Absorption of a tumour in the broad ligament during pregnancy / A. Norman McArthur.

Case 7 was very interesting, as showing the sudden marked decrease of the eosinophiles after operation, the number falling below normal (28·4 to 0·4 per cent.), and rising to normal three days later. It was further interesting, in that the closed method was successfully practised, although suppuration took place in the parietal wound, probably owing to infection of the buried catgut sutures. The common absence of eosinophiles in the presence of suppuration, and the attendant increase of the polymorph. neutrophiles, are well shown in Case 8, in which, after a rigor, the temperature reached 106° F., promptly falling after operation. In Case 9, the contents of the cyst were most unusual in colour. On standing, an orange-yellow crystalline pigment settled, leaving the supernatant fluid exactly like thin cream in appearance.

As I can find no reference to eosinophilia in the Australasian literature on hydatid disease, these few cases are reported in the hope that some more general investigation may be made into the question, in order to find out if any practical value can be attached to the blood examination of cases of hydatid disease.

ABSORPTION OF A TUMOUR IN THE BROAD LIGAMENT DURING PREGNANCY.

A. Norman McArthur, M.B., B.S. Melb., M.R.C.S. Eng., L.R.C.P. Lond.

Hon. Obstetric Surgeon, Women's Hospital, Melbourne.

Hon. Gynæcological Surgeon to In-patients, St. Vincent's Hospital, Melbourne.

On the 18th of September of last year, a woman, married nine years, and aged 30, was sent to me at St. Vincent's Hospital from Werribee. She was pregnant four months, and Dr. Kelly informed me that her health had failed somewhat during the last three years, in fact, since the birth of her last child.

Fourteen days previous to admission she was attacked with severe pain in the lower abdomen, about the left iliac region. She had rigors, and a temperature ranging from 100° F. to 99° F. She was very constipated, her bowels acting only by enemata. She had had three children, the oldest 9 years, and the youngest 3 years of age.

On examination, there was found a large rounded, fairly firm elastic swelling, occupying the left broad ligament, and encroaching

upon Douglas' pouch. The cervix was pushed away to the right side and to the front, and was exceedingly high up and difficult to reach. The os was patulous. Marked pulsation over the tumour could be felt from the anterior fornix. I diagnosed a tense abscess in the broad ligament.

The next day, under chloroform, I did colpotomy, making a deep puncture with the knife into the tumour through the left lateral fornix. I then inserted a Doyen's clamp forceps into the swelling, widely separated the blades, and withdrew it, and to my surprise found no pus. I passed the finger into the wound and felt the tumour, encapsuled, evenly rounded, quite firm, and incorporated with the cervix of the uterus. I then passed the finger into the deep wound made in the tumour by the forceps, and the firm structure felt exactly like that of fibro-myoma. Dr. Murphy, who assisted me, felt it, and also concluded it was a fibro-myoma. A gauze drain was inserted, and she was sent back to the ward.

Her temperature afterwards kept up for many days, never going above 101° F., and her pulse-rate about 100. She suffered very much with persistent vomiting, and informed me she had always done so from the beginning to the end of term of all her previous pregnancies. She had almost persistent headaches, and from the vagina for each day there was a slight semi-purulent discharge, evidently coming from the colpotomy wound. She did not improve at all, and was, owing to the vomiting, unable to retain her nourishment. I concluded that it was right to make an attempt, without interfering with pregnancy, to enucleate the fibro-myoma per abdominalis. As my senior at the Hospital, Dr. O'Sullivan, was away in Europe, I asked Dr. Adam to see the case with me, he advised me to make the attempt, and agreed with me that it was a fibro-myoma.

It was three weeks after the first operation that I opened the abdomen, and discovered a tumour between the layers of the left broad ligament, evenly rounded in shape, firm, but elastic, and as large as the head of a seven months' fœtus. It was intimately incorporated with the cervix and lower segment of the uterus, so that no pedicle or isthmus could be defined. Coursing over it as it lay between the layers of the broad ligament were large dilated threatening veins. It had all the appearance of an organic growth, and was seen by Drs. Kelly, Davis, Murphy, and myself. I decided that she would have to go to term and undergo Cæsarean section. I

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closed the abdominal wound in three layers—the peritoneum by continuous catgut, the deep fascia by interrupted catgut, and skin by continuous catgut. I put in three supporting sutures of silkworm-gut through the skin, fascia, and muscle.

Afterwards, she never seemed well. There was great difficulty in obtaining an action of the bowels. The temperature still kept up occasionally as high as 102°. The pulse-rate increased to 120 and 130. She was unable to sleep, and there was increasing abdominal distension. She was vomiting and hiccoughing, and unable to retain nourishment. The hiccoughing and retching continued, and distension became so extreme that all the sutures in abdominal wound cut through, and four or five inches of wound gaped, showing the uterus below and sloughing margins of parietal peritoneum.

Later, she gradually improved, and at intervals I made attempts to close the abdominal wound, freshening its margins and putting in silkworm-gut mattress sutures, guarded by tubing, to prevent cutting, and silver wire guarded by lead plates.

Finally, all except about an inch of the middle portion of the wound united, which ultimately granulated over. The greater part of the anterior uterine wall was adherent to the abdominal parietes.

I made a vaginal examination three weeks after the second operation; the colpotomy wound was closed. The tumour was as large as before. I kept her in the hospital; she was remarkably well, and had never been better in her previous pregnancies, and helped the ward's maids diligently in their work.

Three weeks before I expected the onset of labour, I made a vaginal examination. The cervix was in normal position, placed centrally. The os was patulous, admitting three fingers, and the fœtal head could be felt presenting. No tumour could be felt anywhere. I thought, perhaps, the tumour had been drawn up above the true pelvis, and could not be defined in the abdomen during pregnancy. I, however, told her that I might be able to deliver the child naturally.

On the first of March of this year, just about term, she had a very free uterine hæmorrhage. I ordered morphia and immediate removal to the Women's Hospital. There I dilated the os with Champetier de Ribes' bag, applied forceps, and a healthy living child, weighing seven pounds was delivered without any difficulty. After the third stage of labour was completed, the tumour was searched for and could not be defined. She ran a perfectly normal

course during the puerperium, uterine involution being perfect in spite of the gross adhesions. She was discharged on the eleventh day after I had most carefully examined the pelvis, and could find no sign of a tumour. The uterus could be most easily palpated, and all that remained was a small dimple where the colpotomy wound had healed.

Notes and Comments.

Varicocele.

Varicocele is one of those affections in which the surgical interest bears little relation to the mental estimate of misfortune made by the sufferer. The condition forms a foundation upon which the most extensive edifice of quackery has been erected, and it would seem that orthodox teaching is itself largely responsible for the very undesirable position into which the subject has been allowed to drift. There is, perhaps, no affection concerning which tradition has remained so long unquestioned. In every text-book the same vague statements are handed down from generation to generation, and many of them are not merely inconsistent, but actually contradict each other.

The text-book presentation of all subjects is necessarily made to assume a flat surface, and it is only after some years of dealing with human nature that the practitioner is able to view certain affections in the right perspective. To inform a patient that varicocele is present, is very often to disturb a state of blissful ignorance, and condemn him to a life of misery, even though an operation be performed. Is varicocele ever a disease in the popular sense? Might it not be regarded as a comparatively trivial malformation. It would, at least, mean that the occupation of many advertising "specialists" would be gone, if the text-books were unanimous.

Hypnotism.

Since the time of Mesmer, the application of mesmerism, or to use the more modern term, hypnotism, to medicine has been re-discovered on many occasions. A Royal Commission in South Australia, has recently discovered once more that hypnotic suggestion provides a means of "cure" for alcoholism. Dr. Norman Kerr, who made a life study of inebriety, after an exhaustive examination of the claims of hypnotism, deliberately rejected it, and pertinently pointed out that, if any case could

be established for its employment, it would be the merest folly to apply it only to confirmed drunkards. Its proper scope would be in the schools. He likewise drew attention to the fact that if it is possible to make men sober by suggestion, it is also possible to make them intemperate, and such a power is too dangerous a means to cultivate in profusion. Milne Bramwell, who has probably had as large an experience as any English writer, declines to use the term "cure" in connection with it, as one of his cases relapsed after eight years of total abstention.

No force of suggestion, beyond the natural strength of character in a physician, is likely to achieve much as a general measure, and special cases are too limited in number and susceptibility to merit sustained interest on the part of the individual practitioner in hypnotism as a remedy.

Drink Cures.

Like the famous treatise on snakes in Ireland, an article on drink cures might consist of the three words, "there arn't any." The term "cure" is, however, so loosely used by the general public (and it must be confessed by members of the medical profession also) that the results of certain treatment are regarded in that light without any adequate consideration being given to the question of their probable permanency, or essential stability.

Drink cures appeal, as might be pre-supposed, most forcibly to the clerical mind, and almost every "cure" of any notoriety has had the public support of more or less distinguished members of the churches.

The medical profession is frequently blamed for ignoring the claims of these alleged remedies, but in no instance have the proprietors made their formulæ accessible to medical criticism, or offered them for trial under professional supervision. The evidence put forward in support of the claim to have cured patients of alcoholic craving, has never been sufficiently trustworthy to commend itself to any person qualified to judge.

Special Cures.

The oldest and best known of alleged remedies for alcoholism is the Keeley treatment. Some years ago, the *British Medical Journal* published a series of articles on this topic, from which much of the following information is taken:—

In 1880, Dr. Keeley (he was a graduate of Rush Medical College, Chicago) opened an "Institute" for the treatment of alcoholism. It was closed for two years, and re-opened in 1887, the directors "having added a hypodermic treatment, and perfected the internal remedies." There are now Keeley institutes all over America and in England (also, we believe, in Melbourne). The exact composition of the remedy is secret, but it is popularly known as the "Gold Cure." In 1880, Keeley stated that he had "proved that the chloride of gold and sodium, or double chloride of gold, would form the basis of a specific remedy." The Keeley treatment is given by hypodermic injection, and requires the patient to become an inmate of the institute where it is applied. Alcoholic liquors are permitted, if desired, during the course. Keeley died in 1900.

The "Hagey" cure is the product of another graduate of Rush College, Chicago. This is also a hypodermic treatment by means of a secret preparation "several times a day," and a tonic which is swallowed every two hours. Alcoholic liquor is permitted.

The Leyfield (Hayden) cure is another hypodermic method of administering a drug compound, of which "chlorate of gold" is said to be an important ingredient. It is apparently a nauseating remedy, which produces "sensations akin to those of seasickness."

Lesser Cures.

Of cures that can be taken by the mouth and used at home there are many varieties from the "Hutton Dixon" and "Tacquara," which are pretentious, to more humble preparations like "Mrs. Terry's" and "Antidipso," which cater for the million. Of these, the most picturesque is the "Tacquara," which was "made known to the inebriate and shiftless son of a well-known officer in the British army by the medicine man of a nomadic tribe near the falls of the Parana River, a hitherto unexplored country."

It is a little disheartening to find that alcoholism is, after all, not a disease of civilisation and over-crowding, since the unqualified practitioner of Parana found it to his advantage to possess a remedy even in the wilds of an unexplored interior.

The composition of Mrs. Terry's "cure" is stated to be sugar (98 %) and salt (2 %); while "Antidipso" is said to consist of chlorate of potash and sugar. With all the foregoing no indulgence in alcohol is permitted while they are being taken, except in the case of the "Tacquara." The most remarkable fact about drink

cures is that the proprietors of each particular method do not hesitate to express their contempt for the claim of all other competitors.

A San Francisco Appeal.

Professor Allen forwards the following letter, which we publish in case any of our readers having complete sets of periodicals for late years or other works of reference they can spare would care to communicate with the Editor of the *Pacific Medical Journal*:—

Pacific Medical Journal. New Location,
1914 Pacific Avenue, San Francisco,
April 30, 1906.

Medical School Library,
Melbourne University.

Gentlemen,—Our late disastrous fire destroyed the entire plant of the *Pacific Medical Journal*, including our magnificent library and all books we had on hand for review. We shall be grateful to you if you will send us such publications as you can spare to form a nucleus of a medical library, as there is none in San Francisco. We shall take great pleasure in acknowledging any donation you may be able to make.

As soon as we can borrow a press, we shall get out the May issue of the Journal, which will probably be in about a month.

Thanking you for many past favours, and anticipating a generous response for our new medical library,

We beg to remain, your friends in the West,
Pacific Medical Journal.

Medical Society of Victoria.

Ordinary Monthly Meeting.

Wednesday, July 4, 1906.

(Hall of the Society, 8 p.m.)

The President (Mr. O'Sullivan) occupied the chair. There were 33 members and 2 visitors present.

The minutes of the last meeting were read and confirmed.

The following gentleman was elected an ordinary member of the Society:—

S. V. Sewell, M.B., B.S. Melb., of the Melbourne Hospital. Proposed by H. C. Maudsley, and seconded by R. R. Stawell.

Exhibits.

Dr. Moore showed a case of severe old injury to arm.

Mr. Syme showed a case of partial gastrectomy, which had been performed after a preliminary gastro-enterostomy and a case of plastic operation for scarring after burns.

Mr. BIRD remarked on the advisability of getting the cases of malignant stomach early. He had just heard of the death of one of his cases, in which he had performed a partial gastrectomy three years and four months ago. It was really wonderful how large an amount of food was ingested after removal of the stomach. A friend of one of his cases had remarked that it was pleasant to see the man enjoying his corned beef and cabbage! The recurrence, when it took place, was usually rapidly fatal. In reference to the burn case, he (Mr. Bird) said he had been surprised to find the large surface of skin it was possible to graft by the gliding process. Mr. Syme's was an excellent result.

Mr. KENT HUGHES insisted on the importance of early and daily massage of the edges of a burn, in order to keep the skin here free. In the case of children, the mother could be easily taught to do all that was necessary. The skin would keep on growing so long as it was kept on being moved.

The PRESIDENT remarked that he had had the pleasure of seeing Mayo do a gastrectomy. Mayo advocated early exploration.

Dr. MOLLISON exhibited specimens of pathological anatomy.

Dr. MCARTHUR read the report of a case of absorption of a tumour (probably fibroid) in the broad ligament during pregnancy. (See p. 382.)

Dr. MURPHY said that he had seen the tumour during the operation, and had examined the case afterwards. It was recorded that such tumours did retrogress, but, as far as he knew, no authority had described their disappearance.

Dr. MAUDSLEY asked if there were any relation between the headache, rise of temperature, and other signs suggestive of inflammatory trouble, and the disappearance of the tumour.

Mr. SYME remarked that he did not feel competent to discuss the case, as he had not had the opportunity of examining, either before or after the disappearance of the tumour, but he thought it was possible that a mistake had been made. The symptoms were certainly more suggestive of an inflammatory origin of the tumour, more especially the toxic symptoms and the vaginal discharge. The most extraordinary fact was its disappearance during pregnancy. However, he would not for a moment dispute Dr. McArthur's diagnosis, but merely suggested an inflammatory origin, as a possible explanation of the tumour.

Dr. HORNE supported Dr. McArthur's diagnosis. He had seen one marked case of the disappearance of an œdematous myoma during pregnancy, in a woman of 28. He had examined her at the hird month of pregnancy, and had warned her of the possibility of severe operative measures at her confinement. However, delivery took place normally, and there was no sign afterwards of the tumour. Of course, these conditions were more likely to be aggravated by pregnancy, but his was a parallel case to that of Dr. McArthur's.

Dr. H. O. COWEN thought, with Mr. Syme, that the symptoms suggested are inflammatory origin of the tumour. He would like to know if there had been any pelvic trouble after her first confinement. Still, it was difficult to think that any inflammatory thickening could attain the size of a seven months' fœtal head.

The PRESIDENT congratulated Dr. McArthur on having struck what appeared to be so unpromising a case, and yet which ended so favourably. Of course, pelvic tumours were notoriously hard to diagnose. But seeing that this one had been explored through the vaginal fornix, and was palpated through an abdominal incision, he could not do otherwise than admit the correctness of Dr. McArthur's diagnosis. Lawson Tait had described two methods by which the disappearance of myomata was possible—the first by normal post-partum atrophy, and the second by necrosis. The probability, in Dr. McArthur's case, was that slitting the capsule led to the necrosis of the tumour, assisted by the increasing pressure of the enlarging uterus. The absorption of its contents would lead to symptoms of septic intoxication. A similar condition occurred in the absorption of ligatures. During its drainage by the vagina, of course, there was some risk of infection of the tumour.

Dr. MCARTHUR, in reply, said that until the tumour had disappeared he had never had a doubt as to its being a fibro-myoma. He was quite as sceptical as most surgeons as to the possibilities of an organic tumour spontaneously disappearing during the later months of pregnancy, but with such an array of clinical facts before him, his scepticism must give way. Dr. Maudsley had spoken of the temperature, headache, and vomiting, as being strongly indicative of some inflammatory pelvic condition. But in the patient's previous pregnancies, headaches were common, and vomiting invariable and persistent, from conception to delivery. A rise of temperature often occurred when a fibro-myoma became œdematous

The suggestion that the condition was an inflammatory exudate, drained slowly by the colpotomy incision, was not acceptable. The tumour was quite as large as ever, after the colpotomy wound had closed, and drainage had ceased. No inflammatory exudate could have been so definite in outline, with so distinct a capsule, surrounded by the large threatening veins, and whose consistence was so definitely organised as to distinctly convey the impression of a fibro-myoma. The President suggested a necro-biosis of a soft œdematous tumour. But during the process of necro-biosis was there not a febrile reaction, increase of pulse-rate, headache, &c.? During the whole of the period of febrile reaction, there was no diminution in the size of the tumour. It was during the inactive afebrile period that the tumour disappeared, when the patient was convalescent, and in the later months of pregnancy, when the physiological activity of the uterus was greatest, and any tumour present would be likely to be well supplied with nutrition. There had never been any ecchymosis, suggestive of a hæmatoma, and no medicinal treatment had been employed, either pot. iod. or ergot. In reply to Dr. Cowen, he stated that there was no history of pelvic trouble, or of puerperal infection. Moreover, during the exploration it was noted that the tubes and ovaries were perfectly healthy.

Many cases of spontaneous disappearance or shrinkage of a fibro-myoma during the menopause or puerperium had been recorded, but he considered that the authentic cases of absorption, during the later months of pregnancy, were very few indeed. A large proportion of such reported cases were quite unconvincing. He was quite convinced that this tumour was a fibro-myoma, which had disappeared when the uterus was physiologically active—a time at which he would least expect its disappearance. The pathological process of its disappearance he, however, failed to explain.

Foreign Medical Literature.

C. A. Altmann, M.B. Melb., F.R.C.S.E.

Pancreatitis and Cholelithiasis: Quenu and Duval.

That cholelithiasis and inflammatory conditions of the pancreas may occur simultaneously is a pathological fact that has been known for some 30 years. The writers have had the

opportunity of observing and operating on four such cases. In addition, they have collected 114 cases from literature. In the majority of these, the gall-stone symptoms could be dated far back, the extreme figures being 18, 20, 25, and 36 years. All varieties of pancreatitis were noticed during the course of the cholelithiasis, but the chronic form was the most frequent. It occurred in nearly 50% of all cases. In some rare instances, pancreatitis developed suddenly without any previous symptoms of gall-stones, and such cases were always of hæmorrhagic, a necrotic rapidly fatal form. Chronic pancreatitis was nearly always confined to the head of the pancreas, and consisted either of diffuse induration, or of numerous scattered nodules. The hypertrophic form is the rule. The tumour formed by the head of the pancreas is of very variable size, and is generally only discovered at the autopsy, only very rarely by a clinical examination. Regarding the pathogenesis of this combined pathological condition, the writers do not consider that the principal theories hitherto held, viz., infection by contiguity, or an ascending infection having its origin in the bile passages or duodenum, are confirmed by the investigation of their cases. But they hold that, in the majority of cases, the supposition is justified that there is a common infection of the pancreatico-hepatic systems leading on the one hand to cholelithiasis, and on the other to chronic pancreatitis. The symptoms of the later are overshadowed by and lost in those of the gall-stone trouble. Generally, however, the attacks of colic are unusual, the seat of pain is sometimes referred to a spot midway between umbilicus and ensiform cartilage, sometimes between the shoulder blades or towards the left shoulder; these may be violent pains in the epigastrium, and colic, not related to the ingestion of food. Vomiting occurs more frequently than in simple gall-stone colic, and is sometimes intractable. Icterus does not appear to have any great diagnostic value, but the jaundice of pancreatitis is, as a rule, not so well marked, and subject to great fluctuations.

The functional activity of the pancreas should, of course, be investigated, and consists of the examination of urine and fæces.

With regard to treatment, the acute and chronic forms must be differentiated. In the latter, operation is generally

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