Notes on the Constitution of Ovaricotomy.

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Case 1.

A lady, aged 53 years, residing at Hartlepool, came into my care in August 1879.

The Complainist of an abdominal Swelling. History. Her family are plaintiffs and healthy.

She has always been well except for one good circumstance. She only illness she has had was an attack of "diarrhoea fever" 12 years ago.

For the last 3 years of her menstrual life, she had a swelling at each period.

Nine years ago, without any known cause, she noticed a swelling in her abdomen. She consulted a medical man who told her that there was a pear shaped tumour. At this time she had some pain in both groins and occasionally a burning down.

At the menstruation period, which ceased 5 years ago, the tumour increased, according to her account, to such an extent as to cause breathlessness.

For the first year the tumour grew quickly. At the end of this time, she was suddenly seized with pain in the lungs, a vomiting and severe was dangerously ill; so ill, that a surgeon who was sent for to Newcastle to remove the tumour, said, "nothing was of any use, she could not live until morning."

She recovered from this attack slowly and found the abdominal swelling much less. For up to the end of the 1st year, it remained less. At the end of the 2nd year, the tumour began to increase rapidly in size, a caused vomiting, breathlessness, swelling of the face, and dysuria. It was now tapped, and a large quantity of blood and mumps (or the Swelling) was obtained.
She was actually relieved by the tapping and slowly improved.

She was tapped again in 3 years (the end of the 18th) at a similar fluid in the first instance.

A year and a half later she consulted my partner Dr. Shaw, and was then, on account of her immense size and the weight of the swelling, confined to bed. Dr. Shaw tapped her and removed 13 gallons of a dark chocolate coloured fluid in which, under the microscope, I found a large quantity of altered blood cells and granular matter. After the tapping she was very ill, slept feebly, and returned when she raised her head. She became very anemic and took 3 weeks to recover. I saw her how I persuaded her to consult Dr. Thos. Keith of Edinburgh.

His diagnosis was, "an unincised multilocular broad cyst ovarian cyst," with no adhesion to any ties more of importance above umbilicus, but in account of his care or rupture the possibility of posterior adhesions to the bowels in mind, if an operation is to be performed. The anemia does not contraindicate operation.

She could not make up her mind to submit to operation and in 9 months after the last tapping was again so large as to require relief. On attempting to tap her Dr. Shaw formed the capsule blocked with large pieces of dessicated blood clot. So soon as one piece was removed another filled the capsule and the attempt had to be abandoned without evacuating sufficient fluid to relieve her.

It was now evident to herself and her friends that operation gave her the only chance.
She consents & this, provided, I did the operation at her own house.

Present Condition
She is a tall well built, large featured, sallow woman, very anaemic, fairly well nourished, with some flabby muscles, and a cool somewhat rough skin. She rests least on her right side. There is oedema of the feet & calves & at the superficial veins of the legs.

She is married & has had 2 children & 5 miscarriages. The vessel child is 27 years younger.

She's miscarriages all occurred about the 6th month of pregnancy.

The tongue is white & flabby, coated by the teeth. Lips white, from anaemia. Appetite good. No leucorrhoea. She is occasionally troubled with deafness.

She sleeps mostly badly well & though nervous is clear cut.

Her chest is healthy though she has had slight cough & expectoration for years.

The Pulse is 96 of fair strength. At the base of the heart there is a systolic murmur which can also be heard in the vessels of the neck. The circulatory organs system is otherwise normal.

The urinary organs are in every respect healthy.

Abdomen is
On inspection seen to be enormously enlarged. There are traces of linea alba at the lower part & a dilated vein runs upwards from the left of the umbilicus. The abdomen is rounded & prominent in front. In a good light & looking from the side the abdominal
Contents can be seen to move downwards during forced inspiration.

On palpation:
The parietes are found to be of natural thickness.
The abdomen is tense all over on pressure. There is no eustatic note felt. The abdominal cavity is found to be filled with what appears to be a thick walled cyst, which is movable from side to side and in which fluctuation can be distinctly felt from side to side—
from the umbilicus to each lumbar region. Here and there small resisting masses can be felt on the surface of the swelling, possibly small stone or cysts.

The measurements of the abdomen are:
- Round umbrella: 51½ inches.
- From right ant. superior spine to umbilicus: 14½ inches.
- From left ant. thoracic vertebrae to umbilicus: 16 inches.
- From ischial cartilage to umbilicus: 12½ inches.
- From umbilicus to symphysis pubis: 12 inches.

On percussion:
The abdomen is distinct all over and unity is retained 2 inches below the ischial cartilage. In flanks low down & lumbar region a clear note is elicited.

The difference in percussion dulness superiorly or deep in inspiration & expiration 1 inch, the tympan appearing to descend to that extent.

On respiration no sound is audible.

Vaginal examination shows the vagina & the pelvis—The cervix atrophied—the uterus freely movable and pushed downwards by the tumour.
Operative

Done lay me at her own home on August 28th 1847.

Chloroform was administered and an incision made in the middle line commencing below the umbilicus. The vessels were picked up with Forceps as they were divided and the forceps were kept hanging on. The superficial structures were divided until what was taken to be the cyst wall was reached. Having what I took to be the peritoneum I extended the incision 1 1/2 inches above the umbilicus, where what I took to be the cyst wall was also exposed. I had begun separating what I took to be the abdomen on the right side and went steadily on until finding myself on the wrong side of the ileum. I knew that I was not in the peritoneal cavity but had separated the peritoneum from the parietal structures. I divided the peritoneum, which was much thickened in the middle line and exposed the cyst through the whole length of the incision. After separating some fine parietal adhesions low down, I ligated in two portions, with catgut, a piece of gauze, then divided theomentum between his two ligatures; I tapped the cyst with the largest oracular trocar. No fluid would pass through this so I incised the cyst after passing it well forward and keeping the abdominal walls firmly adjusted to it, introduced my hand.
with which I scooped out a large and glistening cholecystic clot, allowing the fluid to escape or drain out the cyst. The cyst was now found to take its origin from the right side of the uterus by a pedicle about 2 inches long & 4 fingers in breadth. It was transfixial and ligatured with thick cords of silk prepared by being soaked for a week in a 5 per cent Carbollic Solution. The pedicle was as thick as a little finger on one side turning off to the opposite one. It was tied in its half & the other which was surrounded by the portion of ligature which had served to arrest the tumour half of the pedicle. The cyst was cut off, leaving about half an inch of pedicle beyond the ligature, the ligatures cut short & the stump dropped into the Peritoneal cavity. The opposite ovary & uterine were found to be healthy. There was no hemorrhage coming up at first & no fluid had escaped into the Peritoneal cavity. The Pears were now removed from the vessels in the abdominal walls to which they had been applied & the wound was closed with 12 silver wire sutures - 5 of the sutures were applied so as to include the peritoneum separable on one side & 7 of them were superficial. The Peritoneum was so thick & resisting that the abdomen was beamed convex and after the motion of the sutures it was passed down on the abdominal contents. The wound was dressed with a Lister's dressing, the thigh & all other Listerian precautions having been followed throughout.

The operation lasted 1 hour & was well
The quantity of fluid removed was about 30 quarts. The solid matter weighed 7 lbs. It consisted of an minute thick walled cyst with numerous tendons attached in different parts more particularly near the peritoneum.

After Progress

At 10 Am. August 28. (Ewing of operation day) I am very well. Perspiring. Pulse 100 Temp. 99.8° Troubled with occasional eruct which shakes her. A fair quantity (16 oz) of urine drained off by catheter which is passed every 6 hours. No sickness.

August 29 10 Am. Has not slept during the night. Is very pale and perspiring. Pulse 108 Temp. 98.4° No pain in belly but is tender on being touched. To have in addition to small quantities of milk, water 3 oz of Champaign every 4 hours. Urine Secrete very free & drawn off by catheter. Is not stained with Carbolie Acid. No sickness.

August 30 10 Am. Has had a favourable night. Pulse 100 Temp. 100°. The wound dressed & looking well. Still perspiring freely.

10 Am. Pulse 108 Temp. 101° 4

September 1 10 Am. Slept at intervals. Some pain in bowels. Pulse 98 Temp. 101°. Dressed. Some tenderness & swelling on right side incontinence where peritonum was separated from parietes.

10 Am. Pulse 120 Temp. 100° Perspiring freely.

September 2 10 Am. Slept at intervals. Pulse 100 Temp. 101° 4 Complains of griping pains.

10 Am. Pulse 110 Temp. 101° 5.

September 3 10 Am. Pulse 100 Temp. 101°. Dried. Complains of pain & considerable tenderness over right side of abdomen at spot previous.
noticed a fluctuation can be felt here.
10 Am. Pulse 108 Temp. 101.2

Sep 4. 10 Am. Pulse 110 Temp. 101.4. Complains of right side of abdomen which is hot & very distending. No fluctuation was still very distinct this was visited under the spray & 10 ounces of Sanguineus fluid removed. A 3 inch long, Sutured drainage tube was inserted & a large antiseptic dressing put on. The discharge was odorless. 5 stitches were removed.

10 Am. Pulse 108 Temp. 102.2. Feels easier.

Sep 5. 10 Am. Pulse 100 Temp. 99.8. Brought a table spoonful of discharge in dressing. Some sutures were removed. Feels easier.

10 Am. Pulse 90 Temp 99.2

Sep 6. 10 Am. Pulse 94 Temp. 99.5. All remaining stitches removed and only one inch of drainage tube kept as the discharge is

10 Am. Pulse 84 Temp 98.

Sep 8. 10 Am. Pulse 100 Temp. 99. An enema given & bowels moved freely for first time since operation.

Sep 10. 10 Am. Pulse 80 Temp. 98.8. Sutures removed. Incision in median line healed. Carlutie regimen all over skin & abdomen causes great improvement.

Sep 12. Small granulating wound where tube was. Dressed with Lug Penisar. Regiments skin dried & dusted with equal parts of Oil of Linie & Starch Powder.

In 6 weeks this patient had quite recovered & remains firm (1884) well. She wears no bandage as her abdominal sakes are firm & strong.
Case 2

J.T., aged 32 years. Married residing at West
Street, consulted me May 23, 1880.

She complained of an abdominal swelling.

History: 3 years ago, a few weeks after the birth of her first child, she felt a pain in the right groin, and a sensation inside, as if something were dragging when she laid on her left side. She continued in poor health, unable to go out. She noticed that her abdomen was beginning to enlarge. She grew bigger slowly, a year ago saw a medical man who told her she had a tumour. During this time menstruation was regular; the tumour was not affected by it or anything that she was aware of; her only trouble was the presence of the tumour.

The tumour grew gradually till December last when menstruation ceased. She began to feel ill. A fortnight ago she began to feel what she desires to be the movements of a child in the abdomen.

She knows of no cause for her illness unless the birth of the child. She has been healthy, though not robust, all her life.

Her mother a other relatives died of consumption otherwise there is nothing of interest in her family history.

Present Conditions

She is of average height, well nourished. Her face is freckled with florid cheeks and at sides of face & forehead. Temperature 98.4. Externally the abdominal swelling is a well marked mammmary areola are the only things noted.
The lips are bright red. Tongue clean and moist. Appetite good. Bowels regular.
Her pulse is 72 a regular. Circulatory system in other respects normal.

Respiratory system normal with the exception of an impaired percussion note at the left apex but nothing abnormal can be discovered. Auscultation shows there are no signs of any heart.
(This fact was verified by Dr. Alwyn Macdonald.)
She sleeps well & being unremarkable. Eezy going is not nervous about a proposed operation.
The urinary organs are healthy.

The Abdomen:
On inspection found to be enlarged & prominent in front. Liver & spleen well marked. The abdominal contents move freely upwards & downwards during forced respiration.

On Palpation. Varieties of natural thickness. No abdominal tenderness or oedema. Two swellings can be felt in the abdomen. One, the smaller, rounded a firm, at the lower part, a pointing towards the right side. The upper had been in the right iliac fossa. The other larger swelling occupying the greater part of the abdominal cavity is softer, more elastic, freely movable in all directions, & fluctuating from the right of the umbilicus to the left flank which is most prominent. There is no fluctuation from side to side of the abdomen.

On percussion. The abdomen is dull anteriorly from pubis to within 2 inches of right groin. Contours laterally & posteriorly, clear. From a line drawn upwards from centre of iliac crest & in the left side anteriorly also to nearly half the length of
Preliminary examination in the lower abdomen. The liquor is pushed down to the level of the umbilicus.

With an umbilicus = 3½ inches

From right anterior sup. iliac spine to umbilicus = 8½ inches

From symphysis pubis to umbilicus = 6½ inches

An auscultation on the right side a murmur is felt up to the umbilical level, a possible fetal heart.

Vaginal examination. The examiner finds on the left side is continuous with the cervix. Balloon is not used. The cervix is soft, granular, pink, and has some scars or lacerations on it. The anterior roof of the vagina is stretched a bit. Neural of a dark color.

Diagnosis. A multilocular ovarian cyst.

After removal a pushed to left leg by a uterus 5 months pregnant.

Prior to operating, I took this patient to Edinburgh to see Dr. Angus Mac Donald. I read my notes to him to be confirmed any observations. He agreed with me that ovarian cyst was the correct diagnosis.

Operation

I performed the operation on June 11th at the patient's home. Chloroform was used to induce. The ovary is a large, reaching almost 5 inches. Measurements from the umbilicus made. The bleeding points were severe. The Ren's forceps which were left hanging on. The peritoneum was reached and easily divided when two swellings came into view. The ovarian tumor is 3 inches to the left, the pregnant uterus to the right. In appearance
The difference between the two was slight. The ovarian tumour had a peculiar 'bunch knot', the pregnant uterus looked yellower more leathery.

The difference was so slight that unprepared for the actual condition it would have been easy to suppose two ovarian cysts present.

Two long cervices as heuris & urterum were ligatured with catgut & divided. One cyst was tapped with the largest trocar, particularly wider, then used for the purpose of introducing the hands to break down the membranes softer.

The Peritone was almost 4 inches long & broad sprang from the left side of the uterus. It was transfix'd a tied in two halves with silk prepared as in Case 1. One cyst was removed the cervices leaving 1/4 an inch of peritone below the ligatures, the ligatures cut short & tied. Stump of the Peritone dropped back into the abdominal cavity.

The uterus relieved from pressure now came to occupy the middle line.

As no fluid had escaped into the abdominal cavity the wound was at once closed with 4 deep (including peritoneum) sutures 1 4 superficial of silken silk. No sponging of the abdominal cutends or feeling for the other wery was indulged in.

A lintless dressing was applied, the operation being then continued throughout with every anticipatory detail.

The operation lasted 1/2 an hour & was well borne.

The quantity of fluid removed was 6 quarts. It was the usual grey yellow ovarian fluid. The weight of the solid matter after breaking up all the numerable small cysts of which the whole was composed was 12 lbs.
Progress
June 11 9 Pm. Complains of restlessness. Sied 3
Times since operation. Pulse 124. Temperature 100°
Orders Supposions Magnesia 3 gr. Some mucus drawn up by catheter.
June 12 10 Am. Had a quiet night after tur
Supposition was siek twice. Pulse 100 Temp. 98.8
10 Pm. Sickness still continues. Pulse 108 Temp. 98.8
June 13 10 Am. Pulse 120 Temp 98.4. Sickness still con
tinues. He vomits every thing he eats. Has
faul of water. Ordered gr of Hysocyamine Creba
and gr of Acid salicylic acid 2 times.
June 13 9 Pm. Sickness severe after 3 hours of
rest. Feels easy. Pulse 116 Temp. 99°
June 14 10 Am. Still Convalescent. Pulse 94 Temp 98.7
9 Pm. Convalescent. Pulse 94 Temp. 98.8.
June 15 10 Am. Convalescent. Pulse 100 Temp 98.
9 Pm. Jaccies eaten. Siche again. Pulse 116
Temp. 99.4. Ordered an After-seeing mixture.
June 16 10 Am. Still sick. Has complaints of slight
pressing pain in her abdomen. Pulse 120 Temp. 98
12 Am. Pulse 120 Temp. 100.4
Ordered Suppos Magnesia 1/2 gr.
June 17 10 Am. Convalescent. No Sickness since last
being pulse 100 Temp. 98°. Dresses for the first
time and half of the Sutures removed.
10 Pm. Pulse 100 Temp. 98. Afterward normal.
June 21
Sutures removed.
June 22.
Got up and walked creek bed without
intervention.
Oct 10. Untined, after a natural Calving, of a
Strong male child.

This patient is at present in excellent health and has another child in February 1883. She shows no tendency to palsy or other support. There is no tendency to dementia.
Am. ced. 59 years. Married residing at

She complained of pain and swelling in the
left side of the abdomen, difficulty in passing
water, loss of flesh and strength.

History. Her family history is good. There
appears to be no hereditary disease. She has
been well for a moderate time, though keeping a public
house. She has worked hard for many years
and been much troubled by pulmonary disorders.
She is the mother of 6 children, 2 sons and 4 daughters,
which is 39 youngest 19. Two years ago I
attacked her for a tertianis by the side of
the bed. While these appearances she has
had no illness except present one.

Her present illness commenced in February 1879.
She had then a severe attack accompanied by
severe pain in the lower part of the abdomen on
the left side. This passed off, but after a week she was able to get about again. In the
middle of April of the same year she had
an attack in which she passed no water for
36 hours. She was very sick, vomiting everything,
it was alternately chilly and hot. She now visited
by her doctors, which were paintful. The swollen
herd medical man passed at catheter but it
swelled escaped by it. Shortly afterwards, however,
it came away freely when she felt much easier.
An unusual flow continued for 3 or 4 days. She
was sure that the abdominal swelling markedly
increased in size. After this the abdominal
swelling grew rapidly, she was confined to
bed for several 3 days. She vomited frequently,
and lost a considerable amount of blood.

On the advice of the doctors she was
brought home, where she was attended
by a physician who prescribed a
mixture of laudanum and
morphine. She took
these regularly and
improved gradually.

The abdomen
swelling gradually
subsided, and she
began to feel better.

However, she
continued to have
occasional
episodes of
vomiting
and fever,
which
continued
over
several
weeks.

Ultimately,
she
recovered
completely.

The
abdominal
swelling
continued
to
subside
and
by
the
end
of
the
year
she
was
virtually
cured.
was feverish & chilled alternately. Present Condition

The patient is confined to bed. She is a solemn, unhealthy-looking woman of fair complexion who, though not emaciated, is very anemic. Than when I last saw her, she has lost weight. With the exception of her creatur or the convexity of the abdomen in the right side, there is nothing noteworthy externally. The rectum is on the right side. Her temple this evening is 100.2. Pulse 104 weak regular.

Her tongue is large, white, and feathery. Appetite for meals fair. No secretion in mouth. Bowels regular but much troubled with flatulence.

She sleeps well & is resigned. Her respirations, a circulatory system are normal. She has pain originating from left side towards breast. The bladders is involved causing her to get up about 12 times a night to urinate.

An examination of the urine shows the quantity passed in 24 hours 36 oz. of a light straw-colored fluid specific gravity 1.012, an alkaline reaction at a quarter in the chlorid of muriatic acid. Boiling + the addition of nitric acid shows a slight opaqueness. Under the microscope, pus cells.

Menstruation has ceased for 14 years. It commenced at the age of 13 and was irregular & normal through life. The pulse was

On Palpation Inspect the spleen to be enlarged, particularly on the left side. The Pancies appear relaxed & are touched with dilated veins. Plenomeiciebut no dilated veins. The enlagement is round & prominent in front.

On Palpation The pancreas are of natural thickness...
A swelling can be felt on left side of abdomen, extending from below the ribs into the pelvis, & extending to the right of the umbilicus. It does not move freely from side to side, and appears deeply fixed below in the pelvis. The ascension can be felt from side to side of the swelling.

The abdomen is slightly tender all over. The presence of a solid mass of intestine in front of the tumour can be detected by Murphy's sign. A hand was rubbed over it when peristalsis could be felt, and the loops of intestine can be seen or felt as they run across the tumour. There is no crepitus.

The felt:

- The measurements are:
  - From umbilicus to spine 4 1/2 inches.
  - From right anterior spine of ilium to umbilicus 11 inches.
  - From ilium to superior pubis 8 inches.
  - Umbilicus to symphysis pubis 9 inches.

Percussion:

Dull was found on abdomen from pubis to 3 inches below the ilium cartilage with the exception of the position of the intestinal air. Percussion

The abdomen a lateral boundery wall was left side except a small lump occupying the full length of the lower lateral region. The tumour region yields a clear note. The tumour is very little influenced in position by respiratory movements.

Vaginal examination shows the cervix elevated high up. The uterus moves with the tumour by which it is drawn to the right side. It ascends.
Diagnosis

From the history of pain in her kidneys accompanied by bloating and suppression of urine I concluded that possible a calculus had lodged in the left ureter—that a stone or pyфрæxis had resulted in a lesion of this kind. The blood had allowed of a diminution in its size and that it would account for the absence of irritation. The presence of a coil of intestine in front of the eye, too, I took to confirm the diagnosis of this pain.

Shortly after this examination the patient's health improved somewhat. I took her carefully to Edinburgh University Clinical wards where she was examined in my presence by Professor John Logan and Dr. Munro Heron. While Dr. Thomas Keith was there. After making an examination, Dr. Keith said it was a suppurating left ovarian cyst—adherent is the ovary, bursa, uterus, bladder, perineum. Left iliac fossa $1$ at once aspirated it.

He removed 1½ gallons of moderately thick ovarian fluid stained yellow with pus, numerous cells of which were readily seen under the microscope. The degree of the operation, Dr. Keith states, was to relieve her and enable her to receive some improvement in her condition provided it was performed. He also warned her against getting out of bed too soon or too early exercise, while he said would result in a rapid return of her symptoms. She came back to start recovery in a few days not feeling tired, but being tempted by her friends or her daughter to see her, she got up, walked a mile a few times, evening as usual with prizing sickness. This attack
did not pass off at the last. Every day a slight
fever returned. She gave no signs of
her temperature was over 100° at night.

As every day appeared to lessen her chance of
getting better, I operated on June 26th at her
own house.

Chloroform was administered in the usual
manner, and ether given until the patient was
completely unconscious. The abdomen,
being opened, the neck of the bladder,
the child was removed with blankets, and
the sides and feet were kept warm.

The incision was made in the median line in
the ordinary way, and bleeding points were taken
up as the vessels were divided. The peritoneum
was drawn up to the right side so that the division between
the muscles was easier. The wound being closed, the
muscles were reunited. The peritoneum, being
left open, was drawn up from that point. A short distance above the
the umbilicus, a pouch, or extension
was necessary, as the cyst was found, as
Dr. Keith reassured, unirritated as of

The bladder as received were comparatively
positively separated by two small cuts, a few of small
litmus v. color were so firmly united to the
that as to require a suture for their separation.
A piece ofomentum was ligatured between
the two pieces of cavity, and divided.

Funmi as received in the left iliac fossa a
bladder and uterus occasioned great trouble. During
their separation, which was mostly done after
emptying the cyst, I found the greatest assistance,
from keeping one hand in the yolk cavity whilst the other was used to separate adhesions. The hand in the cavity allowed the blinded cavity, determined, a damage to the important organs is which it was as heretofore, avoided.

Finally the cyst, which was as heretofore all over, was removed.

The Peritoneum was about 3 inches lucent, 1½ inches long, and 8 inches from the left side. It was transfixed and ligatured with carbolic acid in two layers a half an inch in front of the ligature. The ligatures were not divided till all bleeding vessels in the Peritoneum had been secured. When they were cut short, 1% dropped into classical cavity.

The Pancreal and intestinal adhesions did not bleed. Several vessels especially at the back of the uterus and the funis & ligatured in the Peritoneal. So ligatures had been applied a time was still free running from what appeared the larger new veins in the Peritoneal. The day was dull & light not very good. I put on two fore-head mirror or the Lambeoscope as suggested by Mr. Spencey Wells but found it immediately got ruin useless from the spray. With a good head glass, not of reach of the spray, I succeeded in getting the whole Peritoneus cleaned up and stopped all bleeding.

The Peritoneal Peritoneal was carefully opened.

The opposite cavity & uterus were found blue.

The uterus was brought together by 14 Silkworm sutures & superficial at 6 deep, including the peritoneum.
The wound was dressed with a Liester dressing and isoeptic precautions being observed throughout. The operation lasted 2½ hours. The patient on being put to bed was somewhat collapsed.

The amount of fluid taken in was 6 quarts of tea, about 1 quart was pure water which lay at the bottom of the cup. The other fluid floating on the tea was not clear.

The weight of the solid matter removed was 4 pounds. The bile of it consisted of a purely bile-cystic color. The gall-bladder tube ran along the superior posterior surface was twisted. The normal orifice lay on its under side. It was glued to it by a mass of tissue apparently unaltered in structure. The cyst occupied a portion between the uteri in a left ovary.

After Progress

June 25 9 Pm. She has been sick once since

operation but is comfortable and warm. Pulse 108

of fair strength. Temp 98.8. Ordered a urine glass

of warm water diluted with an equal quantity

dilution of soda in water. Every half hour if not

sleeping.

June 26 9 Am. Has had a good night free from

pain and sleeping at intervals. Vomited twice.

Pulse fair 108 Temp 98.4. She says she feels as

well as she expected. To continue soda in water.

3 Pm. Is complaining of pain in her back so

she was put on a water bed which was at hand.

Pulse 108 Temp 98. Lived comfortable on flat bed.

9.30 Pm. My assistant, in my absence, saw her

in answers to a message. At 9 o'clock she has been

sitting suddenly with severe pain in the region of
11 P.M. I visited her & found her Enduring dying. Skin cold & clammy. Tere was pulse. Complaining constantly of pain in her heart. Turning about violently through consciousness & gasping for breath.

She died shortly after this. I was unable to assist.
No P.M. could be obtained.
Case 1

E.B. age 28 years, married, a native of Ireland, at West Meath. Report was first seen by me March 15th 1881.

She complained that her lumbar were gravely painful. Two years ago she fell and hurt her lumbar in doing so against something in the ground. From this she states the commencement of her illness although no swelling showed itself for months after. At first she had pain in the pubic region, pain in both legs with some swelling at the sides of the thighs, a sensation of vaginal fullness, pain in having the bowels moved, and much heaviness in the legs so marked as to prevent her from going about except with extreme difficulty.

These symptoms were all increased at the menstrual periods which had always been progressively painful.

These symptoms appeared most at a time when the term was fixed in her periods.

Here pain disappeared suddenly at the end of 4 or 5 months. Shortly after, 16 months ago, she got married.

Then or four months after marriage she first discovered a swelling at the lower part of the legs. A thought she was pregnant throughout menstruation was continued regular throughout. She went consulted a medical man who examined her and told her she was pregnant.

The swelling, at first, rapidly increased in size, but lately has progressed very slowly, remaining high up.

As the time had now long passed for pregnancy to terminate she came to me to know if anything was wrong.
There is no history of tumors in her family. Her father died of consumption. She has always been in good health. Her present illness has been gradual. There is nothing that can be except the accident for her illness.

She has had no illness.

Present Condition:

She is a healthy, plump, fair-complexioned woman of average height and well developed. She has been on right side.

The abdominal system was in every respect healthy.

Inspection:

The abdomen is seen to be enlarged, equally round; a prominent mass from above in the right side and with the light shining on the abdomen, the tumour can be seen to move more freely upwards and downwards on deep expiration. On inspiration, with the patient in her back, her arms laid across the chest, she attempts to raise herself. In a sitting posture, makes the recti muscles of the abdominal wall prominently out.

On palpation, a large round, hard, elastic tumour can be felt occupying the greater part of the abdominal cavity. It is freely movable from side to side and from above downwards.

The measurements are:

Width at umbilical level - 33 inches,
from right ant. supr. spine to umbilicus 8 1/2 inches,
from breast to umbilicus 8 1/2 inches.

From spinous processes to umbilicus = 9 inches.
From umbilicus to symphysis pubis = 8 inches.

The parietes were thick. There was tenderness on pressure over the pubic region on right and left sides.
There was no Tumour but felt any where in the skin or any pressure on internal organs.

On Percussion - There was dullness all over the front of the abdomen except in the epigastrium region and below the diaphragm. The percussion area which was separated by a clear band about 1½ inches broader - The last part of the sides of the abdomen r lumbar regions yielded a clear note. On Percussing one side of the abdomen which flat hand on the opposite side fluctuation lines felt. The upper limit of Tumour dullness was found to ascend an inch or a half on deep inspiration.

On Auscultation no Sound came the heart.

On Vaginal examination the uterus was found fully pushed back by the Tumour but was freely movable. The cervix was large, small r pointed. The Rectum anus r Vagina were normal.

The breasts were well developed but no marked cystola was present & no Colostomy lines were seen.

The urine passed in 24 hours amounted to 2 pt. It was of a pale straw color - Specific gravity 1.004. Acid Reaction. Contained a trace of albumin but no incrustation of the ureteroscope. A few granular r hyaline casts.

The circulatory & Respiratory organs were healthy.

I kept her under observation till Sept 32 & as the urine has now become normal & she was anxious to have the Tumour removed seeing no objection I consented to do it.

Diagnosis: A multilocular ovarian cyst without ascension or any fluid.

Operation Sept 32. The patient was under ether. She walked from the table when ether was administered in Ormeaus
Inhaler. An incision 5 inches long, was made above the mandible, in the linea alba. Several bleeding vessels required to be tied as the case was getting very vascular. The pleats themselves were to be closely connected in the mid-vein; thus as to require a careful dissection to effect their separation. The Peritoneum was opened with the point of the bistoury, a director introduced a the peritoneal opening enlarged on the outside to a distance of the external wound. No adhesions were found. The cyst was tapped with a fine glass broach the tumour reduced & easily removed. The Pedicle which was about 3 inches long was ligated broad ligament above (above ligatures with Carliol's silk). The cyst was cut off with scissors leaving 1 inch of pedicle stump beyond the ligatures. The right ovary was found to have connected with it a Bladder cyst about the size of a walnut which after due consideration I thought was best left alone as the patient was a married young woman & cursonis is here a family.

The operation was completed by cutting the ligatures short, dropping the stump of the pedicle into the abdominal cavity, a appearing has deep a 6 Superficial wound Sutures.

An ordinary Leukoma dressing was applied for whole operation having been carried out with antiseptic precautions, including spray.

The quantity of fluid removed was 1 quart. It consisted of 91% watery, while of 8% looking fluid.

The weight of the fluid matter after freezing and all Sphagnum was 2 lbs. The solid matter consists chiefly of one large cyst with the broken remains of numerous
Septa inside a nummulara Smaller eggs varying in size from a green nut to a pea.

After Progress
Was very happy, no complaints. For the first two days she complained of Cough & Phlegm in her throat which lasted of the Ether. The day after the operation she was slightly sick. She never was sick. Her temperature was never above 100½, a pulse only on one occasion 105.

The wound was dressed on the 4th day when 1 deep & 2 superficial sutures were removed. The sence dressing was done at the end of two weeks when the remaining stitches were removed and the wound forms healed. A piece of Ivy gauge a pad of Cotton wool with Steril Flannel bandages were applied. On the 10th day after the operation she sat up & walked herself with ease. At the end of a fortnight she walked out.

A year afterwards 3 March 1882 at my request this patient visited me. She was in excellent health. But had no family. She wears no Bandage. The abdominal scar is very small & abdominal feels perfect. On vaginal examination the Enlarged ovary can be felt distinctly in Douglas's pouch. But does not appear to have increased at all in size.

In December 1883 she died of Pneumonia Pulmonali, after ailing for 9 months. I heard of her illness & sent her occasionally till she died. Though very anxious for a Post Mortem Examination I was unable to get the consent of her friends.
Case 5

C. D. aged 25 years married a native yrs residing at Hartlycourt was first seen by me Sept 10th 1881.

She complained of pain & swelling in the loins that she was of no less size than when her child was born a fortnight ago & that since then she has been very ill.

Her temperature was 101.4.

Her family are all healthy. For has worked hard at farm but been fairly well fed. She has had the usual diseases of children whooping cough measles & scarlet fever. She has been married 2½ years & had 2 children, the last a fortnight ago. Ordinarily she has been healthy, but never very robust.

History of Present Attack. Early in December 1880, 10 months before the birth of the last child, she noticed a swelling of the lumbs after 3 days of severe sickness. She thought she was pregnant. The swelling increased rapidly at first & by Easter 1881, 3 months after she was very large. After this the increase was more gradual but she did not feel any child till two months before its birth.

During the whole of this time she suffered from pain in the lumbs, irritability bladder & occasionally incontinence of urine for which she had taken opiates of her own accord.

Before the birth of the child she had difficulty in getting about on account of her size & the weight of her abdominal contents but her confinement a fortnight ago was easy & rapid & the baby strong & healthy.

After her confinement she has been unwell.
pain in the lumbar that she seek for Dr. Duncan
who recognized the nature of the case gave her
frequent doses of Morphine Grise but pain con
I asked to see her with him

I found her a tall thin woman with
what in reality woman have been a bright complexion
She looked very ill anxious a anemic but
gave me the impression of having a good constitution
with ample energy

She was perspiring freely. Caused only lie on
her left side. Temperature 101.4. Pulse 120.

The Tongue was dry and flabby. Lips and gums with
Appetite entirely lost. Considerable twist. Barrels
Enlarged. Vomits frequently.

She stops fully because she Can see lie on
one side r has pain in her curises.

The Respiratory & Circulatory Systems are
healthy

The urine passed in 24 hours is 1 pint. Specific
gravity 1025. No Reaction. 2 1/2 days deposit of
Prussi Luminous - Otherwise normal.

The Abdomen on
Inspection is seen the Much Swollen greatly
with difficulty. She turns on her Back when
side. The shape of the abdomen was seen to be
pneumia. It was spread out towards the
left side it at its prominent part appeared the
pubis like a sugar loop abruptly terminating
in a ledge which ledge forms the anterior
boundary of the flattened left side. This gave
the impression when she was lying on their
backs that the woman was lying on to the
left side. The skin was reddened over the most
prominent part & it was seen treat the pneumia
Sweeling was the result of an acute peritonitis. On making her lie down, she fell into a sitting posture without raising her arms. It was seen that the rectus muscles were drawn down to the surface of the abdomen.

**Palpation.** The abdomen is very tender on pressure over the left iliac region. On the left side the parietes are much thickened from os sacrum, at the thickest part probably about 3 inches. Elsewhere the parietes were thin. At large tumours is found feeling the abdomen this is immovable from side to side, from above downward. A marked sense of fulness could be felt from side to side of the abdomen from umbilicus to lumbar region. No excreta could be felt.

**Percussion.** On the left side a very dull sound. On right side it is resonant. Behind a line drawn directly upwards from the right iliac crest. The liver dulness is separated from the tumour dulness by a space about 3 fingers breadth.

The tumour does not extend directly behind the intestines. The tumour was found to be anterior to the intestines. The tumour - it was freely movable. The condition of the os cervix showed a recent delivery. There was still a considerable discharge of mucus, and bloody suds from the vagina.

No measurements were taken as the uterus was already palpated with the examination, and it was thought that the diameter of the abdominal walls would make such measurements an indication of the size of the tumour. At this time she could not sit up or even move, except carefully for pain. Her breathing too was difficult on
account of the swelling a painful condition in her abdomen. Her legs were not swollen.

Diagnosis: An inflamed, suppurating, subcutaneous ovarian cyst - Ruptured.

Treatment: At this time I recommended tapping as it was evident that the bulk of the tumor was made up of one large cyst. I thought ovariotomy would have a better chance if performed some time further from the Gilt of the Closs. This I did the same day with an ordinary trocar and an尔斯 serum. Eleven quarts of a watery synovial fluid escaped. The Cast 2 or 3 Jaleeponsins were nearly pure pus. This fluid drained into the one's coppor containing blood cells. Pus - Gastrichm a Sone Celles resembling pus cells but about twice the size of the main pus cells.

After the tapping I left her in the care of Dr. Dunne. I was away from the town for 18 days. Dr. Dunne reports that her treatment became easy. She felt more comfortable than before. The next day, she was still bloody, had not seen appetite, had an average temperature of 100° in the morning and 101° at night.

In my return, I found she had lost flesh rapidly from the time of my leaving her. I was so weak as to be unable to sit up or more about in bed. Her urine was still bloody and deposits in her. I thought. I told her that immediate operation came her the only chance to pass her to go into the hospital where it done as
her neighbour's house. There was Typhus Fever or a
feverish condition. This she absolutely refused to do.
She prepared to die at home, and that if I
would do it at home she was willing. Her
temperature the day before operation was—
101.5 pulse 12.0 Eversion 101.5 pulse 11.5.
Operation on 1st at her own home.

The patient had the carriers out of bed or in
the operating table where ether was administered.

The operation was first made about 10 miles long
in the line of a bleak cool and rainy weather, which
was found the adherent, extended to about 4 inches
about the nelus. The cyst was found adherent
downwards and in the left side two strong
the adhesions were particularly firm. These were
separated by the hand. The posterior and transverse
colon were adherent by strong bands of the
which were lacerated by catheter a directed. Portions
of the small intestine which were adherent at
different points were carefully separated by the
finger. The cyst was not detached. The opening,
accidental made or already existing, in
the cyst wall whilst separating adhesions from
the point where the tapping had been performed.
The cyst was then removed. The finger
from inflammation. In separating it from the intestine
the cyst was torn at several points from the same
cause. Whilst tearing through intestinal adhesions
the lining of the cyst were easily detached, by
keeping one hand in the cavity.

The pedicle was about 3 inches broad & 3½
inches long a sprain from the left side of the
uterus. It was transfixed and ligatured in two.
leafs by strong Carbolic acid solutions.

The hemorrage was inconsiderable. A few small vessels in the abdominal wall were compassed by Raou's loops before opening the cavities. Sponging with exposure to air stopped bleeding from the vascular peritoneum, as did the small intestine were divided together by recent ligature.

The opposite as a rule was found the healthy

The uterus enlarged from subacute infection.

A large quantity of fluid, some of it purulent, which had escaped into the peritoneal cavity was carefully sponged out.

The incision was brought together by 5 deep sutures and sutures including the peritoneum,

2 superficial ones.

Two full sized and rubber drainage tubes were introduced, one into the Abdominal cavity and the other the Pelvic cavity, through the wounds. The tube was presented by sutures from within a depth of 3 inches to the tube's 5 inches, anterior to the uterus, aseptically in the wounds. The tubes were presented from falling through the wound by having a safety pin passed through their free end.

A large gauze dressing was applied, the operation having been conducted throughout with vein anti-

The operation lasted from 2 to 3 hours and a half.

The quantity of fluid removed was as nearly as could be estimated 7 quarts. It varied in clarity. Some of the gauze contained nearly pure pus, others white of egg looking fluid, others dark, like that originally obtained at the first laparotomy.

The weight of solid matter was to 10 lbs. It consisted of one large egg, or a multitude of

Dec 1. 9 Pm. Comfortable v. Dyspepsia.  No sickness. Pulse 120, Temperature 101.3. Respiration 22. She Nurse has removed 3½ oz of urine by catheter.

Dec 2. 9 Am. Has been sick twice during last night. Cephotamis v. a cough which 9½ am. Her am. air v. pleurisy in her chest. Pulse 89. Temperature 100°. She was dressed & almost 10 o'clock. Culture was found in the dressing.


Dec 3. Sick 3 times during last night. Temperature 100.3. Pulse 96. Discharge in dressing still adhered. Amount 8 mm. ni small quantity

9 Am. Pulse 94. Temperature 100.8. 3 Suppositories

Dec 4. Had a good night v. no cough v. pain. Pulse 94. 100°. The upper pulse (abdominal) 4 & stitches were removed. The discharge is discharging. She was allowed pouding for dinner.

9 Am. A good day. Pulse 96. Temp. 99.5°. From this time her progress was uninterrupted. Her temperature never exceeded 100°.


Dec 8. Had an emesis which lasted satisfactorily.

Dec 10. Dressed. Remaining stitches & drainage tubes were removed.

She recovered so rapidly as 15½ days i. e. in 10 days, 11½ days after operation.
In January 1883 this patient was removed from a hospital where she was in perfect health. The labour was rapid and natural. She wears no bandage and her abdominal walls appear as strong as ever after operation.
CASE 6.

Mrs. aged 38 years, married a widow at West Hartlepool consulted me concerning an unexplained swelling.

She complained that it was so large she could not get about her house. She told me that when she went into the street people stared at her in account of her unexplained sight.

Her family history was good time was no history of any hereditary disease. She has always been well except for a few quins in she has had no disease except the present one, from infancy.

History of Present Illness. Twenty years ago when 18 years of age she noticed herself, short a full time's health. She was examined by a medical man who told her then that she has water in her bowels. The gradually but slowly increased in size and at each menstrual period had severe pain and propose discharge. Between the 10 and 11 years ago she consulted Dr. Taylor of Hartlepool, who told her she had an ovarian tumour for which an operation would be required. She gave her some medicament after taking which she was sure the tumour diminished considerably in size.

Since her marriage 9 years ago, she has had 1 abortion (the first pregnancy) and 3 living children. After each child was born the tumour grew more rapidly. After the birth of the last child 1½ years ago the tumour became so large it caused so much inconvenience that she came under my care. She was now an unexplained sight. Girth round umbilical level 58 inches. She refused even to think of operation so I tapped her a hundred of gallons of a dark fluid. This caused the...
disappearance of the bulk of the Swelling but Small clusters of Cysts lined the Fossa and the abdominal wall and when she sat up a mass remained in the epigastric region showing adhesion of the whole peritoneum.

The Cyst slowly receded a little Swollen cysts remained so that at the end of a year it was necessary to tap again. 50 pints of a fluid similar to the first was evacuated.

After this tapping a large tumour composed of several Cysts still remained.

At the end of 4½ months it was found necessary again to empty the Cysts 35 pints were removed.

Six weeks after this her abdomen had again become tense and her general health was failing and her legs swollen. She was now persuaded that nothing but the Radical Cure could be of use.

Present Condition
She is a tall thin sallow looking woman with characteristic fingers acrosia but looked very feeble and weak.

Her Pulse 100 Temperature 98.4
Respiratory Circulatory Nutritional and Nervous Systems normal.

Urinary quantity in 24 hours averaged for a week 8 ozs and although to a variety of different measures were tried to increase the quantity they had no effect. Dark Colour Sp. gr. 1028. Acid No Alumina Sugar or other abnormal indications.

Abdomen
On Inspection tumours higher Swelled up and rounded. Linea Albae also were marked. Abdominal contents do not appear to move downwards during deep inspiration - Recti muscles seem to be bound down.
to surface of tumors. The tumor can be felt to be divided into separate portions i.e., there are rounded unicellulars of different size on it.

On Palpation

The Paries are thin. The abdomen slightly tense all over. There is no ecchymosis. The abdominal cavity appears to be completely filled by an enormous mass distinctly composed of many cysts which can be mapped out by their shape to every limited areas of fluctuation to which they give rise.

The ribs + lumbar are pushed forwards upwards. The tumor is not freely movable either from above downwards or from side to side. Fluctuation can be felt in every direction.

The measurements are now:
- Right: umbilicus 52 inches.
- Left: umbilicus 51 inches.
- Spina iliaca anterior superior: 14 inches.
- Spina iliaca posterior superior: 16½ inches.
- From iliac crest to umbilicus: 17 inches.
- Umbilicus to symphysis pubis: 12½ inches.

Perussion

Dull all over full & solid of abdomen except at extreme lower part on each side with patient lying on her back.

On Vaginal Examination

The tumor appeared to be firm in the pelvis. The uterus lay in front of it. It was of normal size, tense.

The only unfavorable condition was the insufficient action of the kidneys which I hoped would disappear when the organs were relieved from pressure by the operation.

Operation

Performed by me at the patient's own home March 3rd 1882.
...was administered on the operation table to which the patient walked.

An incision about 12 inches long from above the umbilicus towards the pubis was made in the linea alba. A few bleeding vessels in the abdominal wall were compressed with thai forceps. When the peritoneum was divided it was found that the cyst was as heretofore the umbilicus in every part but a white line at the umbilicus was free. The adhesions were separated by the hand. The cyst was happy and easily removed. The pedicle was about 4 inches long and broad. It was in relation to the depth of the uteri. After tying to transfix the ligatures in two halves the cyst was cut and the pedicle dropped into the abdominal cavity. Bleeding was free from the parietal peritoneum where as lesions had been torn and a number of catgut ligatures were employed.

The opposite ovaries were healthy. Some fluid was observed escaped by the side of the trocar into the abdominal cavity. During the tapping it was said. The woman was united leg 6 deep silers were inserted which included the cut peritoneum and 27 superficial ones of catgut.

The quantity of fluid removed was a large 4 gallons.

The weight of the substance 18 lbs. There were 3 cysts of the size of the bulb of the thumb was made up of 3 large cysts.

It is unnecessary to say that the operation done into the Douglas's cavity of adherent multilocular ovarian cysts.
The operation lasted 1 hour & was well borne. It was performed with every Military detail.

The new Constitution which caused me any anxiety after operation was the Constitution of the kidneys. A small quantity of urine voided.

From March 3rd (operation day) at 12 o'clock till March 5th at 12 o'clock only 3 III of urine could be obtained. A mixture of Acetate of Potash & Digitoxin was ordered every 2 hours. This first urine was slightly green (Carbolised) & contained a trace of Alkali.

During the next 24 hours the quantity passed was 3fl. She was complaining of slight headache. I ordered her a drink at least a quart of hot water during the next 12 hours.

Next morning (14th day) she passed 3xxx & from two to two the kidneys continued to act satisfactorily.

From first to last her temperature never exceeded 100°. She never vomited & her pain was trivial.

The wound was dressed for the first time on the 9 1/2 day when the silver were sutures were removed. She was up on the 11 1/2 day & down stairs on the 14 1/2.

On the 16 1/2 day dressing was finally removed his wound being healed & the Catgut knots being loose in the dressing or on the abdominal wall.

P.S.

In April 1885 this patient was examined after a perfect balance of a healthy mind & recovered well. Since the operation she has enjoyed excellent health.
I. A. L., age 23 years. Married farming at
West Springfield was born Aug. 1st, 1882.

I arranged with her to visit her at home on her
following day July 27th.

She then complained of an abdominal swelling
which she noticed first shortly after the birth
of her only child 3 years ago.

History: She has had a sister die of consumption
of an attack of some internal cancer otherwise
there is nothing noteworthy. She has always been
very well for years but at the present time
she has been much worried by her
husband's drinking habits. Her previous illnesses
have been unimportant.

History: After the birth of her first child 3
years ago, she did not regain her health and
remained large in the breasts. At this time she
was troubled by pain and numbness in her
right foot.

Sixteen months ago she went to a medical
man who examined her and told her she was
pregnant. This she believed as in addition to
his opinion she felt movements frequently in the
region of the umbilicus. She was sick in the
mornings. During this time, however,
menstruation occurred profusely every fortnight
as was usual with her.

The swelling gradually increased greatly
more upwards.

Six months ago she has, apparently, an attack
of Peritonitis as she was seized with severe pains
accompanied by tenderness in the whole bowels

Casa 4.
aggravated by coughing or breathing deeply. She vomited and was emulsified in her bowels.

Three months ago she had 1 litre of fluid removed from her lungs due to difficulty in breathing when a large quantity of fluid resembling water was taken away. She was diagnosed with a large fluid-filled tumour. The patient was informed that the fluid had escaped into the cavity of the lungs, and then caused the fluid to flow. It also explained that the mass which remained after tapping was too thick for her breathing to be normal. After the tapping, the patient replied to her request for further treatment.

Present Condition:
The patient is a thin pale delicate looking little woman unable to lie down on account of difficulty in breathing. Her feet are swollen. Temperature 100°C. Her tongue is not remarkable looking. Appetite has not been regular. Bowels regular.

She sleeps best on account of being unable to lie down.

On examining her chest I find the right side completely dull all over. No abnormal breath sounds, vocal resonance, or vocal resonance. There is no right pleura. The fluid of fluid.

The pulse is 96. When she is quiet, it beat after an interval of hour next time up to 120. The heart sounds are normal. She is in 15 positions.

The urine is normal in every respect.

This man:

On examination the muscular palpation: perineum, anus, cul-de-sac. A large, multilocular ovarian tumour was diagnosed. There was distinct fluctuation.
From 3d. to 3d. of the above. On examination his friction caused the heart and vicinity a suspicion showing that the empyema was at present not ashen.

On vaginal examination the empyema was found free in the pelvis, & the uterus was behind it. Measurements of the abdomen were:

- Height at umbilicus 11¼ inches
- Depth: from right angle to umbilicus 11 inches
- Right side: 11½ inches
- Left side: 11 inches
- From supraventricular to umbilicus 8½ inches

The presence of the Pelvic Effusion ovario was postponed & the cyst was tapped on 14th Feb. 15-gallons of the usual clear gelatin ovarian fluid were removed.

She was ordered thrice 3d. of Syr. Periido 3

Twin a day to have the chest packed with

Lumina coitum 10. 5

She was relieved by the tapping but had severe attacks of dyspnea at night, so on Feb. 19 she applied aspirated the chest, removing only 25 oz. of fluid.

From this aspiration she experienced some relief, but the Dyspnea returning aspiration was again necessary. On Feb. 24th I aspirated 2 times removed between 50 oz. as much fluid as could conveniently be done. The operation was done with a small syringe needle, ample time being taken over the process for a half pint of fluid had escaped before any complaint was made, when a slight cough or feeling of tension about the chest caused me to withdraw the needle.

The lungs expanded well a few cases the head

Cutting it firmly all at once.
A mixture of ½ 4 drams Perchloric + 40 gr. Iodine was substituted for the iodine or iron mixture.

The chest rapidly repelled a by Feb. 28th, a few days after the last tapping, was full again, with a return of the chyphoma.

The medicine was tried, with different external applications, till March 2nd, when the chyphoma had become so severe as to necessitate Paracentesis thoracis again.

This time I resolved to draw off slowly a pint each time, and to repeat this bile aspiration every few days, hoping by this means to gain on the fluid.

Paracentesis was accordingly performed on Feb. 28th at a pint removed March 2nd - 1 pint March 6th - 1 pint March 10th - 1 pint and on the 12th the chest was found the same full as when I commenced.

During this time the temperature varied from 99° in the morning to 101° in the evening. Many times sleep, proper perspiration, the frequent tappings and a freible appetite my patient was surely steadily losing ground.

Something more must be done. I knowing from previous experience that auto-esthetic air in the pleural cavity was harmless, I hoping that for drainage I would prevent the tendency to fresh effusion, as I knew it did in cases of hydroptic atelectasis, which I had visited all other treatments. I resolved to secure the chest auto-omptically, or put in a full sized drainage tube.

Accordingly on March 14th under Carbochloridised ether, all other auto-esthetic precautions being Carefully observed, I made a free incision into the pleural cavity, in the middle Arterial line between the
1 to 8 o'clock after 6 p.m. I asisted 3 inches of the largest sized drainage tube, with a safety-pin introduced through its outer end prevented it from being drawn into the pleural cavity. I was not prepared to see such a sudden and forcible rush of fluid from the chest nor did I expect to see the patient bear such a rapid discharge so well. Two or three times I put my finger over the opening to prevent any infection of a few, but this precaution seemed unnecessary as the patient was entirely able to answer my questions. The fever was still affected.

The physical signs on the right side of the chest were now those of complete Pneumothorax. No sound came to the head except that of air rushing through the opening in the chest wall. The sputum was, of course, stopped during examination of the chest as the sound seemed to indicate the possibility of clearing the lungs. The opening was protected by a small piece of wet gauze kept in place by the hand of the assistant. The patient, however, felt little the worse for the operation that helped in clearing the dressing. I tried a test with which the late Professor Sander's considered pathognomonic of Pneumothorax. Appearing a coin flat on the anterior surface of the chest affected side of the chest I got my assistant to tap it with another coin at a point opposite to the coin in front of the chest. The result was that I did not hear the metallic rattle which Professor Sander's considered so important. The room was filled with the case of Pneumothorax, spontaneously produced, which I have examined several times.
Afterwards, I tried this again but with the same results. I presume the difference in tension of the air in a closed space vs one with an opening in it will explain this.

The chest was now covered with an unguent antiseptic dressing or & change a salicylic oint. as I anticipated a "purse" from such a large a cavity. My anticipation was more than realized. At the dressing visit I found the dressing completely soaked & the cess very wet from discharge.

The patient was easy whilst sitting up but was troubled with cough when lying down. She rested best on her back & better on the sound side than on the other.

Her Temp. was 100.4 Pulse 120. A similar dressing was again applied & an addition of a large quantity of salicylic oint. was laid under her on a mattress.

March 15th morning. She has rested badly, partly as the result of coughing & partly from being wet. The discharge keeps soaking the dressing & bed. Naturally too she is a bad sleeper.

Temp. 100.6 Pulse 120 Respirations 24 -

Necid a dressing at first applied

During Temperature 99.8 Pulse 110. Has been comfortable all day but has changed the wool on the bed frequently as it soon gets soaked. Dressed again. The only apparent effect of this purgative discharge is to cause slight dryness of the tongue, observed tonight for the first time.

March 16th morning: Temp. 100.2 Pulse 100 Resps. 24.

Has slept better again. Discharge still very purgative though somewhat less than yesterday. It can be
The temperature was 99.8°. Pulse 100. She has been sitting up for 8 hours today and felt as usual—dressed again.


March 20. Temperature 100.2. Pulse 96. Sit up all day. No discharge through dressing. A just a stain on it.

Thinking from the sudden cessation of discharge that there was some block, I introduced a sponge through the tube into the chest. I satisfied myself that this was not the case. Percussion still symptomatic as before.
March 21 & 22 Dressing left undisturbed as not much has come through.

March 23 Dressing removed, only a slight stain on the surface taken off. Supposed to be disapearing.

When the opening is temporarily closed, distant breath sounds can be heard in front of the upper third of the sternum posteriorly. The breath sounds are of a metallic ring. She sleeps a restless sleep, feels in her usual health but has a slight cough. Desires no change.

March 30 The dressing was not changed till today. Wound is superficial. The percussion signs of the heart are still present but the breath sounds are becoming more distinct. Can hear breaths all over the chest. She wants dressing to be done.

From this time to April 7th she continued to improve. Slept better. Appetite general appearance much improved. Temperature normal. Cough gone. Idea of chest laboured with the exception of a slight high percussion note over a faint weakness of the local sounds as compared with the opposite side. (It was very offensive with the other side that anything could be detected, the variation was so trifling) From this date she began to feel off a little.

No best time for ovariotomy.

The summer again gave trouble to the body causing pain in vomiting. Her temperature rose to 101 in the afternoon. A somnolence, the legs laboured, abdominal pains appeared.

Sputum was not of the question as the cough disappeared now to be made up by a large number of small cysts. So ovariotomy was performed.
Operation

On April 13. the Patient walked to the table where he was administered. An incision about 10 inches long was made from above the umbilicus. A sheen's were found to present all over the face of the tumour & after separating them I found the cyst not yet cleared of fluid. At first I thought I had commenced even against my mistake of Case 1 a mistaken the peritoneum for the cyst wall & that the inferior tumours down to the cyst wall, to which it was for the most part closely adherent & I found it terminated off & terminated towards the sides. On examining it afterwards it took in type a large of organized lymph, which might the accounted for there, as similar false membranes are accounted for in the pleura, as a similar B & & movement of the tumour accompanied by effusion was known there existed.

The detachment of this membrane caused rupture of several of the cysts whose were thin & easily penetrated but after careful working I managed to get the bulk of the tumour free. It was now held by a strong adhesion to the left lumbar region & the peritoneal I transfixed, ligatured & divided the vessels leaving over the cut adhesion to the detached & thus allowing of easy manipulation of the tumour. At least the removal of two whole was accomplished satisfactorily & the bleeding was quite with the blockade of the tumour which was quite with the blockade of the tumour.
Patient. I at once drew her tongue forward & commenced artificial respiration but we all thought she was dead. After a short time she gasped & slowly began to breathe again. The operation was at 10.15 and lasted 1 hour. No evisceration was put through the patient & in her lieu a her head kept up. The abdomen was cut open & the signs of peritonitis were carefully cleansed. The bleeding points were ligatured & two intravenous drainage tubes introduced as in Case 5. The wound was closed by 18 catgut sutures & dressed. Antibiotics, all other antiseptic precautions having been carefully carried out. Altogether another half hour was occupied in completing the operation.

The patient was put back to bed looking exceedingly ill, never having recovered any color, & died in 20 minutes.

The quantity of fluid removed was 4½ quarts. In several of the dysenteric feces was present.

The weight of the dead matter was 12 lbs. The bulk of it consisted of an enormous growth, high & of a bright flesh color. This was the part adherent in the left iliac region which occasioned most trouble in its separation.

No 5. The case is obtained.
Mr. J., aged 35 years, married, residing at Bute Park, was admitted into the Heartsease Hospital under my care on Sept. 16th 1882.

The complaint was a swelling in the lumbar region, with a feeling of the internal generative organs.

This patient had been treated by Dr. Sherrin of Newcastle upon Tyne for the overflowing of the ovarian fluid. She desired to have the ovarian tumor sent her to me for operation.

On examination I discovered all her organs to be sound with the exception noted.

There was slight prolapse of the uterus and the mucous surfaces of the labium, where the uterine was worst were reddened, probably from rubbing them to relieve the congestion. There was nothing found to account for this irritation unless the ovarian tumor caused it.

A special examination was made for tumor in the womb, but none existed.

A diagnosis was made in the usual way of a multilocular ovarian cyst. The site of an abdominal wound, thicker than the peritoneum.

The operation was performed on Sept. 19th, under ether, with full antibiotic precautions including the spray.

The tumor was easily removed. The diagnosis was fully borne out by the result of the operation as the patient went home on the 21st day after operation - cured.

Her future progress was most satisfactory. No symptoms causing the slightest anxiety having arisen.

She visited me in December 1882. She was in excellent health and complained that her lumbar were weak, where the cut had been made.
On examining her I found a vertical hernia from stretching of the criatris. To relieve this, I ordered an abdominal belt, which she has since worn and has had no further trouble.

The Pruritus still troubles her if she neglects care. She should always bathe with a Borax Lotion, but with this care she can keep it entirely in check.

P.S. She has been the mother of two children and her menstrual periods have been normal though prolonged.
Case 9.

Mrs J aged 51 married residing at West Heathcote was seen by me first on 3rd January 1883

The complaint of vomiting and diarrhoea of twelve years duration in her breast.

Living there is nothing noteworthy in her family history. She has always been well for the most part during the 12 years has been married. Her family trouble.

Her present health has been fairly good, though she has frequently suffered from minor illnesses when she was told arose from liver derangement.

She is the mother of 3 children. She has had gonorrhoea. No maladies. Her menstruation has been regular except for painless but constant for up to the present time.

She has noticed her bowels larger than usual for about 5 years but has only been copiously bleed with vomiting and diarrhoea for six weeks. She feels the bowels have gradually increased in size, though slowly, but twelve 6 weeks ago she was able to go about and be fairly healthy.

Six weeks ago she was suddenly seized with diarrhoea and began to vomit. A doctor was sent for who told her she was ill with inflammation of the bowels and sent her blood. She has been considerably Hobbes since a week ago, generally in the afternoon had a violent attack of diarrhoea. The vomiting has continued the whole time, often every meal of solid food she took.

A week ago she began to feel her heart.
9 Woman and a man son has since joined which
changes a deal of matter. She has taken
fever in strong rapid eye.

Present Condition

She is a tall brown looking woman, limber
flexible, with a dry unclean skin. She lies on
her back in bed with her head raised high in
patient's a answers questions slowly, laying her arm
between each few words.

Her Pulse is 108. Temple 101.5. Propper, 24.

Her feet are edematosus feeling on pressure.

Her Tongue is red and glazed. Appetite good.

Constitution. Vomit at first as soon as she gets
it. Bowels irregular, occasionally constipated at others.

Headache. Numbness of opposite.

With the patient supine on her baed.

The Abdomen

is seen by palpation, dilated prominently in
front. Lumbur Blanche are marked with no other
abnormal appearance externally.

On palpation. Palpation are of natural thickness.

Tenderness felt all over on pressure. The abdomen
appears blue.节味 with a large cyst, not feel
materia, in which fluctuation can be felt
from side to side, as from umbilicus to flanks.

On Provocation the abdomen is Chinese all over his
front except at the upper limit of the tumour
where a series curvus true breadth of the
umbilicus. Forwards.

The right side is clear below a line drawn
upward from umbilicus Spine towards ribs.

The left side the clear field is with limited
of the stomach lower part. The tumour appears to
have in white down wards in deep in suspicion.

On Auscultation. Over the upper part of the tumour
Aneurysm Can be heard during forced respiration.

In vaginal examination the uterus is found to be pressed downwards by the tumour but is freely movable and not connected with the cyst. The tumour appears blue just beneath it in the pelvis.

Integumentary System - She sweats profusely at night, but during the day, when asleep, especially with her head down. There is no skin complaint in either the exceptions or a red face over the scrotum about the eye or half a crown there is nothing abnormal.

Menses System - She has always been a menstruating woman - her courses has increased the the time of the least exposure such as was necessary in making the examination. There is a thinning of the skin over the pelvis and buttocks. The skin is otherwise in good condition.

Urinary System - She has a frequent desire to urinate, but passes only small quantities at a time. The quantity obtained in 24 hours was 12 oz. - Specific gravity 1020. Acid reaction 1352 degreer of 

Circulatory System - normal.

Respiratory System - No or Respiration per minute 24. She complains that she cannot breathe when lying with her head low, but this, she says, is from the weight of the tumour pressing upwards. A few tender subcutaneous nodules are heard over the base posteriorly, others are nothing abnormal can be discovered.

Diagnosis: Suppurating multicellular ovarian cyst with subsequent peritonitis.

Treatment - A trained nurse was obtained, she
was placed in a water bed & the bed set for vomiting treated.

She somewhat improved, though her temperature still averaged 101.8 at night.

By February 5th the bed was kept nearly heated, the sickness only occasional, & as

omens improvement could be looked for, from the palliative treatment adopted, had

resulted. Drainage was therefore determined on.

The operation

was performed by me at patient's own house on February 6th.

The water bed was filled with warm water & a careful arrangement of hot water bath ree

d blankets, made up to keep up a good supply of artificial heat. A large douchebath was used

to prevent any wetting of the sheets & the operating

dies. The Carolina spray had been kept going in the previously prepared room

for an hour before the time fixed for operation,

so that the air smelt very strongly of Carolina

acid. With the exception of the spray on this

occasion, all other Listerian details were observed.

When was administered & an incision made

in the median line from the umbilicus to

above the pubis. The structures were successively

divided till the peritoneum was reached.

The organ was arrested by forcible forceps & the

Peritoneum divided on a vector after opening with the point of a bistoury.

The gall was found & was almost sinus freely

adherent anteriorly, clashing column & very firmly.

The incision was therefore extended 2 inches above

the umbilicus.
The as hernia were soft & easily broken down by two hands, except on the left side, towards the lumbar region where they were firm.

The tympanum was brisk in several places; allowing the contents, in spite of every care, to escape freely into the peritoneal cavity, was drawn out.

The Pedicle was transversed, tied with a tourniquet ligature in two separate portions a branch of the cut away.

After Carefully exploring the abdominal cavity, the ligatures on the pedicle were cut short & the stump dropped with the Pelvis.

The Pedicle spaying from the left of the uterus, the uterus & right ovary were healthy.

Four deep silver wire sutures were used to bring the peritoneal surfaces into contact & superficial ones of Catgut.

A dressing of Gauze (earlweave) & Jellie were applied.

The operation occupied 1 hour 15 minutes, & the patient rapidly recovered from the effect appearing white & well.

My record of the condition of the chest amount of pain was unfortunately lost by the nurse.

After Progress

Fely & Pm. Is comfortable & looks well - Pulse 100, Temperature 99.5°. Has not been sick since the operation & taken a good supper of milk.

Fely 6 10 Am. Has slept several times during the night for a short time at a time. Ventilated very well, looks well, Pulse 100, Temp. 99.8°.

Pm. Pulse 100, Temp. 100.2°. Has had a comfortable day. Sick once in the afternoon. Complains of a little gripping pain in the abdomen. Ordered Supper.
7 A.M. At 2 o'clock this morning was violently sick & vomited. Pulse 120. Temp. 101°. Has been sick several times since C. entered. In apathetic. Complains of long trembling. Temp. 102°. Pulse 120. Thinking there might be some fluid in abdominal cavity, I opened the lower part of the wound under the Serena. It was already united. Through the opening made, I introduced a free suit needle-rubber drainage tube to the most available point of the pelvic cavity, with long dressing forceps, and applied a good family dressing across this with lint and bandages. The syringe aspirated satisfactorily, but only about 3 fluid ounces of blood-stained serum was obtained. It smelled sweet, and a canning under the microscope was found to contain no bacilli.

The drainage tube was left in position on the wound dressed as before.

9 A.M. Temp. 101°. Pulse 120. Wounds still in excellent condition. Has been frequently sick. Complains of gripping pains. Wound dressed under spray. No discharge has escaped on to the dressing or can be sucked by the syringe from the tube. Alarms Swollen & Sympathetics ordered 5,000 Suppositories. Morphine 1/4 g. Small quantities of cordia and wine given by Drinker with Brown's Champagne.


9 P.M. Pulse 120. Temp. 102°. Subjective pains continue.
Dressing not removed. Suppo. Inj. JR. Patient left bed on mm. chewful.

July 9 Am. Pulse 130 regular v. normal. Temp. 102.4

Ponged abdomen. Considerable v. semi opaque in exterior. Sickness is almost constant since early this morning. Sponging of fluid from nasal hole. Had a fairly fecal odour.

The dressing not changed as patient is evidently dying.

9.30 Pm. Died. Temp. 103.8 Suddenly became weaker.

July 10 I was permitted to make a Post Mortem examination. But limited to Abdomen.

On removing the dressing the discharge was found on it.

The wound was limited firmly except where drainage tube had been.

The abdominal peritoneum was stripped with telescopes where as lesion had been separated.

There was no sign of Peritonitis (menses)

There was no fluid in the abdominal cavity.

t he end of the drainage tube was seen resting in Darco's pouch.

The intestinal coils were much distended with gas.

The pedicle was drained in situ but with difficulty on account of the tension in the intestinal coils. Some of these were punctured a far whole turned aside.

The pedicle was found lying on the left side v. was adherent. Hae. Pelvic Peritonitis. It was found the completely surrounded by a loop of the ileum which was adherent. Hae. There was no further evidence of Pelvic Peritonitis. On separating the loops
of substantia from the psyche. It was seen that
markedly collapsed & preserved a striking contrast
in their substantia immediately above it.

There were no feces in any part of the intestine.
Only a small quantity of fea were found in the upper
part of the intestine & stomach.

The liver, pancreas, kidneys & spleen were all

Chirp 10.  
M. S. 53 years, single, a housekeeper, residing at Kirkcudbright, Kirkcudbright, was admitted to the Marieport Hospital under my care on April 15, 1883.

The complaint of Swelling of the limbs or legs. Temper. 98.4.

History.

One of her brothers died of Consumption - the rest of the family are healthy & her relatives long lived. She has worked hard but has always been well fed and cared for.

She has enjoyed good health, until her present illness, with the exception that at her menstruation period she suffered a good deal of pain.

She first noticed her limbs increasing in size 2 years ago - she has no pain & noticed no change in the swelling from any cause - until 3 months before her admission to hospital she worked on a twist - no notice of the swelling.

Then her legs began to swell & her limbs grew larger so that she was unable to get on with her work.

She was consulted a medical man who told her it was water & said she required tapping. He tapped her, & after doing so, said it was a watery tumour which would need operations.

For a few weeks after the tapping she was relieved, but soon began to swell again.

Finally, the swelling became so extreme, that something was required & she consulted me. 

Present condition: She is a thin, haggard, looking woman of dark
Considerable, considerably enaciated, on account of difficulty in breathing. She is considerably edema of the thighs and feet which pit deeply on pressure. Her tongue is clean. Appetite poor, she has no thirst. Her muscles are regular.

She sleeps badly on account of difficulty in breathing. Respiration 24 per minute.

On examining the chest posteroanteriorly, the base of the left lung up to the angle of the scapula are found to give an impresion percussion note. On auscultation maximum moist rales can be heard. Otherwise the chest is normal.

The Pulse is 100 of fair strength. Heart sounds and percussion are normal.

Urinary system: There is no difficulty with micturition. Urine is 24 hours 24 ozs. Dark straw color. Specific gravity 1.024. No albumin. Sugar. Deposit of albuminuric 118 mg.

Abdomen.

On inspection is seen the abdomen is prominent and distended. Specially below umbilicus. The abdominal contents can be seen to descend fully on deep inspiration.

On palpation, the parietes are found thickened and from edema. An irregular rounded tumour can be felt about the size of a 6 months' pregnant uterus occupying the same situation. The tumour is found to be freely movable from side to side but cannot be raised from the pelvis. The tumour feels elastic and, no distinct fluctuation can be felt in it. A distinct fluid wave can be felt from side to side of the abdomen.
On Percussion. An area owing the tympanum is found 15
be the line on percussion. Towards the 3 inches a clear
area exists, which extends to an inch behind a
thin division upwards from the anterior superior
gap of the ilium bones. Below to behind this
line, with the patient lying on her back, percussion
yields a dull note. By changing the position of
the patient, the latter dulness described, is altered
instantaneously.

On Vaginal Examination the hymen is found
the intact, the vagina small, cervix high up in
vaginal. The hymen can be moved from the alar
surface from side to side independently of the uterus,
but an attempt to draw the uterus upwards causes
slight accompanying movement of the uterus. There
is no evidence of any adhesion in the pelvis.

Diagnosis: A multilocular ovarian cyst not
adherent & complicated with ascites. Gynaecial
brasses & Lingos & Lower Extremities.

Treatment. The patient was kept in bed, feet
on mets alone, I had r10 of Gent. Digitalis &
r10 of Swine. Ferri Pacheus 3 times a day.
This treatment had no appreciable effect in
diminishing the dropsy, and Ovariotomy was done
on April 19th 1883.

The operation.
Chloroform was administered and the os. was
opened 5 inches long made in the linea alba.
When the peritoneum was reached it pouched
at the bottom of the womb, like a thin walled
bluish cyst. A small opening was made in
it with a bistoury & the fluid was slowly squeezed out
of the peritoneal cavity.
The peritoneum was then divided the whole
length of the wound, which was extended to an inch of the introduction of the hand, 1 the eunuch by a power, while Colonel Biles exposed.

I now passed my left hand in over the upper part of the limb, the eunuch, pushed it forward through the wound and wrenched it with a twisting, clearing it of the contents to escape.

The eunuch was now drawn well forward and pedicle, with some difficulty, exposed.

The pedicle was not more than an inch long and about 4 inches broad. It was transfixed with a needle, in two halves as low as possible, with a carbolised silk ligature.

The eunuch was now cut off with scissors. As soon as the eunuch was cut away, I felt the ligature slip. I then Lumen large was immediately drawn down.

I introduced my fingers into the wound. I was, fortunately, guided, and once by the strong jet of blood is the main artery of the pedicle, whereas close to the uterus, and which I tied at about the size of the pedicle. I seemed the piece of tissue in which the artery was minced, between my fingers. Then, below, where my assistant tied firmly, a piece of fine carbolised silk.

The pedicle was now sponged with considerable bleeding was found. The still going on. This was traced to another artery, about the size of the pedicle, towards the centre of the stump of the pedicle, which was caught with the artery forceps and ligatured with fine silk.

The whole stump of the pedicle was now clearly seen and extended as a narrow raw surface, covered at its inferior end, from the left side of the uterus.
up to the Samson flexure, which was small & closed, wound down in its natural position.

The whole raw surface was ligatured in 3 different parts with fine Carlisle's silk, the peritoneal cavity sponged dry & the wound closed with 3 deep silks with a 6 superficial catgut sutures. A dressing of Carlisle gauze & Saltwick's wool was applied.

With the Deception of the spay, all antiseptic precautions were carried out. The spay had been going in the wound for an hour previous to the operation and was turned off when the operation commenced

After Progress

Her temperature after operation never rose above 100°. There was a slight abscess or disagreeable symptoms & she was so well on the 14th day that she wished to go to stay with some friends in West Hartlepool.

In February 1864 this patient visited me. She had grown strong & strong, & was no bandage as she had no need of use.
Remarks.
These notes are a record of the first ten cases in which I performed Ovariotomy.

Of these, eight were done at the patient's own house, and two at the Harlepool Hospital.

In some of the cases where the operation was performed at home the sanitary arrangements were far from perfect.

Before operating on patients, I urge a trained nurse to come a day or two before the operation to give her directions about the house & the patient's persons operation & the care of the patient after it.

In a private house I select two rooms, one for the patient, the other for the nurse.

The patient's room is prepared either at her home or in the Hospital in the following way.

In the morning before operation every thing is cleared out of it - the drapes & curtains are removed - the windows thrown open - the floor washed with Carbolic Soap & hot water - the room is then closed by means of the open windows and a good fire - When dry it is thoroughly strewed with Fuller's, aired for an hour & is then ready for the necessary furniture.

A narrow Hospital bed is chosen (if possible) with bedding which has been thoroughly purified by heat & a hot liquid bath & this a tea necessary. Chairs & tables are allowed to be put into the room.

The patient is prepared, if she can bear it, by having a thorough hot bath with Carbolic Soap & a dose of Castor oil; the night before operation.

Next morning, the day of operation, she breaks fast at 8 or 9 o'clock, tea or Dr. sheer, after which an enema is administered & the patient sponged all over with...
Carbolic soap and warm water.
A folded towel dipped in 5 per cent solution of
Carbolic Acid is tied around her browses and she
is then dressed in clean clothes ready for
operation.

An operating table of convenient height was used
in every instance except Case 9 where it was deemed
advisable on account of the patient's weakness
to keep her in bed. Folded blankets are laid
on the table, a convenient number of pillows
put under the head, a when anaesthesia is
produced the patient is tied with her hands
fixed so that she cannot bring them over the
alowman's head. Blanket or the table by
a roller three passes over them a tied under
the table by a tourniquet.

Chloroform, sprinkled freely on a towel, was
used in the first 3 cases. In the last 3 cases
was given 12 the remaining six on Ornesley's
inhaler.

The reason why Chloroform was not given in Cases 12 and
was that I had no experience of it as an anaesthetic
at the time these operations were performed.
Afterswards, having tried it in my ordinary surgical
work I gained in this way the necessary
Knowledge, I used it in all my Cases except those
of Dr. Rood's strong recommendation influenced
me even more in its favour.

In Case 10 the presence of some oedema of
the lungs decided me in favour of Chloroform.

From this limited experience I believe that for
the majority of cases Ether is the preferable
anaesthetic. Dizziness is somewhat less after
the same after Chloroform, there is not much
differences between the actual number of times resting
seems, but the sickness produced by Chempom is not always
by his same nausea and depression that follow Chempom.
the greatest disadvantage arising from the prolonged
administration of Chempom is that up to the 30th day it
causes a secretion of mucus, tasting of sulfur, from
the pharynx & oral passages. This causes a
mucoussome cough, which is in effect, particularly
as the result of pain it causes the streaming of
sputum, & from the diminished salivary gland
infection.

The chief reason for my preference is that I
believe shock like that felt when Chempom has been
used, is consequent the patient is better & more
cheerful on the first day than when Chempom
has been given.

In all the cases except Case 9 & Case 10 a
free antiseptic treatment as practiced by Professor
Lister has been carried out.

In Cases 9 & 10 the spray was omitted at the
beginning of the operation from a few or its chilling
effect.

It seemed to me that the merits of Carbolie
acid penicervia & other disadvantages of the Antiseptic
treatment are capable of being very satisfactorily
dealt with than the risk to which these measures
are opposed, in my practice at all events.

The dressing I use is, a small strip of gauze,
dipped in the 40 Lotion of Carbolie Acid, laid directly
on the wound & covered up with a good pad of
Salveject

A flannel bandage sufficiently
fixed keeps this in position till it requires changing.

As Sutures I prefer a limited number of Stony
Silers on which must include the pectoral &
as many superficially at once as may be necessary.
Along the skin edges is no perfect coaptation.

The Pedicel is ligatured with thick loosely ended silk which is prepared by being soaked for at least a week in Carolus Lotion (1:20).

I prefer silk with 15 centimetres for the deeper sutures because it is more resitant and keeps the parts shewn, acting as a light splint; the silk used for the Pedicel is loosely cored as previously. Its absorption is faster than the tightly rolled silk.

Drainage was used in 3 cases viz. 4, 7, 10.

In Case 4 the object was to prevent accumulation of fluid in the peritoneal cavity. Many adhesions required separation, & the tumour was implanted at suppurating one, from which some of the purulent fluid unavoidably escaped into the peritoneal cavity during extraction. Judging from the quality of the fluid which escaped from the tubes the drainage was probably superficial & the wound might have been closed, leaving the fluid to be absorbed without difficulty or danger.

Therapy was Lennert's in a similar case but I found not use than 15 centi with about 1 ampoule of signs symptoms arose, open the wound & introduce me as in Case 10.

In Case 4 they were treated for the same reasons as in Case 4 but the patient died two days after operation for them. The 7 was only treated.

In Case 4 the drainage tube was introduced by opening up the wound. When the temperature rose it was thought that a collection of fluid might be the cause which improperly turned into but 16 in the case. The Pm. showed that the tube would have been efficient.
Ordinary 183 subcutaneous drainage tubing of the largest size was used in all 3 cases and when aspiration was necessary the riggle of a good syringe introduced into the outer tube.

The drainage tube is inserted about an inch from the lower edge of the wound; first to insure a larger surface from which drainage may be obtained, and second, that the wound may be closely sutured round it, so that when the tube is removed more rapid healing may follow, a ventral hernia be avoided. Early removal of the tube too leaves cosmesis with coloration.

After operation, the patient is kept on a very light diet for the first two or three days. Then, generally, finds it necessary to have the calomel passed every other day. An enema is administered on the 1st or 2nd day.

With regard to the operation and its difficulties - the operation, in all its steps, as laid down in the text books, is, in my opinion, near perfection, with one exception, the emptying of the cyst by trocar. This is seldom accomplished satisfactorily. Most of the fluid usually escapes by the sides or, missed or through the instrument, when first introduced, and is with difficulty kept from escaping into the peritoneal cavity, or flooding the room. When the cyst has been partially emptied, I am pleased if it can hardly be tied to the trocar but as it can also be drawn forward if not as herefol the trocar at this stage can be dispensed with. Sir Spencer Wells Villiers connected with the trocar I have never been satisfied in my hands.

If the herna is small & can be partly turned out, an incision may be made into it & the...
contents guided into some circumstances acceptable as I did in Case 10. Where the cyst is large or adherent probably the trocar will continue to be used.

As to the difficulties of the operation. It is not easy to give any estimate where the conditions are so variable; but, personally, I feel no less anxiety in undertaking many other surgical operations where the exact circumstances like those cannot be accurately estimated, such as ulceration of the large arteries in their continuity, removal of deep seated tumours in the neck or anyone in the habit of operating will not fail to remember how impatient circumstances occurring in the course of some apparently simple proceeding may surround in difficulties.

A great deal, almost every thing, depends on an accurate Diagnosis I recognize the fact that a fair amount of diagnostic skill can only be obtained by the most patient taking a thorough investigation of every case and study of the subject for a considerable period of time.

I have endeavoured to show in my notes the system I pursue which is only making a use of the methods usually adopted.

The history of the Case. So far as I can judge, gives very little assistance. In Case 3 the history misled me, an unperceived observer, Dr. Kline did not take the minute to form a correct opinion from physical examination alone.

The only noticeable feature in the history, again, but by my notes was—

1. That mean temperature had been abnormal, with pain in different parts of the body in Cases 1, 2, 4, 5, 6, 7, 9.
2. That none of the cases of the Ovarian Cyst had large families except Case 3. In Cases 2, 4 the tumor was noticed after the birth of the first child.

Three cases 2, 4, 5 a 6 are interesting as showing the effect of pregnancy as a complication of Ovarian Tumor.

In Case 2 Ovariotomy was performed during the 6th month of pregnancy to relieve increasing distress from the condition. The patient was in at least time it seems and is not highly improbable that she and the child would both have survived if she had been left alone. Tapping was out of the question on account of the nature of the tumor. Bringing up normal liberal doses of ice water has disappeared the child if left the mother with her tumor. Ovariotomy saved both, I nothing could have been more satisfactory than her recovery.

In Case 4, pregnancy was terminated satisfactorily 3 months of the presence of an enormous cyst. The woman passed through a long and dangerous illness only terminated by a severe operation. The child deprived of its normal food had a hard struggle for existence.

In Case 6 the tumor was of so sluggish a nature that such minuscule pulsations in the internal organs had so gradually become accustomed to the normal pressure that the acute effect of 3 pregnancies was to increase it.

That removal of one ovary is no hindrance to further child-bearing is shown by these cases, each of which has had a child since operation.

All the patients who recovered from the operation are still alive except one who died of heart disease.
Case 4 - In Case 4 a radical hernia resulted from stretching of the epiplon. Possibly she was allowed to get almost too early, but she was a person of feeble v relaxed muscular system and the uterin prolapse appeared a predisposition favorable to such an occurrence. In none of the other cases is there any teething in this direction, but in this case where a child was born after operation the patient found themselves as strong as ever in using their abdominal muscles.

In Case 5 it was unfortunate that to be born alive. The child obtained his death as being due, to the best of my knowledge of belief, a Pulmonary embolism following ovariotomy. My explanation for the case and the clot policy originated in the René Maslo.

A year afterwards I was consulted by a patient with a case though not so large in the same situation. She had been examined by a surgeon a total but ovariotomy would be necessary with no distinct date. After a careful examination my belief was that the woman was corrected, with surrounding parts treated, by as herein, as in the case of the (Case 3) as the end it in of months found in this case, led me to the conclusion, that a less severe measure might have been adopted with success, I determined to try my ideal but if necessary.

As time went the patient resolved to have nothing done a she and nothing further from her for 3 months. She then died for me. I found her in great emotion among pain in the tumor, a rapid rise some in the eye, shriveling a vomiting. The tumor was tender on pressure, increased in eye, which increase was said to have occurred in the
last few days. Her temperature was 100.2 F. I aspirated the tumor and removed 36 quarts of fluid, kept her in bed a fortnight, and advised her for a month longer. When I last saw her a few months ago (more than a year after the aspiration) there was no return of the fluid and signs of any tumor.

Inflammation had undoubtedly commenced in the cyst when I saw her a true removal of the fluid at an opportune time, before suppuration had occurred, might have cured, possibly by the same kind as occurs in deep wounds of the skin. Vaginal's after tampon & the injection of an


up. If the aspiration had been successful or suppuration had followed I would have made an incision in the median line, near the umbilicus down to the cyst. If at hemos had formed at this point I would have pierced the cyst, allowed the fluid to escape & quelled by the finger or a suitable instrument inside of the cyst, opened it as far below in the left side as was possible without injuring the intestines. A full-sized drain age tube passed from the opening to the other wound have allowed of the drainage, if necessary irrigation, a true position of the opening would be such, that a large dressing could be applied without danger of septic contamination by rectum or vulva. Without the strictest antiseptic precautions throughout I would not feel justified in taking such a step, but with these precautions I feel satisfied there would be little danger.

The result of such a proceeding would be contraction of the cyst in possible. cure, aided, if need be, by
instant injection; when the cavity had become such if not a drainage tube might be passed from the abdominal opening through the lowest part of the cyst into the vagina. The tube being by this time too small to cause a future danger unless from septic injection.

In this way I think Dr. At. might have been cured without injuring the great vessels of the patient in her feeble condition.

In May 1881 I ran matrix there an opening in the vagina of a woman who had suffered from the results of a pelvic abscess, following confinement for 15 years. I succeeded in curing her after three years of no drainage. She had been under the care of Professor Leishman at Dr. Buchanan’s Glasgow Infirmary and was discharged by them as incurable. She came to Karl Reper While with her mother on a parish allowance. I found her with a 5 mm. opening in the lower abdomen, which she herself palpated a month after operation and kept her in miserable health and spirits. She consulted a surgeon who communicated with all the surgeons and I was large enough to have held an orange, was preceding unless, yet healed steadily from the time a dependent opening was made. I have related this case as it shows the probability of effecting the obliteration of any obstinate suppurating cavity when the wound is recognized. Surgical rule is misunderstood to have a jet of dependent opening.

In Case 2 the matrix with epistaxis, complicating the ovarian cyst, was cured by incision and free drainage (see notes). So far as I am aware this has not been attempted before. Looking back on the case I cannot think of anything else which
words have given her a chance. The large amount of fluid which daily escaped was a severe trial for the anti-septic dressing. If any, I think, were to have been neglected alone. My caloric, of course, was applied. In a suitable case, I used to put with a dressing to which a long tube was attached. Keep the dressing in position by a suitable dressing and protect the skin of the long tube, lying in some suitable vessel, by an antiseptic. A satisfactory method, one so far as the wound, unknown, is to put the end of the long tube in a sponge, which must be kept pure by frequently passing on it some antiseptic such as 20 per cent. carbolic acid solution.

When the perforation was cured, the disappointment I experienced at the unsuccessful result of the operation was the greater. I regret, now, not having done the operation on a warm water bed with the same precautions as in Case A. A spray in the ear or nose or other in the case must have a cooling effect, very sparing in a feverish patient.

It was unfortunate that the wound was not a part of a Post Mortem. An examination of the case would have been most interesting.

In Case A the condition found Post Mortem was important. It is needless to say that it was not suspected during life, if it had. The difficulties of getting to the obstructed loops of intestines was, I believe, made by grief. Any operation, in fact, impossible. It is so exhausting a patient intraperitoneal operation that any will would have been, in fact, impossible.

The Page 394 of Sir Spencer Wells' books on Diseases of the brain's 1872 edition, will here found a diagram which shows exactly the condition found in any case.
In Case 10 the extreme shortness of the pedicle is worthy of note. It probably explains the oedema of the legs, and possibly the ascites. In the case of the left side the uterus was firmly bound down by the pedicle in such a position as to pass on the large veins behind it. Was the pedicle short because the uterus had never been moved from its position by pregnancy? This seems to me the most satisfactory explanation.

In the cases where ascites existed the pedicle, it was commonly noticed that those on the left side were firmest. A reached well down to the lumbar region. This is probably due to the anatomical arrangement of the large uterine veins, which in the right side is freely movable, v would assist in preventing fluid as readily passing, whereas in the left side no such vein is formed here much with. Cases 4 7 8 9 are especially noteworthy in this connection.