CASE III.—Mrs. P., aged 66. I saw this patient with Dr. Tisdell, of Liverpool, on September 10th, 1897. She had been ailing for some months, had suffered greatly from diarrhœa; for the last five or six weeks very little had passed by the rectum, some scybala a week before, and at times a quantity of clear boiled sago-like fluid. The abdomen was greatly distended, and the movements of the small intestine could be seen and felt through the abdominal walls. In the right side of the abdomen hard lumps were to be felt, giving the impression somewhat of masses of fæces, pain at the epigastrium, vomiting of foul-smelling material. At 10 A.M. on the 11th, Dr. Mann giving chloroform, assisted by Dr. Tisdell, I opened the abdomen. Small intestine, much congested, bulged at once; on examining the right side the hard lumps were found to be the gall bladder and liver. The colon was empty. I traced the distended bowel down until I came to the obstruction, which was a hard mass surrounding and almost obliterating the bowel like a tight ring, evidently malignant. This mass continued into the mesentery towards the spinal column, the mesentery being much contracted. As it was impossible to remove the disease I made an opening immediately above the stricture, and stitched the intestine to the skin. At 4 P.M. she seemed to be progressing favourably, but at 7 P.M. she died suddenly.

CASE IV.—Miss A., aged 47. I saw this patient with Drs. Roe and Glasson, of Ellesmere, on the 16th September, 1897. She had an attack of jaundice many years ago, otherwise has enjoyed fairly good health until last February, when she had a severe domestic affliction. Since then she has not been well, complaining frequently of pain in the right side of the abdomen. Four days ago she was in violent pain in the same place, and sent for Dr. Roe, who ordered an enema which brought away a quantity of small fæcal masses. Neither fæces nor flatus has passed since. The temperature has at no time been higher than 99.4°, pulse 90; the pain is intense at times, the abdomen is extremely tympanitic—it appears to bulge a little more to the right of the middle line. I opened the abdomen just above the right inguinal region as if for colotomy. An enormously distended intestinal wall was exposed, and at first it was impossible to discover its extent; it appeared like a huge bladder, on the point of bursting. There were two or three black spots on the surface. It was clearly a distended cæcum. A little searching showed the ascending colon quite empty, and a strong band across its commencement. I divided this band, and then opened the distended bowel, letting out a large quantity of gas, and half a chamber utensil full of liquid and semi-solid fæces. This distended cæcum was at least 8 inches across its longest diameter, and 5 to 6 inches across its smallest diameter. Temporarily closing the opening I examined farther, and found the small intestines as empty as the colon. I stitched the opening into the bowel to the skin. She progressed very favourably for several days, her pulse varying from 90 to 112; on the third day the temperature was normal both morning and evening; she was free from pain, and had had many hours sleep. On the fifth day Dr. Roe writes that he found her pulse stronger and better, her general appearance good, no sickness for thirty-six hours; but later in the day at 4 P.M. she said that something had cracked; she had great pain; a hypodermic injection of morphine relieved the pain; she fell asleep, and died about 9 P.M.

CASE V.—Mr. D., aged 67. Seen with Dr. Trubshaw, of Mold, and Dr. Williams, of Flint, on October 7th, 1897. On the previous Friday, the 1st, he was attacked suddenly with pain in the lower part of the back; as he had been eating freely of mushrooms, it was at that time thought that this might in some way have caused the pain. On the 3rd he was much better, and on the 5th he was up, and had his bowels well moved, but late on the evening of the 5th he suddenly became faint, cold, and pulseless. His abdomen was distended, he passed no flatus, the surface of the abdomen was very much inflamed from the application of turpentine. A lotion of carbolic acid was applied, and we decided to wait until the next day. 8th, abdomen not so distended; both he and the nurse say that he passed flatus last night and this morning; temperature normal, pulse 96. 9th, pulse weaker, hands clammy, breathing irregular. abdomen very tense. I opened the abdomen, and a loop of distended colon protruding, I opened it and stitched it to the skin. He gradually became weaker, and died the following morning.

CASE VI.—H., a fireman, aged 33. I saw this man on January 15th, 1898, with Dr. G. Harrison. On January 10th he went very hurriedly to the fire station. During the day he had violent pain across the abdomen above the navel. Since then the bowels have been moved slightly with enemata. He is doubtful as to passing flatus; there is great rumbling at time; abdomen is very tympanitic and tender; has been vomiting for two or three days, brown material, but not fæcal. I advised operation, so he was removed to the infirmary. At 9 P.M. the same evening I opened the abdomen. Small intestine, very much distended and deep red in colour, at once protruded. Not detecting at once where the obstruction was, I began passing the bowel through my fingers: shortly there was a check, and then a coil came forwards with a tense projection on it, and empty bowel beyond; in a few seconds this projection began to disappear. I stitched the most distended portion of the intestine to the skin, made an opening into the bowel letting out a quantity of brown fluid. I then washed out the stomach. On January 16th, thirteen hours after the operation, there had been no more vomiting, no tympanites; temperature 99°, but the pulse was very feeble. He had a fairly comfortable day, quite free from pain, but in the evening he became delirious, vomiting again came on, and he died late in the evening.

CASE VII.—Mr. T., aged 22. I saw this patient on December 21st, 1898, with Dr. Purdon, of Connah's Quay, late in the evening. He had had a severe attack of diarrhœa some days before; the diarrhœa stopped suddenly on the 19th, severe pain coming on at the time the motions ceased. He has been in great pain since, the abdomen is very tense, no motion nor flatus has passed since the 19th, As his pulse was good and his general condition not bad we decided to wait until the following morning, applying carbolic lotion to the abdomen so as to have the skin clean in case operation were necessary. On the morning of the 22nd he was no better and the pain was very severe I opened the abdomen. After failing to find the obstruction at once, I began to pass the distended intestine through my fingers and soon met with a check. Some brown purulent fluid appeared close to the bowel. This I found to come from an abscess lying in the angle between the mesentery and intestine; the bowel was bent over this collection of pus, distended up to it and empty beyond. The pus was very foul smelling. I cleared it all away, cleansing well the surfaces which had enclosed it. No perforation could be found. Before closing the abdominal wound I washed out the peritoneal cavity. He recovered rapidly without a single unfavourable symptom.

REMOVAL OF A SUBMUCOUS FIBROID BY SECTION OF THE UTERUS (MYOMECTOMY).

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THE idea of removing a fibroid in the manner adopted in the following case was originated in my mind by the ease with which a Cæsarean section is done, but I have subsequently read what has been written on the subject. I find that Martin of Berlin first removed an internal fibroid in this way, and his case is about the only one published. He also enucleated intramural fibroids by abdominal section. Curiously, however, he seems to have recanted and abandoned the plan.

Mrs. R., aged 41, was sent to me by Dr. Percy V. Fry, of Haworth, near Keighley; married two years; nulliparous. The symptoms complained of were hæmorrhage and dysmenorrhœa. The sound passed 3⅜ inches point forwards. Bimanually there was no marked irregularity of outline, but the uterus was enlarged. The cervix was dilated with great difficulty, and at the fundus a sessile tumour could be touched. Enucleating this and removing it by *morcellement* was out of the question, as the cervix was so undilatable, even with Reid's powerful screw dilators. I therefore determined to remove it by abdominal section and section of the uterine wall.

This operation was done on December 26th, 1899, and I was assisted by Dr. Oldfield of Leeds. A median incision was made in the abdominal walls, the lower end being nearer the pubes than usual in abdominal sections. The uterus was brought up to the wound, and its rounded anterior surface came well into view. It was packed round with sponges to protect the peritoneum, and a rubber tourniquet applied tightly round the cervix, so that the operation was almost bloodless. A central perpendicular incision in the uterine wall, about 2 inches in length, exposed the attached surface of the tumour, which was recognisable by its glistening white colour.

The incision was prolonged a little, so as to open the cavity of the uterus below the tumour. The tumour was pushed out by the finger with its mucous surface entire and removed. A drainage tube was then passed from the uterine cavity into the vagina, and the wound closed by strong catgut sutures, three to the inch. These all missed the mucous surface of the interior except two, which were passed just within the cavity to loop up tags of the capsule of the tumour. The tourniquet was then removed, and hæmorrhage from the needle pricks stopped by sponge pressure. There was no bleeding or oozing from the wound itself. The abdominal wound was closed as usual. The patient has made an uninterrupted recovery. The drainage tube was removed from the vagina in twenty-four hours.

With the exception of two cases, to be mentioned, the case just related is, I think, the first which has been done in this country—that is, the first in which the womb has been deliberately opened in order to remove a solid internal tumour.

The two cases referred to are related by Dr. Alexander, of Liverpool, in a most interesting paper read before the British Gynæcological Society in April, 1898, upon enucleation of external and intramural fibroids. In only two of these the cavity of the uterus was opened, accidentally I think in one, and a small pedunculated polypus being found, it was snipped off. In the other case, only a thickening of the wall of the fundus was found, and it was "shaved down," so that my case remains the first fibroid removed by section of the uterus. (I say this open to correction.)

An earlier paper than Alexander's was one by Dr. Howard A. Kelly, of Baltimore, U.S., published in the *Journal* of the American Medical Association on October 2nd, 1897. This paper, however, like Dr. Alexander's, is upon enucleation of intramural and external tumours. In Kelly's magnificent work, however, on *Operative Gynæcology* (Henry Kimpton; 1899) will be found a full description of the operation just as I have described it, but no cases are related. I had not read this description at the time of performing my operation.

This operation is not recognised as yet as the proper mode of removing tumours which cannot be removed *per vaginam*, or which, on the other hand, are so large as to require the uterus, or part of it, to be removed along with the tumour. I think, however, that a little time and experience will show that it is the best means of so removing them. Why should such a case as the one I have related lose her ovaries or part of her uterus instead of merely the tumour. She will leave the private hospital where the operation was done with all her organs perfect. Moreover, the operation is not one attended with any particular danger or difficulty, provided complete antiseptic precautions are used.