An account of one hundred and ten consecutive cases of abdominal section performed since the 1st of November, 1880 : read before the Midland Medical Society, November 2nd, 1881 / by Lawson Tait.

AN ACCOUNT OF

ONE HUNDRED AND TEN CONSECUTIVE CASES OF ABDOMINAL SECTION

PERFORMED SINCE THE 1ST OF NOVEMBER, 1880.

(*Read before the Midland Medical Society, November 2nd,* 1881.)

BY

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AN ACCOUNT OF

ONE HUNDRED AND TEN CONSECUTIVE CASES OF ABDOMINAL SECTION

PERFORMED SINCE THE 1ST OF NOVEMBER, 1880.

Analysis of the Series.

		Cases.	Deaths.
Exploratory incisions		14	0
Removal of one ovary for cystoma		38	2
Removal of both ovaries for cystoma		9	0
Removal of parovarian cysts		4	0
Removal of both ovaries and tubes for	Myoma	11	1
	Hydrosalpinx	5	0
	Pyosalpinx	3	0
	Chronic ovaritis	2	1
Opening and draining of pelvic abscess		11	0
Hepatotomy		4	0
Enterotomy for intestinal obstruction		2	0
Hysterotomy		4	2
Cæsarian section		1	1
Extra-peritoneal cysts (peritoneum not opened		2	2
		110	9

In giving an account of the work which I have done during the last twelve months, I shall continue the practice which gives, as I believe, the only just method of showing

its value, or the general progress which is being made in this department of surgery, by placing on record every case in which I have opened the abdomen, in a tabulated statement. This, as will be seen, contains columns, two of which will serve sufficiently for the identification of any particular case, should my critics require it. A third column gives the nature of the disease, and another the kind of operation performed; whilst the results are given for the primary effect of the operation in all cases, and for the secondary effect in a few, chiefly those in which malignant disease has killed the patient after recovery from the operation.

It is first of all to be noticed that the number of operations has increased nearly 45 per cent. over those performed last year, and as by far the larger number of the cases have been placed under my care by my professional brethren, I take this as a most gratifying proof that the results I have obtained are satisfactory to them.

The total mortality amounts to nine deaths, or only 8·2 per cent., a result which would be remarkable enough in itself if all the cases had been mere ovariotomies, but still more so when its details are examined. If I had confined the definition of "abdominal section" strictly to those cases in which the peritoneal cavity was opened, I should eliminate two of my deaths (Nos. 26 and 56), but none of my successful cases, and thus the total mortality would be reduced to 6·4 per cent. I include these two cases, however, the details of which will be given further on, in order that no charge may be made against me of dealing unfairly with my results.

Of the fourteen exploratory incisions, I may say that they all occurred in cases of malignant disease. In many of them I was certain that the disease was of a hopeless kind before I operated, but I offered the patients the chance of a harmless opening in order that I might be sure that I had made no mistake. In a few of the cases there was doubt, and in two I was wholly mistaken, having been under the impression that I was dealing with ordinary cystoma, whilst the disease was really malignant sarcoma. Two per cent. of error is, however, not large, and I am greatly comforted by the fact that this percentage has immensely diminished during the last few years.

I now make exploratory incisions to make sure I am not wrong, whereas formerly I used to make them only to find

l was entirely mistaken. They serve the purpose of complete tappings, and, as the patients uniformly recover, they do no harm at all.

By far the most satisfactory statement I can make, both for myself and for the general advancement of abdominal surgery, is that there is not a single incomplete operation on the list. Not a single tumour which I have attacked have I not completely removed; and the reproach which has been made on the operation for the removal of small ovaries (the so-called oöphorectomy), that there was such a large proportion of incomplete operations, will, I hope, no longer be applied with justice to my practice. Increased experience, and greater boldness and manipulative dexterity thereby acquired, have enabled me to complete a large number of the operations in the list now submitted, which, two or three years ago, would have been left unfinished.

Of the operations which were formerly grouped together under the name of ovariotomy (and most improperly so), I have performed fifty-one with only two deaths, or 3 49 per cent. These were all cases of cystic tumours affecting one ovary in thirty-eight cases, both ovaries in nine cases, and the tubules of the broad ligament in four cases. The mortality obtained in this group is most satisfactory, and is an immense advance on anything hitherto obtained, save in the practice of Dr. Keith, of Edinburgh, to whose teaching and example it is very largely due—a fact which I here proclaim by no means for the first time. I have already said enough of the so-called antiseptic system of Lister to be able to say that it has been finally dismissed from this department of surgery as having done far more harm than good. I venture to predict a similar fate will meet it everywhere else; and I take to myself some credit for having burst one of the largest, best blown, and most attractive bubbles ever displayed to a surgical audience.

The main factors in the success, as I have said before, and as I have increasing reason to believe, are three—the discontinuance of the clamp treatment of the pedicle, increased personal experience, and a general improvement of the conditions under which operations are performed. There can now be no question that our former high mortality was mainly due to the clamp, and for this Mr. Spencer Wells is solely responsible. Before his day the intra-peritoneal treatment had been completely established by Mr. Baker Brown, in whose hands its mortality was reduced to 10 per cent. between 1865 and 1867. Neither Mr. Spencer Wells nor anyone else got results from the clamp, after 1867, much better than 25 per cent. mortality. Mr. Baker Brown's ruin was, therefore, a great misfortune for humanity, and Mr. Wells has never yet explained on what grounds he neglected the lesson of Baker Brown's practice, and why it

was left for Dr. Keith to put ovariotomy in its legitimate position. For twelve years Mr. Wells went on with a mortality more than double that which he would have had with the cautery; and, unfortunately, he led others into the same mistake. Not only this, but the whole progress of abdominal surgery, which has been so rapid during the last four years, was retarded, for no one dared to perform operations which are now completely to be justified, so long as ovariotomy was fatal in one case in every four.

One item to be classed under the head of the general improvement is of very great importance, which is, that I get the patients now in a much earlier stage of the disease than I used to do, for my professional brethren generally send me their patients as soon as the presence of a tumour is recognised. This is proved by the fact that only two out of the fifty ovarian tumours which I have removed during the past twelve months had been tapped before they were sent to me. If ovarian tumours were never tapped I believe that 98 per cent. of recoveries would be the rule in ovariotomy. The two deaths which I speak of occurred in cases where the patients were so situated that the disease was not recognised till too late. One, sent to me by Dr. Williams, of Dyffryn, had obstinately refused to be examined till she was at death's door from persistent vomiting. Her emaciation and exhaustion were extreme, yet the operation was performed within a few days of the recognition of the case by Dr. Williams and Dr. Roberts, of Portmadoc. She went on very well till the third day, when, during an attack of vomiting, she was suffocated by the vomited matter being drawn into the trachea. Death was quite sudden. I had left her not many minutes before, and had felt no unusual anxiety about her recovery. Had the operation been performed three months before, her recovery would have been certain.

The second death occurred in a case sent to me by Dr. Hamp, of Wolverhampton, within a few days of her being seen by him. She had been under some one else, who had failed to recognise either the nature of the case or its gravity. She was of enormous size. The operation was prolonged and serious from the adhesions. It was a case which I ought, I fear, to have drained; certainly I should do so now. And here I wish to make a recantation of what I have said about drainage. I have no doubt now that Dr. Keith is right when he says that drainage will save three or four cases in each hundred. Previous to August last I had often said that I never had drained, and that I did not think I had lost anything by abstaining from the practice. I fear I was in error, yet my splendid results without it almost justified my belief. But there comes a train of striking coincidences in every line of life, and it came to me in August last. I

spent a few days with Dr. Keith in that month, and at his table we discussed drainage, and I expressed my views about it. Dr. Keith told me that I would alter my opinion; and I can only say with Solomon, that he is a fool who never does so, and he is a wise man who does so seldom. Dr. Battey accompanied me home from Edinburgh, and next morning he assisted me to remove a large ovarian tumour, at the base of which was a large malignant adhesion which I had to tear across. The hæmorrhage from it was very profuse, and I had to pack the pelvis with sponges for its arrest. Looking across the table to Dr. Battey, I said, "I think I had better change my opinion now, and use a drainage-tube." He concurred, and I fastened in a tube. The patient made an easy and uninterrupted recovery, and went home, though since then she has succumbed to the cancerous growth.

Next morning I removed, with Dr. Battey's assistance, an enormous tumour, in which the pelvic adhesions were as formidable as it is possible for them to be; again I drained, clearly with advantage; and—to make a long story short—I have done so in four other cases, all with the happiest results. These six cases were so very bad that I do not think I could reasonably have expected them all to have recovered without drainage, and I retract everything that I have hitherto said on the subject. I have also re-opened the wound in two cases which were doing badly, in the stage of acute peritonitis, have cleaned it out, and then fastened in a drainage-tube; and both cases from that moment mended and made speedy recoveries. So satisfied have I been with the results in these cases, that the next case of peritonitis to which I am called, of whatever sort it be—even puerperal,—I shall advise and perform, if allowed, abdominal section, shall cleanse out the cavity and drain it; and, if the operation be not deferred till the patients are moribund, I believe this treatment will prove eminently successful. Our views of peritonitis will, I am certain, soon undergo an immense alteration. The terms "septicæmia" and "septic peritonitis," for which Mr. Spencer Wells is mainly responsible, and which have appeared in the mortality column as the explanation of the deaths after ovariotomy, are simple nonsense, and have led us astray altogether. In future we shall treat the peritoneum on the same principles as we treat other suppurating cavities, and with quite as secure results. Upon this subject I have much more to say, but cannot find space here. It will be fully discussed in a work now in the press.

I do not find that removal of both ovaries for cystoma is in any way a more formidable operation than removing one, and the removal of parovarian cysts has been in my hands uniformly successful.

One Hundred Consecutive Cases of Abdominal Section performed since November 1, 1880, *by Lawson Tait, F.R.C.S.*

No.	Residence.	Medical attendant.	Age.	Married or single.	Disease.	Operation.	Date.	Hospital.	Private.	Recovered.	Died.	After result—Remarks.
							1880.					
1	Malvern	Dr. Weir	64	W	Cystoma	Left ovary removed...	Nov. 1	...	P	R	...	
2	Liverpool	Dr. Parry	46	M	Malignant sarcoma...	Hysterotomy	„ 2	H	...	...	D	
3	Wolverhampton ...	Dr. Lycett	19	S	Pelvic abscess (?) ...	Exploratory	„ 2	...	P	R	...	
4	Bradninch, Devon..	Dr. Stephenson	42	W	Myoma	Both ovaries removed	„ 16	H	...	...	D	Intestinal obstruction.
5	Feckenham, Worc.	Dr. Leacroft...	50	M	Cystoma	Right ovary removed	„ 20	...	P	R	...	Had tetanus, and gangrene of tumour.
6	Walsall	Dr. Day...	56	M	Malignant sarcoma ...	Exploratory	„ 25	...	P	R	...	
7	Hednesford	Dr. Marsh Stiles... ...	41	M	Parovarian cyst ...	Removed	Dec. 2	H	...	R	...	
8	Coventry...	Dr. McVeagh	21	S	Cystoma	Left ovary removed...	„ 7	H	...	R	...	
9	Nuneaton	Dr. Hammond	20	S	Dermoid cyst	Opened and drained	„ 10	H	...	R	...	
10	Birmingham	Dr. J. W. Taylor ..	44	S	Myoma	Both ovaries removed	„ 18	H	...	R	...	Complete cure.
11	Knighton, Radnor	Dr. Coventon	43	M	Cancer of liver	Exploratory ...	„ 20	H	...	R	...	
12	Stratford-on-Avon	Dr. Gill	42	S	Cystoma	Right ovary removed	„ 21	...	P	R	...	Died of cancer of liver, Mar. 30, 1881.
							1881.					
13	Hembleton, Worc.	... ...	56	M	Cystoma	Right ovary removed	Jan. 4	H	...	R	...	
14	Baddesley, Warwck	Mr. S. F. Palmer ...	49	M	Cystoma	Right ovary removed	„ 5	...	P	R	...	
15	Wolverhampton ...	Dr. Totherick	11	S	Pelvic abscess	Opened and drained	„ 7	H	...	R	...	Complete cure.
16	Coventry...	Dr. Plowman	32	M	Myoma	Both ovaries removed	„ 13	H	...	R	...	Complete cure.

17	Liverpool	Dr. McFie Campbell	21	S	Chronic ovaritis ...	Both ovaries removed	„ 26	H	...	R	...	
18	Coventry...	Dr. Fenton	23	S	Suppurating kidney...	Exploratory	„ 28	H	...	R	...	
19	Llanbedr, Merion.	Dr. Williams	49	M	Cystoma	Right ovary removed	Feb. 2	...	P	R	...	
20	Birmingham	Mr. H. Bracey	15	S	Cystoma	Right ovary removed	„ 2	H	..	R	...	
21	Brierley Hill	Dr. D'Arcy Ellis	41	M	Cystoma	Both ovaries removed	„ 5	H	...	R	...	Complete cure.
22	Birmingham	Dr. G. P. Hadley ...	56	M	Cyst of liver	Hepatotomy	„ 6	...	P	R	...	Complete cure.
23	Dyffryn, Merion....	Dr. C. Williams... ..	49	S	Cystoma	Left ovary removed...	„ 7	...	P	...	D	Complete cure.
24	Leamington	Dr. Thompson	25	M	Hydatids of liver ...	Hepatotomy	„ 9	H	..	R	...	
25	Birmingham	Dr. Kenny	43	M	Myoma	Both ovaries removed	„ 12	H	.	R	...	Complete cure.
26	Shifnal	Dr. Lamb	56	M	Extra-peritoneal cyst	Removed	„ 13	...	P	...	D	
27	Chesterfield	Dr. Booth	32	S	Cystoma	Left ovary removed...	„ 14	...	P	R	...	
28	Leamington	Dr. W. Tomkins ..	21	S	Hydatids of liver ...	Hepatotomy	„ 15	H	...	R	...	Complete cure.
29	Birmingham	Mr. Raffles Harmar ...	48	M	Cystoma	Left ovary removed...	„ 17	H	...	R	...	
30	Leominster	Dr. Barnett	23	S	Cystoma	Left ovary removed...	„ 19	H	...	R	...	
31	Birmingham	Mr. J. W. Taylor ...	53	M	Large spleen	Exploratory	„ 26	H	...	R	..	
32	Nuneaton	Mr. R. B. Nason ...	56	M	Cystoma	Left ovary removed...	„ 27	...	P	R	...	
33	Wooton-und.-Edge	Dr. Forty	25	S	Cystoma	Both ovaries removed	March 2	..	P	R	..	
34	Leicester	Dr. Cox-Hippisley ..	31	M	Cystoma	Both ovaries removed	„ 3	H	...	R	...	
35	Church Stretton ...	Dr. McLintock	37	M	Double pyosalpinx ...	Both ovaries removed	„ 6	...	P	R	...	
36	Harbury, Warwick	Dr. Lattey	63	M	Cystoma	Both ovaries removed	„ 9	H	...	R	...	
37	Lancaster	Dr. Cassidy	56	M	Cystoma	Right ovary removed	„ 9	...	P	R	...	
38	Feckenham	Dr. Leacroft	52	M	Fibrocyst of uterus ...	Hysterotomy	Mar. 10	H		...	D	
39	Solihull	Dr. Page	22	S	Cystoma	Both ovaries removed	„ 12	...	P	R	...	
40	Wolverhampton ...	Dr. Walton Hamp ...	21	S	Cystoma	Left ovary removed .	„ 16	H	...	...	D	Obstructed intestines.
41	Rugby	Drs. Simpson & Sadd	39	M	Urinary cyst	Opened and drained	„ 19	H	...	R	...	Had a miscarriage, and died of it.
42	Ashby-de-la-Zouch	Dr. Betts	43	W	Cystoma	Right ovary removed	„ 26	...	P	R	...	
43	Birmingham	Mr. J. Greene	26	M	Pyosalpinx	Opened and drained	„ 28	H	...	R	...	
44	Ombersley	Dr. Hughes	61	M	Cancer of omentum...	Exploratory	April 2	...	P	R	...	Died subsequently of cancer.
45	Cannock	Dr. Moses Taylor ...	38	M	Cystoma	Right ovary removed	„ 2	H	...	R	...	
46	Birmingham	Dr. Bailey	30	M	Cystoma	Left ovary removed ...	„ 9	H	...	R	...	

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							1881.					
47	Darlaston	Dr. Sutton	35	S	Myoma	Both ovaries removed	April 20	...	P	R	...	Complete cure; tumour has wholly disappeared.
48	Fazeley	Dr. Buxton	55	M	Malignant cystoma...	Exploratory	„ 25	H	...	R	...	Died subsequently of cancer.
49	Birmingham	Mr. H. Bracey	15	S	Malignant cystoma ..	Exploratory	„ 26	H	...	R	...	Same patient as No. 20.
50	Birmingham	Mr. Hall Wright ...	12	S	Intestinal obstruction	Enterotomy	„ 27	...	P	R	...	
51	Coleshill	Dr. Taylor	29	S	Chronic ovaritis ...	Ovaries and tubes removed	„ 28	H	...	...	D	
52	Cradley	Dr. Standish	29	M	Cystoma	Left ovary removed	„ 29	..	P	R	...	
53	Nottingham	Dr. Huthwaite	47	M	Cystoma	Right ovary removed	May 7	...	P	R	...	
54	Lichfield	Dr. Bastable	36	M	Cystoma	Right ovary removed	„ 7	...	P	R	...	
55	Birmingham	Dr. Cox	57	M	Ruptured cystoma ...	Right ovary removed	„ 19	H	...	R	...	
56	Hanley	Dr. Craig	39	M	Extra-peritoneal cyst	Removal	„ 19	..	P	...	D	Complete cure.
57	Birmingham	Dr. Welch	7	S	Hydatids of liver ...	Hepatotomy	„ 20	H	...	R	...	
58	Darlaston	Dr. Cameron	40	M	Cystoma & hydrosalp.	Both ovaries removed	„ 21	...	P	R	...	
59	Nuneaton	Dr. Hammond	20	S	Dermoid cyst	Opened and drained	„ 27	H	...	R	...	Same patient as No. 9.
60	Dolgelly	Dr. E. Jones	29	M	Malignant sarcoma...	Exploratory	„ 31	...	P	R	...	
61	Birmingham	Dr Drummond	27	W	Suppurat. hæmatoma	Opened and drained	June 9	H	...	R	...	
62	Cradley	Dr. Standish	29	M	Pyosalpinx...	Tubes and ovaries removed	„ 13	H	...	R	...	
63	Malvern	Dr. Weir	48	M	Ruptured cystoma ...	Right ovary removed	„ 15	...	P	R	...	
64	Droitwich	Dr. Cuthbertson... ...	43	M	Myoma	Both ovaries removed	„ 15	H	...	R	...	
65	Birmingham	Mr. Hall Wright ...	47	M	Myoma	Both ovaries removed	„ 17	H	...	R	...	Complete cure.

66	Atherstone	Dr. Handford	33	M	Chronic peritonitis ...	Exploratory	„ 23	H	...	R	...	
67	Shustoke	Mr. O. Pemberton ...	35	M	Papilloma	Exploratory	„ 29	H	...	R	...	
68	Aston	Mr Lawson Tait ...	31	M	Cystoma	Left ovary removed	July 4	H	...	R	...	
69	Wellington, Somer.	Dr. Edwards	22	S	Ruptured cystoma ...	Both ovaries removed	„ 5	...	P	R	...	
70	Walsall	Dr. G. Sharp	39	M	Cystoma	Left ovary removed	„ 6	H	...	R	...	Pregnant 4 mos.
71	Ashby-de-la Zouch	Dr. Betts	34	M	Cystoma	Both ovaries removed	„ 7	...	P	R	...	
72	Derby	Dr. G. Copestake ...	35	W	Cystoma	Both ovaries removed	„ 13	...	P	R	...	
73	Redditch...	Dr. Bosworth	39	M	Double hydrosalpinx	Both tubes and ovaries removed	„ 14	...	P	R	...	
74	Alfreton, Derby ...	Dr. J. J. Bingham ...	45	M	Cystoma	Right ovary removed	„ 28	...	P	R	...	
75	Aston	Dr. Smith	33	M	Double pyosalpinx ...	Opened and drained	Aug. 2	H	...	R	...	
76	Birmingham	Dr. D. Nelson	38	M	Cystoma	Right ovary removed	„ 2	...	P	R	...	
77	Chirk	Dr. Aylmer Lewis ...	17	S	Cystoma	Left ovary removed	„ 2	...	P	R	...	
78	Durham	... ...	47	M	Myoma	Hysterotomy	„ 3	H	...	R	...	
79	Birmingham	Mr. Lawson Tait ...	40	M	Parovarian cyst ...	Removed	„ 8	H	...	R	...	Pregnant 4 mos.
80	Maentwrog, Wales	Dr. Roberts	63	M	Hydatids of liver ...	Hepatotomy	„ 15	...	P	R	...	
81	Stourbridge	Dr. Hammond Smith	27	M	Hydrosalpinx	Removed both tubes and ovaries	„ 19	H	...	R	...	
82	Derby	Dr. Rice	18	S	Cystoma	Right ovary removed	„ 22	...	P	R	...	
83	Sutton-in-Ashfield	Dr. J. J. Bingham ...	25	M	Cystoma	Both ovaries removed	„ 24	H	...	R	...	Died subsequently of cancer.
84	Ironbridge, Salop ..	Dr. Law Webb	38	S	Myoma	Both ovaries and tubes removed	„ 25	...	P	R	...	
85	Birmingham	Dr. Kenny	43	S	Myoma	Both ovaries and tubes removed	„ 27	...	P	R	...	Complete cure.
86	Aston	Dr. Fairley	36	M	Pelvic abscess	Opened and drained	„ 17	H	...	R	...	
87	Worcester	Dr. Coombes	52	M	Cystoma	Left ovary removed	Sept. 3	H	...	R	...	
88	Adderbury, Oxon.	Dr. Colgrave	46	M	Cystoma	Right ovary removed	„ 5	H	...	R	...	
89	HorneSuckley, Wor	Dr. Woodward	51	M	Parovarian cyst ...	Removed	„ 12	H	...	R	...	
90	Bilston	Mr. Lawson Tait ...	35	M	Cystoma	Left ovary	„ 13	H	...	R	...	
91	Wolverhampton ...	Dr. Pope	40	M	Myoma	Both ovaries and tubes removed	„ 19	...	P	R	...	
92	Birmingham	Dr. Kenny	30	M	Cystoma	Left ovary removed	„ 20	H	...	R	...	
93	Festiniog	Dr. Evans	39	S	Malignant sarcoma ..	Exploratory	„ 23	...	P	R	...	
94	Llandulas, N.W. ...	Dr. Turner	48	M	Parovarian cyst ...	Removed	„ 24	H	...	R	...	

No.	Residence.	Medical attendant.	Age.	Married or single.	Disease.	Operation.	Date.	Hospital.	Private.	Recovered.	Died.	After result - Remarks.
95	Liverpool	Dr. McFie Campbell ...	22	S	Suppurat. hæmatoma	Opened and drained	Sept. 29	H	...	R	...	Same as No. 17.
96	Oldhill	Dr. Ker...	25	M	Hydro and pyosalpinx	Opened and drained	Oct. 3	...	P	R	...	
97	Broseley	Dr. Bartlam	51	S	Myoma	Both tubes and ovaries removed	„ 4	H	...	R	...	
98	Walsall	Dr. Sharp	37	M	Hydrosalpinx	Right tube removed...	„ 7	H	...	R	...	
99	West Bromwich ...	Mr. Langley Brown ...	55	S	... ...	Enterotomy (?)	„ 9	...	P	R	...	
100	Leominster	Dr. Edwards	35	S	Deformed pelvis ...	Cæsarian section ...	„ 11	...	P		D	
101	Birmingham	Dr. Madden	47	M	Papilloma	Exploratory	„ 11	...	P	R	...	
102	Bridgnorth	Dr. Collis	28	M	Pelvic abscess	Opened and drained	„ 12	H	...	R	...	
103	Birmingham	Mr. J. R. Harmar ...	63	W	Cystoma	Right ovary removed	„ 15	...	P	R	...	
104	Birmingham	Mr. Hall Wright ...	34	M	Double hydrosalpinx	Both tubes and ovaries removed	„ 19	H	...	R	...	
105	Wolverhampton ...	Mr. S. F. Palmer ...	57	S	Cystoma	Both ovaries removed	„ 21	...	P	R	...	
106	Dudley	Mr. Berry	31	S	Double pyosalpinx ...	Both tubes and ovaries removed	„ 21	...	P	R		
107	London	Dr. T. Chambers ...	29	M	Double hydrosalpinx	Both tubes and ovaries removed	„ 24	H	...	R	...	
108	Ombersley	Dr. Roden	63	M	Cystoma	Right ovary removed	„ 28	H	...	R	...	
109	Wolverhampton ...	Dr. Scott	34	M	Cystoma	Right ovary removed	„ 29	...	P	R	...	Pregnant 4 mos.; acute peritonitis.
110	Ludlow	Dr. Brooks	37	S	Myoma	Hysterotomy	„ 30	...	P	R	...	

Four of the cases of single cystoma were pregnant at the time of the operation, and all recovered. In two cases I operated in the course of acute peritonitis, with completely successful results.

There are, of course, many of the cases having features of special interest, such as suppurating and gangrenous tumours, and operations performed during pregnancy, but these have now been reduced by extended experience to the compass of ordinary treatment, so that I need not trouble you with their details.

One case, however (74), deserves some brief notice, for there I had to deal with a rotten, gangrenous, and adherent tumour, which gave me trouble of a most unusual and unexpected kind, which I had to meet as best I could, and I am glad to say I did successfully.

In turning out the stinking, rotten mass, I suddenly caused a most alarming hæmorrhage, which, of course, I controlled with Kœberle's forceps, and proceeded with the removal. I could find no pedicle, but the point from which the hæmorrhage came was undoubtedly the pedicle which I had torn across before I had recognised it. When Mr. Harmar tried to tie its bleeding points, the more he tied the more it bled. The cautery equally failed me, and I was at my wits' end. Nine pairs of forceps were fastened upon something in the pelvis—I knew not what,—and from it I dared not move them. I therefore closed the wound over them, went up to the hospital next morning, and reopened it. Then, in fear and trembling, I released the forceps, one pair after another. No bleeding came. I fastened in a drainage-tube, the patient recovered slowly, and went home on August 9.

I now come to a group of twenty-one cases of removal of the uterine appendages for various conditions, and these had best be divided into two groups, according to the nature of the two leading symptoms—hæmorrhage and pain. This division, however, like every other, is unsatisfactory, because it is quite impossible in some of the cases to say to which group they ought properly to belong, for pain and hæmorrhage were often so pronouncedly in combination as to afford a double justification for surgical interference. I must, however, enter here the protest which I have again and again advanced, so far in vain, against these operations being styled "oöphorectomies," or "cases of Battey's operation." I do so, in the first place, because I have completely established the fact that removal of the Fallopian tubes is quite as necessary as removal of the ovaries; in fact, I think it is far more necessary in all cases, for upon the tubes, it seems to me, the periodic function of menstruation exists, and ovulation and menstruation are wholly independent the one of the other. As Dr. Battey limited his definition of

the operation he performed to the removal of the ovaries, I would plead for this that I advocate, if we are to indulge in clumsy pedantry, the name of *salpingo-oöphorectomy*, or *prosthekotomy*. If the names of the advocates of the various proceedings are to be employed—a practice I object to—then it should be called "Tait's operation," but not "Battey's." Dr. Battey practically purposed his operation for the "production of the menopause or the arrest of ovulation." I am wholly indifferent on the question of ovulation in most of my cases, and I care not about the menopause in a large number. Therefore, in the whole of my large experience I have only three cases of "Battey's operation." One has been a complete success; the second I am not sure about, as I have lost sight of her; and the third I am afraid will turn out a failure, though it is too soon yet to pronounce judgment.

For my own part, I speak always of the operation as one "for the removal of the uterine appendages," and for the treatment of uterine myoma it is one of the most brilliant additions to modern surgery. It is perfectly absurd for anyone to start the discussion of this subject with the assumption that uterine myoma is not a fatal disease. If this is so, why do we hear on all hands of the employment of surgical proceedings for its treatment, which have had, up to the present, a perfectly murderous mortality? I have condemned them utterly; and though, in the present list, four such cases are given, I will not willingly perform another. It will be seen, in explanation of this, that every now and then hysterotomy will be performed, and till the operation is finished, or almost so, the surgeon will be ignorant of what he is doing. Removal of a uterine polypus, already completely extruded, or nearly so, is the only operation for uterine myoma which is safer than removal of the uterine appendages. Enucleation I shall never again attempt; and hysterotomy I shall equally avoid, if I can.

To tell us, as was practically done in a recent discussion, that hæmorrhage due to uterine myoma is only exceptionally fatal, is wholly opposed to my own experience since the first death I saw from it, nearly twenty years ago, in which case I made a post-mortem examination. But even if this were true, our operative practice, like our therapeutics, is surely not to be limited to the saving of life, but is to be extended to the restoration of health and the relief of physical distress. I ask anyone who has had such a case under his care, what ill-health is more distressing to the patient or her friends, or what suffering greater than that endured by a woman who bleeds profusely for ten or fourteen days every month, and who spends the rest of her time vainly endeavouring to replace what she has lost? Even if it were true that the deaths from removal of the uterine appendages in such

cases were more numerous than the deaths from the disease, I urge that it is the interests of the majority we have to consider, and that it is far better to cure ten women out of eleven, and that the eleventh should die, than that the whole eleven should spend year after year in a state of misery to themselves and their surroundings. But this will not be the proportion in the hands of extended experience. I have now a larger experience of this operation than any yet published by any other operator, and I know that every failure points out the road for future success, and will ultimately yield me a mortality as low as that of any other operation in my province. The only death in my present series would, I think now, have been obviated by the use of a drainage-tube. Of the ten cases in the present list which recovered, I have to report complete arrest of the hæmorrhage up to the present date, and in one of them (47) a large tumour, which I estimated to weigh at least five pounds, has completely disappeared (*Lancet*, October 22, 1881) within six months of the operation.

The diseases which I have classed as hydro- and pyo-salpinx arise from a glueing of the fimbriated extremity of the tube to the ovary, and an occlusion of the uterine extremity. These alterations are due, of course, to inflammatory action, arising from gonorrhœa or exanthematic peri-oöphoritis; and the method in which it occurs is probably something like this. The ovary is in a condition of subacute or even acute inflammation when the trumpet-shaped extremity of the tube approaches it and grasps it in the ordinary method. What would have been a mere cellular adhesion, lasting only a few hours, becomes intimate and permanent by the inflammatory action. The uterine end of the tube becomes occluded probably by exfoliation of epithelium—a process common enough in ducts.

The contents of the tube may consist of simple serum, the most common variety; of pus, much less common; or of menstrual blood, of which I have seen only two examples. The patients suffer terrible pain during menstruation, and are rarely free from distress at any time. They wander about from hospital to hospital, or from doctor to doctor, seeking relief and finding none. Menorrhagia is a very frequent symptom. Drugs do no good whatever; and of the opinions concerning the nature of the disease, given by the various men consulted, we may fairly say, "Quot homines, tot sententiæ." On careful bimanual examination, it is quite possible to diagnose exactly many of these cases; and in all cases where the history of the patient indicates the presence of this condition I open the abdomen. In all of those in the present list my diagnosis has been correct: I have removed the appendages, the patients have recovered, and they doubtless will be permanently cured; so far, they are all relieved.

In one of my recent cases I operated on the patient in order that she might be married. She was a helpless cripple by reason of a pint of curdy pus in the right Fallopian tube, and about half as much in the left; and, as she was, marriage was altogether out of the question. She consulted a lady from whom I had removed both tubes and ovaries in order that she should be married, and who has been married for quite a long time now, and the result of the conference was so satisfactory that the operation was promptly accepted.

I may be asked, Why do I remove the ovaries when the tubes only are at fault? For the reason that without the tubes the ovaries are useless, and nothing will be gained by having an ovum dropped into the peritoneum every now and again; and removing the ovaries complicates the operation very little. The results of these cases, so far, are all that could be desired; and only let me say further about this class of operations, that anyone who imagines that their performance is an easy matter—no more difficult than sow-gelding—will speedily find out his mistake after he has seen one or two.

In the present list I have removed the appendages for chronic oöphoritis in two cases only. They occurred in servant-girls, who had been rendered wholly unable to make their living on account of their sufferings. Such cases will rarely be operated on in the better ranks of life; but in such a case as that sent to me by Dr. McFie Campbell of Liverpool (17), the operation affords the only prospect of relief. Dr Campbell (and others) had in this case completely exhausted the whole range of other plans of treatment, and only after that did he send me his patient as one in whom he thought the operation ought to be tried. The operation was as difficult as can well be imagined, and in my earlier practice it would have been left incomplete. The patient was not so steady as she might have been, and the result was that she got a big hæmatocele, and menstruated regularly after. This effusion ultimately suppurated, and I had to readmit her, open the abdomen, and drain the abscess (95). She is now perfectly free from pain, and, I trust, is permanently cured. The second case was very like this, but she unfortunately died from septic infection caught from a patient who had preceded her in the ward. It happened that this operation was performed with complete Listerian details, and it was one of the experiences which convinced me of the uselessness of this practice. I wish now that I had re-opened her abdomen and cleansed her out as soon as the symptoms were marked, though, as the disease was more systemic than local in its manifestation, this might have failed.

I have performed eleven operations in this series for the treatment of pelvic abscess, upon the principles which I

advocated for the first time in a paper read before the Royal Medical and Chirurgical Society on May 11, 1880. Every case which I have treated in this way has yielded, so far, brilliantly successful results, and I have no doubt that it will become the established practice.

After having opened the abdomen, I open and empty the abscess, and stitch the margins of the opening into it to the margins of the parietal opening, and then insert a drainage-tube. In a few cases I have made a circular drainage, that is, I make a counter-opening in the vagina and tie the two ends of the tube together. Two of these cases (75 and 96) have been collections of pus in the Fallopian tubes, where removal of the tubes was impossible

Of my four cases of hepatotomy, two have been already published (*Birmingham Medical Review*, October, 1881), and the others will form the subject of a special paper. The operation consists in opening the abdomen, then opening the liver, stitching the edges of the two apertures in accurate adaptation, and draining the cavity. This is a departure of surgery which is altogether novel, which we owe to the brilliant example of Dr. Marion Sims in performing cholecystotomy, and the success of which is as yet limited to Birmingham. I can now count seven cases without a death, and these are all that have been performed up to the present date.

The performance of abdominal section for intestinal obstruction is a subject which has received much attention, and many efforts have been made, as a *dernier ressort*, for the avoidance of impending death.

The usual practice has been to open the abdomen in the middle line, and search for the obstruction—a search which has been very exceptionally successful. I have only once found the obstruction in seven cases in which I have made an exploratory incision for the purpose, and then it was due to malignant adhesions in the pelvis. I have therefore given up the search, and my rule now is to open the intestine and make an artificial anus as low down in the canal as I can, and trust to nature for the rest. In the two cases in which I have carried out this practice the results have been perfectly successful. One of these instances (50) I show here to-night in the person of one of my few male patients, who was placed under my care by Mr. Hall Wright. Obstruction had existed for eighteen days, and the abdomen was distended to a size relative to the patient's body such as I never saw before, and could not have believed possible had I not seen it. After the establishment of the fistula, some gallons of liquid fæces were passed. On the twelfth day fæces passed by the rectum, and the boy rapidly recovered, the fistula having now closed completely. Here the obstruction must have been due to volvulus or to mere paralysis, which was overcome by the relief of the distension.

The second case was operated upon on October 9, and had a history which pointed to suppuration of the gall-bladder, and the probable rupture of that organ into the intestine. Such was the combined opinion of Dr. Foster and Mr. Langley Brown. The result was intestinal obstruction, and they asked me to make an exploratory incision. This I did, and opened into a cavity close to the umbilicus, from which came a large quantity of pus and liquid fæces. What that cavity was I do not know; it was either the cæcum or the gall-bladder—more probably the latter. On the third day the fæces came by the rectum, and, as the patient is rapidly recovering, we shall probably never know the exact conditions which were dealt with. A detailed account of the case will form the subject of a special publication.

Hysterotomy is one operation I would gladly get rid of, and the last time I wittingly performed it was in a case (2) from Liverpool, of malignant sarcoma, and I had resolved that it would be the last. In March last, however, Dr. Leacroft, of Feckenham, sent me a case (38) which I had seen five years before, and had diagnosed as a parovarian cyst; which he had tapped many times without discovering anything to modify this view; yet in which we were entirely mistaken. The patient had resolutely refused to have any operation performed till she was very much exhausted. When I came to operate I found the tumour unusually adherent, and the process of removal was most difficult and protracted. The tumour had no pedicle, but consisted of one huge sessile cyst arising from the pelvis. It was only when I cut across its base that its true nature—that of a huge fibro-cyst of the uterus - became apparent. The patient died on the sixth day of suppuration of the pelvis, and I regret that I did not drain the cavity. The third case occurred in a patient from Durham (78), with two large sessile cystic tumours, which I could remove only by cutting off the uterus close to the vaginal insertion, along with a large myoma. She made a perfect recovery. The fourth seemed to me to be a solid tumour of the broad ligament, but on examination it turned out that it was a uterine myoma, and that I had cut through the right uterine cornu.

It thus seems that it is quite impossible to avoid an occasional ablation of the uterus, and this proceeding is always very risky. The chief trouble is hæmorrhage, for the uterine tissue seems little inclined to yield security with ligatures. Those cases which have been successful have had both the ligature and the cautery applied to the stumps—a proceeding which I advocated for the first time a few months ago. But so had one of my fatal cases (38), where the absence of drainage seemed to me to account for the failure. Therefore I shall always in future add the precaution of a drainage-tube where I am at all in doubt as to the security

of the pedicle. Where we can use the clamp we shall get a security on this point which the ligature cannot give, but then we shall have all the risks of the extra-peritoneal treatment, and I doubt if this would be any improvement. I have had one case of Cæsarian section, in a rickety dwarf, thirty-eight inches high, with a pelvic area like the crest of the Isle of Man. She died, apparently of embolism, on the fourth day; but the child is alive and flourishing. I shall publish this case separately.

The last group of my series consists of two most remarkable cases of huge cysts altogether outside the peritoneum, in the removal of which the peritoneum was never opened, and in both of which the operation was, unfortunately, fatal. I could not obtain in either case a post-mortem examination, so that the exact nature of the cysts remains quite uncertain, though I have reason to believe they grew from the remains of the urachus. I can offer no other explanation of their relations.

The first (26) was under the care of Dr. Lamb, of Albrighton, and had been seen by Dr. Saundby and Dr. Heslop. For twelve months she had complained of pain in the abdomen, apparently depending on flatulence, and also of pain at the scapula. In October, 1880, she began to suffer from occasional vomiting, and up to the time of my seeing her in February had taken no solid food. Some swelling of the lower part of the abdomen was noticed, and was regarded as ascitic. The liver dulness was much diminished. The urine was free from albumen, and continued so.

On February 11 she was tapped by her attendants, and ten pints of fluid were removed. It was of a dark brown colour, and gave an abundant flaky yellow deposit on settling, and this was composed almost entirely of pus and disintegrating blood-corpuscles. When shown to me, I unhesitatingly expressed the opinion that it had been obtained from a cyst, and could not have been the result of peritoneal effusion. When I saw her on February 13, the abdomen was largely distended with fluid, and the signs were all those of a unilocular cyst, and therefore I thought it was a parovarian cyst in a condition of suppuration. Under the circumstances, the clear course was to attempt its removal. This was agreed to, and was at once proceeded with. I made an incision five inches in length, and exposed a cyst which was outside the peritoneum. I opened it, and emptied out at least thirty pints of the same fluid, in which floated masses of disintegrating clot. I then tore off the cyst from the transversalis fascia for about five inches on either side, and came upon a reflection of the peritoneum on to the posterior wall of the cyst. I separated onwards till I came round to the corresponding point on the opposite side. Then upwards I found the same relation almost as far as the margin of the

ribs, and down to the brim of the pelvis in front. When I got the cyst all out, the peritoneum was quite unopened, and the viscera could be felt through the posterior covering of the cyst, which really was, of course, the parietal layer of the peritoneum. The uterus and ovaries could be made out quite easily. I closed the abdominal wound, leaving in a small drainage-tube. She rallied very well, and gave us no reason for anxiety till the third day, when diarrhœa came on, and on the morning of the fourth she vomited. She sank, and died late that night.

No post-mortem examination could be obtained, so that we are entirely without exact information as to the relations of this extraordinary extra-peritoneal cyst, or as to the cause of death. I can see no other explanation than that it was a cyst of the urachus, and I fear that the cause of death was the gangrene of the denuded peritoneum. I believe it would have been better had I removed a great portion or the whole of the great peritoneal sac, which I left bereft of the source from which it derived its blood-supply.

The second case was operated upon on May 19. During my absence from home she had been sent to me, and was found in my waiting-room by my wife, in an apparently moribund condition. They were glad to get her out of the house alive and placed in lodgings. On my return I found evidence of a large tumour suppurating, and I at once proceeded to remove it. I found it extra-peritoneal, just like the other, quite rotten, and full of pus. The condition of the patient was entirely due to her obstinate refusal to have anything done for three years during which her attendant had recognised it. When she at last consented it was too late. The removal of the tumour was a matter of the utmost difficulty. She lingered till June 7—nearly three weeks—and died of exhaustion.

As far as these cases go they speak for themselves, and I do not think I need say that the series marks in many respects a distinct advance in abdominal surgery; and it is a matter of no small pride to me to have taken a part in a line of practice in which I venture to think that results have been obtained in this, the town of my adoption, which are second to none on record.

I cannot conclude without paying a tribute, well deserved, to one whose modesty will not permit that he should speak for himself. Much of my success I must attribute to the loyalty and skill of my assistant, Mr. Raffles Harmar.

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