6. Whilst its chief indication will be found during the first stage of labour, the fear of rapid delivery following its use is not a contraindication.

In conclusion, we wish to thank the Master, Dr. Hastings Tweedy, for permission to publish our results and also for much advice and help in our investigations and case reports.

CAESAREAN SECTION FOR DYSTOCIA DUE TO VENTRIFIXATION OF THE UTERUS.

By AMAND ROUTH, M.D., F.R.C.P.,
OBSTETRIC PHYSICIAN, CHARING CROSS HOSPITAL, LONDON.

THE very interesting and successful case of Caesarean section for dystocia due to ventrifixation, which was narrated by Dr. Manson Fergusson at page 1970 of the BRITISH MEDICAL JOURNAL for December 24th, 1910, is followed by the statement that he does not know of Caesarean section having been recommended for the condition.

I have recently collected 1,282 cases of Caesarean section by living obstetricians and gynaecologists of the United Kingdom (published in the January number of the *Journal of Obstetrics and Gynaecology of the British Empire*), and amongst these there are seven of these very rare cases. Dr. Fergusson and others will be interested in the details of these seven cases and of an eighth case which occurred in my own practice about a month ago.

CASE I.

Dr. Herbert Spencer's Case (January 13th, 1903).—"Ventrifixation resulting from myomectomy, the pedicle being treated as extra-peritoneal stump." Caesarean section performed before onset of labour. The patient recovered, the child unfortunately dying of haemorrhage from a loose ligature on the funis. Mother not sterilized.

CASE II.

Dr. Targett's Case (February 4th, 1907).—Ventrifixation in 1902 for retroversion and prolapsus uteri. Patient not in labour when admitted, but fourteen days over full term. At the Caesarean section the fundus was found firmly adherent to the abdominal scar. Child was lying in enormous distension of the posterior wall of the uterus. Mother and child survived. Mother not sterilized.

CASE III.

Dr. Jardine's Case (October 6th, 1908).—Ventrifixation after last pregnancy. Caesarean section during labour, with threatened rupture of uterus. Fundus found densely adherent above the symphysis. Mother and child recovered. Mother sterilized.

CASE IV.

Dr. Murdoch Cameron's First Case (December 7th, 1908).—Ventrifixation after fourth confinement. Admitted in labour. Membranes ruptured. Tonic contraction of the uterus. Transverse presentation. Mother and child survived. Mother sterilized.

CASE V.

Dr. Murdoch Cameron's Second Case (November 5th, 1909).—Three previous children delivered by craniotomy. Cervix could only be reached by passing whole hand into vagina. Mother and child survived. Mother sterilized.

CASE VI.

Dr. Munro Kerr's Case (March 20th, 1910).—Operated upon during labour. Mother and child survived. Mother sterilized.

CASE VII.

Dr. Ranken Lyle's Case (May 21st, 1910).—Ventrifixation two years previous. Chronic intestinal obstruction twelve months.

Obstetric History.—Twelve previous pregnancies. Seven abortions before ventrifixation. Eighth and tenth, normal deliveries; ninth and eleventh, "instruments," followed by puerperal fever; twelfth, "instruments" used. In labour but membranes intact. Hand had to be introduced into vagina to reach cervix. Uterus much anteverted, and at the Caesarean section was found to be densely adherent, and the cervix was found to be 4 in. above the sacral prominence. Hydramnios present. Uterus freed and adhesions ligatured off. Abdomen reopened sixth day after operation for intestinal obstruction, but mother died next day. Child also died (hydrocephalus).

CASE VIII.

Dr. Amand Routh's Case (November 25th, 1910).—The patient had a still-born child (forceps) in 1898, and a living child in 1899. Ventrifixation was performed in 1900, and for three and a half years a sinus remained open in the abdominal scar. Since then she has had three dead children, and has been attended by Dr.

Ernest Higgs, of Oxford, in each confinement. In each case he had the greatest difficulty in delivering the child by forceps, the uterus being firmly adherent to the abdominal wall, and at a high level, and he was only able to reach the cervix by inserting the whole hand in the vagina. The children were very large, 12 to 13 lb. He strongly urged Caesarean section on this occasion, and as the parents keenly desired a living child, I performed Caesarean section at Charing Cross Hospital at the thirty-ninth week. Labour, though not waited for, had evidently commenced. Both mother and child (9 lb. 12 oz.) survived, and are now well. There were extensive adhesions for about 3 in. above the pubes, so I incised the uterus at a higher level than usual, and did not interfere with the adhesions. Mother not sterilized.

These cases show that where ventrifixation causes dystocia, living children can be delivered with small risk to the mother by Caesarean section, and Dr. Fergusson's case shows that Caesarean section may be safely done after other attempts at delivery have been made, provided that (as in his case) antiseptic precautions had been carefully adopted. The only fatal case (No. 7) died of a bowel complication present before the operation.

ABSENCE OF THE FALLOPIAN TUBES AND OF MENSTRUATION, ASSOCIATED WITH RECURRENT PERITONITIS.

(A SECOND CASE.)

By W. G. SPENCER, M.S.,
SURGEON TO WESTMINSTER HOSPITAL.

AT page 926 of the issue of the BRITISH MEDICAL JOURNAL for October 1st, 1910, was published by me an illustrated account of a case in which the Fallopian tubes and menstruation were both absent, but monthly attacks of peritonitis took place. The condition was relieved by an operation, which joined the ovarian pouches with the uterine cavity.

On reading this case, Dr. E. A. Chill of Ealing communicated with me through Mr. Alban Doran, and allowed me to operate on a second case, which has proved altogether similar to that already mentioned. I am, therefore, particularly indebted to Dr. Chill for the opportunity he has afforded me.

Previous History.—The patient, aged 31, married three years, never pregnant, had never had any menstrual flow. No blood nor blood-stained fluid had ever been passed; the only escape from the vagina had been whitish-yellow material, and that never enough to require a diaper. At the age of 14 attacks of pelvic pain began and recurred monthly, lasting three to seven days, during which there might be a very little whitish-yellow discharge, but not always. These attacks have not lasted longer than a week, but have become more and more severe, recurring regularly at intervals of four weeks. The attacks affected the lower half of the abdomen, beginning on one side and spreading to the other, but the pain has always been worst on the left side. She had been under treatment privately and at two hospitals without benefit.

Subjective Symptoms.—On June 7th a very severe attack of pain began on the right side, then spread across the pelvis to the left side and down the front of the left thigh. Pain of less severity was also felt about the umbilicus and round to the back. This was accompanied by headache, vomiting, and sweating. Opium diminished the pain. On October 5th the attack of pain came on so severely that she said she thought she would go out of her mind. Owing to the vomiting neither food nor drugs could be retained, but morphine suppositories lessened the pain.

Admission to Hospital.—She was admitted to Westminster Hospital on October 12th, and continued to have some pain until the 13th. When I examined her on this day there was tenderness to palpation in both the iliac regions, with some rigidity over the lower abdomen. On vaginal examination a tender swelling could be felt on each side behind and external to the uterus. On the 15th all tenderness and rigidity had disappeared, and Mr. Doran did not feel any tender swelling on vaginal examination.

The woman was weak and thin, with a haggard look, beyond this everything appeared normal—the breasts, pubic hair, external genitals, vagina, and uterus.

Operation.—On October 18th I operated, Mr. Doran and Dr. Chill being present. A median hypogastric incision was made, and the omentum found adherent over the pelvis, especially to the abdominal wall. This was freed and turned back. Then the small intestines were pushed upwards without any adhesions being noted, and the uterus was drawn up by means of a volsella. The uterus appeared quite normal; the right tube had a normal junction with the uterus, but at 2 cm. from the uterus it ended conically in the upper edge of the broad ligament. The left tube was also normal at its junction with the uterus, but ended conically 1 cm. from it. Both ovaries were