

**The revival of ovariectomy, and its influence on modern surgery : the inaugural address of the session 1884 of the Midland Medical Society / by Sir Spencer Wells.**

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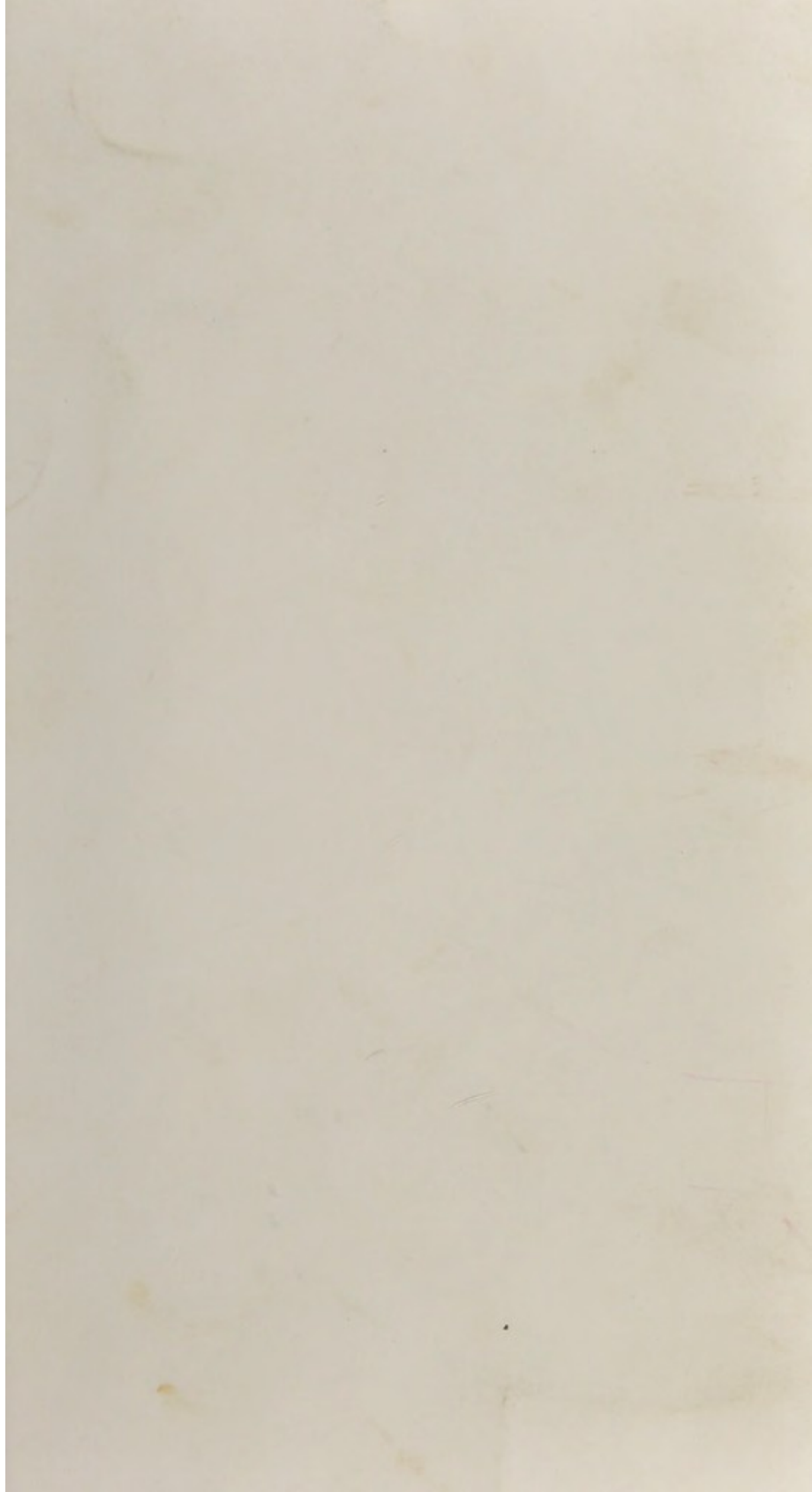
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*Catalogued*

THE

# REVIVAL OF OVARIOTOMY

AND

ITS INFLUENCE ON MODERN SURGERY

An Address

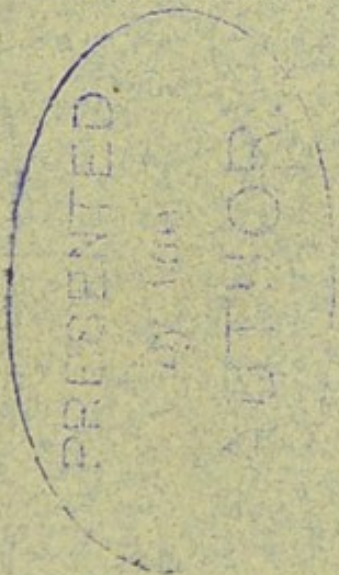
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Nov. 5, 1884

BY

SIR SPENCER WELLS, BART.

LATE PRESIDENT OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND



LONDON

J. & A. CHURCHILL

11 NEW BURLINGTON STREET

1884

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THE

REVIVAL OF OVARIOTOMY,

AND ITS INFLUENCE ON MODERN SURGERY.

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*The Inaugural Address of the Session 1884 of the  
Midland Medical Society.*

BY

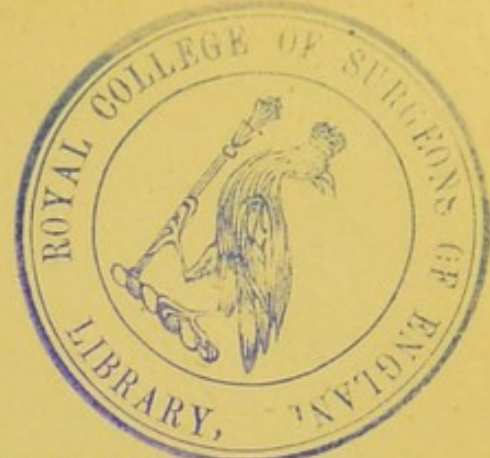
SIR SPENCER WELLS, BART.

*Late President of the Royal College of Surgeons of England.*

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MR. PRESIDENT and GENTLEMEN, MEMBERS of the MIDLAND MEDICAL SOCIETY,—

Next to the satisfaction which attends the fulfilment of the first duty of our calling—the relief of suffering and the prolongation of human life, which the Roman orator said raised the giver of health to man nearer to the Divine Giver of life—I know of no higher privilege than that of being permitted to address educated minds,—of endeavouring to influence for good, medical thought and opinion and practice—whether by the aid of the art of the printer—that ‘magic which embalms the thought’—or by addressing such an assemblage as this, with the knowledge that what may be said before you (after as much careful preparation as the too scanty leisure of a very active life permits) will be carried as far as our language is read or translated. The honourable privilege, as rare as it is enviable, of addressing a great gathering of fellow-workmen, of corresponding pursuits and tastes, from whom one may confidently expect a sympathetic hearing and active response, can hardly be over-estimated. Much or little as we may know of each other, we are all united by the strong tie of professional interest ;



by the ambition to do well our daily work; and, I hope, by the desire so to make use of the meeting as to fuse temporary contact into durable friendship. I know that I see before me an assembly of no average intellectual standard. In days gone by, in this favoured district of our fatherland, there were 'mighty men which were of old men of renown,'—the generations who have helped to make Birmingham what it is—the Areopagus of the Midlands. So to-day, the men who still kindle its enthusiasm, still direct its energies, and are the master-spirits of its industry, its patriotism, its loyalty, are aided and influenced by a residential doctorate equal to the task of keeping such a population sound in body, sound in mind, and of thus economising the vast financial interests depending on its sanitary condition. The members of this Society now take the place, as a protective educational power, which was formerly filled almost entirely by the Priest. Perhaps in many cases you do for the bodily health what is done by the Rector or the Nonconformist Teacher for the moral direction of the Parish. You are ready and willing to fulfil your high vocation, guiding your course of action as a beneficent, irrigating stream in the midst of a people whose bodily and mental welfare is entrusted to your charge.

What to say to such an audience is of course the first question. Of local affairs you know more than I do. Medical politics and controversial topics must be avoided. I have been told that you would probably be disappointed if I did not tell you something more of my own work—of what I have done and how I did it—why I did it—of my successes and my failures—how mistakes have become less frequent and progress more certain—than can be learnt from anything I have yet published. Acting on this hint, and knowing that in the minds of many of you my name is more closely associated with the practice of ovariotomy than with any other surgical question, I would first ask your attention to one phase in the history of the development of the operation—that which has been well termed the

#### 'REVIVAL OF OVARIOTOMY IN ENGLAND.'

There are not many here who can carry back their reminiscences so far as mine go. Without being formally apprenticed,

I had all the advantages of the old apprenticeship system under an unusually able and worthy man, the late Michael Thomas Sadler, of Barnsley in Yorkshire. For one year I lived with one of the parish surgeons of Leeds, attended the lectures of Hey and Teale, and saw much practice in the Leeds Infirmary. In 1837-38 I was in Dublin, under Graves and Stokes, Crampton, Beattie, Harrison, Apjohn, and Jacob. In 1839-40 I worked hard in St. Thomas's Hospital under Green, Travers, and Tyrrell. I obtained the prize for the fullest reports of examinations of the bodies of patients dying in the hospital during that period. But neither in the dead-house, nor in the wards, or out-patient room of St. Thomas's, nor in Dublin, nor in Leeds, nor during my pupilage, can I remember ever having once seen a case of ovarian disease. I never heard a lecture upon the subject. Very little was said about it in any of the text-books; and the way in which it was introduced showed that it was not thought of sufficient importance for the attention of students to be drawn to it.

I very much doubt whether it ever formed any part of the examination at either the College or the Hall. We now know that, though Morgan, Key, and Bransby Cooper at Guy's Hospital, in 1839 and 1840, and Phillips at the Marylebone Workhouse in 1840, each operated once, the matter was not in any way brought under the notice of the medical students of that time. I have no doubt that the operations at Guy's were done under the influence of Blundell, who had been professor of obstetrical medicine in that hospital. In the edition of his 'Obstetrical Medicine,' published in 1840, there is a chapter on ovarian dropsy very far in advance of the general knowledge of the day. To illustrate the routine treatment of the disease, he relates a characteristic saying of Abernethy, who, consulted on a case where tapping was useless on account of the viscid character of the contents of an ovarian cyst, said, 'It won't do to go on boring holes in the belly.' Probably Sir Astley Cooper's famous story of a case of 'dry tapping' may be explained in the same way.

But I had not seen Blundell's book, and it was not till many years afterwards that I even heard of the name of McDowell, or of any of the fourteen cases of ovariectomy done in

Great Britain between 1825 and 1839. It was not until I had myself written on the subject that I learnt what William and John Hunter had thought and suggested, or that John Bell had so lectured as to inspire McDowell with the determination to do what he afterwards did. In fact, I believe that most teachers and students of that day knew as little or cared as little about the subject as I did.

Very soon after becoming a member of the College of Surgeons in 1841, I entered the Royal Navy as Assistant Surgeon, and for some six years served in the Naval Hospital at Malta. In addition to naval practice, I saw many patients, both male and female, and did many operations, in consultation with resident practitioners in Malta. But I can only recollect one case, which I now believe might probably have been a case of ovarian tumour, but which at that time was a puzzle to us. My old friend Dr. Waters, of Chester, has lately reminded me that he and I had conversed on the subject of ovariectomy in Paris in 1848. But he spoke with knowledge acquired in Edinburgh under Hughes Bennett—I in complete ignorance. Still it is curious that we both came to the conclusion that, upon the facts as they then stood, ovariectomy was not a justifiable operation.

It was not until after settling in practice in London, which I did in 1853, that I ever saw a patient whom I knew to be suffering from ovarian disease.

In 1854 I joined the Samaritan Hospital—at that time a dispensary for the diseases of women—a subject of which I knew less than of any other special division of our profession. In my young days I had done an unusual amount of midwifery, but latterly my practice had been almost exclusively surgical, with a strong tendency towards ophthalmic surgery. I was editing the 'Medical Times and Gazette,' and so became acquainted with Baker Brown. He occasionally came to the Samaritan Hospital, which he wished to join, and I two or three times saw patients with him at St. Mary's. In April, 1854, I and my friend Nunn, of the Middlesex, assisted Baker Brown in his eighth case of ovariectomy. This was the first time I had ever seen the operation attempted; and it certainly did not encourage me to look favourably upon ovariectomy. The patient

died, and her death discouraged Brown. He, Nunn, and I talked the matter over, and I well remember Brown's saying, 'It's the peritonitis that beats us.' His first three cases died, the fourth recovered, his fifth and sixth died, the seventh recovered, and the deaths of the eighth, in 1854, and of the ninth, in 1856, led him to cease operating for more than two years and a half, and again to advocate treatment by pressure and iodine. He did not perform ovariectomy between March, 1856, and October, 1858.

When the Crimean War broke out, I left London, served with the Army in the East, and of course lost sight for a time of all the diseases of women. Any impression that I had received as to ovariectomy was certainly not favourable; but I did see cases of abdominal wounds which taught me that the peritoneum would bear much rougher handling than I had previously believed permissible. I had written about hernia, and had advocated division of the stricture without opening the sac whenever possible, simply to avoid the danger of admitting air or blood into the peritoneal cavity. But I learnt in the Crimea that a man's abdominal wall might be lacerated by fragments of shell, his intestines protruding and covered with mud, so remaining for several hours; and yet, that after careful cleansing of the cavity and accurate closure of the wounds, complete recovery was possible. When I returned to London in 1856, I was certainly much less afraid than before of abdominal wounds. I took up my work at the Samaritan Hospital again, but saw very few cases at first of ovarian disease. The first made a very painful impression upon me. Snow Beck tapped a very fine young woman, and injected iodine, he thought into the cyst; but he really injected the peritoneal cavity. He had not taken the precaution of passing a long catheter through the short canula of his trocar; the emptied cyst slipped off the canula, and several ounces of tincture of iodine passed directly into the peritoneal cavity. Beck was grievously distressed; but the case did not so much deter us from the use of iodine as awaken us to the necessary precautions as to the mode of injection. But we had very few cases of ovarian disease, and it was not till December, 1857, that I made my first attempt to perform ovariectomy. I wish I

could recollect more accurately than I do how the question of operating in this case was discussed among us—who was in favour of operating, and who opposed to it. But I cannot call to mind more than may be found in a tolerably full report of the case which was published at the time, and reprinted in 1865 in my first book, except that Baker Brown was present, and strongly dissuaded me from going on with the operation, on the ground that, as the tumour was behind the intestines, it could not be ovarian.

It is not easy to estimate correctly the part played by Baker Brown in the progress of gynæcology. In the minds of many, his really great services have been overshadowed by the errors of his later practice. Some who fully acknowledge and admire what he did to popularise the operations for the cure of ruptured perineum and vesico-vaginal fistula, and who now recognise the great success which attended his adoption afterwards of John Clay's suggestion of dividing the pedicle of an ovarian tumour by the combined action of strong compression or crushing with the actual cautery, forget, or never knew, that when Brown assisted me in the case which I have just referred to, and in another which I am about to mention, his own early experience of ovariectomy had led him rather to oppose than encourage the repetition of the operation. At my second attempt, my first case of completed ovariectomy, Brown again assisted me, and in my first and in all subsequent reports of the operation I have fully acknowledged his zealous assistance. But it was not until after I had had three successful cases that Brown himself began to operate again, after an interval of more than two years and a half. At this third case Tyler Smith was present. He was greatly surprised at the successful result, and it induced him not only to cease the opposition he had formerly offered to Brown's practice, but to operate himself, which he did with great success.

I think it would be difficult to imagine a position more disheartening than that in which I was placed when making my first trials of ovariectomy. The first attempt, as I have said, was a complete failure, and strengthened, not only in the minds of others but in my own mind, the fear that I might be entering upon a path which would lead rather to

an unenviable notoriety than to a sound professional reputation. And if I had not seen increasing numbers of poor women hopelessly suffering, almost longing for death, anxious for relief at any risk, I should probably have acquiesced in the general conviction—have been content with palliative tapping, or making some further trials of incision and drainage, or of iodine injection, or of pressure, rather than have hazarded anything more in the way of ovariectomy. It may be forgotten now, but it is true that at that time everything was against the venture. The medical press had denounced the operation, both in principle and practice, in the strongest terms. At the medical societies the speakers of the highest authority had condemned it most emphatically. The example of the men who had practised it was not followed; some of them had given it up. Only once had a successful result been obtained in any of our large metropolitan hospitals, that by Cæsar Hawkins, at St. George's, in 1846—and he never undertook it a second time. Every other attempt, at Guy's by Morgan, Key, and Bransby Cooper, at St. Thomas's by Solly, had ended in death.

This was how we stood at the end of 1857. It was in February, 1858, that I completed the operation for the first time. I need say no more about it now than that it led to my being congratulated by Dr. West upon 'complete success,' and, with other evidence, to his thorough conversion from his previous condition of conscientious and determined opposition to a state of warm support both in public and private. Let me read to you part of a letter written by my friend Keith, of Edinburgh. In the 'British Medical Journal,' in 1873, Keith wrote: 'Few watched more eagerly than I did the history of this operation, and few know so well the details of the early cases. Till 1858 I could find nothing whatever anywhere to encourage, but everything to deter one from attempting it. Ovariectomy was then as an operation simply nowhere, and had the practice of using Dr. Clay's long intra-peritoneal ligatures been continued, it would have yet been nowhere. Up till that year Mr. Brown had lost seven out of his nine patients, and had ceased operating for upwards of two years and a half. Surely there was nothing for anyone to learn from such results, except, perhaps, what there might be to avoid.' Keith was one of the

first to follow me, and did more than anyone else at that time to assist in the revival of ovariectomy. I had done eight cases when he began, and ever since we have gone on side by side, very friendly rivals, assisting each other, comparing notes, not always running on the same track, but always equally anxious to perfect the operation. You all know how wonderful his success has been. Some of his later cases of the removal of uterine tumours are unsurpassed as surgical achievements. He concludes the letter, part of which I just read, by asserting as others, both before and since, at home and abroad, have also done, and which it is my highest pride and pleasure to feel was not due only to their friendly feelings, but because it is true, that the period of progress, 'the revival of ovariectomy,' began when the results of my earlier operations were made known, and the confidence of the profession was obtained by the publication of every case, whether successful or not.

Anyone who will look over the reports of my early cases, who will see the names of the men who sent me the patients—West, Rigby, Watson, Acland, Hare, Stokes, and Oldham—of those who, as well as my colleagues, Savage, Priestley, Graily Hewitt, assisted me, or were present at the operations, among whom I may mention Paget, Fergusson, Tyler Smith, Bowman, Seymour Hayden, Pirrie, Baker, Grimsdale, Bickersteth—who discussed with me various questions which arose as to pathology and treatment, Aitken, Richardson, Ritchie, Hutchinson, Frank, Druitt, Robert Lee, Churchill, Beatty and Simpson—who, for their personal assurance, like Nélaton, Worms, Demarquay, De Mussy, Péan, Courty, came from France; or De Roubaix and Boddaert from Belgium; or from Germany, as Schuh, Billroth, Esmarch; from Italy, as Porta, Vanzetti; or from America, as Gross and Marion Sims—will find no difficulty in understanding that we had now reached a turning-point. Some of these timely allies have finished their course; some remain ripened and matured by years of experience—not yet worn out, but finding their greatest happiness in their daily work, and in friendly association with their fellows and juniors. When I can name such men as not only having witnessed and sanctioned the operation, but becoming convinced, by following up the cases, that it was at least as successful as other

serious operative proceedings, and when I add that many of these men soon began to perform the operation themselves, and publicly to advocate it—no one, I say, who considers all this will be surprised at the rapid rise and progress of ovariectomy between 1858, when it was revived, and 1864, when it was very generally accepted as a legitimate operation, and was not long afterwards cited as a triumph of modern surgery.

If I were to select from the books and pamphlets (most of which I have carefully preserved) published during these six years, any one work which contributed more than others to form professional opinion, to awaken interest, and to instruct those who had before not thought upon the subject, it would be the tables of cases most industriously collected by your own townsman, John Clay, and published as an appendix to his translation of Kiwisch's 'Clinical Lectures on Diseases of the Ovaries.' The tables are now of far more value than the lectures. One of Clay's chief merits is the example he set of obtaining all the information possible as to every recorded case of ovariectomy, completed or attempted, from the first up to 1860. He collected such a mass of facts, and arranged them for reference or study so conveniently, that he supplied us with fuller and more trustworthy information than had ever before been gathered together upon any surgical question, and I think he may be said to have done more than helped in starting what is now called the 'Collective investigation of disease.'

From these tables as arranged by Clay, and from a perusal of the works published about that time, we can now see how fully the principles and many of the practical details concerned in the matter had been discussed. What may be called the ethical or moral side of the question had been fully argued. The fears and forebodings as to the physical and physiological effects of the removal of an ovary—such as the abnormal accumulation of fat, the development of masculine type, and the restriction of the sex of infants—were dispelled and falsified. The causes of death in fatal cases had been investigated. Many of the mistakes of the earlier operators had been corrected; and, far above all other things, the profession had gained confidence in the accuracy and completeness of the facts laid before them.

The old plan of operating in a hot moist chamber, and keeping the room over-heated for days afterwards, was soon abandoned. The semi-recumbent position of the patient was exchanged with great advantage for the horizontal. Safer anæsthetics than chloroform were used. Simple bandages for keeping the patient quiet supplied the place of an objectionable crowd of assistants. Precautions, never before thought much about, were taken for protecting the patient from any infectious disease; by obliging every visitor intending to be present to declare that he had not made a post-mortem examination, nor been into a dissecting room, nor attended any case of infectious disease within a week; by the utmost attainable purification of the house, room, bedding and clothing, sponges and instruments—in fact, of everything brought near the patient—and all this was insisted on with a pertinacity which often gave offence. A great deal was gained by shortening the incision in the abdominal wall, by emptying the cyst before drawing it out, or by lessening the bulk by breaking down the septa of multilocular cysts; by extreme care in preventing the entrance of ovarian fluid into the peritoneal cavity, or by very carefully cleansing the cavity from any blood or fluid which had entered it—a process christened by Worms the ‘toilet of the peritoneum.’ Sir Benjamin Brodie long ago remarked with regard to lithotrity, that success depended upon attention to a number of minute details. So with ovariectomy. No one of the details which I have just alluded to may be alone of any great importance, but taken together they did a great deal towards preventing failure and securing success. Other modifications of more or less importance were soon made. The old vegetable material for ligatures and sutures, coarse whipcord or twine, was abandoned. After many trials of silver, iron, or platinum wire, horsehair, fish-gut, and other materials, we settled upon pure silk as the most useful and trustworthy, and proved that, after a few weeks’ retention in the animal body, it entirely disappeared. The mode or process of its removal by the insinuation of white-blood corpuscles between its fibres, a sort of untwisting or solution, was watched stage by stage, and long before the treatment of the pedicle in this manner was seriously proposed, we learnt that silk ligatures, and portions of omentum secured by them, might

safely be left within the abdominal cavity. Nathan Smith was the first to do this, but he made his ligatures from a leather glove. Tyler Smith was the first to revive the practice, using silk. A story has been very generally believed—probably some of you may have heard it—that Tyler Smith's first trial was accidental; that he cut off the ends of the ligatures inadvertently, forgot all about them, and was surprised to find that his patient recovered. But on inquiring of his former assistant, Dr. Edwards, who is still in practice in London, I am assured that there is no ground for this story. The operation was performed in June, 1861. Dr. Edwards writes: 'Previously to this operation I had strongly advocated the advisability of dropping the pedicle and cutting short the ligature, and it was at my initiation that it was done. In fact, I did it myself.'

The mode of treating the pedicle became a subject of anxious discussion. The evils which attended the use of the long ligatures were soon found to outweigh any advantage obtained by their service in drainage. The extra-peritoneal method was simplified by Hutchinson's introduction of the clamp, and for a long time it was only in cases where the clamp could not be used that any other method was sought for. I had hoped much from the *écraseur*, but only used it once. Others had spoken of crushing the pedicle and twisting off the cyst. I had an instrument made for tearing through it—a rough bluntish saw. But all these plans, without much trial, gave way before that combination of crushing and cauterizing for which surgery will be for all time indebted to your own Clay. Used at first by him for dividing omentum, both he and I suggested that this might be a good mode of dividing the pedicle in ovariectomy. Baker Brown was the first to carry out this suggestion in practice, and with immediate improvement in the results he obtained. Keith followed him, and, with occasional intermissions, has continued the practice. I also had very good results in thirty cases, and have sometimes blamed myself for not having given it a more extensive trial. I did not give it up, however, until I thought I had proved the ligature to be more trustworthy in cases of short pedicle. What is called the complete intra-peritoneal ligature—by which we mean the transfixion of the pedicle, tying it in two or more portions

cutting off the ends of the silk close to the knots, and returning them with the tied stump after cutting off the cyst—was by no means a common practice until long after the date which I of have been speaking.

The mode of closing the opening in the abdominal wall was one of the first things to attract my attention, and no one before me seems to have cared whether the peritoneum was included in the sutures or not. A very few still maintain that it is a matter of no consequence, and Kœberlé still asserts that it is better not to include it. I have not time now to trouble you with a thrice-told tale of how, by examination of patients who died after ovariectomy, and by experiments on animals, I convinced myself that by passing the sutures through the whole thickness of the abdominal wall, including the peritoneum, at such a distance from the divided edges as to permit two surfaces of the serous membrane being brought into contact when the sutures were tied, instead of merely bringing the edges together, a more permanent and complete union was obtained, and that one source of immediate danger was avoided—I mean the oozing into the abdominal cavity of blood, or serum, or fat from the divided tissues. So, too, we got rid of the inconvenience which patients who recover sometimes suffered from the adhesion of omentum or intestine to the abdominal wall.

I need not say much about the mode of dressing the wound, but I think it is of some importance to note that from the first I was very careful to keep the wound as dry as possible. I had become convinced in my naval and military practice that water dressing and other moist applications (without going into any discussions as to the cause of pyæmia) were far inferior to dry dressing. For several years I used pads containing Skinner's mixture of calcined oyster-shells and oil of tar, covered with layers of cotton-wool, and supported by the gentle pressure of a flannel bandage; and the only modification, made of late years, in these dry dressings has been the substitution of the elegant and comfortable pads devised by your townsman, Gamgee, for the antiseptic and absorbent powder of Skinner.

The chief improvement made in the after treatment was in greatly diminishing the amount of opium. Large doses had often injured the patients, and, I thought might have been the cause of death in some of the earlier cases.

By careful consideration of all the sources of danger, and by successive improvements in practical details, the mortality of ovariectomy became less excessive; and it was soon felt that the mortality after other surgical operations, both in London and provincial hospitals, as well as in private practice, was excessive, and ought to be diminished. It was some years after Southwood Smith, Edwin Chadwick, and William Farr had begun their attempt to impress the importance of a knowledge of sanitary science upon the people of England, that its influence was much felt either in hospital practice or in domestic life; and I doubt whether the attention of surgeons was ever fully awakened to the possibility of reducing the mortality of great operations before Sir James Paget, at the meeting of the British Medical Association in London, in 1862, delivered his memorable address upon the study of the large group of diseases confounded under the name of 'pyæmia.'

Two years afterwards, at Cambridge, I addressed the Association upon the same subject; and, after alluding to many sanitary measures, called attention to the bearing of the then recent researches of Davaine and Pasteur, and to the value of Polli's experiments upon the use of sulphurous acid and the alkaline and earthy sulphites in the prevention and treatment of many of the infectious and contagious causes of excessive mortality after operations. We were on the dawn of that phase of modern surgery when the so-called laws of sanitary science were tested in the laboratory by physiological chemistry and experimental pathology, and were afterwards acted on by Lister and his followers.

During this time of reaction and activity in abdominal surgery, there was a corresponding development of the literature of the subject. It appeared in all shapes, and came from all quarters. The names of men who have since become celebrated were ushered in with their first contributions. Essays and records of cases abounded in periodicals. Pamphlets fell thick upon the public, and books were published which, though more or less incomplete, showed how fast material was accumulating for the future composition of elaborate treatises.

A review of all this matter poured out by the press, both English and foreign; on the question of ovariectomy, a few

years before and after the date of 1865, enables us in a measure to gauge the extent of the interest the operation had excited, the change of opinion in reference to it, the success that had attended it, and to trace the indications which the reports contained of the spreading eagerness of the profession to seize every opportunity of giving to humanity the benefits which the practice was capable of conferring. But that which most forcibly strikes the attention in reading this literature is the contrast furnished by its tone and tendency with that which preceded and made way for the revival. Previously all that had been written was sceptical, doubting, speculative, or even prohibitory. Wavering expectation was modest in its demands, timid in its forecastings. There was more of fear than hope for the future. That future came, and with it the revival. Then, instead of the vague prophetic inspirations of the Hunters, the moving exhortations of Bell, the qualified and cautious encouragements of Blundell, the passive admissions of Astley Cooper that ovariotomy might be done—the conscientious shrinking, in an exalted reverence or the sanctity of human life, from the realisation of what seemed so desirable and within the compass of daring power—the pathetic wailings over sufferings unrelieved and deaths unresisted, and the despondency of professional inaction—we had reports of accomplishment which proved, by the wideness of their sources, their numerical importance, and the character of their authors, that the revival was assured. The question now changed from one of possibility to one of improvement, and reports of cases merged into discussions of practical details of operative and therapeutical interest. These, from their precautionary or conservative bearing, gave good augury of the vast ameliorations which we have seen within the last twenty years, and have brought us at the present time to a degree of success that in the very nature of things leaves but little room for further hope. One may truly affirm that in all these outpourings of the revival period there was nothing vainglorious, boasting, presumptuous. As contributions to science they were serious, candid, plain, aiding further progress, informing to the profession, and useful to mankind. They bore upon them the signs of a wise resolution to

advance circumspectly upon the path now open; and if tinged with a glow of the personal satisfaction which flows from a sense of duty in part fulfilled, and brightened with a gleam of the complacency reflected from the visible evidence, now so constantly before the public in the living, healthy survivors of the operation, that the profession as a corporate fraternity was equalling in its philanthropic energy that which had made the reputation and had been the pride and solace of its older 'men of renown'—we can only say, not that it was excusable or admissible, but that this gratulation was no more than the circumstances prompted, or than may justly be felt by all who join in working, with a right mind and to a good issue, for the welfare of their fellow-creatures.

And here with 1865 I may end this retrospect of the revival of ovariectomy—of a rapid revolution in opinion and practice in less than ten years. Before 1858, the operation, like all good things, had been of slow growth. One hundred years ago, it was but a germ that might be described in a lecture by John Hunter. Ten years later it was seed that fell from the hand of Bell. In little more than another decade it germinated as a living vitalizing reality in Kentucky. Sixty years ago it was transplanted to the land of its philosophical conception. In twenty years more we find it a sapling on English soil—growing slowly at first, and up to 1858 looking as if it might prove no more than a withering gourd. But by 1865 its root had struck firm, its stem stood erect, its branches were wide and strong, known and sought as a refuge by the sick and dying. That it was no withering gourd has been proved by all that the world has since seen. Thousands of perishing women have been rescued from death; many more thousands of years of human life, health, enjoyment and usefulness have been given to the race; and to all future victims of a malady before inevitable in its fatality, it gives consolation, hope, and almost certainty of cure.

And passing over another twenty years—advancing from 1865 to 1884—we can rejoice that in all our metropolitan and most of our provincial hospitals, and from the best teachers on both sides of the Atlantic, medical students of to-day may hear of the good already done—may see for themselves how success is attained, and possibly, by the establishment of some

new fact, or the discovery of some new device, they may increase our power over disease, and carry on the work to our successors.

I must leave it to others to speak of our great hospitals and important schools. But I cannot close this part of my address without one word of hearty congratulation to my successors at the small hospital where, with seldom more than six or eight beds at my disposal, in twenty years I completed 408 cases of ovariotomy, the deaths having diminished in successive periods of 5 years from 1 in 3 to 1 in 4 or 5, and in the last two years to 1 in 10. In six years, 1878-83, my three successors among them had 496 cases—some 90 more than I did alone in 20 years—the deaths falling from 1 in 5 in 1878 to 1 in 18 in 1883. And the recent publication of my colleague Doran adds to the satisfaction I feel in seeing my operative work so efficiently continued the pleasure of noting how happily he is supplementing the opening of his career as an operator by the intellectually higher distinction of being acknowledged as a penetrating investigator and clear expositor of the obscure subject of ovarian pathology, to which he is devoting his philosophical earnestness. On this centenary of Hunter's Lecture we may truly claim that his example is followed, his foresight verified, and our exertions rewarded.

## II.

In asking you to consider the influence which the revival of ovariotomy has had upon modern surgery, I think we may not only assume the revival as complete by the year 1865, but that, in the words of Paget, 'the influence for good was not limited by the increased success of ovariotomy, but extended to every department of operative surgery, and will always continue to be felt in the whole practice of surgery.' And the rapidity with which the success of ovariotomy led, again using Paget's words, to 'an extension of the whole domain of peritoneal surgery,' is not less remarkable than the rapidity with

which ovariectomy had advanced in professional opinion between 1858 and 1865. The first extension naturally enough was to the

#### REMOVAL OF UTERINE TUMOURS.

At first, this was only done after a mistaken diagnosis. But before many years had passed it was done designedly, at first only in cases of pedunculated sub-peritoneal out-growths; but latterly, under conditions most unfavourable, success has been obtained in a proportion of cases very surprising even to those who in their long experience have many times been astonished at their own success. Nothing in the whole history of surgery can be at the same time so gratifying and so astounding as the records of Keith's later cases of the removal of uterine tumours, collected and published by his son. Taken alone, they would almost justify a general law to the effect that no woman should be allowed to die of any innocent uterine growth without attempt to save her life by operation being made. When the earlier cases of Kœberlé were criticised in the French Academy by Boinet, Richet cautioned the audience against summary condemnation of an operation not dreaded more than ovariectomy was not long before. The question since that day has been decided by experience, and if a word of caution is now needed, it is only to warn surgeons of the future that they cannot hope for success unless they prepare themselves for operation upon the living body, by taking every available opportunity of practising upon the dead body, and by a conscientious determination to study rather the true welfare of the patient than, on the one hand, how to avoid responsibility, or on the other hand, how to advance their own renown.

It is fortunate that in some of these cases of uterine tumour an alternative proposal ought to be considered. Both ovaries may be removed with the knowledge that this proceeding has been followed by atrophy of the uterine growth. This, on the part of Hegar, was the legitimate application of a principle, and the practice has often proved successful. In cases where removal of the tumour would have been impossible or exceedingly dangerous, removal of the ovaries and Fallopian tubes has led—with far less risk—to cessation of bleeding and more or less

diminution of the morbid growth. But we must have further experience before we can arrive at a fair estimate of the relative value of the two courses of action. We have learned, however, that if the ovaries are not completely cleared away—if, having been adherent, they have been twisted or scraped away from their connections, and some small portions left—menstruation may afterwards recur quite regularly, even though both Fallopian tubes have been totally removed. I have more than once warned the profession against the capricious extirpation of the ovaries, because they are supposed to be the source of all womanly ills, and I repeat my caution, seeing to what wide-spreading evils its neglect may lead. I think it a charity to lay a checking hand on an erring judgment before it has gone too far—and I would fain save our profession from the public odium which must sooner or later be the penalty suffered by all, if a few indiscreet members of our body act without general sanction, or disregard general disapproval.

I have not time to enter upon the very important question of the excision of the entire uterus, either by the vagina or by abdominal section, nor of that substitute for the Cæsarean section known as Porro's operation, nor on the operative treatment of extra-uterine foetation; and can only say a very few words about the next kind of abdominal tumour, the removal of which followed the ovarian and uterine—

#### THE ENLARGED SPLEEN.

I did not meet with a case which I thought justified the operation until 1865, although I had long before that been determined to do it in any suitable case. My second case was performed in this town, and I have only met with one since. I need not tell you that the example has been frequently followed by other surgeons, and there is every reason to hope that increased experience may be followed by diminished mortality.

And so with

#### RENAL AND PERI-RENAL TUMOURS.

Nephrotomy, nephrolithotomy, pyelo-lithotomy, and nephrectomy, terms hardly entering into surgical literature twenty years

ago, define operations which are now performed in increasing numbers, and, especially to the physiologist, with a wonderful success. My colleague, Knowsley Thornton, can boast of ten nephrectomies, all by abdominal section, as well as four nephrotomies, and three nephro-lithotomies—the whole seventeen cases successful. These cases, and seven successful cases of pyelolithotomy out of eight, as lately recorded by Anderson, can only be the effect of rigidly abiding by the observance of what we now know to be the rule and criterion of good work. So also with a variety of solid and semi-solid abdominal tumours, originating in the pelvic cellular tissue, or in the peri-renal fat, or in the mesentery, the appendices epiploicæ, the omentum, or the abdominal wall, extirpation is effected with a loss of life so small as would have been almost incredible a few years ago.

Already in several cases tumours formed by peritoneal hydatids have been successfully removed. I have not time to do more than barely allude to opening of the gall-bladder and the removal of gall-stones, the opening and draining of hepatic abscesses, of hydatid cysts of the liver, of pelvic abscesses, and of hæmatocele, to removal of the pylorus, gastrostomy, and opening the stomach and removing a large mass of hair. In one remarkable case Mr. Thornton removed a mass of hair weighing two pounds, which was moulded into the shape of the stomach. The incision across the greater curvature was five inches long. Fifteen deep sutures, through peritoneum, muscular coat, and edge of mucous membrane, and fifteen superficial, or through peritoneum only, and a very fine continuous suture over all, united the opening in the coats of the stomach. The abdomen was closed, and the patient is perfectly well. Ten years ago such an account would hardly have been believed. With the exception of this and one successful case by Schönborn, in all other reported cases such masses of hair in the human stomach have only been found after death. But no one who has watched the progress of these operations, has considered the causes of death in fatal cases, and the details of the operative proceedings in successful cases, can come to any other conclusion than that one important element in the attainment of success is the scrupulous observance of the principles laid down as necessary to success in

ovariotomy—not only as regards the hygienic precautions never omitted in modern surgery, but especially as to the importance of a very accurate and exact union, not only of the edges, but of the surfaces of the peritoneal surface of the viscera and of the abdominal wall. In gastrostomy, for instance, it is found that when the stomach is attached to the abdominal wall by a single ring of sutures, the weak attachment may give way, and risk of extravasation into the peritoneal cavity may be great. But when, after dividing the abdominal wall, the parietal peritoneum is sewn to the skin all round the opening, a broad surface of visceral and parietal peritoneum may afterwards be maintained in contact by a circle of sutures, forming loops, passed through the peritoneal coat of the protruding portion of stomach, and through the whole thickness of the abdominal wall, about half an inch from the edge of the incision. Smaller fine sutures being inserted between the larger ones, a very close and secure attachment of the stomach to the peritoneal lined opening in the abdominal wall, and complete occlusion of the peritoneal cavity are guaranteed. This done, we have an example of the carrying out in its integrity of one of the fundamental rules of practice in the operation of ovariotomy as regards the peritoneum—surface to surface, not edge to edge merely—and it is a fact not to be overlooked that in gastrostomy the result of the operation seems to depend upon it; the rule being that the cases in which it has been neglected fail, while those in which it is observed end satisfactorily. Thus the lessons learnt at an early stage of our experience in one operation have been the means of leading directly to the successful performance of the other.

This tracking of Paget's extension of the 'domain of peritoneal surgery' has carried us a long way, and perhaps those who have entered upon their career at a late stage of the successive annexations may find it not easy to understand the fascination which the subject has for their precursors, who remember its dawning, who were pioneers in realizing possibility, and who now live and are still pressing forward to the ever-receding horizon before us. Far as we have come on the way, and much as we have done, there is more to do and more to gain. If formerly we plumed ourselves at our triumphs over the peri-

toneum—or rather, as it really was, over our fears of the peritoneum—upon our ovarian, uterine, renal, and splenic victories, and put up trophies of all those organs in our museums, we now see our way to new conquests. In proof of this, it is a satisfaction to refer to a series of cases and papers in some of the very latest English and foreign medical journals, showing how much more frequently than heretofore obstruction of the intestines is now successfully treated by operation, and that excision of the pylorus, and of parts of the intestines, is already a subject of careful experiment. This is directly traceable to ovariectomy, for one of the very earliest cases was my own union of the upper and lower ends after removing about three inches of small intestine invaded by cancer from an ovarian tumour. In Treves's paper on Excision of Intestine, you will see how firmly an operator of to-day is taking his stand on the true principles of abdominal surgery which we have watched emerging from their obscurity. He does not ignore the teachings from experiments upon animals. He supports himself by the nine successful resections of lengths of the intestines of animals made by Madelung. He traces the failures in many operations of the same kind on the human subject to faults in the details, such as want of perfect adaptation and insufficiency of sutures. And he lays down as rules for his own action that he must separate the peritoneum from the other tissues—introduce abundance of sutures after Lembert's method—bringing the two serous surfaces together, and avoiding the mucous membrane with the needle. A recent paper by Reichel informs us that already 121 cases of resection of intestine have been collected, the conclusion being that the two ends of the bowel should *not* be united at the time of the resection, but that an artificial anus should be established. This can be closed by a subsequent operation. You will probably soon see a report of a case not yet published, where Mr. Jessop, of Leeds, cured a fæcal fistula by separating the injured intestine from the abdominal wall, and uniting the upper and lower parts of the gut by suture. What I said with regard to practise on the dead body before operating on living women afflicted by uterine tumours is equally applicable to the resection of intestine. But here practice on the dead is not

sufficient, and if we are not allowed to experiment on living animals in this country, we must either go abroad or practise on men and women. At my request a young surgeon, Mr. Jennings, from whom I hope and expect great things in the future, has recently cut away portions of the intestines of dogs, uniting the upper and lower parts so as to maintain the continuity of the canal. Some of the preparations may be seen in our College Museum, and they strongly confirm the conclusion that success depends upon complete union of the apposed serous surfaces.

If I were reviewing modern surgery in general, and not limiting myself to the influence upon it of the revival of ovariectomy, I should speak hopefully of pulmonary surgery, of the draining of cavities in the lung, of incising gangrenous lung, of resection of portions of ribs to obtain contraction and closure of the pleural cavity, and of excision of parts of the lungs, or of an entire lung—even of the surgical treatment of purulent pericarditis. But these are subjects to which I can barely allude as proofs that we do not yet know how far we may go with rational surgery, or what may be in store hereafter for surgical enterprise.

But while we modern surgeons congratulate our science on its liberation from the trammels of tradition; upon its working in an atmosphere cleared of the mist of superstition; upon the changing of its mode of action from a blind grappling with the phantom entities of disease to a study and manipulation of over-nourished or degenerating tissues; upon its having laws which can be understood, and rules of practice which can be followed, we ought not to overlook one fact, which perhaps is more evident to outsiders than to ourselves, standing as we do in the dust and turmoil of the arena of our work. I mean that that work, good and useful as it is, has too much the character of what is technically called “salvaging”—is too much in correlation with what is done by the lifeboat service. Is it there that we ought to stop? I know that we are gradually drawing on beyond that point, and that our investigations are turning in the direction of sources, causes, means of prevention, and outlets for avoidance. But before we can reach the same level of achievement in preventive medicine that we have arrived at

in operative-surgery—before we can arrest the formation of ovarian cysts instead of excising them—we must know and understand what we have to deal with. We must master the problems presented to us by the erratic developments and mortal decadences of the tissues and organs which we are now content to clear away. And we ought to have the means of accomplishing this task on a scale commensurate with the importance of the subject of pathology—the professional desire for original research—and the dignity of the college of which we are members.

Most of the University cities on the Continent have made provision for this necessity, with a liberality and such a profusion of accommodation that the prosecutors of these studies are there at a great advantage. I have visited some of these establishments, and have been able to make comparisons which cause me to regret that so little of the like kind has been done here, and that we have been content to leave a matter which really touches the honour of the profession, and is of national concern, to almost unaided personal zeal and efforts. In England the jesting phrase that ‘science does not pay’ is so common that we scarcely feel the reproach. The history of medical science gives us many instances of unfairly remunerated men (W. Farr, for example), and of the appropriation of the profits of their applied work, and it would be well if the authorities of our profession took the lead in forming an organisation which should aid the modest labourers of its foundations, protect their interests, and reward their industry. I have long desired to see this done by our college, and the munificent bequest of Erasmus Wilson, a man who estimated the value of money by the good that it could be made to do, now puts it in the power of the College of Surgeons to out-rival all other corporations, by setting up round the nucleus which Hunter left the most elaborate combination of all the means and appliances for physiological and pathological research, by concentrating the intellectual power which now runs to waste or is diverted to personal interests, and by guiding and directing all that can be done to the advancement of the purely scientific progress of medicine and science.

Last winter I was away from London for about six weeks.

While staying at Würtzburg and Munich, I could note in the most recently erected pathological laboratories how far our German brethren are in advance of anything which I, at least, have seen in this country. At Rome again, and at Naples, I was both pleased and surprised to find how much our Italian brethren were doing. And during the meeting of the Medical Congress at Copenhagen, I was shown arrangements for the study and cultivation of micro-organisms, quite as complete as those which many of you may have inspected at the temporary rooms of the Health Exhibition in London, under the able and instructive guidance of Mr. Watson Cheyne. Now one may fairly ask why provision cannot be made to insure the continuance of this work, and its extension, in a better and permanent abode?

Something of the kind I hope to see in Lincoln's Inn Fields. I concur completely in the project to make such additions to our noble building as our Council have long felt to be an absolute necessity, and for which they have already considered plans prepared by the eminent architect, Mr. Waterhouse. These constructions are intended to furnish better and more convenient arrangements for the examinations for our diplomas, to guarantee the uninterrupted use of the library, and to give us further facilities for the promulgation of the higher truths of surgical science. Unquestionably this will be in some degree a credit to our college and to British surgery. But I hope I shall not be misunderstood. I have no wish whatever to add to the duties of our college as a teaching institution. We are an examining body, acting for the protection of the public by testing the success of the teaching in the schools and hospitals, and vouching for the competence of our candidates for their calling, after proving to us that they have gone through the course of study we prescribe and possess the average skill and knowledge necessary to meet all the usual demands of practice. Perhaps, hereafter, we may take the higher position of sitting simply as a court of judgment upon the qualifications of those who present themselves for our diploma, irrespective of the mode and time and place in which their knowledge has been acquired—putting aside all interference with the routine, and details of the course of study.

But I aspire to something more than success in securing the requisite skill in practical surgery in those who disperse themselves among the people as practitioners under our warrant and authority. I trust that we may go further ; and, no longer trammelled by State interference and sensational clamour, that we may accomplish that which such men as are on our Council would probably have done long ago, had it not been for the restrictions placed upon them by financial considerations. Now the funds at their command give ample means for the carrying out of any schemes which the most enthusiastic devotee of original research could, in his most sanguine dreams, imagine. My ambition is that we should not merely be the source of honour to students, and the directors and approvers of schools and teachers, but that we should become the centre of medical research, the mainspring of all the developments of medical science. And now that we can do it, why should we not do it? Why should we not have buildings and accessories, imposing in their grandeur and adequate in their accommodation, laboratories, complete in their fittings, instruments and materials, rooms for conferences, and proper places for the storing of records and results? Why should not our fellows and members who are moved with the desire to advance medicine and surgery, by inquiry and experiment, be presented with as great facilities as are to be found in any continental city or university—such as are so profitably enjoyed by Pasteur, Ranvier, Brown Sequard, and their colleagues and assistants—advantages hitherto unapproached on this side of the channel, but which our transatlantic brethren are not slow to emulate? I feel that to support the honour of our profession, to fulfil our duties as the representatives of surgical science, justly to carry out the intentions of our late president and benefactor, we ought to be magnificent in architectural and constructive outlay, active in personal work, and liberal in the encouragement and help we proffer to those who come to make use of the opportunities which our College will give, and promote the object for which we are all so deeply concerned and so heavily responsible.

I am encouraged to augur the completion of such a scheme as this for rendering original investigation in the future

infinitely more easy, precise, and valuable than the surgeons of the past ever hoped for, and to believe in the accomplishment of its designs, when I think that the will of such meetings as this must be obeyed, and feel the conviction that the men of Birmingham will be among the first to avail themselves of it.

I have spoken to you of the past and the present. The future is in your hands; and I appeal to you as men typical of the thought and action of the profession, actuated by the highest moral sentiments, seeking and mutually guarding your honour as a body—chasing out, with instinctive repugnance, that which, ignominious in principle or practice, has accidentally intruded itself among you, and conscious that—by assuming the highest functions of your calling, in the investigation of national interests, in the promotion of public good by giving counsel to princes and legislators, by such a devotion of your energies, by such a sacrifice of personal consideration as is involved in bettering the condition of the people, in shielding them from disease, and in the prolongation of their healthy lives—you will add lustre and dignity to the private confidence, gratitude, and sympathy which the profession has already gained by its power over actual suffering and sickness, and by the skill, conscientious vigilance, and humane tenderness with which you make that power manifest.

‘I SPEAK AS UNTO WISE MEN, JUDGE YE WHAT I SAY.’

Wishing not to exceed an hour in the delivery of the Address, several paragraphs were omitted, which I now add as an Appendix in the form of Notes:

TEXT BOOKS BEFORE 1880—*Note to page 3.*—It cannot be said that the disease was described: it was spoken of as incurable. Remedies were useless. Tapping was to be done sometimes to give relief. When allusion was made to ovariectomy, it was with a few historical references; and when admitted to be possible, it was put aside as improper or too dangerous to call for further notice. Sir Astley Cooper's Lectures (by Tyrrell, 1825) were looked upon as the leading book of reference. They contained a few remarks on what can and what cannot be done to lessen the misery of sufferers from ovarian dropsy; and after speaking of tapping, injections, and spontaneous cure, Sir Astley finishes by saying: 'The removal of an ovarian cyst from the abdomen might be performed in the early stages of the disease by making an opening into it, discharging its contents, and by drawing out the membranous bag from its natural adhesions.' But this was an operation which he never recommended or attempted to do.

Manuals and text-books were not so numerous then as they are at present, when one may count between thirty and forty constantly recommended to students, without including those even more numerous on special departments. Samuel Cooper's 'First Lines' and his Dictionary were mostly used. The 'First Lines' were especially popular, and in the seventh edition, 1840, there is no mention whatever of ovarian disease in the Section on diseases of organs; and seven-and-a-half lines in the paragraph on Paracentesis comprise all he had to say about 'ovarial cysts'; and that is simply, that there are two points of the abdomen at which it may be done and that he has done it many times in both ways.

In the sixth edition of the Dictionary, with the date 1830, there is no article on the ovary or ovarian disease. But after speaking of Dr. N. Smith's case of ovariectomy, which Cooper had mixed up with the subject of paracentesis, his comment is: 'These few particulars show that, though the operation may be practicable, and even end well, it is liable to great difficulties in its execution, and dangerous and fatal consequences in its result.' Then follows an allusion to Lizars, and he contents himself with the remark that some other cases and observations in favour of the practice of extirpation of diseased ovaries have been brought forward.

An article on the ovaries and ovarian cysts, chiefly made up from Cruveilhier, Barlow, and Delpech, appears for the first time in the seventh edition, 1838. That on paracentesis, in which mention is made of ovariectomy, was extended. Cooper says that 'there are some other cases in which the object was successfully accomplished,' and offers a brief history of what has been done, that it may assist others in forming an opinion of the relative chances of success in future cases. But there is no summary of arguments, and, though no direct condemnation, not one word showing that he thought the subject within the range of practical surgery.

The subject was omitted altogether in Liston's 'Practical Surgery,' 1838.

Such was the amount of information on the subject of ovariectomy thought sufficient for students of my date.

Druitt's 'Vade Mecum,' of 1843, contains a page and a half on ovariectomy, giving a short account of the two kinds of operation, by the long and the short incision, with reference in illustration to the cases of Jeaffreson, Lizars, Clay and Walne. He enumerates the objections to the operation, making the greatest to be that 'out of the number performed about one half have proved fatal.'

In Hebra's historical account of the important operations of surgery, written expressly for the students at Vienna (where the examinations included historical details), the word 'ovariectomy' does not occur.

Even ten years later, in the first edition of Erichsen's 'Science and Art of Surgery,' so late as 1853, there is only a very short

notice of ovariectomy, on the last page of the book, as if it came as an afterthought. He says that it has of late been performed frequently with success, and attributes its introduction to F. Bird and Clay. He gives it as his opinion that the objections 'are not of a magnitude to interfere with the performance of the operation, *if other circumstances justify it.*'

BLUNDELL'S WORK—*Note to page 3.*—In the 'Physiological Researches,' published in 1824, Blundell boldly advocated ovariectomy. He maintained that abdominal surgery admitted of greater improvement than any other branch of the science. He satisfied himself, by his long course of observations and experiments, that the peritoneum was more tolerant of injuries than was generally supposed, and that the pelvic viscera could be removed in whole or in part without necessarily fatal results, and he urged these conclusions in reference to 'cases otherwise desperate' of diseases of the womb and ovaries. Fifty years before Battey, he expressed his opinion that the extirpation of the ovaries would probably be found an effectual remedy in the worst cases of dysmenorrhœa. As to ovarian dropsy, he said that ovariectomy will 'ultimately come into general use.' In 1825 he brought the woman successfully operated on by Lizars up to London, that she might be seen. In 1843 he encouraged and assisted Walne in his three successful cases of ovariectomy, and wrote to Clay of Manchester, after his first case, urging him to go on.

INFLUENCE OF CLAY OF MANCHESTER AND OF BIRD—*Note to page 7.*—Before I say more about the first time I succeeded in completing ovariectomy, I ought to say a few words about the bearing which the example of Clay of Manchester had upon the professional feeling of that day. When, in 1865, I published my first work, I used the following words in the Introduction: 'Dr. Clay had steadily continued in the career which he began in 1842, but his operations not being performed in an hospital, before numerous professional witnesses, and no connected series of his cases being published, his example had but little influence.' This sentence led to some controversy. Dr. Clay thought that I had underrated the effect of his work, but after

mature reflection my opinion remains unaltered. His first book called forth a review in the 'Quarterly,' then edited by Sir John Forbes, a review which it is now well known was written by West—written with unusual power and under a feeling of honest indignation, and which must have turned professional opinion much more against than in favour of the operation, so much so as nearly to counterbalance the good effect of the successes of the earlier operators, Jeaffreson, King, West, Burd, Elkington, and other provincial surgeons. So that if I now modify what I said twenty years ago about Charles Clay, it would be to the effect that, although his steady continuance of the practice no doubt had some good result in preventing the subject from falling into complete oblivion, yet that, so far as the practice of the operation by others was concerned, it was rather adverse than encouraging. I think as much might be said as to the effect of the work of the only man who had operated frequently in London—Frederick Bird. His paper, criticised as it was by Cæsar Hawkins, undoubtedly confirmed the suspicion that in many unpublished cases errors of diagnosis had been committed, that many operations were begun which could not be completed, and that operators had made known their successes, but had given no information as to their fatal cases.

LITERATURE OF THE REVIVAL PERIOD—*Note to page 13.*—My own contributions began in 1859. Gustav Simon issued his report on ovariectomy the same year. Worms, and John Clay followed in 1860. Nélaton came over to London in 1862, and, on his return to Paris, gave proof how entirely his opinions had been changed, by open advocacy, and by doing four operations himself; losing two patients, however, as it would seem by his Clinical Lectures, through an impression still lingering in his mind that ovariectomy was a resource only for those women whose lives were immediately threatened, and that the risk was too great to justify the operation in the earlier stages of the disease. The writings of Ollier, Desgranges, and Devaux show how much interest had by that time been awakened both in France and Belgium. Keith began his reports from Scotland, and Breslau from Switzerland the same year. In 1863 Courty took up the subject in his interesting letters, giving a narrative of his 'Excursion

Chirurgicale' in England. Peaslee and Fehr joined the ranks of contributors in 1864; and the reports from the Medical Society of Victoria gave us the information that Tracy had for the first time, with good results, introduced the operation of ovariectomy among our Antipodes. George Buchanan did the first successful ovariectomy in Glasgow in 1864, after seeing me do it twice in London. His success has since been great, and so has that of Grimsdale of Liverpool, and of other provincial surgeons, both in hospital and private practice. My first volume came out in 1865. Peaslee read his two papers before the New York Academy of Medicine, and Elliot boldly came forward with a good example of recording fatal cases. 1866 renewed our acquaintance with Stilling, and brought into notice from Germany the names of Spiegelberg and Martin, of Krassovsky and Maslovsky from Russia, and of Negroni and Fumagalli from Italy. Thenceforward there has been no cessation in the appearance of new operators and new writers on the subject.

RESECTION OF INTESTINE—*Note to page 21.*—Mr. Makins has had a successful case of artificial anus treated in St. Thomas's Hospital this year by resection of more than three inches of small intestine, and suture of the upper and lower ends. His paper in the 13th volume of St. Thomas's Hospital Reports is a valuable contribution to modern surgery.





