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A RECORD OF PERSONAL EXPERIENCE.

BY

CHARLES J. CULLINGWORTH, M.D.,

OBSTETRIC PHYSICIAN TO ST. THOMAS'S HOSPITAL.

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FIBROID TUMOURS OF THE UTERUS COMPLICATING PREGNANCY:

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So much stress has been laid upon the often very serious character of fibroid tumours as a complication of pregnancy, that considerable apprehension is apt to be excited in the mind of the practitioner whenever a pregnant woman is known to have one or more of these undesirable possessions. Whatever be their size, relations, or position, he pictures to himself all sorts of formidable difficulties, if not actually during the pregnancy, at any rate during labour. I believe most men would prefer to be confronted in their obstetric practice with a case of marked pelvic contraction than with a case of uterine fibroids. There is a degree of uncertainty as to the behaviour of the latter that increases the dread with which their presence is almost invariably regarded. It is obvious, however, that it is only under certain circumstances that the presence of fibroids is likely to prove formidable, and my chief aim in this communication is to allay unnecessary fears and to show that this complication does not necessarily portend disaster. With this object in view, I shall commence with a brief sketch of some cases that have come under my own observation, in which the fears expressed during pregnancy with regard to the probable effect of the fibroids upon the course of labour proved

to have been needless or exaggerated. In some of these cases I took upon myself the responsibility of advising against operative measures that others had proposed. It is sometimes forgotten that the responsibility that attaches to anyone who opposes an operation is quite as great as that which is involved in recommending it. For myself, I have seen so much unnecessary suffering result from delay and timidity in advising and carrying out operative treatment in obstetrics and gynæcology, that I never dissuade a patient from consenting to undergo an operation without a keen sense of the heavy responsibility I am taking upon myself. In order to make this record of my personal experience complete, I shall add to the paper a tabular statement of my other cases of fibroids in pregnant women (in all of which operative treatment was considered desirable or necessary), and I shall conclude with a case illustrating my views as to the advice that should be given to patients who, being the subject of uterine fibroids, are contemplating matrimony.

Case I. *Sessile subperitoneal fibroid of fundus uteri; another tumour, thought at time to be cystic, lower down and behind uterus; induction of abortion suggested; pregnancy allowed to go on; uncomplicated labour at term; delivery of living child; subsequent history.*—On July 5th, 1893, I saw, in consultation with Dr. X, a lady æt. 34, who had been married on February 7th, and who was now nearly fifteen weeks advanced in pregnancy, her last period having commenced on March 19th.

On the right side of the fundus uteri was a broad-based subperitoneal fibroid, at least as large as the closed fist, pushing the uterus over to the left. Also on the right, but behind the uterus, and not low down in the pelvis, was a swelling, thought to be cystic and ovarian.

The questions presented to me were:

1. Shall the pregnancy be allowed to go on?
2. Should the ovarian cyst be removed?
3. If so, should it be removed before or after the uterus is emptied?

I expressed the opinion that the pregnancy should for

the present be allowed to take its normal course, the case meantime being carefully watched. My reasons were that the fibroid was subperitoneal, and that the probabilities were that the cyst, being small, would rise out of the pelvis so as not to obstruct delivery. I then learnt that Sir John Williams had been consulted on June 30th, and had expressed himself in favour of arresting the pregnancy, and subsequently removing the cyst. Dr. X was himself rather disposed to agree with this advice. He consented, however, to recommend the provisional adoption of the course I suggested.

On October 30th Dr. X and I again met and examined the patient, as he had once more come to the conclusion that interference was desirable. I still counselled against it, and Dr. X again courteously agreed to abide by my advice.

On January 3rd, 1894, the patient was delivered of a living female child quite easily by means of forceps. There was no abnormal hæmorrhage. The fibroid was scarcely felt, and the swelling lower down, which the doctor who attended believed (no doubt correctly) to be in all probability another and softer fibroid, did not cause any appreciable obstruction.

The doctor who attended the patient in her confinement, in a letter dated May 23rd, 1894, after giving me some particulars about the labour, goes on to say that "before the end of the ninth month [of pregnancy] the fibroid above the pelvis and to the right side seemed to flatten out with the enlargement of the uterus. At any rate, it did not form such a prominence as at the fourth month, when it felt like a large orange on the side of the womb. After delivery, when the womb contracted, it could still be felt, causing the latter to feel a double tumour, and not very much larger than an ordinary contracted *post-partum* uterus. There were no abnormal symptoms after delivery for a fortnight or more, . . . when phlebitis occurred, first in one leg, then in the other, without any uterine discharge being present. She had to keep in bed for several weeks owing to this, and still has some swelling—dilatation of veins and venules. The urine does not contain albumen. I examined her a few days ago, and found above the symphysis pubis

only an indistinct feeling of tumour on pressure externally. *Per vaginam* the uterus was somewhat fixed, and on bimanual examination appeared considerably larger than normal, but I could not make out a distinct outgrowth of fibroid, as was readily done previously. I could not feel any tumour towards the prominence of the sacrum, or laterally in this position separable from the uterine tumour. I did not examine the rectum, however.

"She is three weeks beyond her period, and there is a suspicion of pregnancy. I should like you to examine her and give your opinion as to the condition of things; also, if she is pregnant, is she to be permitted to go on?"

I saw the patient two days after this letter was written, viz. on May 25th, 1894. She looked very well, but there was some œdema of the left leg. She had last menstruated April 8th to 12th or 13th. Nothing definite could be made out on abdominal examination. A little clear fluid could be pressed from the nipple. On bimanual examination a group of fibroids could be felt reaching to the level of the umbilicus to the right of the middle line, the large one equal in size to at least an adult fist, and a smaller one below this and behind the uterus. There appeared to be an irregular swelling in front of the uterus. The body of the uterus was not easy to be defined on account of the tumours and the great thickness of the abdominal wall, but it was thought to be situated a little to the left of the middle line, with the axis of the canal straight.

I was unable to say with certainty that pregnancy existed, but there seemed little practical doubt about it. Apart from the condition of the veins of the legs, there was in my opinion no reason why, if pregnancy existed and were allowed to go on, it would terminate less satisfactorily than did the first pregnancy. I therefore advised that things should be allowed to take their natural course.

On January 16th, 1895, the patient gave birth to a son weighing $8\frac{3}{4}$ lbs. Everything went on satisfactorily and normally, both during delivery and subsequently. The existence of the fibroids was said to be only just ascertainable, and the patient herself had no consciousness of their presence. In writing to give me these particulars, the

husband expressed his gratitude for the advice that had secured to them two living and healthy children.

The patient had a third child about four years later, the confinement being in every respect normal. In April, 1900, the fibroid tumour was said to be certainly not larger, perhaps smaller, and the patient's health was reported to be excellent. I am informed that a fourth child was born in January, 1901.

Case II. *Large subperitoneal fibroid of lower part of body of uterus; Cæsarian section in thirty-ninth week suggested; spontaneous rise of tumour out of pelvis; delivery of living child* per vias naturales *; subsequent history.*—On March 2nd, 1898, a medical man consulted me about his wife, aged 37, who was in the thirty-second week of her first pregnancy, and was said to have fibroids of the uterus. She had been married nearly four years. Menstruation had been profuse, and the patient had been curetted by an obstetric physician about two years ago. The last period had occurred July 20th to 24th, 1897. There was a large subperitoneal fibroid low down on the right side, not implicating the cervix, which was pushed over to the left. The tumour was just above the vaginal roof, but did not depress it. An opinion had been expressed that labour could not take place naturally if pregnancy were allowed to go to term, and it had been recommended that Cæsarian section should be performed about the 20th of April, *i.e.* in the thirty-ninth week. After examining the patient carefully, I formed the opinion that the tumour was tending to rise into the iliac fossa, and I advised that before Cæsarian section was resorted to, an attempt should be made under anæsthesia to push the mass up sufficiently to allow the head to enter the pelvic inlet, provided, of course, that it had not already moved up spontaneously.

Labour commenced naturally on April 22nd, the day on which the obstetric physician first consulted had arranged to come down and induce labour. On his arrival he found that the tumour had risen and could not be reached *per vaginam*. The labour was tedious, and delivery was effected by the high forceps operation. The child during its birth

narrowly escaped asphyxia. There was no other complication, and both mother and child made a satisfactory recovery.

On leaving her bed the patient found that there was some dribbling of urine on stooping or moving about. There was no incontinence during the night, or when patient was lying or sitting. Menstruation was re-established in six or eight weeks, and became very profuse. I was once more consulted about her six months after delivery. On examination I found a large fibroid resting on the anterior vaginal wall. I advised that mechanical support should be tried ; first, a cradle pessary ; if this should fail, a Blackbee's pessary ; and, finally, if neither of these answered the purpose, a cup and stem pessary. In the meantime ergot was prescribed in doses of ℥20 to ℥30 three times a day, for a week before each period. On November 29th, 1898, after a month of treatment, I was told that no relief had been obtained. The question of operation was now mooted. At that time I thought that myomectomy might be feasible. The question as to whether the patient could be safely allowed to run the risk of another pregnancy was also discussed. She was anxious to have another child, but it seemed to me undesirable, as it was by no means certain that she would have as easy a delivery as she had on the former occasion.

On February 6th, 1899, the symptoms had all improved, and the patient was looking and feeling very well. The tumour was quite above the pelvis. The sound passed 3½ inches in a direction forwards and to the left of the tumour. It now seemed to me certain that if any operation were done it would have to be hysterectomy.

On April 15th, 1899, the husband reported that his wife had decided against operation, that marital relations had been resumed, and that, in spite of precautions, there was reason to believe pregnancy had occurred, as there had been no menstruation since February 8th to 11th. It was arranged for her to come up and see me later in the month, but in the meantime, viz. on April 25th, miscarriage occurred, and I have heard nothing of the case since.

Case III. *Large, lobulated, subperitoneal fibroids of uterus pushing the three months pregnant uterus to the right ; preg-*

nancy allowed to continue; uncomplicated delivery at full term.—A. C—, aged 37, was admitted into St. Thomas's Hospital on February 25th, 1899. She had been married for 5 years, and was now pregnant for the second time. The first pregnancy occurred four years ago, and ended in an early miscarriage. She had last menstruated three months previous to the date of her admission. Five weeks ago she had attended as an out-patient at a suburban hospital to obtain advice with regard to some hard lumps she had recently detected in the lower part of the abdomen. There had been no menorrhagia previous to the pregnancy, or any interference with the functions of the bowel or bladder. The lumps had not been painful. Dr. Umney diagnosed them as uterine fibroids, and, in view of possible complications, he decided to send the patient up to St. Thomas's Hospital for my opinion.

On examination of the abdomen, a swelling with the characters of a pregnant uterus was found lying to the right, and reaching from the pubes to the level of the umbilicus. There was a hard lobulated swelling in the left iliac region, extending upwards to a distance of an inch above the anterior superior spine of the ilium, and inwards so as to encroach on the hypogastric region. There was another hard rounded swelling, of smaller size, in front of the lower part of the uterus on the right side.

Examination *per vaginam* showed the cervix to be soft and directed downwards and backwards. Its canal was patulous, admitting the finger up to the first joint. What appeared to be the fundus uteri lay in the middle line, its summit being $3\frac{3}{4}$ inches above the symphysis pubis. On the left side there was a solid, slightly moveable tumour, depressing the vaginal vault, and extending outwards to the lateral wall of the pelvis. It could not be separated from the left border of the uterus and, being harder and more easily defined than the body of the uterus, it was thought to be an out-growth from it. The softer swelling on the right was entirely above the pelvic brim. Its lower part was felt to be hard, solid, and irregular. Its upper part was smooth, soft, and fluctuating. As pressure upon its upper surface did not convey the same direct impulse to the

cervix that was conveyed by pressure on what was believed to be the fundus uteri, and on the solid tumour lying in front and to the left, the nature of the swelling was at first considered to be doubtful. But a day or two later it was felt to contract and become harder during examination, and ballottement was distinctly obtained. Hence it became evident that the softer swelling was the pregnant uterus displaced to the right by the hard swelling on the left, and that what had been thought to be the fundus in the middle line was either a separate fibroid or a lobe of the mass on the left side.

The patient remained in the hospital for a fortnight, and was then sent out with directions to place herself under the supervision of Dr. Umney. Meantime I wrote to him explaining that as the fibroids were mainly, if not entirely, subperitoneal and did not displace the cervix, and as the probabilities were against their interfering with the normal course of pregnancy or labour, it was not considered necessary either to operate on the tumours or to arrest the pregnancy. The patient presented herself occasionally at the Hospital, but no such alteration occurred as seemed to indicate the need for interference.

On July 17th Dr. Umney reported that the head appeared to be presenting, and that the fibroids were out of the way. On the 31st of July there were indications that labour was commencing.

As Dr. Umney was leaving home next day for his autumn holiday, and his substitute did not care to have the responsibility of the case, the patient was sent into Queen Charlotte's Hospital, where she had a normal labour and made a quick and uneventful recovery.

Case IV. *Group of subperitoneal fibroids in a uterus six weeks pregnant but enlarged to size compatible with a pregnancy of five to six months; myomectomy advised; pregnancy allowed to go on; delivery of living child at term without complication.*—On the 8th of March, 1899, I was asked by Mrs. Garrett Anderson to see a patient with her under the following circumstances:—The patient's age was 33. She

had been married about two months and a half, and as menstruation was now nineteen days overdue, she was presumably about six weeks pregnant. She had consulted Mrs. Anderson in November, 1897, when unmarried and engaged in teaching, on account of an aching and feeling of weight low down on the right side of the abdomen. No tumour was at that time discovered on abdominal examination. She had not been seen again until shortly after her marriage, namely, in February, 1899. There had then been no missed period, and there was no evidence of pregnancy, but the same symptoms were complained of as in 1897, and on examining the abdomen a tumour was now plainly to be felt, causing an enlargement equal in size to a three months' pregnant uterus, and apparently affecting the anterior uterine wall. When next seen, on March 3rd, menstruation was a fortnight overdue and the swelling was considerably larger. A second opinion had been taken and operation (myomectomy) advised, whereupon I was consulted.

The uterus was enlarged to the size of a five to six months' pregnancy. A solid, rounded tumour, 4 inches in diameter, was felt in the anterior uterine wall to the right of the middle line, lying immediately beneath the anterior abdominal wall and not pedunculated. *Per vaginam* two other smaller, hard, rounded tumours were found, one in front of the upper part of the cervix uteri, the other to the right and behind, somewhat higher up.

The question of myomectomy was discussed. The presence of other tumours besides the main one, and the doubt as to whether the tumours would really offer any obstruction to delivery, made me hesitate to recommend operation without further consideration. The chief danger of letting matters take their course lay, to my mind, in the risk of irregular contraction after delivery and *post-partum* hæmorrhage. I suggested that another obstetric physician should be asked to see the case with me, as the decision was one of exceptional difficulty and responsibility. The husband, however, said that as there was evidently some reason to doubt the necessity for operation, he would prefer accepting the risk and avoiding operation. He further

said that he would never reproach us if the event proved unfortunate. The patient and her husband thereupon returned to their home in the country.

On the 20th of April the family practitioner came up to town, accompanied by the husband, to report that the swelling had undergone a very sudden increase in size, reaching up to the costal margins, and that the patient was in such severe pain as to necessitate the administration of morphia. I expressed the opinion that the symptoms were probably due either to alteration of position *plus* normal increase in the growth of the tumour, or to continuous and painful uterine contraction, the result of some concealed intra-uterine hæmorrhage, in which latter case spontaneous abortion might be expected to follow. Meantime I advised that a vaginal examination should be made, in case abortion should be threatening, and that under any circumstances there should be as little interference as possible. I further recommended that everything should be in readiness for hot douching in case of need, and for packing the uterine cavity if douching failed, and I arranged to go down immediately if wanted.

Nothing more was heard of the case until November, when Mrs. Garrett Anderson very courteously forwarded me a letter from the patient's husband, in which he announced that his wife had been confined of a fine healthy boy on the fifth of that month, and that when writing, four days afterwards, he was able to report that she was doing wonderfully well. A trained nurse (he informed Mrs. Anderson) had been in almost constant attendance throughout the pregnancy, and the patient had always been carried up and down stairs, and had only been out of doors in a bath-chair. "I thought," the letter somewhat naïvely continued, "I should like to let you know what wonders a perfectly quiet life and Nature have done for my wife."

A few days later the doctor wrote to tell me that "luckily nothing untoward happened, there being practically no hæmorrhage to speak of." He was rather alarmed for the first thirty-six hours after labour by the rapidity of the pulse, 120 to 140, and by a certain amount of blanching. Both these signs had improved. The tumour was then

(Nov. 13th) still large, reaching nearly to the right costal margin. As this paper is passing through the press, I learn that the patient, having become tired of her tumours, is about to have them removed by hysterectomy.

I append a table of all the cases in which I have thought an operation necessary. Three of them proved fatal; these have already been published in detail. The references are given in the last column of the table. Of the two cases of myomectomy, one (No. 2 in the table) was that of a doctor's wife (recently a hospital sister), who, being six weeks pregnant, had a pedunculated subperitoneal fibroid attached to the fundus uteri. As the tumour was the seat of considerable pain, and appeared to be capable of being easily removed, I advised that it should be taken away. This was accomplished without any injurious influence upon the pregnancy, which continued to term, and ended in the birth of a healthy child. When I last heard of the patient (March, 1900) she was in excellent health, and at about mid-term of her fifth pregnancy.

The other case of myomectomy (No. 5 in the table) was specially interesting from the point of view of diagnosis. The patient, aged 33, had been married four years. There was a history of one doubtful miscarriage a year previously. Otherwise there had been no previous pregnancy. She was first seen by me in consultation with Dr. Dysart McCaw, on September 29th, 1897. She had last menstruated May 22nd to 25th, 1897, and was therefore four months pregnant. Sickness had begun during the third week of June, and had, with short intervals, continued ever since. Six weeks previous to the consultation the sickness had become more constant, and the patient had been almost entirely in bed from that time, though during the last fortnight the vomiting had been less severe.

On examining the abdomen I found two tumours. One of these was soft and ill-defined, and was situated in the right inferior quarter of the abdomen, reaching upwards to within an inch of the umbilicus. This was evidently the pregnant uterus pushed to one side. The other tumour, situated on the left side, was hard, and reached much higher, dis-

Abdominal Section for Pregna

No.	Name.	Age.	No. of pregnancy.	Date of operation.	Hospital or private.	Period of gestation.	Indications for operation.
1	Mrs. H. (sent home from Gibraltar)	35	1st	Oct. 6, 1892	Establishment for invalid gentlewomen, Harley St.	22 to 23 weeks (married April 27; no menstruation since)	Had been taken serious 6 weeks after marriag continued ill and in pain ever since. Large lated, solid tumour filli lower part of abdome upper part of pelvis; a portion of tumour upper corner, where movements are felt; c canal greatly elongat displaced to extreme l
2	Mrs. L.	32	1st	June 16, 1894	St. Thomas's Hosp.	7th week	Pain in situation of pe lated subperitoneal size of fist, attached to fundus in front an right.
3	E. L.	43	13th	Sept. 13, 1894	St. Thomas's Hosp.	20 to 21 weeks	Large abdominal tumou ing up pelvic inlet; h lobulated to left and softer above and t where fœtal heart is
4	M. A. S.	46	5th	Oct. 10, 1895	St. Thomas's Hosp.	21 to 22 weeks	Large, solid, elastic, i abdominal tumour up pelvic inlet an pelvic cavity; fœta ments felt in left p tumour.
5	Mrs. H.	33	1st	Oct. 6, 1897 (Mr. H. Morris)	Private	18 to 19 weeks	Large, solid tumour a hind, and to left of uterus; thought to peritoneal and unc with uterus.

For case of fibroids complicated by *ectopic* p

uted by Fibroids of the Uterus.

ature of operation.	Result.	Cause of death.	Reference to full report of case or remarks.
section. Fœtus: female n. long.	Death in 36 hours	Shock (no p.m.)	'Lancet,' June 16, 1894.
omy. Tumour 4⅛ in. n., connected with uterus itoneum only.	Recovery	—	Pregnancy uninterrupted. On Mar. 14, 1900 patient was about mid-term of 5th pregnancy, 2 previous pregnancies having ended at term and 2 at 10th week.
n section, with removal rine appendages. Fœtus n. long. Tumour growing ly from cervix.	Death in 18 hours	Shock. P.M.—Tumour 22 lbs., filling abdomen, growing from cavity, covered by peritoneum, derived from broad ligament and abdominal wall, both anterior and posterior. Uterus 12 in. long; body lay behind and to right of upper part of tumour	'St. Thomas's Hosp. Reports,' vol. xxiii, for 1894, pp. 470—474.
inal hysterectomy, with -peritoneal stump, and val of both ovaries and pian tubes. Multiple -myomata, the large one ing downwards into pelvis state of necrosis. Fœtus: ale = 10 in. long. Uterine ty not opened before re-al.	Death in 48 hours	Exhaustion (no p.m.)	'St. Thomas's Hosp. Reports,' vol. xxiv, for 1895, pp. 472—476.
ectomy. Tumour a large nculated fibroid, 4 lbs. in ght.	Recovery	—	Pregnancy uninterrupted. See 'Obst. Soc. Trans.,' vol. xl, for 1898, p. 256.

st. Soc. Trans.,' vol. xl, pp. 285—294.

appearing beneath the left lower ribs. It rested on the muscles of the back to the left of the lumbar spine as the patient lay on her back, but it did not cause bulging either in the flank or the loin. It could be tilted forward by the finger passed under the loin. There was resonance over the whole anterior aspect. The tumour was tender, but not painful. When the finger was placed on the cervix uteri, *per vaginam*, and the tumour was pushed upwards beneath the abdominal wall, no dragging sensation was imparted to the cervix, or other impulse given. The urine was free from albumen.

The possibilities that occurred to my mind were tumour of the kidney, tumour of the ovary, and pedunculated subperitoneal fibroid. I thought the most likely diagnosis was renal sarcoma. Upon my advice Mr. Henry Morris was asked to see the case. He agreed with me as to the tumour being almost certainly retro-peritoneal and unconnected with the uterus. He thought it was either a renal tumour or a retro-peritoneal lipoma. Being asked my opinion as to treatment, I told him that I thought the tumour ought to be removed without delay, leaving the pregnancy undisturbed. I did not think it would be wise to let the case go on without something being done, and to cut short the pregnancy would be to leave the patient with the more serious operation still before her. In this view Mr. Morris entirely concurred. The patient and her husband having given their consent, Mr. Morris opened the abdomen on October 6th, 1897. The tumour proved to be a large pedunculated subperitoneal fibroid, 4 lbs. in weight, lying behind and to the left of the uterus, and attached to the left cornu. The tumour was removed, and the patient made a good recovery without interruption to her pregnancy. She was delivered by Dr. Dysart McCaw, instrumentally, of a living male child, 10 lbs. in weight, on February 24th, 1898, and both she and the child did well.

The following case will illustrate my views as to the conditions under which alone marriage should be sanctioned in the case of patients with fibroid tumours of the uterus of such a kind as to make pregnancy dangerous.

On the 11th of October, 1899, I was consulted by an unmarried lady of 31, with an abdominal tumour which had been known to exist only for a few weeks, and about which no doctor had been consulted until a week ago. The letter that the patient brought from her medical attendant described the tumour as an ovarian cyst, and stated that, in view of her approaching marriage, my opinion was sought as to the desirability of an operation. I found on examination that the supposed cyst was a slightly moveable, soft, elastic, solid tumour, forming one of a group of fibroids connected with the uterus and with each other, pushing the os and cervix uteri towards the left, partially filling the upper part of the pelvis, extending an inch above the umbilicus, and causing a prominence of the whole of the lower half of the abdomen. I gave it as my opinion that the tumours were subperitoneal fibroids, and that, inasmuch as it would be unsafe for the patient to become pregnant, she ought either to break off her engagement and remain single, or to have the uterus removed before her marriage. I stated that the latter alternative would only be justifiable if the gentleman to whom she was engaged, having been made aware of the circumstances, and especially of the fact that she could never become a mother, gave his consent to the operation and expressed his readiness to fulfil his promise to marry her in the event of her recovery. The gentleman, on learning my views from the doctor, very naturally desired that another opinion should be obtained. The patient willingly consented to this, and her doctor took her therefore to see Sir John Williams. He was of opinion that she ought to break off the engagement and not have any operation. This advice, however, failed to commend itself to the patient, who desired me to undertake the operation forthwith. I insisted upon her taking a few days to consider the matter, and if at the end of that time she should be still in the same mind, I promised to accede to her request. At the end of the time specified, I was informed that there had been no alteration in her wish. I thereupon admitted the patient into the Hospital (for though well educated she was by no means well off), and on the 7th of December, 1899, performed abdominal

hysterectomy, leaving both the ovaries. The patient made a good recovery, and was married six months later. When I last saw her, in January, 1901, her health and spirits were excellent.

Postscript.—The following case escaped my recollection, or I should have included it in the foregoing table.

On July 3rd, 1897, I was asked by Dr. Glover, of Highbury, to see with him a lady, æt. 35, the wife of a medical practitioner. This lady had two solid abdominal tumours of considerable size, and had, for the first time since she had been married, missed two menstrual periods. Dr. Herman had seen her a few days previously, and, although he could not say with certainty whether the tumours were uterine or ovarian, he had expressed the opinion that they ought to be removed. It was on this question of operation that I was consulted.

The patient had been married ten years and had had no children. She had enjoyed good health until about five weeks previously, when she had first noticed some abdominal enlargement. Since that she had on two occasions suffered from retention of urine, and had had a good deal of pain in her back and thighs. I found that the uterus was pushed up against the left side of the pelvis, the cervix projecting normally. There was a solid tumour, equal in size to a fœtal head at term, filling up the pelvis, depressing the vaginal vault, and extending upwards into the right iliac fossa. Another solid tumour lay higher up, between the costal margins and the crest of the right ilium. I expressed the opinion that the case was one of early pregnancy associated with tumours, that the tumours were either fibro-myomata of the uterus or solid (? sarcomatous) tumours of one or both ovaries, and that an operation was desirable.

A few days later Dr. Herman operated. He found the case to be one of pregnancy with fibroids. He first opened the uterus and removed the fœtus, and then removed the tumours and uterus by abdominal hysterectomy. The patient made an excellent recovery.

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