Fifty additional cases of complete ovariotomy ... / by J. Knowsley Thornton.

5.

FIFTY ADDITIONAL CASES

OF COMPLETE

OVARIOTOMY

WITH

BRIEF NOTES OF SIX OTHER CASES OF ABDOMINAL SECTION

Reprinted from Brit. Med. Journal, Oct. 19, 1878.

ALSO

REMOVAL OF HYDATIDS OF THE OMENTUM

AND FROM

THE PELVIS DURING SEVENTH MONTH OF PREGNANCY

RECOVERY

Reprinted from Medical Times and Gazette, Nov. 16, 1878.

BY

J. KNOWSLEY THORNTON, M.B., C.M.

SURGEON TO THE SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.

LONDON

H. K. LEWIS, 136 GOWER STREET, W.C.

1879

OVARIOTOMY.

In May 1877, I brought before the Royal Medical and Chirurgical Society a table of twenty-five cases of complete ovariotomy. The Council did me the honour to publish that table, together with a paper which accompanied it, in the *Transactions* (vol. lx). The table, which I now place before the profession, contains particulars of fifty more complete ovariotomies, and the two together contain all my cases up to May 1878. With the present table, I have given a brief analysis, and also some particulars of six other cases, which, together with two cases of hysterotomy already published (*Medical Times and Gazette*, April 7th, 1877, January 5th, 1878), complete my practice in abdominal surgery during the period which the accompanying table covers.

Of my first twenty-five cases, I lost seven, a mortality of 28 per cent. Of the fifty cases I now publish, I have lost four, a mortality of 8 per cent. This very satisfactory lessening of the mortality, I attribute, partly to increased experience, both in dealing with the complications met with at the time of operation and in the after-treatment of the patients, and partly to the method of drainage perfected by Dr. Thomas Keith, and employed in many of my cases until I commenced antiseptic ovariotomy in October 1877. The performance of the operation, strictly on the Listerian method, I commenced with Case 39 in the table; and very much of the decrease in my mortality must, without doubt, be ascribed to its use: thirty-seven cases, with only two deaths. I

do not intend at present to enter into a discussion on the details of the antiseptic method in ovariotomy. It would be manifestly unfair to attribute the whole improvement in my results to its use, to the exclusion of the other factors already named; and I do not think we are yet in a position to fairly and thoroughly compare the results obtained on the old plan with those which we now obtain. I think, however, we have seen quite enough of the results of antiseptic ovariotomy to make us persevere; and I, for one, am sanguine that, when we have had more experience in this method, we shall be able to reduce the mortality to something less even than 8 per cent.

I have already published full details of three of the fatal cases in a paper read before the Harveian Society, and afterwards published in the *Medical Times and Gazette* for June 1878. No. 72 needs a few remarks, as it appears as a case of septicæmia among the operations performed antiseptically. I am very sorry to have to record a case of septicæmia, because it shows me that my arrangements for shutting out sepsis are not yet perfect. I am, however, quite certain that they may be made so, and I am not going to credit, or rather discredit, the system with a failure, as is too much the fashion. The case was in all respects a very unfavourable one: a large fat unhealthy woman, with an enormous tumour unusually firmly adherent to the abdominal parietes. I only used one spray-producer, and I felt while performing the operation, that the parts could not be properly and constantly covered by the spray-cloud. The adhesions were such as frequently ooze after the abdomen is closed, the patient an exceedingly likely one to get septicæmia, and I should have been much wiser, had I abandoned antiseptics and put in a tube,

though drainage would have been very difficult to carry out perfectly, from the thickness of the abdominal wall; and, however well carried out, it will not always save us from septicæmia. The lesson to be learnt from the case, is to take extra antiseptic precautions, and use another spray-producer when dealing with a tumour of unusual size.

Of the fifty cases, forty-five were performed in the Samaritan Hospital, and among these the four deaths occurred. Four were operated upon in private houses, and all recovered; one at a nursing-home also recovered.

The first death really belongs to the mortality after tapping; the patient had been tapped in one of the large hospitals, and violent inflammation and suppuration of the cyst had followed, causing such adhesions that the case was hopeless.

The second I have already published, as due to imperfect knowledge of the dangers to be avoided in using the ligature for the pedicle.

The third I have also published. Death was due to a very acute pleurisy, which must have been latent and overlooked before the operation.

Thus, one death is due to tapping, and the other three to preventable causes. Surely, these facts tell us how great is the future of ovariotomy, and how much we have still to do to make it perfect.

So far as my experience goes, neither age, condition, nor the season at which the operation is performed, affects the result. The life-history of the patient and the life-history of the tumour, and the sum of their results in the present health of the patient and connections of the tumour, are the only factors we have seriously to consider before advising an operation. I believe this is more than ever true, now that we have antiseptics to aid us.

A glance at my table will show that my incision rarely exceeds five inches, and I much prefer to extract the tumour through an opening three inches long, if possible. With the short incision, there is less exposure of intestines and peritoneum generally —a matter of some importance now that we use the spray—and the wound when healed, is much smaller and firmer, and the patients are far less likely to suffer from the life-long misery of ventral hernia.

In every case in this table, ligatures—cut short and returned—have been used for the pedicle; and I have nothing to add to what I have already published on the subject (*British Medical Journal*, January 26th, 1878), except to say, that I am more and more convinced of the advantage of using fine silk, and of tying in several pieces and not too tightly.

In twelve of the cases, both ovaries were removed. It is often a difficult matter to decide whether to remove the second ovary, when it is found very slightly enlarged, and I think we must be guided somewhat by the age and condition of the patient: we may sometimes leave an ovary about which we are a little doubtful, if the patient be a young girl, when we should unhesitatingly remove it, if she were already past the age of sexual vigour.

In thirteen cases, there were no adhesions, and two of these had burst cysts, the rupture evidently not recent in one of them, which proves that this accident is not necessarily attended by adhesions or other complications.

In fourteen cases, the adhesions were parietal and omental only, or of such a nature as to add but little to the risk.

In all the remaining twenty-three cases, the adhesions were such as may influence the result un-

favourably. In cases 26, 32, 33, 34, 35, 48, 49, 50, 51, 54, 56, 60, 61, 64, 67, and 72, they were sufficiently extensive to render the operations formidable to the operator, and very dangerous to the patient; 54, I think I may safely say, owes her life to the antiseptic system. I do not think recovery would have been possible without it, and yet she never had a temperature over 101·0 deg. Fahr., and that only for a few hours; and was up on the couch on the twelfth day after the operation.

I must turn now, for a short time, from the pleasure of recording increasing success in the complete ovariotomies, to the less pleasant duty of recording some sad cases, in which exploratory operation only hastened the final catastrophe. I have put together six cases, in which I have opened the abdominal cavity without performing a complete ovariotomy. The first was that of a poor woman with malignant disease of both ovaries, which I correctly diagnosed; but she begged so hard that I would do something, that I attempted to remove them, but was obliged eventually to close the wound, leaving portions of both tumours adherent in the pelvis, and part of one adherent to the liver. She lived for a week, and I believe might have recovered the actual operation, had it been performed antiseptically. The second was a case which I believed to be a ruptured ovarian cyst, and commenced as an ovariotomy. I found both ovaries healthy, and a cystic tumour growing between the layers of the great omentum, and closely connected with the spleen. I removed it, and she lived a week, dying of exhaustion after almost conquering septicæmia. It was found, at the post-mortem examination, that the splenic artery and vein were both ligatured, but the spleen seemed not to

have suffered in any way. Before commencing the operation, I drew off some fluid from the peritoneum, which exactly resembled ovarian fluid in every respect. I cannot say whether this was really a splenic cyst, or merely one accidentally adherent to that organ; if the latter be the correct view, the adhesions were remarkably close.

With this case, I take leave of operations performed without antiseptics.

The third case, I saw in consultation with my friend Dr. Rice of Cadogan Place, and we fully recognised its unpromising nature, and placed the risks plainly before the patient and her friends. The operation revealed malignant disease of both ovaries, and a much enlarged, probably cancerous, liver. I removed one ovary, but was obliged to leave the other, after freely opening and emptying some cysts in it. The quantity of fluid secreted by these cysts and the diseased peritoneum was enormous, and it poured away from the wound so that dressings were useless, and she died of exhaustion in about forty hours. Probably septicæmia played its part in the exhaustion in this case, as, I believe it generally does, in cases dying within thirty-six to forty-eight hours, which are often put down as deaths from exhaustion. I do not believe any method of dressing could prevent sepsis in a case, where the discharge was so great.

The fourth case was that of an old woman, whom I saw in consultation with Mr. Owen Willis, near Monmouth. He had tapped her some weeks before, and the fluid had rapidly accumulated; her general condition was most unpromising, and the physical signs made the possibility of removing the tumour most unlikely. I began by tapping, and then proceeded to make a small exploratory incision, and,

finding it quite impossible to remove the tumour, which I have little doubt was malignant, I closed the incision. The shock of the operation was too great for her constitution, already enfeebled by habits of intemperance, and she sank in about forty-eight hours; the result fully confirming the opinion of Mr. Willis, who had advised against operation, and to whom my best thanks are due for the kindness and courtesy with which he assisted me, when an exploratory operation was decided on.

The fifth case was that of a single woman of thirty-eight, sent to me by Dr. Newstead of Clifton. He had already formed an unfavourable opinion of the case, and I entirely agreed with him, but consented to make an exploratory incision. I found a malignant mass, involving uterus and ovaries, and closed the incision after letting out fluid from some cysts, to relieve the tension, which was a source of great suffering. The patient made a rapid recovery from the operation, but died in six months.

Looking at these four cases of malignant disease, one cannot but feel that the deaths, following shortly after the operation and with but little suffering, were better for the patients than the lingering death in the last case, though this one is more satisfactory to the surgeon. In such cases, it is very hard to refuse the patient the last chance of life, though one knows that neither surgery nor surgeon will gain anything but discredit from an exploratory operation.

The sixth case was one of hydatids of the omentum and pelvic peritoneum, removed during the seventh month of pregnancy, the patient making a good recovery; but, as I am publishing it in full as a separate case, I shall not say more about it here.

No.	Medical Attendant.	Place of Operation.	Condition.	Age.	Date Operat
26	Dr. Lacy	Hospital	S.	19	1877 April
27	From another hospital	Hospital	S.	19	April
28	Dr. W. H. Day	Hospital	W.	48	April
29	Mr. Thornton (out-patient)	Hospital	M.	41	May
30	Dr. Connor, Leicester	Hospital	M.	56	May
31		Hospital	M.	29	May
32	Dr. Wynn Williams	Hospital	M.	26	June
33	Dr. Pesket Leyton	Hospital	M.	38	June
34	Dr. Rice, Cadogan Place	Hospital	M.	33	July
35	From another hospital	Hospital	M.	46	July
36	Dr. Gray, Oxford	Hospital	M.	61	July
37	Mr. Pollard, Torquay	Hospital	M.	29	July
38	Messrs. Mathias and Bethell, Bridgnorth	Hospital	M.	41	July
39	From another hospital	Hospital	M.	33	Octob
40	Dr. Pickett, Notting Hill	Hospital	M.	37	Octob
41	Dr. Nield, Plymouth	Hospital	S.	16	Octob
42	Mr. Woodward, Pershore	Private house.	M.	57	Novemb
43	Mr. Crossley, Leicester	Hospital	S.	25	Novemb
44	Dr. Royston Pike, Southsea	Hospital	M.	40	Novemb
45	Mr. Square, Plymouth	Hospital	S.	20	Novemb
46	Dr. Duplex, Torrington Square	Hospital	S.	54	Novemb
47	Dr. Lorimer, Farnham	Hospital	M.	20	Decemb
48	Mr. Tarzewell, Sturminster Newton	Hospital	S.	30	Decemb
49	Dr. Bell, Chatford Bridge	Hospital	M.	37	Decemb 1878.
50	Dr. Gray, Oxford	Hospital	M.	32	Januar
51	Mr. Reed, Pool	Hospital	M.	38	Januar
52	Mr. Thornton	Hospital	M.	29	Januar
53	Dr. Lowe, Burton	Hospital	M.	57	Januar
54	Mr. Spencer Wells	Private house.	M.	31	Januar
55	Dr. Cole, Bath	Hospital	S.	20	Januar
56	Dr. Iliff, Kennington Road	Hospital	M.	47	Februa
57	Mr. Thornton	Hospital	W.	46	Februa
58	Mr. Wheeler, Bexley	Hospital	S.	26	Februa
59	Mr. Bailey, Cavendish Place	Hospital	M.	54	Februa
60	Dr. Meadows, Ipswich	Hospital	M.	29	Februa
61	Dr. Deeping, Southend	Hospital	M.	40	Februa
62	Mr. Napper, Cranleigh	Hospital	S.	42	March
63	Mr. Glencross, Bourne	Private house	S.	16	March
64	Dr. White, Nottingham	Hospital	W.	38	March
65	Mr. Bucher, Chichester	Hospital	W.	46	March
66	Mr. Clifton, Leicester	Hospital	S.	35	March
67	Dr. Godfrey, Freemantle	Hospital	M.	49	April
68	Dr. Anderson, East India Road	Hospital	M.	50	April
69	Mr. Meredith	Hospital	M.	28	April
70	Mr. Thornton	Private house	S.	24	April
71	Dr. Oxley	Hospital	S.	57	April
72	Mr. Spencer Wells	Hospital	W.	54	April
73	Dr. Priestley	Nursing home.	M.	35	April
74	Mr. Spencer Wells	Hospital	S.	50	April
75	Mr. Gregson, Newcastle..	Hospital	S.	14	May

CASES OF OVARIOTOMY.

Adhesions.	Length of Incision.	Treatment of Pedicle.	Weight of Tumour	Result.	No.
omental, intestinal, gastric, splenic, hepatic and vesical	8 inches	Ligatures, both ovaries	7 lbs.	Died in 72 hours: suppression of urine	26
Parietal	5 "	Ligatures	24 lbs.	Died in 9 hours: hæmorrhage	27
Parietal and omental	5 "	Ligatures	24 lbs.	Recovered	28
Burst cysts; no adhesions.	4 "	Ligatures, both ovaries	7 lbs.	Recovered	29
Parietal and pelvic	5 "	Ligatures	14 lbs.	Recovered	30
Parietal and omental	5 "	Ligatures	60 lbs.	Recovered	31
l, omental, intestinal, uterine, and ovarian	4 "	Ligatures	10 lbs.	Recovered; now pregnant	32
rcoma of mesentery adherent to left ovary, etc.	5 "	Ligatures	25 lbs.	Recovered	33
sts; both adherent to all the pelvic viscera	5 "	Ligatures	11 lbs	Recovered	34
l, omental, intestinal, uterine, and vesical	6 "	Ligatures	16 lbs.	Recovered	35
None	5 "	Ligatures, both ovaries	22 lbs.	Recovered	36
None	5 "	Ligatures, both ovaries	35 lbs.	Recovered	37
rietal, omental, and intestinal	4 "	Ligatures	12 lbs.	Recovered	38
None	4 "	Ligatures	21 lbs.	Recovered	39
Parietal and omental	3 "	Ligatures	9 lbs.	Recovered	40
rietal, omental, and intestinal	4 "	Ligatures	13 lbs.	Recovered	41
Parietal	5 "	Ligatures	5 lbs.	Recovered	42
Parietal and pelvic	4 "	Ligatures	20 lbs.	Recovered	43
rietal, omental, and intestinal	5 "	Ligatures	5 lbs.	Recovered	44
None	3 "	Ligatures	29 lbs.	Recovered	45
None	4 "	Ligatures	21 lbs.	Recovered	46
Burst cyst; no adhesions	5 "	Ligatures	25 lbs.	Recovered	47
, omental, and intestinal (twisted pedicle)	5 "	Ligatures	8 lbs.	Recovered	48
rietal, omental, and intestinal	5 "	Ligatures	19 lbs.	Recovered	49
Peritoneal cysts.	5 "	Enucleation & ligatures	10 lbs.	Recovered	50
rietal, omental, and intestinal	5 "	Ligatures	15 lbs.	Died in 28 hours: acute pleurisy	51
Parietal	4 "	Ligatures	16 lbs.	Recovered	52
Parietal	5 "	Ligatures	24 lbs.	Recovered	53
rating cyst; universal adhesions	4 "	Ligatures	14 lbs.	Recovered	54
arietal omental and intestinal	4 "	Ligatures	16 lbs.	Recovered	55
Uterine and pelvic.	5 "	Ligatures, both ovaries	34 lbs.	Recovered	56
Parietal and omental	5 "	Ligatures, both ovaries	34 lbs.	Recovered	57
None	4 "	Ligatures	15 lbs.	Recovered	58
Parietal	4 "	Ligatures	18 lbs.	Recovered	59
mental, intestinal, and uterine	4 "	Ligatures, both ovaries	4 lbs.	Recovered	60
Pelvic and uterine	4 "	Ligatures, both ovaries	14 lbs.	Recovered	61
Parietal and omental	5 "	Ligatures	20 lbs.	Recovered	62
Parietal and omental	3½ "	Ligatures	13 lbs.	Recovered	63
elvic, uterine, and intestinal	6 "	Ligatures, both ovaries	9 lbs.	Recovered	64
None	4 "	Ligatures, both ovaries	38 lbs.	Recovered	65
None	4 "	Ligatures	11½ lbs.	Recovered	66
arietal, omental, and intestinal	5 "	Ligatures, both ovaries	40 lbs.	Recovered	67
colloid cyst omental and intestinal	5 "	Ligatures	31 lbs.	Recovered	68
None	4 "	Ligatures	10 lbs.	Recovered	69
None	3½ "	Ligatures	8 lbs.	Recovered	70
Pelvic	4 "	Ligatures	17 lbs.	Recovered	71
Parietal and omental	6 "	Ligatures	75 lbs.	Died in 79 hours: septicæmia	72
None	4 "	Ligatures, both ovaries	12 lbs.	Recovered	73
Omental	4 "	Ligatures	1 lbs.	Recovered	74
Omental	4 "	Ligatures	21 lbs.	Recovered	75

REMOVAL OF HYDATIDS OF THE OMENTUM.

On March 5th 1878, I was asked to see a woman at Tottenham, who was some months pregnant, and was suffering much from some obscure abdominal tumour. I saw her the same evening, and was very much in doubt as to the nature of the case, and advised her removal to the Samaritan Hospital, in order that I might have her under observation for some few days, and take the advice of my colleagues at our weekly consultation. She was admitted on March 7th.

E. P., aged thirty-two, married five years, and mother of one boy three years and a half old; a dark, sallow woman, with furrowed brow, as if in constant pain, markedly emaciated.

History.—Had enjoyed fairly good health up to the time her child was born, three years and a half ago. On the third day after her labour, she had a sharp attack of pleurisy in the right side, which passed off in ten days. She did not, however, regain her usual health, but continued weak, and in three months noticed a lump in the right side of the abdomen. It gave her a good deal of pain, and she also suffered from pain over the pubes. She consulted a London physician, who told her that she had fibroid tumour of the uterus. The lump first noticed, continued to grow slowly, and with increase of pain, and at times much bearing down of the uterus. In the early part of 1877, she was supposed to have miscarried at the fourth month of pregnancy; but as no fœtus was seen, and menstruation seems to have been irregular

rather than suppressed, I think it must have been a mere menorrhagia from some other cause.

Her last period before admission ceased on September 8th, 1877, and as the pregnancy advanced, her size increased more than it should have done; other lumps could be felt in the lower part of the abdomen; and the pain and uterine bearing down became much more severe, so that at the time I saw her, she had been spending most of her time in bed, and was constantly taking sedatives; without them she could not rest at all.

I kept her under observation for a week, and found that the pain was really constant and severe, and that the emaciation was rapidly increasing. At this time, there was a large dull tumour occupying the left side of the abdomen, in which the fœtal movements could be readily detected, and the fœtal heart heard. In front, and to the right of this, were several round hard masses, to some extent moveable over its surface and from each other; one, immediately over the pubes, was of considerable size, and in this an indistinct sense of fluctuation could be detected. The pelvis was occupied by a grape-like bunch of small round bodies, which lay behind the uterus; these did not seem to be connected with the abdominal tumour or with the uterus. More to the right, there was a separate soft elastic body, about the size of a walnut; it appeared to be fixed to the sacrum. The os and cervix were in the normal condition of pregnancy. Vaginal examination caused much pain, especially down the left leg, which was also the seat of pain when she got up and attempted to walk.

I was inclined to regard the tumour in the abdomen as ovarian, and closely connected with the

uterus; the pelvic tumour, I thought was probably the other ovary, in an early stage of cystic degeneration. The discovery of the separate fixed nodule, together with the fact that certain fresh small nodules in the upper part of the abdomen had appeared while she was under my observation, made me fear that there was infection of the peritoneum from rupture of one or more of the cysts. On March 15th I presented her to my colleagues for consultation; and I extract the following from the report published in the *British Medical Journal*, March 23rd, 1878:—

"Mr. Thornton now wished for the opinion of the staff as to the best course to pursue. He was himself decidedly in favour of making a small exploratory incision with careful antiseptic precautions, proceeding either to the removal of the tumour, or to the mere raising of the pelvic portion, according to circumstances. He advocated this course as affording the best means of obtaining a perfect diagnosis, with the chance of complete relief and but little risk to the patient. The alternative course—induction of premature labour—would, if found necessary, still be available, after the small exploratory incision had healed. The success which had attended ovariotomy during pregnancy, in the practice of Mr. Spencer Wells, rendered the course clear in any ordinary case, as to the alternative of removal of the tumour or the induction of premature labour; but in this instance, there were peculiar difficulties. Dr. Greenhalgh was in favour of an exploratory incision, with removal of the tumour, if then found practicable. This was preferable to the induction of premature labour, to which he saw grave objections. Mr. Spencer Wells admitted that this case was of more interest than ordinary cases of ovarian disease co-

existent with pregnancy. He had himself removed ovarian tumours from pregnant women, with perfect ease and excellent results. But in this patient, from the character of the growth and the morbid conditions detected in Douglas's space, the operation would anyhow be difficult, and pregnancy much increased the risk. On the other hand, the patient was in a miserable condition, and some interference was imperative. The tumour was too solid for tapping, so as to give the patient temporary relief during pregnancy. The wisest course was to induce premature labour, and to remove the tumour after the patient's recovery. Dr. Day, taking into consideration the nervous susceptibilities and the extreme discomfort from which the patient was suffering, considered it best that an exploratory incision should be made, and the tumour at once removed, if possible. The great liberties, which might safely be taken with the abdominal viscera under antiseptic precautions, contrasted favourably with the admitted dangers of the induction of premature labour. Dr. Bantock considered the case unfavourably, both for operation and for the induction of premature labour, but had no objection to an exploratory incision under antiseptic spray. But if, on making that incision, it were found that the tumour could not be removed, considerable delay would be involved. On the whole, he was in favour of induction of premature labour. Dr. Champneys considered it advisable to wait for about a month, and then induce premature labour; for both that course and ovariotomy were very hazardous at the present stage of the patient's illness; but at the seventh month, delivery would be attended with much less risk, and would remove the main complication. Mr. Doran was of opinion that the sum of the dan-

gers from induced premature labour followed by ovariotomy, was rather greater than the total amount of risk involved in ovariotomy during the patient's present condition, followed by natural labour. Mr. Thornton determined on abiding by his original decision, after duly explaining the patient's condition to herself and her husband, and speaking to them on the proposed alternative of induction of premature labour."

The case having been explained to the patient and and her husband, an exploratory incision was decided on, but as she was suffering much from cough, I requested my colleague, Dr. Day, to be kind enough to examine her chest. He reported her as suffering from subacute bronchitis, and the operation was unavoidably delayed till March 28th.

In the interval, both the abdominal and pelvic growths had considerably increased in size, and fluctuation was now quite distinct in the mass just over the pubes.

At 3.30 p.m., on March 28th, Mr. Meredith administered bichloride of methylene, and, assisted by Dr. Bantock and Mr. Doran, I operated under the spray, and with full antiseptic precautions. I first made an incision three inches long, and gradually prolonged it to five or more. I came upon a white-looking cyst closely adherent to the parietes, and, failing to find my way into the peritoneum either above or below, I cut into it. Some yellowish-green, purulent-looking fluid escaped, and pushing back a small inner cyst which presented, I passed my finger into an irregular cavity, rather to the right of the median line; it had a rough surface, and gave me the impression of a false cyst formed by peritoneal adhesions, and covered with papillomata. Pulling

at its lining membrane, it came out as a thin yellowish-white bag. I now began to suspect what I had to deal with, and ruptured the bag. Pulling it away, I was able to pass my hand into the peritoneal cavity, and felt the pregnant uterus. The nodular parts of the abdominal tumour, I found to be separate hydatids, growing in the omentum (the preparation is in the museum of the College of Surgeons); its whole lower half was fringed and hung with them, from the size of a hen's egg to that of a small marble. By drawing the omentum down, I was able to get above the hydatids, and removed its whole lower half, ligaturing the remainder in five or six pieces with medium carbolised silk. I now removed as much as I could of the mass at first opened, applying several ligatures very close to the fundus of the bladder, which formed the lower wall of the false cyst. The mass in the right side of the abdomen, was so extensively spread out in the parietal peritoneum, and was so difficult to get at owing to the size of the uterus, that I left it untouched. I now attempted to pass my hand over the top of the uterus, but was obliged to enlarge my incision, and then with considerable difficulty passed my hand into the pelvis. I drew out a group of hydatids like a bunch of small potatoes, attached by a long vascular pedicle to the bottom of the pouch of Douglas. I ligatured the pedicle, and returned it. A second similar bunch was then dealt with in the same way, and now I could feel nothing but the small adherent hydatid in the right side of the hollow of the sacrum. It was very difficult to touch at all, and as I had already decided to leave one mass in the abdomen, I left this also. The sponging was very difficult, owing to the hand having to be passed over the large

uterus; but I was determined to clean the peritoneum thoroughly, and hence both the intestines and uterus received rather rough handling. The wound was closed with fine silk sutures, and dressed with protective and carbolised gauze, just as after ovariotomy. The total weight removed was rather more than four pounds, the omental mass being three pounds. She was treated exactly in the same way as a patient after ovariotomy, rather more laudanum than usual being given by the bowel, as she had become accustomed to sedatives, and they did not act readily. Six hours after the operation, the temperature was normal, pulse 112, respirations 20. The skin was acting well, and there was plenty of clear, rather dark urine. Thirty hours after the operation, the temperature was 100·4°, pulse 144 (weak), respirations 24. She had been frequently sick, just bringing up mouthfuls of iced-water and a little phlegm; probably the latter prevented any trouble from the cough. Fifty-four hours after operation, the temperature was 100°, pulse 132, respirations 20. She had had two ounces of beef-tea with half an ounce of port wine by rectum every two hours since the previous night. She was seen by Mr. Wells, Dr. Greenhalgh, and others, it being consultation-day at the hospital. All thought her doing well. At 1 p.m. on the third day, only a very little flatus had once passed, and distension was becoming painful, in spite of atropine and morphia mixture by mouth, as well as frequent doses of laudanum by rectum. Temperature 99·4°, pulse 132, respirations 20. The movements of the fœtus were frequent, and caused her pain.

At 11 p.m., eighty hours after the operation, I removed the dressings for the first time under the

spray. There was a good deal of bloody serum in the gauze, and in the centre of the wound there was a slight inclination to gaping. I sponged the abdomen all over with warm carbolic lotion, with much relief to the patient, and reapplied the dressings. The percussion-note was clear everywhere, showing that the distended intestines had forced their way between the uterus and parietes. I turned her on her left side, and made a prolonged attempt to pass a long rectum-tube, but failed; then on her right, and, after an hour and a half, was at last rewarded by a free escape of flatus with some liquid fæces. The patient was constantly sick during this procedure, and was bathed in perspiration and much exhausted, when it was over. Temperature 99°, pulse 148. From this time, the temperature became normal, once or twice only rising to 99·4° or 99·6°, when there was much pain from flatulence; the pulse also gradually dropped to 104° on the morning of the seventh day. She had some threatening of a return of the pleurisy in the right side, where she had had it before, but it passed off with poultices.

I dressed the wound on the fifth day, and removed alternate sutures, though it had gaped a little in two places; and on the seventh day, the flatulence having subsided, I thought it safe to remove the remainder of the sutures. In the afternoon she had some cough, and at 6 p.m., the nurse noticed a red stain on the dressings. I was sent for, and, removing the gauze under the spray, found the wound open from top to bottom, the large uterus entirely filling the opening, and protruding somewhat. I carefully reintroduced the sutures, and strapped the abdomen very firmly, fearing, while I did so, the effect of the pressure on the uterus. Shortly after I left, labour pains began.

I was called at 10 p.m., and sent for my colleague Dr. Champneys, who had kindly promised to undertake the obstetrical care of the case. She had a slow, troublesome labour, and we remained with her till a fine seven-months boy was born alive at 6 a.m. on the morning of the eighth day. Immediately after the delivery, pulse was 96, temperature 98·4°. The baby lived twelve hours, and weighed after death, three pounds and a quarter. There was little to note after this, the highest afternoon temperature being 100·2° on the second day, when the lochia were a little offensive, and an antiseptic (carbolic lotion, 1-60) injection was ordered every three hours. The bowels acted on the third day, and naturally each day afterwards. On the twelfth day after the operation (fourth after delivery) I dressed the wound, and finding all the sutures rather loose, and causing irritation, I removed them. At 6 a.m. the next morning she had another coughing fit, and something gave way. I was not sent for, and at 10.30., hearing of this, and the patient complaining of pain in wound, I removed the dressings in the presence of Dr. Marion Sims, and found the wound had partially opened again, and two knuckles of small intestine were protruding and lying in contact with the carbolised gauze. They were already sticking very firmly to the gauze and to the lower angle of the wound, and bled when I peeled them off. I washed them with 1-40 carbolic lotion, and returned them, closing the wound with three hare-lip pins introduced through the whole thickness of the abdominal-wall and peritoneum. The temperature on the day before this happened had been all day about 99° to 99·4°, and it continued so for three days afterwards, so that no fresh fever followed the accident. On the morn-

ing of the fifteenth day, while the nurse was syringing the vagina, the patient suddenly complained of uterine pain and faintness, and some hæmorrhage occurred. I saw her half an hour later, and found her with a very anxious expression, very rapid feeble pulse, and bathed in perspiration. Temperature 100°. I believe the nurse had passed the pipe into the uterus, and distended it with the lotion. At noon the temperature was 103·2°, pulse 144, respirations 28. The fever then gradually subsided, and there was no further complication. The wound healed very slowly. On the nineteenth day I removed two pins, and the other on the twenty-third day, but the superficial sore healed so slowly, in spite of a great variety of dressings, that she was not on the couch till a month later, and did not leave the hospital till the beginning of June, two months after the operation. Up to the time when she went home, neither the abdominal nor the pelvic hydatids seemed to increase in size, but the latter caused some return of the pain in the left leg. I have heard lately that the abdominal one has since enlarged a good deal, and she contemplates returning in October for further treatment.

October 21.—Patient has presented herself according to promise. She is in very good health. Abdominal incision sound and strong; abdominal hydatid little if at all increased in size, and pelvic one but very slightly larger, but it still gives her pain in the leg. The patient has gained flesh and colour, and looks altogether so different, that I did not recognise her at first when she came into my room. I have strongly advised her to be content without farther treatment, so long as she continues in such good health.

There is little room for remarks on this case, which

tells its own tale. I think it is unique in so far as the performance of the operation during pregnancy is concerned, and it certainly is so, as regards the patient's recovery, in spite of so formidable an operation, followed by reopening of the peritoneum, labour at seventh month within seven days of such an operation, and a second reopening of the wound six days later. That the patient owes her life to the strict adherence to Mr. Lister's method in every detail, until all danger of reopening of the peritoneum had entirely passed, is certain; and I feel sure that she would have died of septicæmia in the first few days without antiseptics, when I remember the quantity of bloody serum at the first dressing, and the partly gaping wound, with red irritable edges; and, added to this, the enormous flatulent distension, itself often the first serious symptom of septic mischief in my patients after ovariotomy, before I began antiseptics.

The error in diagnosis I do not wonder at, for I believe it is, and always will be, impossible to give an absolute diagnosis in some of the rarer forms of ovarian and other abdominal tumours; but I think it was remarkable that, with all the discussion on this case before the operation, and though she was seen with me by many eminent men outside the staff of the hospital, no one even hinted at the possibility of the case being one of hydatids. I still think the operation was the right course to take, for had the induction of premature labour been attempted, I feel sure that some, if not all, of the pelvic masses must have been broken up; and I think the danger of hæmorrhage from their pedicles would not have been small; and the risk of pouring a quantity of hydatid fluid, blood, and hydatids, free into the peritoneum of a puerperal woman, is great. Judging by her steady

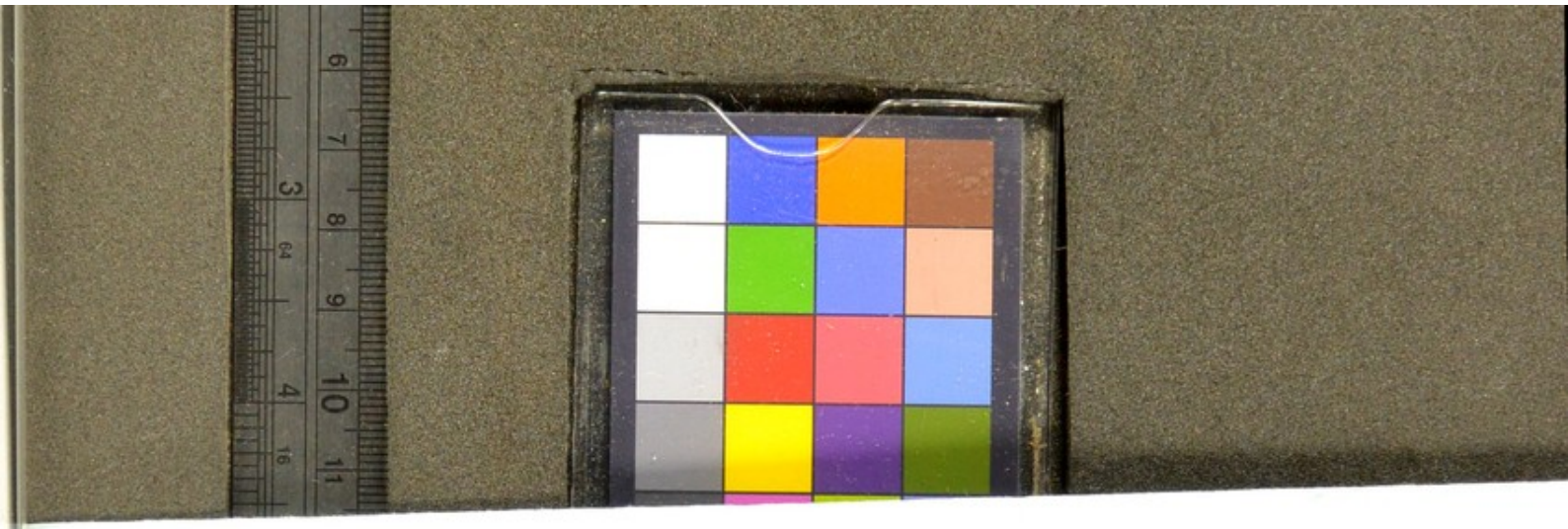
downward progress during the time she was under my observation before the operation, I do not think she would have lived, if left to struggle on to the end of gestation with mere palliative treatment; or had she done so, there would still have been the danger and difficulty of the descent of a larger head through the obstructed pelvis. I never saw a case in which the indisposition to healing was so great, and I do not know whether to attribute it to the puerperal state, or to the fact that the patient had for some time been allowed large quantities of stimulants, as well as sedatives. The carbolic acid, which so often gets all the credit of slow healing in antiseptic cases, certainly was not to blame here, for I tried nearly every lotion I knew of, as well as dry dressings and ointments.

Oct. 7. Patient looks well-nourished
far better in general health than be
cavation. The abdominal wound
ake some time in closing but has comp
led (by the end of September). She has a
gh & free expectoration of hydatid
embrane from a cavity in the centre
left lung; physical exam^n showing a
a of consolidation around that cavity

died 2 months after removal of cyst
pneumonia; hydatids expectorated freely to the
last

London: Printed by H. K. Lewis, 136 Gower Street, W.C.

The specimen is preserved mus. R.C.S. Path
Series, 2371



TABLE(S)
RUN INTO
GUTTER