complaint Dysmenorrhoea and sickness.

Duration 8 years.

Continuation of

Case No. 47.

Family None. Unmarried.

Menstruation $\frac{6}{28}$ Dysmenorrhoea for the first 24 hours, then relieved.

Micturition Normal.

Vaginal Examination Uterus retroverted; sound only passes in for 2"; appendages matted on right side.

Diagnosis. Dysmenorrhoea.

No. 48.

Name S. M.

Age 52.

Address Selkirk.

Admitted 20th March 1896.

Complaint Swelling of abdomen.

Duration One year.

Family None. Unmarried.

Menstruation Menopause six years ago.

Micturition Normal.

Abdominal Examination A large cystic uniform swelling: no Bruit, fluctuation is well marked.

Vaginal Examination Nil.

Diagnosis Par Ovarian Tumour.

No. 49.

Name Mrs. McK.

Age 34.

Continuation of

Case No. 49.

Address Roxburn.

Admitted 23rd March 1896.

Complaint Pain in Pelvis; constant haemorrhagic discharge.

Duration 6 weeks.

Family One, 16 years ago, one abortion 14 years ago.

Menstruation Regular till December 1895. Amenorrhoea till beginning of February, since then constant haemorrhagic discharge.

Vaginal Examination Uterus slightly enlarged, soft, to the front, and right behind and to the right side can be felt a fluctuating tumour which is not separable from the uterus; the mass resembles an extra uterine gestation.

Diagnosis. Extra Uterine Gestation ?

No. 50.

Name Mrs. A. M.

Age 44.

Address Uphall.

Admitted 31st March 1896.

Complaint Pain in left side and menorrhagia, occasional retention of urine.

Duration 2 years.

Family None. No Abortions.

Continuation of

Case No. 50.

Menstruation 8/28 Menorrhagia as above, premenstrual dysmenorrhoea.

Micturition Occasional retention requiring catheterisation.

Vaginal Examination Fibroid Tumour on posterior wall of uterus, pushing uterus against symphysis pubis.

Diagnosis. Fibroid Tumour.

No. 51.

Name Mrs. A. F.

Age 50.

Address Tranent.

Admitted 4th April 1896.

Complaint Downbearing pain: prolapse of uterus, and reddish discharge.

Duration 18 months.

Family 9, Youngest 11 years.

Menstruation Menopause 4 years ago, but for the past eighteen months has had haemorrhagic discharge, above referred to.

Micturition Normal.

Vaginal Examination Cystocele, Rectocele, and cervix very much thickened.

Diagnosis Prolapse of uterus.

No. 52.

Name Mrs. C. A.

Age 31.

Address Leith.

Admitted 7th April 1896.

Complaint Pain in back and lower part of abdomen and haemorrhagic discharge.

Duration 3 weeks.

Family Two. Youngest 9 years old. No abortions.

Menstruation $\frac{3}{28}$ Regular until present attack when patient went 2 weeks past her time, and then began to bleed the same amount as at a period, This gradually became less until a spot or two. On March 22nd it returned freely on the 26th she saw a Doctor, who said it was a Retroversion and put an instrument in; no pain for two days, when discharge and pain returned, the pain being like a knife darting into the ribs.

Micturition Normal.

Vaginal Examination Uterus forward. A mass can be felt in the posterior fornix, fluctuating and tender. On 9th April patient had retention of urine, requiring use of catheter, rectum distended. Tender deposit behind uterus pushing cervix forward against Pubis.

Diagnosis Extra Uterine Gestation?

No.	53.
Name	J. C.
Age.	16.
Address	St Andrews.
Admitted	11th April 1896.
Complaint	Swelling of Abdomen.
Duration	4 years 5 months.
Family	None.
Menstruation	Not commenced yet.
Micturition	Normal.
Abdominal Examination	'A large swelling reaching as high as the xyphisteruum, tense, with a well marked thrill, resonant in the right Iliac fossa, dull in left Iliac fossa; fluctuation can be made out about the middle and to the right of the tumour; the rest of the tumour feels hard and solid, it measures at the level of the umbilicus 33¼", from xyphisteruum to symphysis pubis 16".
Vaginal Examination	Nodular swelling in left fornix.
Diagnosis	Ovarian Tumour.

No.	54.
Name	Mrs. M. M.
Age	31.
Address	Dundee.
Admitted	14th April 1896.
Complaint	Prolapse of Uterus.

Continuation of

Case No. 54.

Duration 9 months.

Family 2. Youngest 2 years old.

No abortions.

Menstruation Sometimes as often as once a week, at other times not for 5, 6, 7 and 8 weeks, never lasting for more than two days.

Micturition Had incontinence for 3 months, but since patient has been in bed this has ceased and she has now control over her bladder.

Vaginal Examination Cystocele, Uterus prolapsed slight thickening of cervix, uterus not enlarged.

Diagnosis Prolapse of Uterus and torn Perinaeum.

No. 55.

Name Mrs. A. A.

Age 29.

Address Dumfries.

Admitted 17th April 1896.

Complaint Pain in lower abdomen, back and right iliac region extending up the side : floating kidney.

Duration Pain 7 years : floating kidney 5 months.

Family 5. Youngest 5 months.

No abortions.

Continuation of

Case No. 55.

Menstruation $\frac{3-4}{28}$ Premenstrual dysmenorrhoea, and also during first 2 days of flow.

Micturition Normal.

Vaginal Examination A small ovarian tumour on either side of uterus, possibly dermoid uterus forward $2\frac{1}{2}$".

Diagnosis Dermoid Ovarian Tumour.

No. 56.

Name Mrs. M. W.

Age 32.

Address Edinburgh.

Admitted 18th April 1896.

Complaint Reddish foul smelling discharge Weakness.

Duration Discharge 5 weeks, the weakness one year.

Family 3, youngest 2 years, one abortion 3 years ago at 2nd month.

Menstruation $\frac{5-6}{28}$ Regular every month, but for the past 5 weeks has had constant discharge above referred to.

Micturition Normal.

Vaginal Examination Projecting through the os is an elongated foreign body about the thickness of three fingers, somewhat irregular in shape, pretty firmly gripped by the external os : the base of

Continuation of

Case No. 56.

Continuation of

Vaginal Examination attachment could not be definitely ascertained, but it is evidently a fibroid, which undergoing the process of expulsion has become gripped by the external os, and the blood supply being thus cut off the exposed portion is sloughing.

Diagnosis Fibroid Polypus.

No. 57.

Name Mrs. J. W.

Age 26.

Address Glasgow.

Admitted 20th April 1896.

Complaint Pain in left Iliac region passing round to the back, brownish discharge.

Duration Pain 3 years and 6 months; the discharge 3 months.

Family One, 3 years ago. 4 abortions. the first at 4 months, 2 years and 6 months ago; the 2nd at 3 months, 18 months ago; the 3rd between the 2nd and 3rd months, a year ago; the 4th between the 2nd and 3rd months, 3 months ago.

Menstruation $\frac{3-4}{28}$ Always regular until her

Continuation of Case No. 57.

Continuation of Menstruation marriage and until last January, since, continuous discharge above referred to.

Micturition Pain during the act.

Vaginal Examination Uterus retroflexed, thickening of right broad ligament. Endometritis.

Diagnosis. Retroflexion Specific Endometritis.

No. 58.

Name Mrs. M. McK.

Age 54.

Address Laggan.

Admitted 23rd April 1896.

Complaint Swelling of abdomen.

Duration 4 months.

Family Two, the last 14 years ago. 3 abortions before the birth of the last child.

Menstruation Menopause one year ago.

Micturition Pain, and occasional retention

Abdominal Examination Reveals a large tumour reaching as high as 2" above the umbilicus, dull on percussion, resonant in the flanks, the tumour is solid and there is friction over anterior surface of tumour.

Vaginal Examination Uterus small to the front and separable from the tumour.

Diagnosis. Sarcoma of the ovary.

No. 59.

Name Mrs. V. T.

Age 31.

Address Hawick.

Admitted 24th April 1896.

Complaint Swelling of abdomen.

Duration 5 months since she first noticed it, but it has become larger since that time.

Family 4. Youngest 19 months ago. No abortions.

Menstruation $\frac{7-8}{28}$ Has always been regular 6 weeks after birth of last child patient commenced to menstruate, this stopped, then after a months interval again menstruated, then she ceased, after that the 2nd or 3rd period (the fortnight after) she had a"flooding", this stopped, and a fortnight later she was again unwell, and since that time she has been quite regular.

Micturition Normal.

Abdominal Examination Reveals a tumour extending as high as the umbilicus, freely moveable, uniform in shape, cystic, dull on percussion and a well marked bruit.

Diagnosis. Pregnancy with Haemorrhages (Raynaud's Disease).

No. 60.

Name Mrs. M. M.

Continuation of

Case No. 60.

Age 28.

Address Kirkcaldy.

Admitted 24th April.1896.

Complaint Slight haemorrhagic discharge, dysmenorrhoea, dyspareunia.

Duration Discharge 4 years, dysmenorrhoea 5 years (at which time patient first commenced to menstruate).

Family None.No Abortions.

Menstruation $\frac{2}{28}$ Regular, dysmenorrhoea above referred to and metrorrhagia.

Micturition Normal.

Vaginal Examination Uterus anteflexed 3½" tender and bleeding, endometritis.

Diagnosis. Endometritis.

No. 61.

Name Mrs. L. W.

Age 28.

Address Edinburgh.

Admitted 28th April 1896.

Complaint Pain in right side and offensive yellow discharge.

Duration 18 months.

Family, One, 9 years ago. One abortion 7 years ago.

Menstruation Very irregular, sometimes once in three weeks, a month, 6 weeks, 2 months and 3 months. Menorrhagia,

Continuationof

Case No. 61.

Continuation of

Menstruation dysmenorrhoea.

Micturition Normal.

Vaginal Examination Uterus to the front enlarged 3½" tender, endometritis; tender right ovary.

Diagnosis Gonorrhoeal Endometritis.

No. 62.

Name Mrs. H. R.

Age 37.

Address Rosewell.

Admitted 28th April 1896.

Complaint Pain in back and lower abdomen general weakness and feeling of something in the vagina.

Duration 4 months, the foreign body in the vagina, a week.

Family 4, youngest 4 years ago: one abortion 9 years ago at the 7th week.

Menstruation $\frac{2\text{-}3}{28}$ Quite regular up to the last two months, since which time, amenorrhoea. Last June stopped menstruating and commenced again about the middle of August, this stopped and saw nothing until the beginning of March, this stopped and has seen nothing since.

Micturition Difficult.

Vaginal Examination Uterus retroverted, enlarged

Continuation of

Case No. 62.

Continuation of

Vaginal Examination and containing an ovum.

Diagnosis. Retroverted gravid uterus.

No. 63.

Name H. C.

Age 28.

Address Edinburgh.

Admitted 28th April 1896.

Complaint Pain and swelling of right labium, and yellow discharge.

Duration 2 weeks, the discharge 8 years.

Family One, 8 years ago. No abortions.

Menstruation $\frac{4-5}{28}$ Regular once a month lasting a fortnight. Menorrhagia dysmenorrhoea.

Micturition Normal.

Vaginal Examination Bartholinian Abscess, right sided.

Diagnosis. Bartholinian Abscess

No. 64.

Name Mrs. A. A.

Age 68.

Address Berwick-on-Tweed.

Admitted 2nd May 1896.

Complaint Swelling of abdomen and occasional breathlessness.

Continuation of

Case No. 64.

Duration 4 years.

Family 9, the last 26 years ago.

Menstruation Menopause 3 0 years ago.

Micturition A large tumour can be felt occupying the whole of the abdomen: fluctuation very well marked; the tumour is tense; the veins in abdomen are distended and there are marks of previous aspiration; the tumour reaches as high as the xyphi-sternum.

Diagnosis. Ovarian Tumour.

No. 65.

Name J. A.

Age 41.

Address Aberfeldy.

Admitted 4th May 1896.

Complaint Menorrhagia.

Duration 4 months.

Family One. 22 years ago.

Menstruation $\frac{5\text{-}6}{28}$ lately once in 3 weeks, and for the past few months, menorrhagia lasting a fortnight.

Micturition Normal.

Vaginal Examination A polypus the size of a small egg can be felt projecting through the os into the vagina; it is pediculated.

Circulatory System Well marked haemic murmur : Bruit de diable specially well marked

Continuation of

Case No. 65.

Continuation of

Circulatory System in the great veins.

Haemopoietic System Marked amaemia : Red blood corpuscles 3,000,000. Whites not increased.

Diagnosis. Submucous Polypus.

No. 66.

Name Mrs. E. S.

Age 28.

Address Kirkliston.

Admitted 9th May 1896.

Complaint Constant haemorrhagic discharge.

Duration 2 months.

Family 2, youngest 2 years; two abortions, the first at six months, the second at the 7th month. These abortions took place between the births of the first and second child, the last one 12 months before the birth of the second child.

Menstruation Amenorrhoea from November till the end of March, since that time has had constant haemorrhagic discharge.

Micturition Normal.

Abdominal Examination A tumour can be felt reaching as high as the umbilicus, uniform in

Continuation of

Case No. 66.

Continuation of

Abdominal Examination shape, Cystic, dull on percussion, well marked Bruit, and the foetal heart can be heard.

Vaginal Examination The vagina soft and moist, the cervix is very granular and with numerous distended neibothian follicles; cervix bleeds freely on being touched.

Diagnosis Pregnancy with haemorrhage.

No. 67.

Name Mrs. A. T.

Age 42.

Address Falkirk.

Admitted 13th May 1896.

Complaint Swelling of, and pain across abdomen.

Duration Swelling 3 weeks, pain 6 months

Family 11, the last one a year and 4 months ago. 2 abortions both at the 3rd month and the last one 12 years ago.

Menstruation $\frac{6\text{-}8}{28}$ Once in 3 weeks lately. Sometimes once a month; premenstrual dysmenorrhoea and during the flow Menorrhagia.

Micturition Difficulty since the swelling of the abdomen.

Abdominal Examination A tumour reaching 3" above the

Continuation of Case No. 67.

Continuation of Abdominal Examination umbilicus can be made out fluctuating, dull in the flanks, which becomes resonant on changing the position of the patient.

Vaginal Examination Irregular nodules can be felt in the posterior fornix, uterus forward 2½".

Diagnosis. Tubercular Peritonitis.

No. 68.

Name Mrs. M. J. B.

Age 25.

Address Lasswade.

Admitted 19th May 1896.

Complaint Frequent abortions.

Duration 12 months.

Family One 16 months ago. Since that time has had 3 abortions the

1st at the 3rd month 9 months ago,
2nd " " 3rd " 5 " "
3rd " " 3rd " 3 weeks ago.

Menstruation $\frac{3\text{-}4}{28}$ Last unwell 4 months ago then amenorrhoea of pregnancy, then an abortion, the discharge lasting a fortnight, since then nothing : dysmenorrhoea.

Micturition Normal.

Vaginal Examination Uterus to the front 4½"

Continuation of

Case No. 68.

Continuation of

Vaginal Examination Endometrium roughened, sensitive and bleeding on passing the sound.

Circulatory Mitral systolic.

Diagnosis. Frequent abortions.

Subinvolution, Endometritis.

No. 69.

Name Mrs. J. B.

Age 41.

Address Leith.

Admitted 19th May 1896.

Complaint Swelling of abdomen and occasional pains in right side.

Duration Swelling about 6 months, pains 3 months.

Family 8, The last 3 years ago, one abortion at the 3rd month 15 years ago.

Menstruation $\frac{4\text{-}5}{28}$ Regular.

Micturition Normal.

Abdominal Examination A large tumour (multilocular ovarian) reaching as high as the umbilicus, tense, fluctuation well marked, dull on percussion, which does not change with the position of the patient.

Vaginal Examination Uterus forward $3\frac{1}{2}$".

Diagnosis. Ovarian Tumour.

No. 70.

Name Mrs. B. S.

Age 34.

Address Carlisle.

Admitted 28th May 1896.

Complaint Swelling of abdomen and white greenish discharge.

Duration Swelling 4 years, discharge 10 weeks.

Family One full term still born on 3rd March.

Menstruation $\frac{5-6}{28}$ Menorrhagia dysmenorrhoea amenorrhoea of pregnancy and has not menstruated since birth of child.

Abdominal Examination A large solid freely moveable tumour reaching as high as 4" above the umbilicus: On the left side of the tumour is a smaller flatter tumour moveable on the larger mass; well marked Bruit. Can be heard on auscultation.

Vaginal Examination A large roomy vagina, cervix high up, os open about the size of a sixpence, and filling the cavity of the uterus is a large tumour. Pulse very rapid and temperature swinging.

Diagnosis. Submucous Fibroid and subperitoneal Fibroid.

No. 71.

Name Mrs. C. R.

Age - 28.

Address Bonnyrigg.

Admitted 23rd May 1896.

Complaint Pain and swelling of abdomen.

Duration 6 months.

Family None. No Abortions.

Menstruation $\frac{3\text{-}4}{28}$ Amenorrhoea since 1st January, presently quite regular.

Micturition Difficult and painful.

Abdominal Examination A large abdominal tumour reaching as high as the xyphisternum, tense, hard, dull on the anterior surface, resonant in the flanks, this does not change on moving the patient. Patient has already had the tumour aspirated before coming into Hospital.

Diagnosis. Colloid Ovarian.

No. 72.

Name Mrs. M. McM.

Age 43.

Address Blackford.

Admitted 30th May 1896.

Complaint Swelling of abdomen, pain in epigastrium and lower abdomen.

Duration 3 months.

Family 2, youngest 3½ years.

Menstruation Very irregular, sometimes ten

Continuation of

Case No. 72.

Continuation of

Menstruation days, sometimes once a fortnight, and once in three weeks. Menorrhagia.

Micturition Normal.

Abdominal Examination Reveals a large tumour reaching 3½" above the umbilicus, dull on percussion in the flanks which becomes tympanitic on changing the position of the patient. In the right iliac region with deep palpation a hard nodular mass can be felt slightly moveable.

Vaginal Examination A large mass can be felt posterior to the uterus, and in the right fornix, a number of small nodules.

Diagnosis. Malignant Purulent Cyst.

No. 73.

Name A. S.

Age 57.

Address Blairgowrie.

Admitted 2nd June 1896.

Complaint Swelling of abdomen.

Duration 16 months.

Family 3. The last 30 years ago.

Menstruation Menopause 21 years ago, after leaving the Infirmary in January 1895 patient had haemorrhagic discharge which

Continuation of

Case No. 73.

Continuation of

Menstruation lasted on and off for 3 months she got medicine, from her Doctor, which stopped her discharge; this discharge returned last week, it has now stopped.

Micturition Normal.

Abdominal Examination Reveals a large tumour irregular in shape and dull on percussion, which does not change with the position of the patient, resonant in flanks, fluctuating.

Vaginal Examination Prolapse of Uterus.

Diagnosis. Multilocular Ovarian Tumour.

No. 74.

Name Mrs. M. A.

Age 43.

Address

Admitted 9th June 1896.

Complaint Pain in right iliac region, swelling of abdomen.

Duration Pain 7 years, swelling 4 years.

Family 5, youngest 12 years ago.

Menstruation Sometimes once a fortnight, once in 3 weeks, menorrhagia, dysmenorrhoea.

Micturition Normal.

Abdominal Examination Solid tumour, freely moveable

Continuation of

Case No. 74.

Continuation of

Abdominal Examination connected with the uterus reaches about 5" above the symphysis pubis.

Vaginal Examination Uterus 4½" continuous with tumour, The tumour seems to have slipped down into the pelvis causing pressure on the bladder.

Diagnosis. Fibroid Tumour.

No. 75.

Name Mrs. B. H.

Age 27.

Address Hawick.

Admitted 15th June 1896.

Complaint Pain in the small of the back.

Duration 2 years.

Family One. 5 years ago. No abortions.

Menstruation $\frac{4\text{-}5}{28}$ Regular except the last occasion, patient was 3 weeks behind her time.

Micturition Occasional frequency.

Vaginal Examination Right ovary prolapsed and tender. Bartholinian abscess on right side. Uterus retroflexed and fixed.

Diagnosis. Prolapsed ovary.

No. 76.

Name Mrs. M. F.

Age 24.

Address Hawick.

Admitted 15th June 1896.

Complaint Continuous haemorrhagic discharge and pain in both iliac regions.

Duration 6 months.

Family None. No abortions.

Menstruation $\frac{6\text{-}7}{28}$ Always over 3 weeks and lasting 6 to 7 days. Menorrhagia. dysmenorrhoea, and during the last six

Continu ation of

Case No. 76.

Menstruation (CONTD): months continuous discharge as above.

Micturition Normal.

Vaginal Examination Uterus retroverted 3½" and tender. Endometritis.

Diagnosis. Retroversion.

No. 77.

Name Mrs. B. M.

Age 47.

Address Dundee.

Admitted 17th June 1896.

Complaint Pain in lower iliac region.

Duration 11 months.

Family 2, youngest 21 years ago. No abortions.

Menstruation Till 7 months ago was quite regular, since that time once in 2 months, in fact very variable.

Micturition Painful and frequent.

Abdominal Examination Reveals a small tumour in the right iliac fossa, hard, nodular, fairly moveable, but with a well defined attachment. There is a pulsation connected with it.

Vaginal Examination The tumour can be felt per right fornix, it is quite distinct over the uterus both ovaries and tubes can be

Continuation of

Case No. 77.

Continuation of

Vaginal Examination palpated and are separable from the tumour. Patient seen by Mr. Millar and Mr Duncan, whom both pronounce it to be a malignant affection of the Caecum.

Diagnosis. Carcinoma of Caecum.

No. 78.

Name Mrs. M. McH.

Age 29.

Address Leith.

Admitted 20th June 1896.

Complaint Pain in lower abdomen and in lower part of back.

Duration One month.

Family 5, the youngest 2 years ago. One abortion at the 7th week, January 1895, and another abortion at the 7th week last January.

Menstruation Amenorrhoea since end of April previously was very irregular, sometimes once in 3 weeks and once a fortnight with menorrhagia.

Micturition Had frequency and pain 3 weeks before admission. This has now passed off.

Continuation of

Case No. 78.

Vaginal Examination Large mass about the size of an orange, can be felt bulging into the posterior fornix. Uterus to the front 3½".

Diagnosis. Extra Uterine ?

No. 79.

Name Mrs. C. R.

Age 28.

Address Fort Augustus.

Admitted 20th June 1896.

Complaint Swelling of abdomen and pain in epigastrium, right hypochondrium, and right iliac region.

Duration Swelling was first noticed in January last, the pain 3 weeks ago.

Family 3, the youngest 3 years. 2 abortions at the 3rd month, the first in January 1895, the second January this year.

Menstruation $\frac{2-3}{28}$ Quite regular till April, since which time Amenorrhoea.

Micturition Normal.

Abdominal Examination Reveals a large tumour extending within a couple of inches of the xyphisteruum, regular in outline, smooth, fluctuating, dull on percussion except far round in the flanks, where it is resonant, the whole mass of the tumour is dull on percussion and this dulness does not change with the position of the patient. Auscultation nil.

Vaginal Examination Vagina soft and smooth, cervix soft, uterus retroverted enlarged and gravid.

Diagnosis. Ovarian tumour with retroverted gravid uterus.

No. 80.

Name R. M.

Age 48.

Address Scalloway.

Admitted 21st June 1896.

Complaint Pain in left iliac region passing round to the back. Swelling of abdomen.

Duration The pain 8 months, the swelling 3 months.

Family None. Unmarried.

Menstruation Very irregular. Sometimes once a fortnight, once in 3 weeks. Menorrhagia. Metrorrhagia.

Micturition Retention with over-distension then incontinence.

Abdominal Examination Reveals a hard nodular mass in the left iliac region.

Vaginal Examination A large submucous polypus about the size of a big cocoa nut is protruding through the cervix pressing against the bladder causing the symptoms already referred to. Urine has to be drawn off with a catheter.

Diagnosis. Submucous and Subperitoneal Fibroids.

No. 81.

Name Mrs. M. W.

Age 44.

Address Leith.

Admitted 24th June 1896.

Complaint Pain and swelling in lower iliac region.

Duration 2 years.

Family 3, the youngest 7 years old. No abortions.

Menstruation $\frac{5-6}{28}$ Regular, Menorrhagia. Dysmenorrhoea.

Micturition Normal.

Abdominal Examination On palpation there can be felt a cystic tumour, very freely moveable, dull on percussion which dulness changes with the position of the mass, which also moves on changing the position of the patient. No fluctuation can be made out.

Vaginal Examination Uterus forward $2\frac{1}{2}$" cervix directed backwards and downwards. In the right anterior fornix the mass can be felt bulging, and fluctuation can be distinctly obtained.

Diagnosis. Ovarian Tumour.

No. 82.

Name Mrs. J. S.

Age 38.

Continuation of

Case No. 82.

Address Dundee.

Admitted 1st June 1896.

Complaint Menorrhagia, Metrorrhagia, a small swelling in the grain and a small sore on external genitals.

Duration 3 months.

Family 3, youngest 13 years old.

Menstruation Sometimes a fortnight, sometimes 3 weeks, and on one occasion in 10 days, Menorrhagia, and metrorrhagia as above.

Micturition Normal.

Vaginal Examination Thickening and erosion of cervix.

Diagnosis. Epithelioma of Cervix.

No. 83.

Name Mrs. M. F.

Age 28.

Address Hawick.

Admitted 1st July 1896.

Complaint Downbearing pain and constant haemorrhagic discharge.

Duration Pain 8 months, discharge 8 weeks.

Family 3, the youngest 2 years and 3 months ago. Had abortion at the 3rd month 5 months ago.

Continuation of

Case No. 83

Menstruation $\frac{5}{28}$ Always regular until 6 weeks ago, since which time metrorrhagia and menorrhagia, premenstrual dysmenorrhoea, also during the flow.

Micturition Normal.

Vaginal Examination Uterus retroflexed to ½", Endometrium tender, roughened and bleeding.

Diagnosis Retroflexion and Endometritis.

No. 84

Name Mrs. B. R.

Age 57.

Address Leith.

Admitted 11th July 1896.

Complaint Very severe pain at the vulva and a burning sensation in the vagina.

Duration 4 years.

Family 3, youngest 14 years old. No abortions.

Menstruation Menopause 10 years ago.

Micturition Painful and frequent.

Visual Examination Examination of external genitals reveals at the vulval orifice, at the junction of the labia minora, the vestibule and part of the anterior vaginal wall; extending down on either side of the nymphae to a short distance, is

Continuation of Case No. 84

Continuation of Visual Examination a thickened nodular and fungating mass, bleeding and with a very foul odour. Inguinal glands thickened and hard.

Diagnosis. Carcinoma of external genitals.

No. 85

Name L. S.

Age 19.

Address Hawick.

Admitted 14th July 1896.

Complaint Constant haemorrhagic discharge.

Duration 18 months.

Family None, Unmarried.

Menstruation 2 years ago was quite regular, then 3 months amenorrhoea, since then constant haemorrhagic discharge.

Micturition Normal.

Vaginal Examination Uterus normal, ovaries slightly enlarged and tender.

Diagnosis. Ovaritis.

No. 86.

Name Mrs. J. McK.

Age 25.

Address Leven.

Admitted 15th July 1896.

Continuation of

Case No. 86.

Complaint Painful menstruation.

Duration 2 years.

Family None. No abortions.

Menstruation $\frac{4\text{-}5}{28}$ dysmenorrhoea during the first day of the flow, afterwards relieved.

Micturition Slight pain during the act and a desire to micturate frequently.

Vaginal Examination Uterus 2½" acutely anteflexed os pinhole.

Diagnosis Dysmenorrhoea.

No. 87.

Name Mrs. C. P.

Age 35.

Address St. Andrews.

Admitted 18th July 1896.

Complaint Constant haemorrhagic discharge, pain in lower iliac region.

Duration 18 months.

Family One, still born 8 months and 2 weeks, 11 years ago.

Menstruation $\frac{8\text{-}10}{28}$ Regular. Premenstrual dysmenorrhoea and during the flow.

Micturition Normal.

Vaginal Examination Uterus enlarged 4" retroverted Endometrium roughened and bleeding.

Diagnosis. Endometritis retroversion.

No. 88.

Name Mrs. J. M.

Age 22.

Address Edinburgh.

Admitted 20th July 1896.

Complaint General debility. Pain in left iliac region constant and persistent leucorrhoea.

Duration 4 years.

Family One, 5 years ago. 2 abortions at the 6th week, the first 3½ years, the second 2 years ago.

Menstruation $\frac{5\text{-}7}{21}$ Sometimes menorrhagia, persistent leucorrhoea as above stated.

Micturition Frequently.

Vaginal Examination Uterus retroverted 3½" tender and bleeding, tender ovary on left side.

Diagnosis. Retroversion left ovaritis and Endometritis.

No. 89

Name A. B.

Age 36.

Address Edinburgh.

Admitted 22nd July 1896.

Complaint Pain in left iliac region passing through to the back.

Duration 4 years.

Family None, unmarried.

Menstruation Very irregular, sometimes

Continuation of Case No. 89

Continuation of Menstruation once in 3 weeks, 4 weeks, 5 weeks, and 6 weeks. Menorrhagia Premenstrual dysmenorrhoea and during the flow, leucorrhoea.

Vaginal Examination Uterus retroflexed. A small body can be felt protruding through the cervix.

Diagnosis. Polypus and retroflexion.

No. 90.

Name Mrs. E. M.

Age 26.

Address Edinburgh.

Admitted 24th July 1896.

Complaint Painful micturition and dyspareunia.

Duration 5 years.

Family One. 5 years ago. No abortions.

Menstruation Patient had double oophorectomy performed. Patient has not menstruated since 12th March 1895.

Micturition Pain just before, during, and after the act, occasional frequency.

Visual Examination Urethral caruncles.

Diagnosis. Urethral caruncles and Dyspareunia.

No. 91.

Name J. J.

Age 27.

Address Midcalder.

Admitted 24th July 1896.

Complaint Prolapse of Uterus.

Duration 9 months.

Family One. 3 years ago. No abortions.

Menstruation Every 2 weeks and lasting 2 weeks. Menorrhagia, dysmenorrhoea.

Micturition Frequent, and pain during the act.

Vaginal Examination Cystocele, Rectocele, Uterus $5\frac{1}{2}$".

Diagnosis. Cystocele, Rectocele and prolapse of uterus.

No. 92.

Name Mrs. M. R.

Age 28.

Address Kirkcaldy.

Admitted 25th July 1896.

Complaint Pain in left iliac region of a down bearing character, occasional attacks of vomiting.

Duration 3 years.

Family None. No abortions.

Menstruation $\frac{2-3}{28}$ Premenstrual dysmenorrhoea and during the flow.

Continuation of

Case No. 92.

Micturition Frequency.

Abdominal Examination Nil.

Vaginal Examination A large mass can be felt bulging the right fornix. Uterus is not separable from the mass, and is pushed to the left side.

Diagnosis. Cyst of the broadligament.

No. 93.

Name Mrs. E. S.

Age 33.

Address Edinburgh.

Admitted 25th July 1896.

Complaint Pain in side. Vaginal discharge.

Duration 3 years and 4 months.

Family 4 children, the last child born 2 years and 4 months ago. No abortions.

Menstruation Every 3 weeks, amount large, duration a week. Discharge generally haemorrhagic.

Micturition Very frequent.

Vaginal Examination Enlarged uterus 3" and heavy endometrium bleeding.

Diagnosis Endometritis.

No. 94.

Name Mrs. R. B.

Age 43.

Address Cockermouth.

Admitted 30th July 1896.

Complaint Pain in left side passing down to the iliac region, then passing round to lower part of abdomen, constant haemorrhagic discharge.

Duration 7 months.

Family 11, the youngest 7 months ago. One abortion 13 years ago at the 3rd month.

Menstruation $\frac{6-7}{21}$ Every fortnight lasting 7 or 8 days, menorrhagia, metrorrhagia, premenstrual dysmenorrhoea and also for the first 2 days.

Micturition Occasional, pain & frequency.-

Vaginal Examination Uterus 3½", heavy cervix, thickened; endometritis.

Diagnosis. Endometritis.

No. 95.

Name Mrs. M. C.

Age 24.

Address Dalkeith.

Admitted 4th August 1896.

Complaint Pain in left iliac region, continuous haemorrhagic discharge, left

Continuation of

Case No. 95.

Continuation of

Complaint inguinal hernia.

Duration Pain and haemorrhage 3 weeks, harnia 8 months.

Family One abortion, between the 5th and 6th months 6 years ago.

Menstruation $\frac{6-7}{28}$ Regular. Menorrhagia and for the past 3 weeks metrorrhagia.

Micturition Frequency.

Vaginal Examination Fibroid about the size of a large orange on the anterior wall of the uterus.

Diagnosis. Fibroid Tumour.

No. 96.

Name H. B.

Age 31.

Address Innerleithen.

Admitted 6th August 1896.

Complaint Constant vomiting.

Duration 3 months.

Family None. Unmarried.

Menstruation $\frac{5-6}{28}$ Regular. Menorrhagia, leucorrhoea.

Micturition Normal.

Vaginal Examination Uterus pushed to the right. A large mass can be felt bulging into the left and posterior fornices, hard

Continuation of

Case No. 96.

Continuation of

Vaginal Examination and fixed.

Diagnosis. Dermoid Ovarian.

No. 97.

Name Mrs. J. H.

Age 29.

Address Edinburgh.

Admitted 6th August 1895.

Complaint Haemorrhagic discharge.

Duration 6 weeks, until last Monday when it stopped.

Family 5, the youngest 16 months ago. One abortion 7 years ago at 2½ months.

Menstruation $\frac{4\text{-}5}{28}$ Patient nursed her last child for 14 months, then menstruated once a fortnight. Later she again began to bleed which continued on and off for 6 weeks. For the last 6 days she has seen nothing. Said there was no bleeding previous to May.

Micturition Normal.

Vaginal Examination - Cervix hard and indurated carcinomatous infiltration. Uterus is freely moveable.

Diagnosis. Epithelioma of cervix.

No. 98.

Name Mrs. E. N.

Age 50.

Address Cockburnspath..

Admitted 10th August 1896.

Complaint Swelling of abdomen and of the left leg .

Family 2, youngest 16 years ago. No abortions.

Menstruation Last menstruated 7 months ago. Previous to this had Amenorrhoea for 3 months and before this had another period Amenorrhoea, previous to this was quite regular.

Abdominal Examination Reveals a large tumour occupying the whole of the abdomen reaching within an inch of the xyphisteruum, dull all over, tense, fluctuation very distinct. There is a scar midway between umbilicus and symphysis pubis of a former operation and there are marks from aspiration.

Diagnosis. Ovarian Tumour.

No. 99.

Name Mrs. A. D.

Age 28.

Address Leith.

Admitted 12th August 1896.

Continuation of

Case No. 99.

Complaint Pain in lower abdomen and constant haemorrhagic discharge.

Duration 2 weeks.

Family One abortion at the 7th week, 3 years ago, one full term (living), 2 years ago, one abortion 2nd month 14 days ago.

Menstruation $\frac{3}{28}$ Quite regular till 2 months and a half ago, then amenorrhoea for 2 months. The past fortnight constant haemorrhagic discharge as above.

Micturition Normal.

Vaginal Examination Os dilated to the extent of admitting 2 fingers, uterus enlarged 3½" endometrium roughened and bleeding . Incomplete abortion.

Diagnosis. Incomplete abortion.

No. 100.

Name Mrs. A. B.

Age 32.

Address Berwick-on-Tweed.

Admitted 14th August 1896.

Complaint Swelling of abdomen and pain in right leg.

Duration 6½ months.

Continuation of

Case No. 100.

Family One, 15 years ago, one abortion at the fourth month 2 years ago.

Menstruation Always regular till January 23rd this year. From this date until the end of June, amenorrhoea. At this time she says she menstruated but not like the usual. There were pieces of tissue like pale skin passed with clots of blood. Nothing after this till the 2nd August, when she was unwell till the 8th of August, on this occasion she passed more pieces of pale skin and clots nothing until to-day and then only a few drops.

Micturition Normal.

Abdominal Examination Reveals a large tumour irregular in outline reaching within an inch of the umbilicus. It extends on the left side to the extent of 3" from the middle line, on the right side it fills up the iliac fossa; it is dull on percussion, solid in parts and cystic in others; there is a well marked linea nigra.

Vaginal Examination A large mass can be felt bulging into the posterior fornix, and in the right fornix a small nodular body about the size of a hazel nut.

Continuation of

Case No. 100.

Continuation of

Vaginal Examination. The uterus is to the front and feels continuous with the tumour.

General History of

Present Attack Patient last menstruated on January 23rd. On February 7th she was seized with pain in the right iliac region and had an attack of vomiting, which lasted for 2 days, she was in bed for a fortnight, then up for a week, when the vomiting returned lasting 2 days after this she was going about for a fortnight and the vomiting started again lasting a week; she was well after this and about March she noticed a small lump in the right iliac region about the size of a hen's egg. This gradually grew bigger. About the end of May patient states that she felt life but only for a fortnight. On the 18th June she was standing, when without any warning she suddenly fainted. She came to on the floor. After this she vomited for 3 weeks. This was accompanied with a very severe pain from the lower part of the abdomen, the pain gradually died away. All signs of life disappeared at this time. About the end of

Continuation of

Case No. 100.

Continuation of

General History of

Present Attack. June patient had a discharge per vagina, pale in character, and with this there were passed pieces of skin like tissue; this discharge lasted a week, At the end of a fortnight it recurred, and she again passed more pieces of skin like tissue, that lasted a week and then stopped. The attacks of vomiting above referred to were always preceded by pain.

Diagnosis. Extra Uterine Gestation.