blood meets with. The same fact—the presence of secondary deposit in the lungs—was observed in most other examples of similar disease—recorded by Müller, Mr. Stanley, Mr. Paget, and others. To one of those cases—the earliest placed on record that I am acquainted with—I shall make brief reference, on account of some peculiar circumstances in its history.

The case occurred in the Gloucester Infirmary, in 1779, under the care of Mr. Cheston, who published an account of it. The patient—a man, aged 22 years—was supposed at first to suffer from rheumatism. He had pains about his back and abdomen. His sufferings, which appear to have been very great, were aggravated by retention of urine; and it was found to be impossible to pass a catheter. The patient sank exhausted. A tumour was discovered occupying half the pelvis, connected with one of the ossa innominata, and extending upwards upon the vertebrae to the level of the kidney. The neck of the bladder had been pressed on, and thereby the introduction of a catheter had been prevented. The mass “was seemingly formed of scirrhous cartilage, bone, and stone.” When dried it was “perfect bone.” The lungs were studded in many parts with the same substance. It was found in large quantity in the vena cava, nearly filling the vessel at one point; and “the thoracic duct was plugged with ossific matter from immediately above the receptaculum chyli.” (*Philosophical Transactions*, vol. xiv, p. 684.)

It is curious to observe that the part of the case which excited most attention at the time of its occurrence was the state of the thoracic duct. The paper is headed “On an Ossification of the Thoracic Duct”. That vessel and a portion of the vein were examined by John Hunter and Cruikshanks, and apparently with a view in each case especially to ascertain if the vessels were pervious.—You will bear in mind the attention then given to the lymphatics. A similar case occurring at the present time, the microscopic examination of the morbid growth commonly receives most attention. So objects are looked at with the light of the time in which they are observed. But probably the difference of observation has its value, for things thus receive a many-sided examination, and the sum of our knowledge is in the end more complete. Let it be understood, however, that the state of the thoracic duct is no unimportant incident in Cheston's case. For osteoid cancer, it will appear by and bye, but seldom affects the lymphatics in any considerable degree; and this is the only instance in which the solid material of the disease—such we must believe it to have been—is known to have been found in the duct.

Seeing the frequency with which the osteoid disease had been found in the veins in the cases I am acquainted with, and the infrequency with which other forms of cancer occurred in the same vessels—at least, in my own experience—I requested Mr. Laurence to gather from books, to be added to those in my case-books, a number of cases of malignant growth in the lower part of the body, and to ascertain whether the secondary disease more frequently followed the course of the lymphatics or the veins; and whether the abdomen or the thorax were the more frequently the seat of the secondary deposits. From the insufficiency of materials for our purpose when attention was confined to malignant disease of the bones, the testis was chosen. The result of the inquiry may be briefly stated thus:—the inferences being taken from nineteen cases of malignant disease of the testis,—1st. That the most frequent seat of secondary deposits is the lymphatic glands of the abdomen; 2nd. That in less than a fourth of all the cases, secondary deposits occurred likewise in the lungs; and in these, wherever the point was inquired into, cancerous material was found also in the veins.

On the other hand, among ten cases of osteoid cancer of the femur examined *post mortem*, the lungs were affected with the disease in all but one; while the lumbar lymphatic glands were involved in only three.

I now come to the immediate object of these observations, viz., the question of the operation. From what has

already been said, it is plain that the operation is undertaken not in the expectation of curing the disease, for it pervades the whole system, but with the intention of diminishing, if not wholly getting rid of the evils attendant on the morbid growth. The removal of the tumour relieves or prevents the direct distress it often occasions. The boy (case 1) suffered extreme pain, was emaciated, and would probably soon have died from intense suffering. Moreover, the operation takes away the source of the secondary taint to the constitution, and at the same time the source of the secondary deposits. It was so that health was restored and life prolonged for three years in the same case. The accumulation of morbid material in the thorax, which actually occurred in the case, was in all probability consecutive to the disease of the clavicle. Would the removal of that bone or the diseased part of it have been beneficial? If the removal had been effected before any deposit took place in the lungs or the mediastinum, the advantage that resulted from the former operation would in all probability have been renewed.

But how as regards the second case? The material facts in this instance are the following. When I first saw the patient, the osteoid disease had existed two years; latent at first, the morbid deposit probably being within the bone, masked afterwards by the accident and the common phenomena naturally expected to arise in the cure of the fracture. The patient had lost the hue of health before he left his home; and a fungoid or hæmatoid tumour (*fungus hæmatoides*) had existed for some time. The limb was much enlarged up to the pelvic bone. The morbid growth was mixed up with the structures that would have formed the flap, if the amputation were performed even at the hip-joint,—the only place possible for its performance. The disease had passed with the lymphatics into the iliac fossa, beyond the limits which the operation could have reached.

The foregoing circumstances, apart from the large amount of disease in the lungs, would have rendered an operation unjustifiable; and when the disease in the chest is considered, the question of operation need not be discussed.

From the facts adduced, it seems likewise to follow with reference to examples generally of the same disease, that the operation, in order to afford the fairest expectation of advantage, ought to be performed as early as the diagnosis is established; and from the proneness of the disease to be propagated to the thorax, I would even say, whatever the original seat of the local growth may be—and this probably on account of the tendency of the morbid material to follow the veins—that strict attention should be given to the search for secondary deposits within that cavity before an operation is undertaken.

London, October 1855.

CASE OF SUCCESSFUL OVARIOTOMY: COMPLICATED WITH PREGNANCY: FOLLOWED BY ABSCESSSES.

By J. G. WILSON, Esq.

[Read before the Bath and Bristol Branch, Sept. 20th, 1855.]

THIS society will probably remember, that in December 1850, I had the honour to bring before their notice three cases of ovarian dropsy in which I had performed an operation for the removal of the cyst, which differed in some essential particulars from the methods previously proposed and adopted in similar cases. There were four cases mentioned in my former communication, but in the first the cyst was opened by caustic issue, and iodine injections were subsequently used; still, though the issue was ultimately successful, yet the cure was too tedious, and the risks during its progress too numerous for me to feel disposed to repeat or to recommend it.

Of the three cases in which my mode of operating was adopted, two were successful, and one proved fatal from causes which I detailed and commented on in my former paper, and which need not now occupy our time.

With both the two successful cases I have had and still have frequent communication. The first patient married two years since, and has had one healthy child, and is, I believe, likely to have another. The second patient has enjoyed uninterrupted good health, and I have very recently learned that she also contemplates matrimony.

From the date of my former paper to the beginning of this year, many cases of ovarian dropsy have been brought under my notice, but none of them proved fit subjects for operation. In more than one instance, there was a doubt as to whether it might not be advisable to attempt the removal of the cyst, but the small preliminary incision, with which I always commence my operations, showed that it was unsafe to proceed. In the beginning of this year, however, I had brought to me the case which forms the subject of the communication I have the honour to bring before your notice this evening, and which I will now proceed, without further preface, to read.

E. E., a dressmaker by trade, aged 29 years, of fair complexion, slight figure, has always been delicate, but not an unhealthy girl, was subject, when a child, to tumid abdomen, but was never supposed to have mesenteric disease. She menstruated about 16, always suffering pain at the time, with rather a scanty flow; first noticed a swelling in the bowels five or six years ago, which soon began to increase; does not remember any circumstance that can account for its origin; thinks the swelling first began on the right side; her general health has only latterly begun to suffer, and until the last four months the catamenia have been regular, though scanty and painful as before. She consulted me first in January last, during the severe cold weather; and although I had no difficulty in pronouncing it at once a case of ovarian dropsy, and, as far as I could judge, one offering a very fair chance of cure by operation, I recommended her waiting until the weather was milder and the days longer.

On the 10th of March I saw her again; and as her general health had begun to suffer, I advised her not to delay the operation any longer, and having previously regulated her diet, and attended to her secretions, I proceeded to operate on the 14th of March, assisted by Dr. Swayne, Mr. Lang, my son, Dr. J. G. Wilson, and Mr. Corbould.

The temperature of the room having been carefully attended to, and the patient placed on a convenient table, chloroform was administered by my son, and I commenced by making an incision, three-quarters of an inch long, an inch below the umbilicus, and a quarter of an inch from the linea alba.

The integument of the rectus muscle, with its sheath, were carefully dissected, and the peritoneum divided on a director to the size of the external wound; this brought the white shining cyst into view. I was now enabled to verify my diagnosis, that there were no adhesions, nor any other circumstance to render it unadvisable to proceed. I, therefore, dilated the wound to an inch and a-half, dividing all the tissues with a probe-pointed bistoury. I then introduced a large curved needle, armed with strong silk, at the upper angle of the wound, and made fast the cyst at this point by tying the silk round a small piece of wood, which, by lying across the wound, prevented the cyst from slipping back during the evacuation of the water. This being done, the trocar was introduced at the lower angle of the wound, and eleven pints of fluid were drawn off. After the fluid was evacuated, the small piece of wood to which the cyst was attached was taken hold of, and the cyst cautiously drawn out. When a sufficient portion was thus extruded, and care taken so as to avoid the more vascular portions, the branch tourniquet was applied, and about an inch from its branches the sac was opened by scissors, and a circular portion removed, measuring fifteen inches in diameter, and being chiefly the upper and anterior portion of the cyst. The cut edges were then reflected over the tourniquet, each bleeding vessel secured by a fine silk ligature, both ends being cut close off. The number of ligatures required was sixteen. All hæmorrhage having ceased, and the parts carefully sponged with cold water, the remainder of the

cyst was returned into the abdomen, and the aperture closed with three sutures. A strip of plaster was applied over these, a long flannel bandage around the body, and the patient allowed to be put to bed.

She had been entirely under the influence of chloroform during greater part of the operation, but the effects gradually wore off during the tedious process of securing the arteries.

The whole period from the time she was placed on the operating table, until she was returned to bed, was exactly sixty-five minutes.

She was not at all faint, and when placed in bed complained very little of pain, and, on the whole, appeared tolerably comfortable. Pulse 90, and moderate in force and fulness. A full opiate was then given, and strict quiet enjoined. A hot bottle was placed at her feet, and an additional warm flannel over the abdomen. When visited the same evening, it was found she had not slept from the opiates, and was feeling more uncomfortable. She complained of nausea when she attempted to doze off; later she did vomit, but her skin was cool, and her pulse barely 100.

It would be unnecessarily tedious to follow the details of the case during the daily visits. Suffice it to say, that nausea and vomiting were troublesome during the first week, arising chiefly from the opiates, which were deemed needful, but which always affected her stomach; that it was requisite to use the catheter for the first five days, after which she was enabled to pass water without it; that there were some fluctuations in her condition, but that for the first ten days there was no serious symptom, or anything materially to interrupt the progress of the case, which seemed sure, though slow. The wound had quite healed on the fifth day; her bowels, though fuller than had been observed in my two former patients at this period, had yet, in a great measure, lost their tenderness; her pulse was moderate; her tongue clean, and her appetite returning; the nausea and vomiting having entirely ceased.

On the 26th of March, twelve days after the operation, my note book has the following entry: "She continues much the same; there is no unfavourable symptom present, but improvement does not progress; her power of moving herself in bed is very limited; and although there is little or nothing to complain of in her constitutional symptoms, she seems to remain stationary; there is a circumscribed swelling in the right iliac region, which is probably the remains of the cyst, which has contracted some adhesions there, as it is higher than the normal situation of the ovary, or than I have known it after my previous operations; besides this, there is a fulness over the pubis, in the region of the bladder, which it is not very easy to explain. She passes her water easily, although it is rather scanty and high-coloured."

On the 29th Dr. Swayne saw her with me; the swelling in the right iliac region had somewhat increased, and we fancied we could detect obscure fluctuation there. There was some pain and tenderness at this spot, but not very great. We were both puzzled about the fulness above the pubis, as it seemed difficult to connect this with the original disease, or with the operation. It was certainly on the increase, and seemed like an enlargement of the uterus.

On the 1st of April, Dr. Symonds was kind enough to see the case with me, and fully shared our doubts respecting the lower swelling. There was more and more reason to believe it uterine, but no placental murmur could be detected. The girl had always borne an excellent character; her parents were very respectable, though in humble life, and there was nothing before this to give rise to the slightest suspicion of her being pregnant. It is true, I had been told, she had a sweetheart, to whom she had been engaged for more than two years. The catamenia had ceased now five months, which would correspond with the size of the uterus, supposing her to be pregnant. Dr. Swayne saw her with me twice after this period, and we then had no doubts that she really was pregnant. And in the night of the 6th of April my assistant, Mr. Corbould,

was sent for, and delivered her of a five months' foetus. There was very little hæmorrhage at the time, and no untoward symptoms; and when I saw her in the morning she was going on well.

After this period, everything seemed to be favourable. The tumour in the iliac region for the first fortnight appeared to decrease, the fluctuation became less distinct, and the swelling seemed to get lower towards the pelvis. On the 24th of April, I found that there was again a disposition in the tumour to enlarge, and become more painful; and the fluctuation was also more perceptible. I now painted it with strong tincture of iodine, with the hope of producing absorption, and at the same time administered internally small doses of iodide of potassium. At this juncture, her general health was again improving. She was able to be taken out of bed and to sit up for a few hours. Early in May, Dr. Swayne saw her with me, and as the iodine had produced no effect on the tumour, a small exploratory needle was introduced, to ascertain the nature of the fluid that gave rise to the fluctuation, and the result showed it was genuine pus.

It was now clear that the best course was to afford a vent to the matter externally, and so avoid the chance of its bursting into the peritoneal cavity. In order, therefore, to produce adhesion of the sides of the abscess to the abdominal parietes before puncturing it, I made a small caustic issue over the swelling. The eschar, though deep, did not penetrate the abscess, and was long in separating; but when it came away, I introduced through the wound a small trocar and canula, and removed about eight ounces of healthy looking pus. The relief was very great. The wound continued to discharge for a week, and then closed. She continued much better for a little while, and was able to walk about her room; but the matter again collected, and in four weeks required to be again evacuated, which was done with a trocar and canula as before.

The quantity of pus was less on this occasion. I have twice had occasion to empty the abscess; each time the interval has been longer; and I have great hopes the cyst of the abscess is becoming less, and that it will eventually contract and be obliterated. I am confirmed in this hope by the manifest improvement in her general health; especially during the last month she has gained flesh and strength, and is able to walk about the house, and to relish her food. The abscess was opened last about four days ago. No ligatures have at any time come away with the discharges, which have always consisted of healthy pus.

I could have wished that the termination of this case had been more complete before I introduced it to the notice of the Society; but there are many reasons which determine me not to postpone its consideration to a later period. Since my last operation there have been two others of a similar kind performed in Bristol, the results of which have been unsuccessful; and I have reason to believe that the minds of many are getting disposed to think that all operations for the removal of ovarian cysts are too hazardous to be undertaken. Now, as my own feeling is entirely opposed to such a conclusion, I am glad to afford an opportunity for discussion on this general view of the subject; but, besides this, I wish again to invite attention to the mode of operation I adopt, and still believe to be the best and safest. There is doubtless a certain proportion of these ovarian cases in which it is altogether unsafe to attempt any operation: it is so in most multilocular cysts; in all where there exist extensive adhesions between the cyst and the peritoneum; and in all where there is solid deposition besides the fluid accumulation; and to these may be added those cases in which the fluid evacuated is very viscid, opaque, or deep coloured: but in all cases where the cyst is unilocular, containing only fluid but slightly opalescent and of moderate viscosity, and where there are little or no adhesions, I think that the operation I recommend may be performed with no more risk than attends many other operations which are daily performed without hesitation.

By the small incision I recommend, the condition of the cyst may be ascertained before proceeding to remove it;

and should any of the unfavourable circumstances just enumerated be found to exist, the fluid may be simply evacuated, and the wound closed, without having subjected the patient to greater danger than there would be in an ordinary case of tapping.

With respect to the individual case I have just read, I am quite aware that I might be blamed for having overlooked the fact of the patient's pregnancy. Had I discovered it in time, I certainly should not have operated; but there was nothing to excite my suspicion, and the very nature of the disease tended to obscure those symptoms of pregnancy which are generally relied on. But, admitting I was thus blameable, I think I am justified in saying that the result of the operation furnishes an *argumentum a fortiori* in favour of its safety. It is true that, inasmuch as abscesses have formed, and will probably form again, it is premature to call the case a decidedly successful one; yet it cannot be considered a failure. It is now five months since the operation was performed, and there never has existed at any time any symptom of immediate danger to the patient's life. The abortion or premature birth, which was undoubtedly caused by the operation, was accompanied by no untoward symptom, and by less amount of constitutional disturbance than is usual in miscarriages at five months. I feel myself justified, moreover, in anticipating a permanent cure, as the patient's general health during the last two months has steadily improved, and the interval between the collection of pus has been each time longer.

Lastly, comes the question as to whether the formation of abscesses in this case was dependent on the state of system induced by the pregnancy, or whether it was wholly attributable to the numerous small ligatures and the mode of applying them.

The results of my two former successful cases lead me to believe that the pregnancy, by inducing a hyperæmic condition of the uterine appendages, and by elevating the broad ligament out of its usual position, strongly predisposed the parts to the occurrence of suppurative inflammation, if it did not wholly give rise to it.

In other words, I see every reason to believe that had the patient not been pregnant at the time of the operation, she would have done quite as well as my two former cases, and would have recovered as they did, without any unfavourable circumstances. Reviewing, moreover, all the circumstances of this case, I see no reason for changing my opinion as to the mode of operating I have already recommended; and should a favourable case to-morrow come under my notice, I should consider myself quite justified in again performing it.

October 9th. The case is still going on satisfactorily.

Bristol, October 1855.

LEUCORRHOEA AS A SYMPTOM OF PHTHISIS.

By W. J. ANDERSON, F.R.C.S., Obstetric Surgeon to the St. George's and St. James' Dispensary.

In every instance where leucorrhœa exists, it is but a symptom of some other affection, and no benefit can be derived from the employment of local treatment alone; the cause must be sought out and removed, which is frequently sufficient in itself to stop the discharge. The following cases tend very much to prove this; constitutional treatment was requisite in all, and in the two first nothing more was necessary to relieve this symptom; in the three last, astringent injections were employed on account of the increased debility occasioned by the profuseness of the discharge. A leucorrhœal discharge is by no means an uncommon symptom in connexion with phthisis, and is, very often, the first and main sign to which the attention of the patient is directed, she not having the least suspicion of the existence of phthisis. In the following examples, which are but a few out of very many similar ones which have fallen under my notice, leucorrhœa was the