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Fifty Cases of Abdominal Section.

(*SECOND SERIES.*)

BY

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REPRINTED FROM

The New York Medical Journal

for August 21, 1886.

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In reporting a second series of fifty cases of abdominal section I have followed the plan adopted in publishing the first fifty cases in the "New York Medical Journal" for April 4, 1885. An outline history of each case is given in tabular form, with some additional explanatory remarks in cases that seem to warrant it. The whole number of cases reported is too small for useful generalization; too small for statistical argument; too small to support any theory or establish any method. It is not too small, however, to afford additional evidence in favor of operating in some doubtful cases, in some very bad ones, and in some cases where the diagnosis has to be made chiefly from the symptoms. In certain of the cases of what is appropriately known as Tait's operation the results have been surprisingly good, the patients having been rescued after years of invalidism and suffering, and restored to the enjoyment of perfect health.

I have little to add to the remarks made in previous papers on the method of operating. I still use the spray, wherever it can be obtained, for an hour or more before the

operation. I use carbolic acid freely and thoroughly, and the bichloride sparingly, unless there are special indications for a powerful disinfectant. Water that has been boiled is used for all the solutions. For irrigation I have used with much satisfaction the double drainage-tube of Dr. H. Marion-Sims.

In every particular I have simply endeavored to do the best that was possible for each individual case, and have been content to let the statistics take care of themselves. Any considerable number of cases of abdominal tumors, taken as they come—and especially as they come to the Woman's Hospital—will necessarily include some cases not entirely hopeless, but desperately bad and very unpromising. It is the duty of the surgeon to do his best in every case that admits of operation; to avail himself of every means, from whatever source, that promises to help his patient or add in the slightest degree to her chances of recovery. Only thus can really valuable statistics be obtained.

In the whole number published there will be found seven cases of hysterectomy for uterine fibroids, with two deaths; one case of removal by abdominal section of a pediculated uterine fibroid, with recovery; one case of the removal of a solid fibroid tumor of the ovary, with recovery; thirty-nine cases of completed ovariotomy, with seven deaths; and of Tait's operation, completed, seventeen cases, with two deaths. Of the latter operation it is yet too soon in the recent cases to judge of the ultimate result, as it often requires a year, and sometimes more, for the benefits of the operation to become thoroughly established. This is true of any operation that brings about the menopause.

Case I.—This patient had been under observation for two months before her admission to hospital. The tumor had been pronounced ovarian, but, as it gave rise to no serious symptoms, the patient was allowed, at her own request, to wait for a time.

Suddenly she complained of severe pain, and she was immediately admitted to hospital. Her temperature was found to vary from 101° to 103° F., and her pain was so severe as to require the constant use of morphine. The abdomen was very tender and the pulse rapid. The diagnosis of inflammation of the cyst was made, and the operation was done as early as possible. The day of the operation the temperature was 103° in the axilla and pulse 140. The surface of the tumor, as seen on making the incision, was of a dark-purple color, having large veins prominent on its surface. On raising the mass, which was on the right side, the pedicle was seen to be twisted five times on itself. It was transfixed and tied with silk, and the tumor removed. The weight of the mass was about three pounds and a half. The contents were partly colloid, and there had been recent hæmorrhage into the cyst. The tumor had evidently been strangulated by the twisting of the pedicle. A small tumor was found on the left side also, and removed in the same way. The wound was closed at once without a drainage-tube. The temperature nine hours after the operation was 98·5° and pulse 120. The patient made an uninterrupted recovery, the temperature never rising above 101°. Seen a year after operation, the patient was in perfect health and had grown somewhat stout.

The case exemplifies one of the dangers of postponing operation when an ovarian tumor of any size has been clearly made out. Had it not been possible to operate until twenty-four hours later, the woman would probably have died of peritonitis, from strangulation of the tumor, or of rupture of the veins of the cyst. The intestines and tumor were very slightly attached by threads of lymph, easily broken by the hand.

Case II.—This patient had suffered for two years from extreme pain before her period, and a very excessive flow. The nature of the mass was distinctly made out by vaginal examination several months before the operation. It was increasing in size, and the pain was becoming constant.

Had a large drainage-tube been put in at the time of operation, and thorough irrigation kept up, the chance of recovery would have been better. The tube was used too late. The condition of the patient before operation was very unfavorable, as she had long been subject to severe hæmorrhages and almost constant pain.

Case III.—There were very dense adhesions in this case, the dilated tube hugging one half of the uterus firmly. The uterus was large and globular, having the appearance of a fibroid tumor. There was so little bleeding that no drainage-tube was deemed necessary. Recovery was good and uninterrupted.

Case IV.—The operation in this case was undertaken as a last resort, and at the special desire of the patient, who wished to have what slight chance there might be of at least prolonging life. She was failing so rapidly in health that a diagnosis of probable malignant disease was made. The tumor was increasing in size almost perceptibly day by day. The patient had the appearance of a woman sixty-five years of age.

Case V.—In this case the patient was supposed to be doing well until the day of her death, ten days after the operation. There was more pain than usual and much nausea, but the temperature seldom rose above 99°. The sutures were removed on the eighth day, and the wound was dry and looked well. Three days later, at 2 P. M., there was a sudden attack of faintness, with a very feeble pulse. Under vigorous stimulation, oxygen, etc., there was no improvement, and death occurred eight hours afterward. The post-mortem showed extensive peritonitis, and a large accumulation of pus between the abdominal muscles and fascia. There was no communication, as far as could be ascertained, between the cavity containing the pus and the peritonæum. The wound was very small, measuring barely two inches in length, and was subjected to very little handling or sponging. The operation was performed with the most careful antiseptic precautions, and there seemed no reason, external to the patient, why recovery should not take place. The unfavor-

able course which followed was probably due in great part to the miserable physical condition of the patient, who had been an invalid for several years, and had suffered much mental anxiety besides. Her dysmenorrhœa was extreme, and the prostration following each period was so great and prolonged that the girl was practically bed-ridden, and her life a burden to her.

This is not the only case in which I have known peritonitis to develop and lead to a fatal termination without any marked rise of temperature, or a very rapid pulse. Pain is sometimes absent also, and abdominal distension is not invariably present.

Case VII.—Peritonitis developed on the third day and the temperature went above 103°. Frequent irrigation by means of the drainage-tube regularly brought down the temperature, and doubtless saved the patient's life.

This patient reported a year after the operation that she was perfectly well, free from all pain, and able to support herself by work as a teacher. Before the operation she had been incapacitated by pain from doing any work, and for a year had been growing surely worse. Life had become intolerable to her. For one year she had, by the advice of her physician, made a thorough trial of all the remedies usually resorted to in such cases, including galvanism, blisters, rest, etc.; and as a last resort she submitted to the operation.

One such case as this outweighs a volume of argument against the practice of removing ovaries when they are hopelessly diseased, and the patient is ambitious to become something more useful than a chronic invalid.

Case X.—This patient was suffering intense abdominal pain the greater part of the time. In 1883 she had the left ovary removed for the relief of dysmenorrhœa, but had been no better afterward. In breaking up adhesions, about four inches of the small intestine had been removed and the cut ends united. Pain continued after the operation. At the earnest request of the patient and her husband, an exploratory incision was made,

and the right ovary and tube were removed. The intestine was firmly adherent to the abdominal wall, and the lines of former intestinal sutures were plainly visible. Recovery from the operation took place without any bad symptoms; but no relief had been afforded six months later, when last heard from.

Case XI.—This woman had been obliged to give up her work because of pains at irregular intervals, but frequent and severe. Menstruation had been very scanty and infrequent; but at the time when it should have come the pain was intolerable. Blisters and galvanism were given a fair trial, but had no effect whatever. Both ovaries were found to be cystic, and the tubes thickened and nearly occluded. The pains have become much less severe, and the patient is looking much better and is able to do light work and support herself. The periodical pain has entirely gone.

Case XIII.—The metrorrhagia in this case was threatening life, and had already seriously affected the general health. In the hope of arresting it, the ovaries and tubes had been removed by Dr. Thomas one year before, but there was no abatement of the symptoms. The uterus was found to be large and vascular, and firmly attached to the left horn was a loop of intestine. This was detached with the fingers. A wire clamp was applied as near the cervix as possible, and the body of the uterus was removed. The pedicle was transfixed with long needles and cauterized. The wound was closed up directly against the stump. Peritonitis threatening, a glass tube was put in the next day, but without effect. There was no hæmorrhage; but the patient died of shock on May 30th.

Case XIV.—This patient was a lady's maid, and, though making a great effort to do her work, had been obliged to spend much of the time in bed, and had been quite unfit for work for some months. For two years she had been growing worse; she had intolerable pain before menstruation, which was at times scanty and at times profuse.

In September, 1885, she reported that she was perfectly well and able to do more than she had done for years, and to enjoy her work. Ten months after the operation she continued perfectly well, and looked like another woman, comparatively

stout, and with a clear and ruddy complexion, looking literally ten years younger.

Case XV.—From the time of her marriage, nine years before the operation, this patient had been subject to epileptic seizures. She was not sure that she had had any well-marked attack before marriage. At first the seizures occurred only once in the month—at the time of menstruation. The attacks then increased in frequency and severity, notwithstanding active treatment by bromides and other drugs. For over a year before the operation she had been subject to attacks at least once a week, and sometimes twice. Her nervous system had suffered severely, and she had much the appearance of a patient exhausted by some malignant disease. The fact that the epilepsy had at first a direct connection with the menstrual period seemed to indicate the propriety of artificially arresting the menstrual process. Apart from this consideration, it was evident that the ovaries were abnormally large. They proved, on removal, to be cystic throughout, and to have undergone degenerative change. For three months after the operation there were epileptic attacks, but less severe, and much less frequent than before. They then diminished in severity and became less frequent until nine months after the operation, when they ceased entirely. The patient reported June 5, 1886, and had not then had an attack of any kind for three months. She had gained in weight and health, and felt as she had not done for nine years past.

There is good reason to expect a permanent cure in this case; but the patient will be kept under observation, and reported on hereafter.

Case XVI.—There was found in this case an ovarian tumor containing dark, grumous, and colloid contents. The lower half of the sac was adherent to the intestines, the uterus, and the pelvic brim. Neither removal nor enucleation was possible. The free portion of the sac was, therefore, excised, and the remainder left in place, with a large glass drainage-tube in it, reaching to the bottom. The abdominal wound was closed round the neck of the sac, the peritonæum being stitched care-

fully at the upper and lower angles to the exterior of the cyst wall. The cyst was irrigated with carbolized water as often as was necessary to keep it sweet—generally every three or four hours. The cavity rapidly diminished in depth, and shorter tubes were substituted, from time to time, for the long one. For some days there were symptoms of peritonitis, but the constant use of the cold coil kept the temperature down. The patient made a good recovery, was able to do her duties as lady's maid early in August, and has been at work ever since.

Case XVII.—A diagnosis of uterine fibroma had been made in this case by two experienced surgeons. There was a mass, apparently solid, filling the pelvis and crowding the uterus down. With the sound passed into the uterus, however, a slight independent movement could be effected. It had a history of having grown entirely within eleven months. Menstruation had not been influenced by the tumor.

On making a small incision, a hard, white, glistening mass appeared, flat on one side and convex on the other or lower, and having within it a small isolated cyst, which ruptured as the mass was raised. The contents looked like ascitic fluid, and escaped into the abdominal cavity. The incision was enlarged and the tumor easily removed, there being no adhesions and a small pedicle, like that of an ovarian cyst. The growth had certainly no connection with the uterus, and proved, on examination, to be a fibroid tumor of the left ovary, the first case of the kind in my experience. The weight of the mass was nearly two pounds. The patient made a good recovery.

Dr. Homans, of Boston, writes me that he met with his first case of ovarian fibroid in May, 1885. Mr. Thornton reports that the first case he had met with was in the autumn of 1884.

Case XVIII.—There is nothing remarkable about this case. There was a large cystic ovary, with obstinate retroversion of the uterus, and consequent dysmenorrhœa. With the removal of the ovary the uterus resumed its normal position, and all the

other symptoms have disappeared. Palliative treatment, pessaries, etc., had been tried for eighteen months before the operation was advised.

Case XIX.—The operation in this case was peculiarly difficult, owing to the very extensive adhesions and the necessity of tying a large number of bleeding points. The danger of the operation was fully appreciated by the patient, but, as the tumor was growing very rapidly, she preferred to incur the risk of its removal rather than to die a lingering death. She was already much emaciated, and suffered greatly from pain and dyspnœa. The operation was done only after consultation with my colleagues in the Woman's Hospital, but it was not one to be undertaken by a compiler of favorable statistics.

Case XXI.—The operation of removing the ovaries and tubes was undertaken in this case with the view of arresting menstruation and thus diminishing the frequency and severity of the epileptic attacks, from which the patient had suffered ever since she first menstruated. Examination under ether revealed slight enlargement of the ovaries, but the symptoms, the failing health, and the increasing mental disturbance, seemed to render the operation imperative as holding out the last and only hope.

The operation lasted thirty minutes, but the patient did not at once recover consciousness, and became blue and comatose. Heat, dry cups over the back, the faradaic current, and the hypodermic use of brandy failed to do any good for several hours. The lungs filled with mucus, which there was not power enough to expel, and there seemed at one time scarcely a chance of recovery. Not until twelve hours after the operation did the patient show the least sign of consciousness. About six hours later breathing was fully established, and convalescence thereafter was uninterrupted.

One point of interest was that, notwithstanding the vigorous manipulations resorted to to induce respiration, and the frequent and rather violent movements to which the patient was subjected in the anxiety of her several attendants, not the slightest symptom of peritonitis followed, and the union of the wound was perfect and by first intention.

Case XXII.—This patient was a strong Irish servant girl, who had "never been sick a day in her life" until a year ago, when she began to have scanty menstruation and severe headaches. The flow became less and less. She had an ovarian tumor in the right side. There was nothing peculiar about the operation. A tube was left in for two days for fear of bleeding. Convalescence was uninterrupted, and the patient has been doing hard work ever since she was discharged.

Case XXIII.—An exploratory incision was made in this case to ascertain if it was possible to remove the ovaries and tubes to arrest frequent hæmorrhages, and the discharge of large quantities of offensive pus mixed with blood. The tubes were found to be so firmly attached to the uterus as to seem like a part of that organ. To separate them was impossible. The uterus was large and vascular. A loop of intestine about four inches in length was detached from the tube on the left side. Nothing more could be done, so the wound was closed. Though feeble and emaciated, the patient made a good recovery, and was almost free from a very severe pain from which she had suffered on the left side, whenever the bowels moved. This was attributed to the release of the loop of intestine. In other respects the condition of the patient was not affected by the operation.

Case XXIV.—This was a case of simple, uncomplicated ovariotomy. On the second day there were unmistakable evidences of peritonitis with abdominal distension, which were not controlled by the cold coil. At one o'clock in the morning of the third day the patient was taken from her bed to the operating-room, and the abdominal cavity reopened and washed out with a blood-warm one-per-cent. solution of carbolic acid. A small quantity of bloody serum was found; a tube was left in and irrigation kept up every three hours until the temperature fell to 98·5°. The temperature had been 102°. The tube was removed three days later, and the patient had no further trouble. She was seen in June, 1886, and was perfectly well.

Case XXV.—The pain complained of by this patient was always on the right side. The right ovary was full of cysts, and, with the corresponding tube, was removed. The other ovary was somewhat cystic, but, at the urgent request of the

patient and husband that both ovaries should not be sacrificed, unless there was much disease of both, that ovary was left. There has since been a return of pain, but now on the left side, and the ovary is considerably enlarged.

I believe that, as a rule, cystic degeneration is not confined to one ovary, that, once begun, it is progressive, and that it is wiser to remove an ovary that gives evidence of such disease than to let it remain. See Case XXVI.

Case XXVI.—The patient and her husband, being very anxious to have a family, specially requested that both ovaries be not removed, unless there was advanced disease of both. The left ovary, though somewhat cystic, was not interfered with, in the hope that time and care might effect a favorable change. For three months after the operation there was very little pain, but the "same old pain," as she expressed it, gradually returned, and in May, 1886, the patient voluntarily sought relief by a second operation, life having become intolerable.

Had the operation been refused by me, it would have been demanded elsewhere, or the patient would have sought relief in opium. See Case XLIX.

Case XXVIII.—This patient entered hospital with a temperature varying from 102° to 103°, and other evidences of acute peritonitis. There was so much tenderness and distension that a satisfactory examination could not be made, but it was evident that there was a tumor behind and to the right of the uterus. On making an incision, it was found that there was sloughing of the fundus of the uterus. So much hæmorrhage followed the attempt to remove the tumor that an elastic ligature was thrown around the uterus. On the left side were a small ovarian cyst and pyosalpinx, and on the right there was a tumor or cyst, which had ruptured, giving rise to the sudden increase of symptoms of peritonitis, which had made operative interference imperative. There had been a tubal pregnancy, but, as this was not evident until the specimen had been care-

fully examined, no search was made for the fœtus. The patient died of shock the day following the operation.

Had an operation been resorted to before peritonitis developed, the result would probably have been different, but the condition of the patient on entering hospital was such that an unfavorable prognosis was made from the beginning.

Case XXIX.—This patient (colored) was obliged to give up a good position on account of constant pain. The right tube was over an inch in diameter and distended with pus. It was removed with some difficulty, but the ovary could not be detached from its surroundings, and was therefore left. The drainage-tube was removed in twenty-four hours. Six months later the patient was well, and had been working steadily since she left the hospital, three weeks after the operation.

Case XXX.—There was a suspicion of pregnancy in this case, on the part of her friends, as she had menstruated only once in six months. Severe and constant pain in the right side was complained of. Examination revealed a mass on the right side. This proved to be the distended tube and a cirrhotic ovary. There were no adhesions. Recovery was speedy, but some pain persisted for three months.

Case XXXI.—There was in this case great emaciation with a shattered nervous system. Physical pain and mental worry had rendered the condition the worst possible one to sustain any kind of surgical operation. Had the disease been recognized earlier, the case would have presented no unusual difficulties. The pulse before the operation was at times hardly perceptible; no proper nourishment was taken, and the patient had come to rely to a great extent on morphine. An ovarian tumor as large as a hen's egg was found on the left side, firmly adherent to the uterus. The right ovary was cirrhotic and the tube diseased. Both were removed. In removing the tumor in the right side, some vessels were torn and the ligatures would not hold. A long forceps was applied and left in the wound till the third day. A glass drainage-tube was left in also. The sutures were removed on the ninth day, and union was perfect. The patient was unable to retain nourishment, either by mouth

or rectum, and an uncontrollable dysentery set in on the ninth day. Death from exhaustion occurred on the tenth day.

Case XXXII.—There was in this case a large parovarian cyst, very firmly adherent, and there was also marked disease of both ovaries, which contained a number of cysts of various sizes and very little healthy tissue. The cyst was emptied and removed, with some difficulty, and both ovaries and tubes were also removed. A tube was left in the region that had been occupied by the cyst. The usual antiseptic precautions were observed in this case with more than usual rigor, and the surroundings were all that could be desired. The patient rallied well after the operation; but there was a sudden development of peritonitis of the ungovernable type, and, notwithstanding the prompt application of the cold coil, large doses of antipyrine, etc., the temperature continued to rise till it reached 107°, and death occurred on the third day.

Case XXXIV.—The operation was undertaken as a last resort, all other means of relieving the patient having utterly failed. There was an indistinguishable mass where the uterus and ovaries should be felt. Nothing could be done but to close the wound.

Case XXXV.—In this case, one of multiple uterine fibroid, galvano-puncture had been tried thoroughly, but with little appreciable effect. Several months had been devoted to that treatment, first by Dr. J. N. Freeman, of Brooklyn; afterward by myself after Dr. Freeman's method. As the tumors were increasing rapidly in size, it was decided to do Hegar's operation, if possible. It was found to be impossible, because the ovaries and tubes were firmly adherent to and imbedded in the growth. The entire mass, with the uterus, was, therefore, raised and removed at the junction of the cervix. The pedicle was transfixed and treated externally, the wound being closed above and below it, the peritonæum having been separately stitched to the periphery of the pedicle. The patient made a good recovery.

Case XXXVI.—This case was carefully examined several times by myself and others accustomed to the diagnosis of abdominal tumors, and the only difference of opinion was as to

whether it was a fibroid of the uterus or a fibro-cyst. It proved to be a multilocular ovarian tumor, with a thick wall and colloid contents. The cyst was very tense, and gave on palpation exactly the impression given by a solid mass. General peritonitis followed the operation, notwithstanding the use of the drainage-tube and the cold coil, and the patient died on the seventh day.

Case XXXVII.—There was such absolute fixation of the whole mass that it was not deemed practicable to remove it. One large cyst was emptied and washed out, but no solid portion of the tumor was removed. The patient recovered, and when discharged was feeling better, probably from the diminished size of the mass.

Case XXXVIII.—The feature of chief interest in this case is the fact that the disease of the ovaries was recognized fully a year before the operation, and that it was steadily progressing. All the other remedies for the disease were tried, and the only measure that from the first could have been of any avail was postponed till the patient was exhausted, bloodless, and broken down from hæmorrhage and pain.

Had the operation been done six months earlier, there is a strong probability that the patient would now have been alive and well.

Case XXXIX.—In this case the doubt as to whether the growth was an ovarian or a fibroid tumor was set at rest only by an exploratory incision, which showed the existence of both.

Case XLII.—Partial relief was afforded to severe intestinal pain by the loosening up of about five inches of intestine. The ovaries and tubes were so matted together by old inflammation that they could not be removed.

Case XLV.—Both ovaries and tubes were removed. The right ovary was markedly cystic; the left less so. The patient was relieved at once of severe pain, and, two months after the operation, was able to do some work for her own support.

Case XLVI.—Athough there were firm adhesions in this case, there was no hæmorrhage after sponging thoroughly, and

therefore no drainage-tube was used. The pain, which was more than usual for so small a tumor, was probably due to the adhesions, as the mass was bound down deep in the pelvis, and was increasing in size.

Case XLVII.—This patient had been practically bed-ridden for a year, and had suffered much before that time, having had repeated attacks of pelvic cellulitis. She attributed her first attack to an attempt made to straighten and dilate the uterine canal for the relief of dysmenorrhœa. Six months before the operation, when she first came under observation, there was a mass on the right of the uterus, giving obscure fluctuation, and evidently fixed, as was the uterus. The patient had intense pain before each period, a rather profuse flow, with partial relief, and afterward a constant discharge of highly offensive pus, sometimes amounting to six or eight ounces in the twenty-four hours. There was extreme prostration. The operation was undertaken as a last resort. It was found on making the incision that removal of the tumor would be absolutely impossible. The upper side presented a convex aspect and the wall was apparently not thicker than thin paper. This ruptured during examination. The cavity was thoroughly cleansed, and the inner wall of the dilated tube was sponged out. A Sims drainage-tube was left in and the irrigation kept up at short intervals. Peritonitis developed and proved fatal on the third day.

In this case an early operation, six months or a year before, when the patient was in a much better physical condition, would have afforded a better chance of recovery. The question of puncturing the tube or abscess through the vagina was often considered, but it did not seem practicable, and, as there was a free discharge of pus *via* the uterine canal, was not particularly necessary. As the operation proved, it would have been very difficult to reach the tube by a vaginal incision, and a long wound would have been exposed to infection by the offensive discharge.

Case XLVIII.—This case was very like Case XVI. A portion of the cyst wall only could be removed. That which re-

mained was drained. The abdominal cavity was carefully closed and the walls of the tumor were secured in the wound. The patient made an excellent recovery. On June 15th there was only a small sinus, about two inches deep, remaining, and it was gradually filling up.

Case XLIX.—See Case XXVI. The patient, only two weeks after the operation, felt herself entirely relieved from a certain pain that she had experienced for months before. It is of course much too early to form any opinion as to what the ultimate result will be.

Case L.—This patient might have recovered had not bronchitis set in. The operation was longer than usual, in consequence of the attempt to close the uterine pedicle by the intraperitoneal method. A wedge-shaped portion was removed and the edges were accurately adjusted by two sets of sutures, deep and superficial. On relaxing the ligature, there was so much hæmorrhage that it was necessary, though other efforts were made to control it, to reapply the elastic ligature and secure the pedicle outside, transfixing it with long needles in the usual way. The post-mortem showed some peritonitis, bronchitis, and hypostatic pneumonia in the lower portion of both lungs.

No.	Whole No.	Date.	Place.	Age.	Married or Single.	Length of incision.	Weight of tumor.	Character of tumor.	Adhesions.	Indications for operation.	Pedicle.	Drainage-tube.	Result.	Remarks.
						In.	Lbs							
1	51	Feb. 26, 1885.	Woman's Hospital.	25	M.	3	..	Multilocular ovarian cyst and double pyosalpinx.	Very firm and extensive.	Pain & hæmorrhage.	Tied with silk.	Tube 2d day.	Death.	Right tube distended with fœtid pus, but removed intact. Patient much reduced by previous hæmorrhages.
2	52	Feb. 27, 1885.	"	26	M.	3	4	Multilocular ovarian cyst.	Slight.	Pain, peritonitis.	"	None.	Recovery.	Pedicle twisted five times. Hæmorrhage into cyst. Peritonitis at time of operation.
3	53	Mch. 15, 1885.	"	28	M.	3½	..	Hæmatosalpinx.	Firm.	Pain & hæmorrhage.	"	"	"	Removed left tube and ovary.
4	54	Mch. 23, 1885.	"	51	M.	6½	12	Sarcoma of ovary, semi-solid.	Very firm and general.	Pain, rapid growth of tumor, failing health.	"	"	Death 20 hrs. after operation of shock.	Severe hæmorrhage from vessels in adhesions, which gave way in the forceps.
5	55	April 12, 1885.	Private case.	24	S.	2	..	Cystic ovaries.	None.	Pain and failing health, dysmenorrhœa.	"	"	Died Apr. 22d, of peritonitis.	Operation remarkably easy. Much suffering after operation, and nausea, but temp'ture not high at any time. Pulse failed suddenly on 22d, and patient died in collapse eight hours later.
6	56	April 13, 1885.	St. Elizabeth's Hospital.	32	M.	3	..	Cystic ovaries & pyosalpinx.	Very firm.	Dysmenorrhœa.	"	Tube.	Recovery.	The tube was removed April 20th. No bad symptoms. Temperature never above 100½°. Both ovaries and tubes were removed.
7	57	April 18, 1885.	Private case.	20	S.	4	..	Cystic ovaries.	None.	Severe and increasing dysmenorrhœa.	"	"	"	Severe hæmorrhage during operation from tearing of left broad ligament. Peritonitis followed, and irrigation was very thoroughly employed.
8	58	April 20, 1885.	Woman's Hospital.	23	M.	3	..	Double pyosalpinx and both ovaries cystic.	Firm and vascular.	Dysmenorrhœa.	"	"	"	Severe hæmorrhage during operation from torn adhesions.
9	59	April 21, 1885.	"	57	M.	4	17	Multilocular ovarian cyst.	Firm parietal.	Increasing size of tumor.	"	None.	Death May 3d.	Not a single bad symptom up to April 28th, when diarrhœa and dysentery began. Died of exhaustion.
10	60	April 26, 1885.	St. Elizabeth's Hospital.	52	M.	3	..	Right tube and ovary.	Intest. adherent to parietes, etc.	Intense pain.	"	"	Recovery.	The patient had operation in 1883. Left ovary and 4 inches of the intestine removed.
11	61	May 5, 1885.	Woman's Hospital.	26	S.	2½	..	Cystic ovaries.	None.	Pain and failing health.	"	"	"	Had menstruated three times only in last two years. One year after operation, much better, and improved physically. Not free from pain.
12	62	May 15, 1885.	"	42	M.	6	11½	Multiple fibroid.	"	Pain & hæmorrhage.	Left outside	Tube.	"	The wound was closed up to the pedicle, which was first cauterized and later treated with iodoform.
13	63	May 28, 1885.	"	30	M.	4	..	Uterus removed at cervix.	Int'stines to uterus.	Obstinate menorrhagia.	Écraseur & wire.	None.	Death May 30, shock.	Ovaries removed by Dr. Thomas a year before for menorrhagia, but without relief.
14	64	May 30, 1885.	"	34	S.	2½	..	Cystic ovaries.	Firm on right side	Constant pain, dysmenorrhœa.	Tied with silk.	Tube.	Recovery.	Patient had been unable to do her work. In bed with pain much of the time. Excessively nervous and despondent. Much nausea.
15	65	May 30, 1885.	St. Elizabeth's Hospital.	29	M.	2½	..	Both ov'ries (cystic) and tubes.	None.	Epilepsy.	"	None.	"	Epileptic attacks every two or three days, becoming worse. See note.
16	66	June 5, 1885.	"	41	.	5	..	Ovarian. Colloid contents.	Firm and extensive	Size & weight of tumor.	Not reach'd	Tube in cyst.	"	Impossible to remove cyst entirely; part cut off and rest drained.
17	67	June 18, 1886.	Private case.	25	S.	4½	2	Solid tumor of left ovary.	None.	Sense of weight.	Tied with silk.	None.	"	Had been pronounced a fibroid of uterus; proved to be a fibroid tumor of the ovary.
18	68	July 29, 1885.	"	28	M.	2½	..	Cystic left ovary.	None.	Pain & sense of weight.	"	None.	"	Left ovary and tube only removed.
19	69	Sept. 19, 1885.	Woman's Hospital.	42	M.	8	22	Fibro-cyst.	Very firm adhesions	Pain & growth of tumor.	Elastic ligat're	Tube.	Death.	The adhesions were so numerous and firm that hæmorrhage was unavoidable. Death from shock.
20	70	Sept. 30, 1885.	"	38	S.	4	12	Multilocular ovarian cyst	None.	Rapid growth of tumor.	Tied with silk.	None.	"	Peritonitis.
21	71	Oct. 17, 1885.	Private case.	19	S.	2	..	Cystic ovaries.	None.	Epilepsy.	"	"	Recovery	Patient nearly died from effects of ether. No report yet as to the epilepsy.
22	72	Oct. 27, 1885.	St. Elizabeth's Hospital.	32	S.	3	1	Ovarian cyst, right side.	Slight.	Pain.	"	Tube.	"	Tube removed Oct. 30th. Temperature did not exceed 99°.
23	73	Oct. 30, 1885.	Private case.	48	M.	3	..	Pyosalpinx.	Very strong & ext'nsive.	Metrorrhagia and pain.	"	None.	"	Impossible to separate tubes from uterus, which they surrounded. Detached a loop of intestine.
24	74	Nov. 2, 1885.	St. Elizabeth's Hospital.	30	M.	3	4 oz.	Small ovarian cyst, left side.	Moderate	Pain and dysmenorrhœa.	Tied with silk.	Tube on 3d day.	Recovery.	Peritonitis developed on 2d day. On 3d day opened, washed out, and left in tube. Coil used first.

No.	Whole No.	Date.	Place.	Age.	Married or Single.	Length of incision.	Weight of tumor.	Character of tumor.	Adhesions.	Indications for operation.	Pedicle.	Drainage-tube.	Result.	Remarks.
						In.								
25	75	Nov. 13, 1885.	St. Elizabeth's Hospital.	32	M.	2½	..	Cystic right ovary.	Firm parietalfr'm old peritonitis.	Pain and dysmenorrhœa.	Tied with silk.	Tube.	Recovery.	Tube removed on 3d day. No unfavorable symptoms.
26	76	Nov. 15, 1885.	Woman's Hospital.	26	M.	2½	..	Ov'ry & tube on right side removed.	Firm on one side.	Pain and dysmenorrhœa.	"	None.	"	The left ovary was somewhat cystic. See Case XLIX.
27	77	Nov. 19, 1885.	"	31	M.	2½	..	Both ovaries cystic.	None.	Pain and dysmenorrhœa.	"	"	"	
28	78	Nov. 24, 1885.	"	28	M.	5½	10 oz.	Tubal pregnancy.	Firm.	Peritonitis.	Elastic lig'ture & wire.	Tube.	Death.	Uterus removed with the tumor. Sloughing of uterus.
29	79	Dec. 8, 1885.	St. Elizabeth's Hospital.	25	M.	2	..	Pyosalpinx, right.	"	Severe pain.	Tied with silk.	"	Recovery.	Did not remove ovary on account of adhesions. Tube full of pus.
30	80	Dec. 11, 1885.	"	35	S.	2	..	Right ovary cirrhotic; ovary & tube removed.	None.	Severe pain in right side, amenorrhœa.	"	None.	"	Had menstruated but once since July.
31	81	Jan. 2, 1886.	"	24	M.	4	4 oz.	Ovarian tumor and pyosalpinx.	Very firm and extensive.	Pain and dysmenorrhœa.	"	Tube.	Death on 10th day.	Right ovary and tube diseased and removed. On left side ovarian tumor firmly adherent to uterus, etc.
32	82	Jan. 11, 1886.	Private case.	28	S.	4	8 oz.	Parovarian and ovarian cysts.	Very firm	Pain and dysmenorrhœa.	"	"	Death 3d day.	Acute general peritonitis.
33	83	Jan. 12, 1886.	St. Elizabeth's Hospital.	28	M.	2	..	Cystic right ovary.	None.	Pain and dysmenorrhœa.	"	"	Recovery.	Right ovary and tube removed. Ovary much diseased.
34	84	Jan. 16, 1886.	Private case.	41	M.	3	..	Chronic ovaritis.	Very firm	Severe pain.	.....	None.	"	The ovaries and uterus were bound together in one mass. Impossible to make any impression on it.
35	85	Jan. 19, 1886.	Woman's Hospital.	30	S.	6	12 lbs.	Uterus and fibroma.	None.	Pain & hæmorrhage.	Elastic ligat're	"	"	Used elastic ligature and transfixed.
36	86	Feb. 8, 1886.	"	36	M.	4	4 lbs.	Multilocular ovarian cyst, colloid.	Slight.	Rapid growth in size.	Tied with silk.	Tube.	Death Feb. 14.	Tumor was diagnosed as fibroid or fibro-cyst by all who examined patient. Punctured the abdomen. Death was from general peritonitis.
37	87	Feb. 12, 1886.	"	42	M.	2½	..	Cysto-sarcoma of ovary?	Firm.	Pain & growth of tumor.	.....	"	Recovery.	Not certain before operation whether growth was of uterine or ovarian origin. Removed fluid only.
38	88	Feb. 14, 1886.	"	..	S.	2½	..	Cystic ovaries.	Very firm	Pain.	Tied with silk.	"	Death 5th day.	Died of sheer exhaustion. Very weak before the operation, which was advised six months earlier.
39	89	Feb. 14, 1886.	"	42	M.	2½	..	Sm'll fibroid tumor in right of uter's & cystic ovary.	Too firm to permit removal.	Dysmenorrhœa.	.....	None.	Recovery.	Ovarian and fibroid tumors and tube on right side bound in one mass. Impossible to remove it.
40	90	Mch. 1, 1886.	"	27	S.	4	1 lb.	Dermoid cyst on right side.	None.	Constant pain.	Tied with silk.	"	"	Had been suffering five years. Menstruation scanty.
41	91	Mch. 8, 1886.	"	22	M.	2½	..	Cystic ovaries.	Slight.	Pain and dysmenorrhœa.	"	Tube.	"	
42	92	Mch. 27, 1886.	Private case.	32	M.	4	..	Chronic ovaritis.	Very firm	Pain.	.....	"	"	Detached 5 inches of intestine, as in Case XXIII. Removed nothing.
43	93	Apr. 21, 1886.	Woman's Hospital.	25	M.	2½	..	Cystic ov. & diseasd tube on left side.	Slight.	Pain and dysmenorrhœa.	Tied with silk.	None.	Recovery.	Left ovary and tube only removed.
44	94	Apr. 25, 1886.	"	19	S.	2	..	Right ovary cystic, left cirrhotic.	None.	Pain.	"	"	"	Small supplementary ovary on left side. Both ovaries and tubes removed.
45	95	Apr. 25, 1886.	"	19	M.	4	..	Cystic ovary on ri'ht side, pyosalpinx.	Firm.	Pain.	"	"	"	Relief from almost constant pain, which had lasted six months.
46	96	May 3, 1886.	"	30	M.	2½	8 oz.	Ovarian cyst and salpingitis.	"	Pain and sense of fullness.	"	"	"	Ovarian tumor on left side. Cystic ovary on other. Removed both, and tubes.
47	97	May 5, 1886.	Private case.	29	M.	4	..	Pyosalp'x, pelvic abscess.	Very firm	Pain and constant disch'rge of pus.	.. ...	Tube.	Death 3d day.	Right tube ruptured while attempting to remove it. Impossible to get it out.
48	98	May 12, 1886.	Woman's Hospital.	48	M.	4½	..	Ovarian tumor.	"	Increasing size of tumor.	.....	Tube in cyst.	Recovery.	Case like No. 16. Removed about two thirds of cyst. Drained the rest.
49	99	May 31, 1886.	"	26	M.	2½	..	Ovaritis.	Slight.	Pain.	Tied with silk.	None.	"	Right ovary and tube removed Nov. 15, 1885. Left ovary and tube removed at this operation.
50	100	June 3, 1886.	"	47	M.	6½	2 lbs.	Fibroid and uterus.	Extensive.	Pain and menorrhagia.	Elastic lig. & needles	.....	Death.	Bronchitis developed early, and the lungs acted badly. Some peritonitis.