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.

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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.,
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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

fixed in Douglas's pouch by dense adhesions at the back of the broad ligaments, external to the uterus. As the finger was passed into Douglas's pouch it entered on each side a sac lying under the ovary, into which the peritoneal surface of the ovary projected. On separating the adhesions and drawing up the ovaries they appeared normal and rather large. There was no sign of a corpus luteum nor of remains of blood clot. The broad ligaments were otherwise normal, the round ligaments being well marked.

I then proceeded as in the former case, of which the diagrams should be examined. Mr. Doran passed a uterine sound upon the point of which I cut down and laid open the uterine cavity. Then a drainage tube was passed downwards to reach from the upper end of the uterine cavity to the vaginal orifice. Next the ovaries and sacs were fixed over the uterine cavity, and all were covered in by an omental graft.

Progress.—Unfortunately the patient had been rendered very weak by the recurring attacks of peritonitis. As I began to separate the adhesions she became faint, and the anaesthetist, Dr. Bourns, had to start saline infusions, which were continued for several days. Her condition made me hurry, and I suppose I left some bleeding vessel unsecured, for broken-down blood clot escaped by the vagina and a little by the abdominal wound for some days.

RESULT.

Apart from this incident the patient made a good recovery. A month after the last attack of pain, when another could otherwise have been anticipated, the patient felt no disturbance whatever. This relief cheered her up, and she notably improved in colour, and put on weight. She went home, and is now quite well.

Since the operation the date for an attack has three times elapsed without the patient being in any way troubled. She thus resembles the first case, who has been again seen more than a year and a half after the operation, and has no feelings whatever relating to menstruation.

CASE OF PROLAPSE OF THE INVERTED UTERUS DURING LABOUR.

BY

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LOWESTOFT.

INVERSION and prolapse of the uterus during labour being a rare occurrence, the following notes of a case may be of interest. The patient was a married woman, aged 24, to whose second confinement I was called on November 6th, 1910, at 1.30 a.m.

Previous History.

The first labour had occurred two years and nine months previously, and was natural except that the placenta was adherent. She had never at any time had any gynaecological symptoms, and had always been strong and healthy. The second child was born about half an hour before I arrived. Labour began at 5 a.m. on November 5th. The pains increased in severity at 5 p.m., but there was a long interval between them.

State on Examination.

On entering the room I found the midwife attempting to deliver what she called a "false conception." A mass, with the placenta adherent, was protruding from the vulva, and, on closer examination, the case was found to be one of inverted uterus with complete prolapse, the whole organ appearing outside the vulva. The placenta was rapidly stripped off, there being absolutely no haemorrhage.

Treatment.

The uterus was returned to the vagina, no attempt being made to correct the deformity at the moment owing to the extremely critical condition of the patient. The entire absence of haemorrhage was considered a further justification for temporizing. Active stimulation was resorted to, strychnine and digitalin being administered hypodermically and friction to the extremities, pending the arrival of assistance.

Dr. Tyson soon arrived, and restored the uterus to its normal condition without much difficulty. The administration of an anaesthetic was considered inadvisable owing to the collapsed condition of the patient. A hot intrauterine douche of 1 per cent. lysol was given, and two pints of normal saline solution were introduced into the rectum; 100 grain ergotin citrate was given hypodermically.

Progress.

During the night the patient felt stiff and cold, and did not sleep. The temperature varied between 100° and 102° for about a week. It fell to normal on November 13th. There was a slight rise for about three days, but on November 16th the temperature was again normal, and has remained so ever since. Quinine, strychnine and iron were given from the outset, and on November 9th 10 c.cm. antistreptococcal polyvalent serum were injected under the skin of the abdomen. As the pulse-rate was

inclined to be rapid, strophanthus was now added to the mixture with very beneficial results. The bowels acted naturally on the second day and were afterwards regulated by sulphate of magnesia.

Result.

The patient was kept in bed for a month, on a couch for a further week, and was then allowed to go downstairs. She now feels perfectly well. Menstruation occurred on December 17th, this corresponding to the time expected.

REMARKS.

There is some difference of opinion as to how to deal with the placenta if it be still attached to the uterus.

Galabin¹ says:

If the placenta is still attached, it should be peeled off first, because the size of the mass to be returned is by that means considerably reduced.

According to Whitridge Williams²:

If the placenta is still attached to the uterus, it is generally advisable to defer its separation until reposition has been effected, because, the contractile function of the inverted uterus being in abeyance, there is always the risk of profuse haemorrhage.

Herman³ states that:

If the placenta is still attached to the uterus it matters little whether you detach it or not. If you can peel it off quickly, do so; if not, reduce the inversion with the placenta attached.

In this particular case, the prompt removal of the placenta greatly facilitated further manipulations.

Referring to the frequency of the condition Williams⁴ says:

According to Beckmann, not a single case occurred in 250,000 labours in the St. Petersburg Lying-in Hospital, while Madden noted it once in 190,833 deliveries in Dublin.

I am greatly indebted to Dr. Wilson Tyson for his very valuable help and suggestions, and for permission to publish the case.

REFERENCES.

¹ Galabin, *Manual of Midwifery*, 1897, p. 741. ² Williams, *Obstetrics*, 1908, p. 825. ³ Herman, *Difficult Labour*, 1895, p. 342. ⁴ Williams, *Obstetrics*, 1908, p. 823.

THE TREATMENT OF RECTAL CANCER.*

BY

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THE subject under consideration is one to the study of which I have devoted a large part of my professional life, so it will be difficult for me to condense my remarks within the proper time limit. It is now over thirty years since I was awarded the Jacksonian Prize for the subject, and between that time and the present I have had under observation over 1,000 cases.

At first sight the pathology of rectal cancer may appear to be of secondary importance, seeing the precise subject of discussion is treatment, but a right knowledge of the pathology of the disease is really the secret of its successful treatment.

With the exception of two or three cases of melanotic cancer and two or three cases of sarcoma out of the large number of cases of rectal cancer I have seen, the whole of the remainder have been adenoid cancer; by this I mean a proliferation or overgrowth of epithelium of Lieberkuhn's follicles and the reproduction of those follicles on a large scale. There are two ways in which these growths appear from Lieberkuhn's follicles: one, when they commence on the summit of some of the folds of the rectum, and the other where they appear to commence at the base. It is the same disease but in a different situation.

Nevertheless there is a vast clinical difference. When the growth appears on the surface of the fold it has a free space to grow in, and grows like a tree in the free space of the rectal passage. What becomes of it? It grows with a pedicle or trunk; it becomes a polypus; it never grows to excess in size; it is not malignant, in that it does not affect the glands or general organs, and if removed properly at the base it seldom recurs.

Adenoid cancer is the same growth turned upside down. If instead of growing free towards the surface it grows

* A contribution to the discussion on this subject at the Royal Society of Medicine of January 10th, see p. 200.