JOHNSON (JOS. T.)

A RECORD OF EIGHTY

MISCELLANEOUS

ABDOMINAL OPERATIONS.

SEVENTH ANNUAL ADDRESS OF THE PRESIDENT, DELIVERED BEFORE THE WASHINGTON OBSTETRICAL AND GYNECOLOGICAL SOCIETY, OCTOBER 4TH, 1889.

BY

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A RECORD OF

ABDOMINAL OPERATIONS.

Another year in the life of our Society has ended, and with it ends my term of office. Your constitution requires that the retiring President should, at the last meeting of the year, deliver an annual address. The present retiring President would spare you this infliction if he could find any clause in the constitution which would permit him to do so.

It is with sadness that I draw your attention to the fact that our ranks have been thinned during the year by the death of one member and the resignation of another, while, on the other hand, two new active members have been received, making our number the same as when we began the year; and Honorary Fellowship has been applied for and conferred upon a distinguished author and teacher across the ocean. No unhappy incidents have marred the debates of our Society, and the President has the happiness to announce that he can turn over the organization to his successor in at least as good condition as he received it from his honored predecessor.

The publication of our Transactions in the AMERICAN JOURNAL OF OBSTETRICS reflects credit upon our Society as well as upon those who participated in its debates, and also upon the energetic and very competent chairman of the Publication Committee.

It has been customary, in the annual addresses to which we have heretofore had the pleasure and profit of listening, to discuss some topic of general and commanding interest. Few subjects in our department of practice and surgery remain for discussion which have not already been thoroughly written up

[1] Being the Presidential address delivered before the Washington Obstetrical and Gynecological Society, October 4th, 1889.

in the journals, or discussed in Society papers and public addresses.

Rather than burden you, then, with a rehash of stale opinions or a sentimental appeal to your prejudices upon any pertinent, prominent, or mooted topic in obstetrics or gynecology, I have chosen the more doubtful and unusual course of making a running report, with brief comments upon separate cases of interest and upon groups of cases, of all my own work in the department known as abdominal surgery.

In this innovation presidents of the British Gynecological Society and of that in Chicago have preceded me, while others in Philadelphia, Pittsburg, and Chicago are quite in the habit of reporting their abdominal surgery by the year. In my own work a number of the cases have been separately reported to this and other medical societies, and have formed the basis of separate papers; but no attempt has ever been made to cover in one paper all my work from the first case to the last, with a full statement of percentages of success and failure in all the groups and varieties of cases operated on, and no analysis has been made and no lessons drawn.

I did my first operation for the removal of the ovaries on August 17th, 1881, and I am informed that the patient is still alive and in greatly improved health. It was a Battey operation, and done for a very bad case of menstrual epilepsy. I had no other case for three years, when I had a Tait operation, but was able to remove only one ovary and tube. The patient was only partially cured, but has since had change of life and recovered, showing that if both ovaries could have been removed she would have been cured completely. My third, fourth, and fifth cases died, which so depressed me that I nearly gave up in despair.

I then went to Europe to see Keith and Tait, Bantock and Thornton operate, and from them learned many points in the technique of abdominal operations, and have since taken many opportunities to witness the methods of abdominal surgeons in various cities in our country.

After resuming work I had a run of twenty-five *ovarian* operations without a death; my twenty-sixth case died. There were no more fatal cases until the fifty-six, when tetanus destroyed a patient who for twelve days gave every evidence

of doing well. The next ten cases recovered. In a series, then, of the last fifty-three ovarian operations, there have been only two deaths, giving a mortality of less than four per cent.

In all the ovarian operations, from the first to the last, numbering exactly fifty-nine, there have been five deaths, three of them being the third, fourth, and fifth in the table forming a part of this paper, the other two being the twenty-sixth and forty-third in the last fifty-three ovarian operations performed.

There are set down in the table sixteen other abdominal sections, making seventy-six in all. Eight of these were supravaginal hysterectomies for the removal of uterine fibroids, four of which died and four recovered. Three were exploratory incisions—all recovered; one was a Cesarean section, one was for the removal of a seventy-four-pound cyst of the kidney, one universal cancer, and one extra-uterine pregnancy, all four of them proving fatal.

Of the thirteen fatal cases out of the seventy-six abdominal sections, most of them ought not to have died; at least most of them did not die from any of the usual causes, such as shock, hemorrhage, peritonitis, or sepsis. Thus the first one to die was an old lady aged 65, who seemed to have made up her mind before the operation that she would never recover. She made her will, bid her friends and relations good-by, and let go her hold on life. She told me, after she recovered from the anesthetic, that she was much surprised and a little disappointed that she had not died under the operation. If I had known her state of mind I would have put off the operation, as I have found that a strong determination and expectation to get well is a great aid to the surgeon. In her low state she fell an easy prey to erysipelas, which I afterwards learned existed in the General Hospital where she had taken a room. A post-mortem showed no peritonitis, septicemia, or hemorrhage.

The second case showed some evidences of poisoning by corrosive sublimate. This was in February, 1885. The sponge water was impregnated with it, and a solution of it was used to wash out the abdominal cavity. I was ignorant of its danger then. I have never used it since for any purpose inside of a cavity. I am convinced now that many cases have been injured by it. Garrigues has recently stated that he knows of

more than twenty deaths caused by its use in irrigating the uterine cavity after labor. Pure hot or distilled water, without any chemical compound in it, is just as good and is free from danger.

A partial post-mortem in the third case revealed a slight peritonitis. She took cold, however, on the night of the seventh day, when everything indicated a perfect recovery, had acute suppression of the urine, and was in a comatose and collapsed state for about ten hours before she died. I could never be quite reconciled to her death. It ought not to have occurred. A lot of ice in a towel was put under the back of her neck, and melted and ran down and chilled her back.

The next case to die was a Cesarean section; and I have always thought if a Porro operation had been done in that case she would have recovered. The patient had been three days in labor. After failing with the forceps, attempts had been made to turn the child, but its head never got further around than the left iliac fossa. Efforts were then made to push it back over the os, so that craniotomy might be more easily performed. I was informed, when called in, that she had been five hours under the influence of ether, and was subjected to three operations, viz., forceps, version, and craniotomy.

The Cesarean section was finally done under the most discouraging and uncleanly circumstances imaginable. The house was a one-story negro cabin, and contained only two rooms. The bed and her room could not have presented a worse environment for an abdominal operation. Notwithstanding all these drawbacks, the patient lived for ten days, and died finally from septic peritonitis caused by an abscess forming in a bruised part of the uterus and discharging into the peritoneal cavity. If the uterus had been amputated below that bruised spot, I believe she would have recovered.

I regret to say that the Cesarean section has not yet been successfully performed in our city, and that we are thus deprived of one of the most potent and convincing arguments when we endeavor to persuade a parturient woman to submit herself to its performance for the sake of science and her unborn child.

In our haste to do away with craniotomy, we should not al-

low the pendulum to swing too far the other way. I know of two cases in a neighboring city where all the preparations had been completed for a Cesarean section; many physicians had been invited to witness the operations at an appointed hour; but, the night before, nature asserted herself, and, unaided by the surgeon's knife, these two women gave natural birth to their children.

Not many months ago I was requested by two physicians to perform a Cesarean section upon a woman whom they had failed to deliver with the forceps after several attempts had been made. While I was preparing my instruments and sponges for the proposed operation, a telephone message was received from the nurse stating that the baby had been born alive in the absence of the doctors, and that the mother and child were both doing well. The errors in diagnosis are not all made by the craniotomists.

Cast-iron rules will not do in regard to the Cesarean section when they cannot be adopted in regard to other surgical procedures or methods of treatment. In the new-born zeal in regard to antiseptic injections in *all* cases of labor and the puerperal state, which some were anxious to adopt, much harm has now been proved to have followed their too frequent use in normal as well as abnormal cases; and papers are now being written by our best men upon the abuse and dangers following their "meddlesome" and too indiscriminate employment.

So I think it will be in regard to the illogical and sentimental logic which has been recently used by those who would forbid the performance of craniotomy upon the living child under any and all circumstances. Even Dr. Harris, who has done so much to influence the profession of America and the world in favor of the more frequent and timely resort to Cesarean section, told me last spring that he did not approve the teachings of those writers who would do away entirely with craniotomy.

It would seem to me to be a great blow at our independence as educated and scientific professional men to have our hands or consciences so bound by rules or laws as to prevent us from doing that which our experience and conscientious judgment indicated to us was for the best interests of the patients entrusted to our care.

The amputation of the pregnant uterus would probably be followed by a greater average good to humanity than the Cesarean section, inasmuch as in cases of pelvic deformity which prevented the birth of a living child future pregnancies would be thereby prevented, and the woman not exposed to repeated operations which involve great danger and risk to both mother and child.

I hardly think that the time is yet ripe for the giving-up of craniotomy, but I think we should do all we can to educate the people as well as the profession in the matter of early diagnosis and the preparation for a timely and properly arranged Cesarean section. Craniotomy will *then* be resorted to only for the neglected cases and those mismanaged by midwives, where surgeons are called in too late and under too unfavorable surroundings to promise success, as in my own case.

The fourth death was my twenty-third abdominal section, which was done for the removal of two large fibroid tumors of the uterus. A supravaginal hysterectomy was performed. I suppose this patient died of septic peritonitis. My thirty-fourth abdominal section was for the same purpose, and the result was the same. Case 41 was also a supravaginal hysterectomy for a very large fibroid which caused constant pain and hemorrhage, making life a great burden, and she died. Case 68 was also a fatal supravaginal hysterectomy, which was done suddenly to relieve intestinal obstruction which had existed for more than a week. The pelvis was apparently filled by this uterine fibroid, and the operation was done to save life. Though much relieved by the removal of the tumor, the obstruction was not overcome, and she died six days later. A post-mortem showed cancerous occlusion of the transverse and descending colon, and a perforation and discharge of feces into the peritoneal cavity. This case is put down in my table as a death after supravaginal hysterectomy, but it is not fairly chargeable to this operation; as she did not recover, I am compelled to state the facts; but as the most natural inference is a little unjust, an explanation is due. In two cases which I feel I am right in reporting as having recovered from ovariotomy and as having been discharged as cured of ovarian tumors, I have since heard that one has died of cancer and the other from malarial dysentery. I think it well to

state this, lest some one, learning of their death later on, might misunderstand the table presented.

There have been eight supravaginal hysterectomies performed on account of uterine fibroids; of this number four died and four recovered. If this were the average mortality of the operation, it would be sufficient to condemn it; but other operators have succeeded better, and I feel confident that I shall do better. A great majority of these tumors fortunately do not require operations, but the gynecologist will occasionally find one which is not prevented from growing and causing symptoms which make death seem preferable to the life these sufferers are compelled to live. Ergot, the curette, iodine, and electricity fail sometimes, and an operation is desired, and we must so improve its technique as to relieve it of its dangers. In the hands of half a dozen operators we all can name, its mortality is now reduced as low as ten per cent, and with a very few there has yet been mortality. Electricity as used by Apostoli, and as recommended by Keith and practised by many others, should be given a fair trial before subjecting a patient to the dangers and mutilations of hysterectomy; but I hesitate to believe that it is within the power of this agent to cause the disappearance of these "too solid" masses of flesh which are removed by the surgeon. Patients are benefited for a time by many different kinds of treatment, principally by ergot, the curette, muriate of ammonia, and electricity; but I have seen all the symptoms complained of disappear just as completely for a while by rest and saline purgatives. In a certain class of cases the symptoms all return again to torment their unhappy victims, the treatment has to be gone through again and again, and still some of these tumors grow, life ceases to possess charms, and hysterectomy must be done to save life.

I feel in regard to this operation, as in regard to craniotomy or the tapping of an ovarian cyst, that circumstances may and are likely to be present which will make their choice the lesser evil and perhaps the greater boon. I saw Dr. Price remove a soft, rapidly growing ten-pound fibroid by supravaginal hysterectomy last week, and he remarked, as it lay in the basin, that he did not believe electricity could have caused its absorption and disappearance, connected as it was

with numerous large blood vessels, any more than it could cause the absorption and disappearance of the heart. Puncturing these tumors with sharp electrodes has been followed by a greater mortality in the hands of some men than hysterectomy in the hands of others. Dr. Chadwick has reported two deaths from its use in his own practice, and we all know of others—even Apostoli had one; while Massey has in truth been compelled to acknowledge at least one of the cases reported as cured in his work, as an electrical failure. I know of one case, referred to in our Medical Society as a glorious example of the power of electricity in causing the disappearance of symptoms and the partial subsidence of her tumor, who is now as bad as ever. The tumor is growing more rapidly, and the pain and hemorrhages are more severe, than formerly, so that her Washington physician came to me three months ago to know if I would operate if he would bring her to me. The first report was correct. I saw the case, and agreed to the use of ergotin and electricity, and she was wonderfully benefited, so that she went home much improved and very happy. But it did not last. As we say with the use of some medicines, they lose their effect, and so it may be with electricity; and I fear that our expectations in regard to the lasting powers of this very fascinating and subtle agent are doomed to bitter disappointment, and that hysterectomy will be the only hope of life for some.

In this connection I might mention that I have had six vaginal hysterectomies for uterine cancer, though they are not stated in the table of abdominal operations; in reality they are, the abdomen being entered through the vagina instead of the linea alba. Of these six operations three died. One of these three has since died from a return of the disease, and another, I think, has symptoms that are unmistakable, and is doomed to an early death. And yet I cannot avoid the belief, and there is abundant evidence to show, that this operation has a place which cannot be filled by any other mode of treatment. The galvano-cautery and Sims' and Baker's high amputation will be more frequently called into use, but they will sometimes fail, and total extirpation may present the only hope. It is quite possible that my cases were badly selected, and the cri-

ticism which applies with force to each case may be that they had progressed too far at the time of the operation.

Where there is absolutely no hope without an operation, one is tempted to offer any chances there are with the operation. The great difficulty rests in the diagnosis. When the operation is the main chance, the patient and her friends do not realize the danger; when they are ready and anxious for it, the time is past when all the infected parts can be removed, and the operation is sure to be followed by a return of the disease. Case 37 was one of universal distribution of cancerous growths. A large mass of something was removed as the only way to arrest bleeding, which had been started up by attempts to complete a diagnosis. With the mass in my hand after the operation was over, I was unable to say what I had removed. Fatal hemorrhage came on suddenly after an attack of vomiting. She was doing fairly well until the latter part of the second day, when she suddenly grew weak, pale, and faint, and in half an hour was dead. I have not ventured to classify this case. It was not an ovariotomy, and it was more than an exploratory incision. The twelfth death was a cyst of the kidney weighing seventy-four pounds. It was supposed by many that this case was an ovarian tumor. I refrained from making any diagnosis. It was evidently a cyst, and the woman was nearly dead, greatly emaciated, with large bed sores on her back; had been in bed many weeks. After opening the abdomen seventy pints of fluid were withdrawn from the sac. It was unusually adherent, and until I found, in the process of enucleation, that the uterus and ovaries were healthy and had no relation to the tumor, I was uncertain of the exact nature of the growth. Its origin was traced to the left kidney. The sac weighed four pounds.

Case 56 died in my private hospital of tetanus fifteen days after the removal of a sarcomatous ovary the size of a child's head. This is the only death which has occurred in the hospital since its establishment, out of over one hundred surgical operations, twenty-one of which were abdominal sections. Case 69 was a very sad case. During the first month after marriage Mrs. S. was taken suddenly with pain in the left iliac region, after a fall while walking about her grounds in the country. She gradually grew worse, until she was compelled

to remain in bed under medical treatment, a part of the time under the care of two good physicians. I saw her with them after she had been seven weeks in bed. Her pulse was about 130 and temperature 103°. In the morning she was often without fever. It was agreed by all that she was growing worse. A tumor could be distinctly made out on the left side of the uterus, which was thought to contain fluid which, from her symptoms, was supposed to be pus. An operation had been proposed as the only means left to save her life, which was seriously threatened. I agreed with the physicians as to its propriety, and, after explaining the situation to the family, an hour was agreed upon for its performance. Upon opening the abdomen the tumor was found to be closely adherent to everything it touched, and the evidences were abundant that she had been suffering from a pelvic and general peritonitis for several weeks. In separating the adhesions from the under portion of the tumor, its walls gave way and at least a quart—some thought three pints—of large, black solid blood clots escaped from the inside of the tumor. They welled up out of the wound in great quantities. We were in doubt then, and I am now, as to the exact nature of the tumor. My belief is that it was a ruptured tubal pregnancy, that the rupture occurred at the time when the patient fell, that blood was poured out into the folds of the broad ligament, and that as inflammation went on additional coverings to the tumor occurred, partly aided by adhesions. It was an incomplete operation, as the sac wall was partly made up of adherent intestines and other viscera which could not be removed. Everything which could be was removed. The toilet of the peritoneum was carefully made after much washing-out of the abdominal cavity, a drainage tube was left in, and the wound closed and dressed in the usual way. She never seemed to rally completely, and died before the end of the second day after the operation. The size and density of the clots composing the tumor were proof that they could not have been removed by any tapping operation through the vagina. It is probable that this belongs to that sad and pathetic list of cases which are classified as "too late." The thirteenth in the group of deaths out of the list of seventy-four miscellaneous abdominal sections occurred in a nymphomaniac who was brought to Providence Hospital from a four years' incarceration in a luna-

tic asylum in Staunton, Va. Battey's operation was done to relieve a terrible, beastly nymphomania which only showed itself for two weeks in each month. She never would be controlled after the operation; was constantly changing her position and trying to get out of bed. She had a large abscess along the line of sutures in the abdominal wall, which ruptured into the peritoneal cavity on the seventh day, just before the removal of the stitches, and she died within two days.

An interesting group of seven cases of the removal of the uterine appendages on account of rapidly growing and bleeding uterine myomata, is worthy of a moment's attention. In all of these cases other treatment had been resorted to, including electricity, without avail. Several of the patients had been a number of times at the point of death from the loss of blood, and I am happy to state that in each instance there has been a perfect and complete cure.

In four of the twenty-nine cases of removal of the ovaries and tubes reported in the table, only one ovary and tube were taken away. In each of these women the trouble returned in the remaining ovary. In one the change of life has now occurred, and she is quite comfortable, but for a number of years she was a martyr to her sufferings and was a constant invalid. She and her family have frequently blamed me for not completing her cure at the time of the original operation by removing the other ovary. In another case the same history has repeated itself, and the day is now set for a second operation for the removal of the ovary which I was persuaded not to remove.[1] In the third and fourth cases "the other ovary" will have to come out before the patients are well. They were quite comfortable for a year, but are now worse than before the first operation. Much has been said and written about "the other ovary" in those cases where one only was sufficiently diseased to demand removal. The history of these four cases would indicate the wisdom of the complete removal of both ovaries and tubes when the abdomen was opened for the ablation of one. Many other operators have had the same experience and are gradually adopting this opinion.

Only one out of the eighty cases in my experience in abdo-

[1] It has since been successfully removed, and she is now quite well.

minal surgery was colored. This is somewhat remarkable, as we have in Washington a population of about eighty thousand colored people.

Of the twenty-nine cases—twenty-five really of the removal of both ovaries and tubes—two women have continued to menstruate the same as before the operation. Battey tells me that this occurs in about five per cent of his cases where the operation is done mainly for the purpose of bringing on the change of life. In a recent conversation he said that in about five per cent of post-mortem examinations a third or supernumerary ovary had been found, which would seem to account for this heretofore unexplained and embarrassing peculiarity.

In the two cases where menstruation continues there has been little benefit following the operation. They were both done for the relief of menstrual epilepsy, and in both cases the convulsions have not been much lessened. It is quite possible that both these women possess a third ovary, whose removal might complete their cure.

TABLE OF ALL MY ABDOMINAL OPERATIONS.

No.	Residence.	Medical attendant.	Age.	M. or S.	Disease.	Operation.	Result.	Date.
1	Shirmanstown, Pa...	Dr. Riley	29	S.	Ovario-epilepsy.....	Ovaries and tubes.....	R.	August 17th, 1881.
2	District of Columbia.	Dr. Leach.....	22	S.	Chronic inflammation..	Battey's operation.....	R.	October 11th, 1883.
3	Washington, D. C...	Her father	21	S.	Cystoma.....	Right ovary.....	D.	June 8th, 1884.
4	Chicago, Ill.....	Dr. Curtis.....	65	M.	"	"	D.	November 12th, 1884.
5	Fargo, Dak	J. T. J.....	40	M.	Chronic inflammation..	Ovaries and tubes.....	D.	February 20th, 1885.
6	Buffalo, N. Y.....	J. T. J.....	29	M.	"	Right ovary.....	R.	January 20th, 1884.
7	Washington, D. C...	Dr. Bromwell.....	24	S.	Chronic inflammation..	Ovaries and tubes	R.	February 21st, 1885.
8	"	Dr. Walter	28	M.	Malignant fibro-cyst of uterus.	Supravaginal hysterectomy.	R.	October 5th, 1885.
9	Falls Church, Va ...	Dr. Gott.....	23	M.	Cystoma.....	Right ovary.....	R.	October 12th, 1885.
10	Washington, D. C...	Dr. Leach.....	21	S.	Five years of persistent pain.	Ovaries and tubes.....	R.	November 1st, 1885.
11	"	Dr. Lincoln.....	32	M.	Parovarian cyst	Left ovary.....	R.	April 21st, 1886.
12	"	Dr. Cate.....	36	M.	Cystoma.....	Both ovaries	R.	May 7th, 1886.
13	Potomac, Md.....	Dr. Kleinschmidt..	19	S.	Hystero-epilepsy.....	Ovaries and tubes.....	R.	May 27th, 1886.
14	Washington, D. C...	Dr. B. B. Adams..	31	S.	Parovarian cyst.....	Left ovary	R.	October 23d, 1886.
15	"	Dr. Bayne	24	M.	Ovario-epilepsy	Ovaries and tubes.....	R.	November 17th, 1886.
16	"	Dr. B. B. Adams..	50	M.	Cystoma; twisted pedicle.	Both ovaries.	R.	November 24th, 1886.
17	"	Dr. Leach.....	27	S.	Dermoid cyst.....	"	R.	February 14th, 1887.
18	"	Dr. Franzoni.....	32	M.	Bleeding myoma	"	R.	February 21st, 1887.
19	"	J. T. J.....	26	S.	Chronic inflammation..	Ovaries and tubes.....	R.	March 7th, 1887.
20	Columbus, Ga.....	Providence Hospit'l	40	M.	Bleeding myoma	" "	R.	April 27th, 1887.
21	Washington, D. C...	Dr. Bayne	35	M.	Cesarean section.....	Died of abscess 10th day	.....	May 1st, 1887.
22	"	Dr. Little.	22	S.	Chronic inflammation..	Ovaries and tubes.....	R.	June 15th, 1887.
23	Dayton, Va.....	Dr. Andrews.....	38	S.	Two large fibroids.....	Supravaginal hysterectomy.	D.	June 20th, 1887.
24	Madison, Wis.....	J. T. J.....	23	S.	Infantile uterus.....	Ovaries and tubes.....	R.	June 28th, 1887.

No.	Residence.	Medical attendant.	Age.	M. or S.	Disease.	Operation.	Result.	Date.
25	Washington, D. C...	Dr. Hazen	27	M.	Dermoid cyst, 65 lbs...	Left ovary.....	R.	October 7th, 1887.
26	"	Dr. Leach.....	26	S.	Chronic inflammation..	Ovaries and tubes.....	R.	October 14th, 1887.
27	Hillsboro', Va.....	Dr. Taylor	30	S.	Cystoma	Left ovary....	R.	October 27th, 1887.
28	Rappahannock, Va..	Dr. Quackenbush..	51	M.	Double ovariotomy and	myoma, 54 pounds	R.	November 7th, 1887.
29	Washington, D. C...	Dr. Frederick.....	32	M.	Cystoma.....	Both ovaries..... ..	R.	November 21st, 1887.
30	"	Dr. Hughes.....	67	M.	"	Right ovary..... ..	R.	November 21st, 1887.
31	Hyattsville, Md.....	Dr. Wells.....	17	S.	Chronic inflammation left ovary.	Tait's operation.....	R.	February 20th, 1888.
32	Jackson, Miss.....	Dr. Sale	15	S.	Ovarian cyst.....	Ovariotomy.	R.	March 3d, 1888.
33	District of Columbia.	J. T. J	30	S.	"	"	R.	May 22d, 1888.
34	"	Dr. J. W. Bayne..	34	S.	Large uterine myoma..	Supravaginal hysterectomy.	D.	June 15th, 1888.
35	Staunton, Va.....	Insane asy. for 4 yrs	30	S.	Nymphomania	Tait's operation.....	D.	September 26th, 1888.
36	Laurel, Md.....	Dr. Stonestreet....	27	S.	Multiple fibroids of the uterus.	Supravaginal hysterectomy.	R.	October 15th, 1888.
37	Providence Hospital..	Dr. H. L. E. Johnson.	34	M.	Cancer, universal.....	Laparatomy. Removed small mass of something.	D.	November 17th, 1888.
38	District of Columbia.	Dr. Dunn..... ..	50	M.	"	Exploratory laparatomy	R.	November 30th, 1888.
39	North Carolina.....	Dr. Freer	38	M.	Bleeding myoma	Tait's operation.... ...	R.	January 2d, 1889.
40	District of Columbia.	Dr. Kleinschmidt..	32	M.	Ovarian cyst	Ovariotomy. ..	R.	January 15th, 1889.
41	"	Dr. Sellhausen ..	42	S.	Very large fibroid	Supravaginal hysterectomy.	D.	January 4th, 1889.
42	"	J. T. J....	20	M.	Ovarian cyst	Ovariotomy....	R.	January 22d, 1889.
43	Georgetown, D. C....	Dr. Richey..... ..	29	S.	Uterine fibroid weighing 20 pounds.	Supravaginal hysterectomy.	R.	May 12th, 1889.
44	Alexandria, Va.....	Dr. Brown.....	50	S.	Hydro-nephrosis; tumor 74 pounds.	Removal	D.	May 10th, 1887.
45	District of Columbia.	Dr. Mary Parsons..	27	S.	Chronic inflammation..	Tait's operation.....	R.	December 16th, 1888.
46	"	J. T. J.....	29	S.	"	"	R.	December 4th, 1888.

47	District of Columbia.	Dr. Bayne	27	M.	Pyo-salpinx and ovarian abscess.	Tait's operation	R.	March 14th, 1888.
48	"	J. T. J.	28	M.	Chronic inflammation ovaries and tubes, and small myoma.	"	R.	February 11th, 1888.
49	Lanham's, Md.	Her father	36	M.	Ovarian abscess	"	R.	May 10th, 1888.
50	District of Columbia.	Dr. Walsh	24	M.	Ovarian cyst	Ovariotomy	R.	
51	"	Dr. J. T. Young	30	S.	Chronic ovaritis	Tait's operation	R.	June 10th, 1888.
52	"	Dr. Muncaster	26	S.	Bleeding myoma	"	R.	May 15th, 1888.
53	"	J. T. J.	28	S.	"	"	R.	June 1st, 1888.
54	Sedalia, Mo.	Dr. Muncaster	25	S.	Chronic salpingitis.	"	R.	June 25th, 1888.
55	Anacostia, D. C.	Dr. Harrison	34	M.	Ovarian abscess	"	R.	September 14th, 1888.
56	District of Columbia.	Dr. Lincoln	43	M.	Sarcoma ovary	Ovariotomy (Tetanus)	D.	October 29th, 1888.
57	"	Dr. Bayne	25	S.	Ovarian cyst filled with pus.	Ovariotomy	R.	December 2 th, 1888.
58	Glymont, Md.	Dr. Chapman	19	S.	Ovarian cyst	"	R.	January 20th, 1889.
59	Shepherd Station.	Dr. Pyles	26	M.	Tumor in abdominal wall extending into abdomen.	Abdominal section and drainage.	R.	March 5th, 1889.
60	Richmond, Va	Dr. Sprigg	24	S.	Chronic salpingitis and ovaritis, and incurable reflex vomiting.	Tait's operation	R.	April 15th, 1889.
61	Frederick Co., Md.	Dr. Fry	28	M.	Ovarian abscess	Ovariotomy	R.	April 15th, 1889.
62	New York, N. Y	Dr. Gardner	61	M.	Ovarian cyst	"	R.	May 15th, 1889.
63	District of Columbia.	Dr. Corey	29	M.	Cancer of ovary	"	R.	June 1st, 1889.
64	"	Dr. Ober	61	M.	Ovarian cyst	"	R.	May 25th, 1889.
65	"	J. T. J.	36	M.	"	"	R.	April 6th, 1889.
66	Hampton, Va.	Dr. Lincoln	68	M.	Ovarian cyst 64 pounds.	"	R.	September 9th, 1888.
67	District of Columbia.	Dr. Roberts	27	S.	Bleeding myoma	Tait's operation	R.	May 10th, 1889.
68	"	Dr. Bromwell	27	M.	Very painful but small, solid ovarian tumor.	Ovariotomy	R.	May 3d, 1889.

No.	Residence.	Medical attendant.	Age.	M. or S.	Disease.	Operation.	Result.	Date.
69	District of Columbia.	Dr. Bromwell.....	28	S.	Obstruction of the bowels, supposed to be due to a four-pound uterine fibroid filling the pelvis. Supravaginal hysterectomy. Died six days later. Obstruction not relieved. Autopsy revealed cancer in the transverse and descending colon and perforation of intestine. No inflammation or sepsis resulting from operation.		D.	June 12th, 1889.
70	Suitland, D. C.....	Drs. Bayne and Pyles.	18	M.	Supposed to be extra-uterine pregnancy ruptured into folds of broad ligament. Had been seven weeks in bed and getting rapidly worse. Pulse 130, temperature 103° in P.M. For three last days chills and irregular sweats. Operated to save life. Tumor size of child's head, filled with black blood clots; irrigated and drained. Died second day.		D.	June 17th, 1889.
71	Washington, D. C...	Dr. Hamilton	20	S.	Ovarian and tubal abscess	Ovariotomy	R.	October 1st, 1889.
72	Hyattsville, Md	Dr. Wells..... ...	19	S.	Chronic inflammation..	Tait's operation.....	R.	October 20th, 1889.
73	Washington, D. C...	J. T. J.....	34	S.	Large uterine myoma.	Supra-vaginal hysterectomy.	R.	December 12th, 1889.
74	Baltimore, Md	Dr. Wales	43	S.	Ovarian cyst.....	Ovariotomy.....	R.	December 20th, 1889.
75	Toledo, Ohio.....	Her family physician.	23	M.	Chronic inflammation..	Tait's operation, right ovary and adhesions..	R.	February 10th, 1890.
76	Boston.....	Dr. Barker and Folsom	42	S.	Chronic inflammation and incurable nervous troubles.....	Tait's operation; right ovary and adhesions..		February 17th, 1890.

NOTE.—The last six cases were added while reading the proof of the paper.