Supravaginal Hysterectomy for Carcinoma Uteri.

This operation is at present young in the annals of surgery but it is growing fast in reputation and gives promise of obtaining an honorable place in the list of serious modern gynecological operations.

The disease is desperate therefore we cannot feel surprised when a desperate remedy is proposed. Supravaginal amputation very rarely totally eradicates the disease can justly be termed not more than a palliative measure. Prof. Trendelenburg was fully impressed with this fact when he introduced the operation of radical resection of the uterus by laparotomy an operation pronounced fatal only justified by the deadly nature of the disease and the occasional
recovery of a patient by its means. Schroeder in 1878 stated that if the disease should return five times out of six he would still operate. Then so many of the leading gynecologists can be quoted to support a perform an operation like that as it shows conclusively that from a clinical point of view, suprazugridectomy justifies itself. The operation in question is just beside being frequently fatal. What is the clinical experience of the general surgeon? If he has to deal with cancerous growths in the urothelium of a muscle in any of the parts of the body he knows that to incur any hope of a non recurrence he must remove the whole of that muscle. Thus surgical principles are arbitrary or holds as well for the bladder as for the rectum. We have yet to learn that unstriped muscle differs from striated in this respect.
The case of the uterine tumor is a more serious one, for obeying the rule in these cases is an incomplete removal of the growth within it. There is the less chance, practically no chance, of a second operation being of any service.

Again, the clinician is in this matter supported by science and gives it as his opinion after in all cases of cancer of the cervix when the endometrium is affected with cancerous disease. Archiv für Gynäk., Bd. XXX, Hft. 2.

If this opinion is correct, how can any partial operation be considered in any case serious? Granted, although disagreeing with Chad a not the condition of the endometrium yet on general pathological grounds approves total extirpation in preference to mere vaginal amputation.

Metastases are occasionally found in the substance of the uterus when of course the amputation of the cervix would be absolutely futile.
The removal of the entire uterus by laparotomy was accompanied by such a high mortality of 32 per cent. This is no surprise to the profession to have M. E. Schrader have introduced the only other method of extraperitoneal uterine removal per vaginam. The first statistic published of the results of this operation gave a mortality of 28 per cent, but I do not intend dealing with the unsatisfactory nature of statistics. In March 1845 the subject of supravaginal section of the uterus was discussed by the Obstetrical Society of London. Only two surgeons were found to say a good word for it, but they and their opinion are not a subject in which I am disposed to be disappointed. Sir Samuel Bell and Sir. George Howitt. Since that time the operation has become better known in surgery and it has been modified and improved by Prof. Sinclair under whom I have had the pleasure of working. I now intend to state a
number of cases & to make a few remarks on the method of operation & the condition under which it should or should not be performed.

Case I. Under the care of W. E. Stimson, Bishop M. S., aged 42, married, 6 children, no family history of cancer. Had good health until February 1905 when she had a menstrual bleeding which was supposed to be a miscarriage & to vary from time to time in amount, irregular & a foul smelling foul discharge, dizzy spells, weakness, pain in the abdomen.

Complaint. There is constant discharge of bloodstained, foul smelling fluid from the vagina, constancy pain in both legs. With the appearance of a caruncular growth, is now filling the upper portion of the vagina & bleeding on sexual excitement from the 6th to 8th. Biennially, the uterine contents to be movable but not freely. There was no fixation to bladder or rectum, vaginal walls intact. The diagnosis was epithelioma of the cervix with
On October 7th 1889, the operation was performed by Mr. Bishop. The pulp was first drained away by the use of very little of the cervical solution, irrigation with a 10% saline solution was maintained throughout the entire procedure. The anterior portion was divided with scissors and a soft sponge mounted on a cotton wire passed behind the interior. The bladder was then separated from the uterus in front and the cervix anterior of the uterine septum, another water pump was pushed through this opening. The left broad ligament was then tied and divided. The process of tying on the right side was very difficult owing to the friability of the uteros and two spermatic vessels passed here to be left on. After flushing, the vagina was packed with Vaseline gauze and a certain lift in the bladder. The operation was followed by much shock.

At first the urine was removed, a more drainage tube was inserted and packed with Vaseline gauze. Until the urethral condition was not very
satisfying owing to renewed cystitis & the
she did well, all the stitches were
removed Nov 21st & she was discharged
well Nov 22nd. This case was reported
in the Scand. Jan 1895. W.B. tells me T.W.
the disease has returned a short time after discharge.
The following ten cases were published
in The Practitioner Vol. XLIII. No. 6. They are
of Sinclair's first cases.
Case II. E.B. aged 39 admitted into the
Manchester Hospital Aug 3rd 1884.
For many months she had been suffering
from profuse intractable haemorrhage
in the region of the vagina & was very anaemic. Vigor
examination revealed the presence of a
gros & prominent of the vaginal portion
of the cervix which bleed profusely
there was also a constant discharge.
The diagnosis was made of the cervix.
The operation was performed
in Sept 14th 1884. The plan adopted was
that described by Blanchard. The bladder
was first partly separated from the uterus
the tubes were without being left involved
An opening was then made into Douglas' pouch. The pouch was finally brought down behind the bowel, ligatures then being drawn above down. Finally the separation of the bladder from the colon was completed, and the latter removed. During the operation the bladder was washed. The peritoneum was stitched. A perforated tube inserted into the ureter. The urine 20 hours after the operation. At the post mortem examination a large opening was found in the bladder. The waters were still intact. The ligatures were all intact, no hemorrhage occurred after the operation. This was the first operation of this kind performed in England.

The next case was operated on after the manner of Dr. T. Heath of Boston.

Case III. E. R. aged 47, 5 children. Admitted into South End Hospital October 25, 1885. The examination & history lead to the diagnosis of malignant ulceration with excision of the entire portion of the uterus. The uterus was quite movable.
The operation was performed Nov. 6, 1845. Every step of the operation was very escape the possible completion of the uleus. For the first few days she cried more and disturbance of the functions of the bladder occurred so she died Nov. 13. At the post mortem it was found that the left urethra was thick and full. There was an abscess beneath the right ovary & there were two ribs of soft parts. Dr. Sinclair then adopted a method which he has practised ever since.

Case IV. This was an incomplete operation & was little more than a superficial amputation only to the common slit at the disease. J. B., aged 48. 7 children. Poor man giving discharge of 3 month duration, papier face & cachetic state. Under per rectum disturbance, disconcerting action & constipation. He had been in and out many times from the disease, being several times carried in an ambulance. This operation was performed Aug. 2, 1847. The anterior lip was separated from the bladder & ligated in several place to stop hemorrhage. Douglas's point was then opened. An attempt
was then made to the parametrium on both sides step by step beginning from below but it was found just at the commencement of the operation to be much more extensive than expected. The operation was finished with care and accuracy. She made a good recovery from the operation but is reported to have died on October 21st.

Case V. E.A. F., aged 31, 4 children. During her pregnancy she had regular hemorrhages which continued up to parturition. 9 months ago since then she has been bleeding almost every day. Estimation is anemic. The upper part of the vagina is found to be filled with a large nodular irregular mass which on more exact inspection appears to be a hypertrophic epithelium of the cervical portion of the uterus. The uterus seems movable. The tumor blods on the slightest manipulation. The ulcerative process also not beyond the vagina. The operation was per-
Performed on Sept. 27, 1887 under constant irrigation of the field of operation with 10 per cent solution of 1 in 5,000. The operation was carried out almost entirely by the method which has been described, although certain revision was made satisfactory. The ovaries were not down. The vagina was packed with toedopore gauze. Two notable things occurred in the first 24 hours. (1) The vaginal tampon became thoroughly soaked with a slight vaginal thrush, if still of
stained - soaked the entire clumping.
(2) The amount of urine was extremely scanty. Only 4 ounces in the first 12 hours and none in the second. Thirty hours after the operation the tampon was removed + a wide rubber tube inserted packed with gauze. The patient made a good recovery. The ovaries were removed.

Case VI. E.P. aged 35, one child, no miscarriages but one in March 1877. P]. There is no family history. Last amenorrhea has been in the occurs & hope of coming childbear.
which has continued since. It ministered in much. No history of cancer. Per vaginam a soft, grayish mass emerged. Dissection was performed to the upper part of the cervical canal, only slightly visible. The uterine fundus was mobile. The operation was performed on Dec. 4 by the same way as in the last case, with slight minor essential modification. The chief of these were (i) the use of peritoneal suturing to check bleeding from uncontrolled vessels, and (ii) in order to diminish the number of ligatures. As no preliminary partial ligation of the parametrium was attempted, the specimen was intermittent. The clamping the wound two prepared sponges were left opposite each broad ligament stump. A drain was placed between them and the wound was cleaned on the 6th. The removal caused much pain. The last ligature came away Jan. 12, 1887. The patient was strong as well.
Case VII. This was a case of cancer of the body of the uterus involving the uterine tubes which was afterwards proved to be cancer by microscopic examination.

Mrs. H., single first case in the summer of 1856, very anemic with symptoms of palpitation, shortness of breath, and dyspnea more or less every day & night for two years. The cervix was almost in level with vaginal roof & the lips thinned out, uterine large, oval opening 3½ inches & cancer hemorrhage, an irregular mode & brought away with the curtain. After this she was better until early in 1857 when all the symptoms returned but were again subsided by medical but soon again returned after some absence. The operation was performed Jan 2, 1858. The uterus was small & the vagina was somewhat difficult to excise in applying the ligature & afterwards in extracting the uterus when cut away. The vagina was packed with Iodoform sponge which was not changed until Jan 6. In August 1889 she was quite strong & well
Case VIII. E.W., aged 51, & children
Admitted into St. Thomas Hospital March 1875.
She first felt pain in November 1874. Pain in deprecation, face melting profusely & frequent haemorrhage, very anaemic almost cachectic. The pain was not only caused by bleeding of the uterus but the mobility of the uterus was poor. The operation took place March 9th, and was performed in the same manner. She never had a local symptom. The first dressing was on the 16th. Seven days after the operation the bed-witch came away on the 25th.

Case IX. E.H.J., aged 53, seen in April 1886. History of haemorrhage for 15 months with pain in hypogastrum. The discharge was found to implicate the cervical canal. The uterus was large & thin & was intact. The uterine was fairly movable. She was very anaemic. The operation was performed May 1886. There was not much difficulty except in removing the uterus from the bladder when a sufficient hole was made in the latter.
stitched & the wound closed in the
usual way. All went well until the
sixth day when the catheter con-
not have been passed through the
wound as the bladders & the uterine
collected & filled the following day.
Case X. M. E. J. aged 43 single. First
seen May 10, 1889. She was thin & lean
and menstruated only profusely for nearly
a year & for the last few months there
had been an offensive bloody discharge.
The uterus was normal in size & quite
movable. She was restless & irritable &
there was profuse sweat loss & a rushing
in with the finger nails. There was
very little ulceration. The operation
was performed on May 14th when it
was found that the division had very
little increase. At the termination of
the operation some anesthesia persisted &
less to be pushed back. The temperature
& pulse went up after the operation & the
next day the woman was doleful &
the drainer was inserted. She died on
May 23rd. In this case I made a pop
modern examination & former reports, as a part of her in the most chronic form of necrotic of the drainer tube, the right lining was found of much damage & one large one.

Case X. J.M. aged 41, five children for 6 months. Has been prone to chronic discharge, flooding for two months. The lining was long since, quite mature, the vagina portion was elevated, as was part of the vagina wall. Before the operation, which was performed June 16, the temperature went up one day to 102. The operation was done only on the side of the uterus. The amount of vaginal mucosa removed. Her back was removed. The endometrium was found to be thickened hypertrophied & of a dark purple color. I took some for microscopic observation but could find no distinct sign of cancer. The course of the nursing she suffered from postitis which of itself gave some danger. The temperature was very high. She is now well, the vaginal mucosa removed is unstable.
Case XII. S.H. aged 33 married, 6 children one miscarriage eight years ago. Has been ill 12 months. The first symptom was NO 
of diarrhoea occurring nearly every week accompanied by severe pain. The diarrhoea is sometimes watery and of left has become offensive. The stool has increased in the last 3 months, the feces grow much thinner and aim of lipoma of the mouth. She was admitted into the Southern Hospital Oct. 22nd 1899. The operation was performed on her right leg next about the diagnosis of cancer. The left arm which was acute was removed and the right arm was left. Two weeks later a pair of ligaments was left on one breadth. After the operation the tumour was cut the wound remained closed. The stump was removed. The sear of the intestine was not recognisable.

The swelling was removed for the first time Nov. 4th, the right leg. After this the tumour frequently rose at night. He noticed on an occasion when it reached over 109° centigrade to a man who said this may have been caused by an infection. But
more probably by contamination with a
septic case in the ward next, but of
this the temperature never rose above
105°. The patient was removed Nov. 16. &
She was discharged well Dec. 2. 81.
Case XIII. D. H. aged 23 married 2 children
Admitted into St. Vincent[s] Hospital Oct. 19. 81.
Last child was born Nov. 5. mo. 4 ½ & was nur.
She had back pain in the back & an
episiotomy discharge. There was marked
erithematic color of the urine. The operation
was performed Nov. 6. The uterus was removed
with both ovaries & was attended with
much dyspnoea & chill. Nov. 7. The pulse
& temperature being both near 100 & 104;
respectively. Enchondral section was performed
this evening. & the abdominal cavity washed
out with saline solution. On Nov. 8. There
was no improvement & she slowly made
& died on the morning of the 9th of November.
The body was not subjected.
Case XIV. A. C. aged 35. married 2 children.
1 has died an episiotomy resting discharge.
For the last 8 weeks with slight pain
in the back, menstruates very fortnight.
She was admitted Dec. 26, 1839. The operation was performed Jan. 8, 1840 after the nature of the disease was fully ascertained. The operation was found of difficulty, bowing the stomach occurring after a good deal of shock followed from which however she was recovered. She was drawn for the first time Jan. 16th. All the stools were removed by Jan. 24th. The recovery was complete except for some incontinence of urine which otherwise proved to be due to a fistulous opening in the bladder.

Case XV: A.M., aged 41; married 11 children; admitted April 10, 1840. It was seen with great The first symptom was diarrhoea of pain chiefly when it was on examination the urine was found to be reddish with causes into the urine mercury. The operation was performed April 22nd. Not time nor work to do some extraction of the disease into the urine. Present the urine on the bladder on April 18th urine was found to be coming from the vagina and a culture was sent into the bladder, first during April. This case is still under observation in the hospital.
Case XIX. E. W. aged 47 marriage 7 children. Mumps occurred 15 months ago but 9 months ago she began to have burning of eye with cough & in the instilled the left and whole side was hot no pain. She lost flesh & suffered from cold mouth only for the last
3 months by the mumps from face in the left lumbar region. On examination a cataract occurred about the edge of the cornea & found on the anterior lip of the cornea, the white was not very fluffy membrane. The operation was performed April 6th 1860 the ulnas was removed but difficulty was experienced in the cure infection of the right breast inguinal.
The wound was closed for the first time April 1861 and the stitches came away on the 20th when the wound was looking very healthy. This case is still under operation.
The last five cases were operated on by Dr. Smith in last home not at present been published in any of the journals, he has done his other cases which were very successful but I am unable to give the notes of them. The next five cases were
Operated on by Dr. Donald of St. Mary's Hospital and he has kindly sent me the notes of these. They have not been published.

Case XVII. E. S. aged 28 single. Admitted October 15, 1868. Complained of profuse watery discharge which was offensive, constant during the last three months, no pain, no hemorrhage.

Physical examination: cervix is retracted by a large, purplish, friable mass in the centre of which the outline can be felt, bloody, freely on being touched, no infiltration of the broad ligaments. Operation Oct. 25.

Semicircular incision in anterior portion of vagina. Uterus exposed from the bladder by means of fingers. The peritoneum opened in front of Douglas's pouch. Thence opened into retro-ligament. Then in section from below upwards, no forceps used. No stitching of vaginal vault. Drained with two strips of gauze. Patient had no pain after operation.
Highest Temperature 105° on the night after the operation. They removed 0.7 lb.
Influenza removed on Nov. 1st & Nov. 4th.
Discharged Nov. 20th. Vomited on one occasion some small quantity which seemed
green & healthy. Patient died Nov. 22nd.
Cecaline has undergone prolapse &
feels as if being pushed. Patient who
was very weak & robust on being
discharged is beginning to lose flesh &
complains of pain in the pelvis.
April 16th letter from patient who
has returned to her home in Germany.
To say she still has pain &
discharge, but her general health
keeps fairly well.
Case XVIII. E.B. aged 32, married,
nine children. Symptoms date back
Twelve months. Complains of copious
melting poster discharges & attacks
of menstruation at times very profuse.
Very cachectic. Locally, cancerous
mass is situated in cervix which
is less opened out. Runs up to
internum. Rectum & bladder open. 
free & no infection can be felt
in the broad ligament.
Operation Jan. 22* 1859. In similar manner to the preceding case - one
of the ligatures slipped from the
broad ligament after clamping. The
nurse + then used one more clampage.
but this was controlled by another
ligature. Soon from this occurs
the operation was free from difficulty
or complication. Patient never seemed
to rally from the operation, she con-

continued to be sick on the same
day & sickness continue throughout
there was no discharge or symptoms.
& she was quite unable to pass the
pee. She seemed weak & slender.
Jan. 27th or the 5th day after operation
*DANCEL states that the only cause
which could be assigned for the
rapid result was death. The cachexia
& anemia were not for advancement
the permit of the patient reliving after
operation. If hemorrhages had not taken
place during the operation beliefs the


results might have been different.
I have merely limited myself to merely one performed in healthy a
mild the first operation I have
mentioned. They are all the same. I do
have been alone and I think that the
results have been well for the fifteen
first operation of this kind cannot
be expected to show triumph
results. Operations done only by their
mistakes, + the greater mistake that
were to have been made is that of
operating on unmarried cases.
The method of Operation

I will now give nearly in his own words the method employed by Dr. Sinclair as it is by his method that the other cases I have cited have with slight modifications been performed. As House Surgeon to St. Vincent Hospital I have had the privilege of assisting in the surgical arrangements of watching the course of nearly all the cases I have related.

The external parts are shaved and thoroughly washed with soap and then with a disinfectant. The operating room is sprayed with carbolic for some hours before the operation. The patient is anaesthetised and placed in the lithotomy position and is kept in this position by leg holders and by two nurses who support a bag with one arm and have the other free to hold anything that may be required. The operator sits on a low stool in front of the patient and introduces a short broad
speculum. The field of operation is then thoroughly washed with a strong solution of cocaine albumin 1 in 500 & a pledget of cotton wool is then reinserted. Then, the same solution is pushed into the canal of the urethra. Constant irrigation is kept up during the operation with a hot solution of cocaine albumin 1 in 500.

1. Separation of the Bladder from the Urethra. The anterior lip is seized with artery forceps & pulled forward & downward by one of the assistants. The incision is now made across the front of the urethra, near the bladder as in Figure. The position of the bladder is uncovered & fixed by means of a curved forceps. The incision is not made with a simple snare of the knife but a silk ligature is quickly passed through the urethra & then the mucous membrane is divided. All the ligatures employed are cut long & held out of the way.
The bladder is then separated from the uterus by means of the index finger or of the handle of a scalpel as soon as this can be done without injury to the bladder. The inner wall of the bladder is then separated, and a small portion of the mucous membrane is carefully separated. The muscles of the uterus may be cut up by means of an artery needle curved with a loop near the uterus and divided with scissors on the side next to the uterus. Dr. Sinclair used a specially constructed slender needle slightly curved with a notch about a quarter of an inch from its extremity on its dorsal aspect.

(2) Steps to prevent haemorrhage. As there is usually considerable veins from the para-uterine vessels, the left pelvic vein must not be divided until at least of the lower end. The vagina is cut through with the same precaution as in front. The needle is then passed in the same manner through the lower portion of the uterus into the uterus portions & the ligature tied tight &
The stoma or tube is divided on the side next the uterus. The same process is then performed on the right side.

(3) Opium into Douglas's pouch.

It is now found that with the aid of the scissors or nippers, as Needless, the uterus can be so kept down that the vulva or vestibular that the speculum can be dispensed with. The vagina behind the uterus is then ligated a cut through as in front. The lower portion of the partition is then pulled off from the cervix for some distance, then the uterus is caught and held with the jaws of the mostatic forceps a short distance from another and divided between them with scissors. The opening so made quickly divided by lateral clips.

(4) To diminish the risk of sepsis—a specially prepared soft sponge is mounted on a piece of strong silk wire and passed up into the back of Douglas's pouch through the aperture just made.
The broad ligament is the step. The vaginal wall has been cut all round & the uterus is only attached by the broad ligament & the peritoneum of the bladder. There is not before given any way. The inner wings of the left hand is now passed through the opening in the pelvis of the front to the lower margin of the broad ligament so as t

The needle when it is passed through either from before backwards or vice versa. Taking its successive portion of the ligament each portion is tied tightly & divided with scissors close to the uterus, care is taken not to cut too much tissue after tying each ligature a small part being left to be included in the next. The fallopian tube doe

The right side is then treated in the same way & lastly the place vesicouterina is torn or cut through & the uterus removed. The wound in then freely irrigated & the dressing only remains.
includes the noninfluence with the overall a tube + the incision of the field of operation before mobilized final dressing; By draining on the whole field of operation in the abdomen be brought to view; the facts are then exposed & clustered with a trocar. The introduction of a tamp AE of trocar gauge is next begun, the strip of material is carried up merely to the cut end of the fallopian tube. Then this process of proceed is partially emptied the ligature are cut leaving about 3 or 4 inches of each & then the remainder of the vagina is filled with the trocar gauge, followed some external absorbant antiseptic material.

This then is Dr. Sinclair operation. I have slightly abbreviate his text & occasionally put in a detail that he has omitted.

I will now venture to make a few critical remarks concerning this method. In an operation of this kind involving the peritoneal cavity, time is of much
importance & I believe that far too much time is wasted in applying
modern ligatures. The man of the

operation should I think always be
removed if possible before the actual
operation is begun & as a test of

exposed to the rapidly imperfectly
formed blood vessels just as used to

the same time lessen the

risk of sepsis. Constant irrigation
is good from many points of view

but I think there is no need

for the use of such a powerful and

corrosive substance during the whole

of the operation, after the first

opening of the parts. I would

prefer a hot saline solution as

being the less irritating & assuming

the same purpose. I do not think

that there is any need for the

preliminary ligature of the vaginal

mucous membrane after little

bleeding. There may be wound &

be easily controlled by the hot

irrigating fluid, the same manu-
be said about the ligature in front of the uterine muscles if and
the bladder in which situation this can neither be any wound
worthy of a ligature, nor only on account of the time involved
in applying them but because this procedure acts as an irritant to the
bladder. Moreover, it was proved that causes the staphy which leads to
obstetrical accidents as an irritant to the bladder. Moreover, it was proved
causes the staphy which leads to
obstetrical accidents. I have noted performed by the Sichosi.
In all cases where the vagina is
made t narrower I think that the
bladder should be incised for
I have noticed that if this is
not done it is generally very
badly bruised or even ruptured
by the scissors, while two stitches
applied to the intestinally inclined
bladder would be ample repair
to cause very little danger in the
operation. The bruising otherwise give
much discomfort to the patient afterwards.
The sponges which are placed before and behind the wound, after the openings have been made into the peritoneal cavity, or if necessary not only for the sake of facilitating removal of contents of the peritoneum and improving its form, but also to help the necessity in getting out of the way during the lifetime of the broad ligaments. I think that if suture
early cases are sufficient to show that the drainage tube is not only useless but also objectionable, it fails in its purpose, the space which is occupied from the injured surface gravitating to the most dependent parts of the pelvis, and of the same time offers an easy path of access for any germ from the outside.

This was particularly well seen in the case of Mr. E. J. Case X., at the Post Mortem. I carefully examined the position of the drainage tube in relation to the pelvic which were collected in the perineum, found that it would have been impossible for the fluid to have escaped by its means and I believe that if the first
Dressing of Todd's pads had been left about it. The tube might have recovered. The Todd's pads act on a system & almost each drop of rain as if it is soaked into it the same manner as a lamp wick, it also has another action which is of almost equal importance, namely, it contains in its membrane as it does a very strong antiseptic, which is offer an almost impossible barrier to the onset of any infection from no much as NEW. The first feeling a dressing may be safely left in situ at least five or six hours I believe TPE & I decline to do more; removal the first dressing before the wound dress by which time the air-tight cavity in generally found to be not open from the field of operation. This change of the position are most immediate & remote. Of the immediate changes which may be mentioned that I believe NEW death from this cause is rare. I have not seen a case mortality & I have always found it to be reso
After an abdominal operation, the most important accidents that might occur is ligation of a vessel but this is now so little now that the shock is not inadvertent or the parts twisted out of their ordinary relations. Wounds of the bladder may occur especially where the disease is far advanced or where there has been much accompanying inflammation. Perforation of uterus or of intestine does not often occur. It is a complication to be guarded against. Actual becoming of the intestine is hardly likely to occur but the tension of the spernum may give rise to peritonitis as it did in the case of J. M. Case XI calling alarming symptoms. Erysipelas is a danger to be probably preceded against. Case XIII being a case in point. The symptoms coming immediately on the patient occurring on the third day she was practically young and strong in all respects a good case for the vesicle operation. Of Danger must we have firstly to introduce a certain amount of which is I believe necessary for
The closure of the wound by the incision amount is increased if it may
easily become general or at any rate serious, causing adhesion of the intestine
and possible obstruction by their contraction.
Slopping of the bladder well a few
days after the operation may come
picture so greatly new the benefits
otherwise derived from a successful op-
eration. The urine should be drawn off
at least every six hours so as to keep
the rest of the bladder free
from even moderate distension. The
bound should be moved on the third
or fourth day so as to prevent adhesion
the urine of the trophic dressing or
the wound remains it necessary to introduce
a tube for that purpose as well as for
The relief of bladder which so often
urine adhesion in all operation on the
vesicovagina. Cystitis very frequently
occurs but as a rule is not a very
serious complication but it causes a
good deal of discomfort to the patient
and should be guarded against by careful
attention to the cleanliness of the exterior of the exterior peritoneum.

Cancer of the uterus is one of the dreadful diseases that all human surgeons will operate when there is only the smallest hope of a new recurrence and no until the time comes, which can hardly be. There are absolute limits to be drawn between the cases fit and those not fit for operation. Statistics of any accuracy cannot be drawn up. The cases I have quoted show this in a marked degree. The surgeon finds it difficult to obey his own limits thinking he may be able to cut wide of the disease and not being satisfied as to its extent until it is proved by demonstration on the operating table. It is by this means that his statistics are spoiled and practically useless. So many circumstances combine to deceive the surgeon and human surgeon, like Dr. Donald's second case (XVIII), the local disease was so circumscribed and its eradication
as early as he was induced to overlook the fact that the patient's constitution had been poisoned with the disease, aided by the accompanying anaemic. I think this case shows the folly of attempting to cure an operation when the cancerous exudate or poisoning is far advanced. Of course if any of the pelvic glands or uterine ligaments are involved the operation is useless. A very important point is raised by Dr. John Williams, as to the direction in which cancer of the uterine spread, at the last meeting of the Obstetrical Society in London, April 29, the state that the disease spreads directly into the parametrical tissues, only at a late stage involving the remainder of the uterus, but I must say that of the many cases I have been able to examine the opposite is the case, but if it was the case the simple vaginal amputation would be equally useless. It is interesting to compare the discussion which took place in the same society
in 1895 & The discussion of this last month, the operation is increasing in favor & nothing is more likely to make it advance than a little healthy opposition & criticism, for my own part I am no convinced that it is the only rational mode of dealing with the disease. Yet I should feel it to be my duty to strongly advise it in case of recent origin & uncomplicated by constitutional or other organic mischief & such as fibrous, bright, chronic & malignant but I would hardly encounter with obvious objections to any recent operation. In conclusion I would state my belief that supergravidal hysterectomy will in the near future be the only radical operation for cancer of the uterus or cervix when & that the supergravidal amputation will cease to be performed & only be remembered as an interesting historical chapter in the evolution of modern gynaecological work.

Henry B. Hetherington