There are three attitudes the physician or surgeon may assume in coming to a conclusion with regard to the nature, probable course, and final result, in any given case in which his opinion is invited. He may feel himself certain of his ground, and assured of his certainty. He may clearly recognise the absence of signs, either positive or negative,—a recognition which brings home to him the difficulty of an assured diagnosis. Or an overweening confidence in his diagnostic infallibility may be due to the simple fact that he is unconscious of his ignorance. In other words, it is another reading of the old classification of those who "know that they know," those who "know that they do not know," and that most hopeless of all classes, those "who do not know that they do not know!"

It is doubtless most pleasant and most flattering to our sense of diagnostic acumen, to feel ourselves amongst the first of these divisions, yet unfortunately the sources of error in the novel and shifting character of the clinical features, subjective and objective, of each fresh case that presents itself to our notice, are such as very frequently to make it a new and complex study. The most dangerous diagnostician is he whose faith in his own experience prompts him to believe that he is more likely to be right than to be wrong. Hence he approaches a case with a prejudgment and bias, derived from impressions which colour and influence the deductions he draws from the clinical peculiarities now presented to him. He is consequently apt to overlook the unlikely sources of error, and does not proceed by a careful process of exclusion to satisfy himself that these are absent, his so-called "experience" thus leading him into the trap which is always open for the self-confident and dogmatic. Of course there is a fair proportion of cases in which the clinical and pathological characteristics are so allied, and the complications so few or comparatively unimportant, as to enable us with sufficient accuracy to arrive at a quick conclusion. These do not, however, come under the class that we are considering, and it is not in the instance of such that we have to be watchful of our impressions and suspicious of our deductions. Therefore, in the diagnosis of obscure abdominal and pelvic conditions, he is most likely to be right who finds himself amongst that class which is conscious of its fallibility.

In pelvic and abdominal surgery we have not only to satisfy
ourselves as to the presence of some gross lesion in any particular organ, but we must also predetermine before operation, if such be decided upon, the nature and extent of those complications that may seriously affect or impede it. This involves not merely those associated conditions or actual connections which locally affect the diseased organ, but such constitutional states, diatheses, or diseases of other organs as may influence our opinion.

There is a large class of cases which appeals to gynæcologists for relief, in which the principal if not the sole trouble is a train of subjective symptoms. The physical signs which are indicative of deviation from the normal state of the pelvic viscera may be slight, inappreciable, or altogether absent; and, associated with this want of any evidence of a pelvic lesion, the presence of visceral neuroses, or reflected morbid phenomena, occurring in such organs as the brain, eye, ear, throat, and larynx, or the cranial nerves, may lead us to conclude that the origin of the mischief is not seated in the sexual organs. Doubtless such a conclusion is often due to an incomplete examination. On the other hand, it is not infrequently to be attributed to the erroneous conviction that because we are unable to detect gross lesions in the generative organs, the cause of the symptoms, either remote and reflected, or local and actual, do not lie in them. Many years since, I knew of a case in which, in my presence, the late Lawson Tait removed the adnexa from a lady æt. 32, who for eighteen years had suffered much, not only from her pelvic organs, but at the hands of many gynæcologists, including myself. For I, at the eleventh hour, had divided the cervix and enlarged the uterine canal, and subjected her to a prolonged course of high tension faradisation, without any benefit. Every internal and external prop had been tried, and the gynæcological therapeutics of the day exhausted. The patient was still the victim of aggravated dysmenorrhœa, severe haæmorrhage, and the increasing use of morphia. I advised removal of the adnexa, but as this had been before discountenanced by many leading obstetricians, it was considered right that a consultation should be held previous to the operation. Consequently, a distinguished obstetrician saw her, and decided that there was no disease of the adnexa present sufficient to warrant surgical interference, and that there was "no alternative but to leave her as she was." Mr. Tait, seeing her subsequently on the same day, with the other opinion before him, decided that it was a case for immediate surgical interference, which view was acted upon, and, under the circumstances, at my request, he operated, with the result that a complete cure was effected, which has lasted to the present day. The lady has been married for some time, and enjoys perfect health. Macroscopically, the ovaries were covered with minute follicular enlargements, and on section appeared rather hard and cirrhotic. The Fallopian tubes were healthy.
It is frequently in such cases of chronic ovaritis, in which there is so-called sclerosis of the capsule, and interstitial fibrous formation in the stroma of the ovary, leading rather to its contraction and atrophy than to hypertrophy, that we find the most severe pain present. In many instances the antecedent ovaritis has led to necrosis, with consequent multiple abscesses, and long before the fusion of such may lead to a pus cyst, the pain resulting from the suppurative ovaritis must be intense. It is not necessary that there need be any tangible enlargement of an ovary, in which follicular degeneration, associated with thickening of the albuginea and recurrent localised attacks of peritonitis, have occurred; and, save by tenderness on palpation through the vagina, and getting the ovary between the fingers in the bimanual method, digital exploration reveals nothing very abnormal. Yet it is often in such instances that dyspareunia, erratic pelvic pains, neuralgia, difficulty in walking, with that heterogeneous group of symptoms to which we give the name of "neurotic" or "hysterical," occur. In the early stages of haematocystic, hydrocystic, and colloid degeneration of the ovary, there may be little enlargement, and yet excessive pain. The point I wish to emphasise is, that pain, in affections of the adnexa, as of the uterus, is a symptom which is most deceptive, both in diagnosis and prognosis. Certainly some of those who have had the most acute ovarian suffering that I have known, have had the least pathological changes in the ovaries and tubes, either discoverable before or ascertained after this removal. The knowledge of this fact does not influence our judgment in testing the relative importance of the sensibility to pain, or the tendency to either exaggerate or minimise it, which we so often find in women of the neurasthenic type on the one hand, or the self-repressive on the other. Contrast such pain as that to which I have referred in the case I have mentioned, with the statement of a patient, an apparently robust woman in all other respects, from whom the pus tubes and sacs shown in Plate IV. were removed.¹ Her only complaint was incontinence of urine, for which she had consulted a surgeon, who, finding pelvic evidences of pressure on the bladder, sent her to me. When she came, the distended bladder reached to the umbilicus, and I drew from it 5 pints of urine. The enlarged uterus was pushed out of the pelvis, which was filled by a hard and unyielding mass,—so hard, that my first impression, fortified by the history of the case, was that I was dealing with a uterine fibroma, nor was it until after some days' observation that I determined that it was a huge infiltration which filled the pelvis and surrounded the uterus. The kidneys in this case secreted, before operation, from 8 to 9 pints of urine in the twenty-four hours. The uterus and ovaries were found imbedded in the old exudation, a mass of adhesions binding everywhere together the uterus, tubes, and

¹ Trans. Obst. Soc. London, 1897, p. 319.
ovaries (Plate IV.). She is a perfectly sound and healthy woman to-day, three years after her operation. Such a case as this is illustrative, not only of the extent to which disease may proceed in a woman without causing, as she repeatedly assured me, "any pain whatever to speak of," but it is an exemplification of a condition of things often most difficult to differentiate and decide upon. In cases of old hard infiltrations, in which there may be enlargement of the uterus, with or without myomatous changes, and where the entire mass is fixed by adhesions and inseparable from the uterus, diagnosis is most difficult; and I have myself been deceived in another case of a somewhat similar nature to the above, believing that I was really dealing with a fibromatous uterus.

Recurring to my reference to subjective and reflected phenomena, arising out of disease of the generative organs, one cannot help feeling that a danger arises to all of us from the habit of concentration of attention on these, and thus we are prone to overlook or to minimise symptoms the presence of which necessitates careful examination of other viscera and organs. This applies, whether we are or are not able to discover some morbid condition in the pelvis. The mischief which has been wrought by a neglected retroversion, a protracted endometritis with a deep and increasing erosion, or some progressive ovarian degeneration, is not necessarily removed because we readjust the uterus, cure the uterine lesions, remove or resect the ovary. And we may have to determine how far a retinal lesion, a unilateral exophthalmos, oculomotor disturbance, disorder of innervation, or ocular neuralgia, may be attendant upon, or the consequence of, such pelvic conditions. The same remark applies to cranial neuralgias, various forms of migraine, paretic and hysterical aphonia, tinnitus aurium, and many other reflex neuroses, associated or not with physical changes in the organs affected. Nor, indeed, do these observations bear on the effects due to affections of the pelvic viscera alone. We need only refer to the number of direct and reflected disturbances which a movable and enlarged kidney will excite, to realise how we are inclined to seek elsewhere for the cause of symptoms which at first sight appear to have but little connection with an unsuspected organ. Indeed, in regard to movable kidney, it is the first suspicious factor that, in examination of the abdomen for any abdomino-pelvic affection, we should look for. Its occurrence is so frequent, the variety of effect following its presence so great, and the serious nature of the renal changes often found associated with it so considerable, that any chance of its being overlooked should be a first consideration. This becomes the more necessary when we reflect that it is not uncommon in those cases in which there has been a general falling off in health, and reduction in fat due to disease of the pelvic viscera, when such loss of support brings about the mobility of the kidney. I
have just performed nephorrhaphy in a case in which a short time
since the adnexa were removed. I have fully recorded the
particulars of a case in which metritic changes and endometritis
complicated the presence of a large movable kidney, where the
persistent elevation of temperature could not be accounted for,
inasmuch as the uterine conditions were relieved, and yet the
hyperpyrexia remained.\(^1\) The operation of nephrectomy disclosed
a carcinomatous kidney, and the nightly pyrexial range appears
to have been due to the inflammatory changes occurring in or
around the capsule. There were no indications of any purulent
deposits anywhere. It is equally unfortunate to overlook some
affection of the uterine organs, having discovered the renal dis-
placement, as it is to fall into the opposite error. I recently saw
a patient, sent to me as suffering from an enlarged and retroverted
uterus, in whom I found a freely movable kidney, to which, as
much as to her retroversion, I attributed her general symptoms.

We must not forget, however, that we are liable to mistake
other tumours or swellings for mobile kidneys. Thornton and
Greig Smith pointed out the difficulty of diagnosis which might
arise in certain cases of distended gall bladder and pyloric tumour.
I have mistaken, in the first instance, a hard accumulation in the
hepatic flexure of the colon for the renal displacement, and we
know that a wandering kidney, which may have been at the same
time enlarged and fluctuating, has been mistaken for ovarian
cystoma, pedunculated fibroid, hydrosalpinx and pyosalpinx. In
one case of mine, the supposed enlarged kidney, the edge of which
could be felt closely simulating the margin of the spleen rather
than that of the kidney, proved to be a completely displaced liver
(hapatoptosis).\(^2\) The patient, who had some time before been almost
in extremis from hæmatemesis, had been treated for gastritis and
gastric ulcer. On abdominal exploration, I found the liver lying
completely at the right side, the gall bladder displaced from its
position, the free margin of the liver lying forwards, the organ
being healthy, but congested, and reaching to the right inguinal
region. The abdominal viscera being carefully examined, and the
liver replaced in its position, the abdomen was closed, with the
curious but pleasing result that since the operation the patient
has been in excellent health. That renal cystic tumours, hydrone-
phritic and pyo-nephritic enlargements have often been mistaken
for ovarian tumours, or solid tumours of the ovary, is well known.
One such case I have seen in which a large perinephritic abscess
was thought to be an ovarian cyst. Aspiration in the renal
region decided its nature. In speaking of genito-urinary compli-
cations, perhaps the most difficult of all that the gynaecologist has
to differentiate are those in which he has to decide if the genito-
urinary symptoms and signs are caused by coexisting adnexal

\(^1\) Brit. Gynec. Joum., London, August 1897.
\(^2\) Trans. Med. Soc. London, 1898, vol. xxi.
Double Pyo-salpinx.

Salpingo-oophoro-supra-vaginal hysterectomy—showing the pus tubes and large ovarian sacs—the left ruptured in removal, the right removed without rupture. The uterus and ovaries were imbedded in a dense and hard infiltration filling the pelvis. The patient made an excellent and permanent recovery.
Cysto-sarcoma of the left Ovary.

The sarcomatous growth filled the pelvis, pushing the uterus out of it to the right. When seen and diagnosed as myoma of the uterus, the degeneration converting a portion of the tumour into a cyst had not occurred; ascites followed. The cyst was tapped and the mass removed. Up to the present the recovery has been uninterrupted.
Fig. 1.
Solid adenoma of the ovary with cystoma mistaken for pregnancy. Removed after a severe attack of general peritonitis followed by ascites; rapid and permanent recovery.

Fig. 2.
Cyst of meso-metrium, simulating early ectopic gestation. Removed by colpotomy. Recovery.
Dual Myoma of the Uterus.

There were no urgent symptoms. The patient was otherwise in good health, but the tumour was perceptibly increasing in size. Operation was decided upon, and supra-vaginal hysterectomy performed. On section, a considerable necrotic area was found in the upper myoma, and the canal of the uterus greatly enlarged and full of mucoid fluid.
disease, involving either the ureters or bladder, or have arisen independently of these. Fortunately the occasions are rare in which suppurating adnexal tumours, tubercular or other, involve the ureters, but such a complication has to be borne in mind. The absence of any evidence of renal enlargement, or disease by palpation, the presence of pus in the urine, and the coexistence of an adnexal tumour, will help us to a decision. Remembering the possibility of tuberculous infection passing thus to the ureter and bladder, indicates the importance of an early bacteriological examination in these cases. It is in this class of affection that Howard Kelly’s methods of exploration of the bladder, ureters, and kidney, by direct inspection and catheterisation, are of such great value.

There are two conditions that may complicate the presence of an abdominal tumour, and which considerably increase the difficulty of diagnosis,—the presence of ascites or pregnancy. There are few with any experience in abdominal and pelvic surgery who have not realised this. I recollect my second case of ovariotomy, in which there was considerable difference of opinion amongst my colleagues as to the presence of an ovarian tumour, but no doubt as to that of ascites. The abdomen was greatly distended with the ascitic fluid, and I was able to disassociate the uterus, which was of natural size, in a nullipara, æt. 20. I had the fluid examined at the time, and some of Drysdale’s granular cells were detected. After careful examination, from the negative evidence, in the absence of all signs of organic disease, and the history of the case, together with a careful physical examination, I came to the conclusion that it was ovarian cystoma. On making the preliminary incision, I was disagreeably surprised to find that it was a large quantity of ascitic fluid that escaped from the peritoneal cavity which I had opened. Turning the patient on her side, I drained off the fluid, and was relieved by the discovery of a large polycystic colloid ovarian cystoma, which had ruptured in several places, and had evidently caused the ascites. But my experience was a very unpleasant one before I discovered the tumour. This was the case I referred to in my previous paper in this Journal.¹

Quite recently I showed at the Gynaecological Society an ovarian cysto-sarcoma, which I had diagnosed as a myoma of the uterus. The patient consulted me at the latter end of 1899, being sent to me for a myomatous tumour requiring operation. Examination revealed a hard mass filling the pelvis, the uterine cervix being felt above and to the left side, and giving the usual feeling found with myoma. I did not at the time, by bimanual examination, detect any fluid. Not seeing her again until she was on the table for operation, some three months subsequently, I was surprised to find, when she was under the anaesthetic, that there was evidently fluid in the peritoneum, and also that I could detect fluctuation in the upper part of the tumour. I then thought I

¹ Edin. Med. Journ., 1900, vol. vii. p. 413.
had to deal with a fibrocyst of the uterus, and that there was some accompanying ascites. The tumour proved to be a cystosarcoma of the ovary, the solid portion completely filling the pelvis, and the upper part enlarged, which had, as reported by Mr. Targett, who examined the specimen, softened into a cyst with fluid contents. The patient made an excellent recovery, and so far has done well (see Plate V.).

Many years have passed since I saw in a Metropolitan hospital, when ovariotomy attracted more spectators than it has done of late years, an operation commenced for ovarian cystoma, and interrupted because it was not possible to proceed with a large hydatid cyst of the liver. And in connection with this reminiscence, I recall a case in which a large semisolid multilocular, ovarian cystoma filling the abdomen, the solid upper portion of which could not be dissociated from the spleen and liver, caused me considerable anxiety both in diagnosis and operation. In a case in which a rather magical cure was attributed to me, a difference of opinion between a distinguished general physician and obstetrician had occurred as to the nature of an abdominal swelling. The one considered it to be ovarian, and the other ascitic. As a consequence, tapping was recommended. This was carried out, and again the fluid accumulated. On seeing the patient, I came to the conclusion that the tumour was not ovarian, and advised that the fluid should be again drawn off, and at the time a careful abdominal exploration made. This was done, and I saw the case the following day. On examination, I found rather a hard mass in the neighbourhood of the lobus Spigelii. I determined to explore this, and, after making a small incision over its site, I passed a rather large-sized aspirating needle well into the mass, so as to test its nature. Nothing returned save blood, and I was afraid that the growth would prove to be malignant. The result of the experiment was, that this mass shrank, there was no recurrence of effusion, the lady married, and has children.

I have referred to pregnancy. The many obstetric complications that may arise during its course, and which may or may not be detected before parturition, are familiar enough to us all. Yet, realising this as we do, we are still liable to overlook them, and to experience considerable difficulty in differentiating and isolating them. It may seem impossible that a modern gynaecologist would mistake a myomatous for a pregnant uterus, yet few of us, I think, but know cases in which this error has been fallen into, and that by men who have had no inconsiderable work among such tumours. Of course it is in those cases in which the myoma complicates pregnancy that an error is most liable to be made, and this oversight may occur at any stage of the pregnancy, whether in the earlier months, when we may be confronted with small interstitial myomata in the lower zone of the uterus, or
later on, should miscarriage not occur, when the myoma has increased in size with the pregnant uterus, and is situated in the upper or middle zone of the fundus. Small intramural myomata, when complicating early pregnancy, escape detection, attention being concentrated on the signs and symptoms of pregnancy at this stage; but there is the possibility of such a tumour being attended by the same symptoms in the absence of pregnancy. By the appearance of the catamenia or the occurrence of irregular losses, the presence of erratic pains and uterine contractions, through the rapid growth of the tumour and the absence of the usual alterations found in the cervix which are consequent upon a fibromatous growth, by the pulsations transmitted to the ear through the tumour, and which may simulate the foetal pulsations of pregnancy, by the presence of a cyst in the tumour, giving to it the more elastic feel of the pregnant uterus, and by the complications of ascites and oedema,—by these and other misleading signs, is a myoma likely to be mistaken for the pregnant uterus, or the complication of pregnancy and myoma overlooked. More nearly concerning obstetricians, are the difficulties which have deceived some of the most experienced, where, at the time of labour, a myoma has been mistaken for an ovarian tumour, a growth of any kind originating in the pelvic wall, a faecal tumour, and even placenta previa.

Perhaps no form of pelvic disease opens so many possibilities of error to both physician and surgeon as ovarian cystoma. Even assuming that we are correct in our differentiation of a true ovarian cyst, apart from a simple cyst of the parovarian, we have in our preliminary examination to decide as to its nature, whether unilocular or multilocular, whether benign or malignant. This assumption, however, removes at once some fifty or more abdominal conditions, each of which so far simulated ovarian cystoma as to have led to operative errors as a consequence. There are the more frequently occurring complications to be determined,—ascites, pregnancy, ectopic gestation, cystic or other disease in the kidney, spleen, or liver, uterine myoma, suppuration in the cyst, and extensive adhesions.

Pregnancy, associated with more or less hydramnios, has probably been the most frequent of these conditions to act as a pitfall for the gynaecologist; and those forms of cystoma which give rise to ascitic accumulation are amongst the most difficult to determine, when the ovarian disease has attending it some of the signs, negative or otherwise, of pregnancy.¹ I have recorded an interesting case, in which a practitioner was called in to attend a patient in labour, the pains having, as she thought, begun, though in reality it was but the commencement of a severe attack of peritonitis, which ran a most serious course. A large tumour was found inclining towards the left side, and a rapid ascitic distension

¹ Brit. Gynaec. Journ., London, August 1898.
followed. Her life was in extreme danger for some days. I
operated just one month after the onset of her attack, removing the
tumour shown in the Plate, extensive adhesions, both of the sac
wall and of the intestine, having to be separated. The peritonitis was
due to considerable twisting of the pedicle, and the tumour proved
to be a multilocular adenoma of the ovary (Plate VI., Fig. 1).

To show the importance of discarding previous impressions in
approaching a case, I may record one in which I myself narrowly
escaped the consequences of too rapid an examination. I
was asked by two medical men to see an abdominal case, supposed
to be ovarian, with a view to operation. The patient was over 40
years of age, her last pregnancy having occurred twelve years
previously. The catamenia had been irregular for some time, but
had ceased for a few months before my seeing her. Her general
health had suffered, and distress both with regard to micturition
and defaecation had increased. The abdominal tumour had
grown in size, and no suspicion of pregnancy was entertained.
Seeing the case a day or so before operating, and prejudging
from the description I had been given, I made too cursory an
examination of the abdomen, and on examining per vaginam
found a cervix which conveyed no impression of pregnancy. On
examining through the posterior fornix, I found fluctuation and
a solid mass, and remarked that the ballottement I felt must be
due to a solid intracystic tumour, suggesting to the medical
advisers that they should feel for themselves how closely the
ballottement of pregnancy was simulated. Preparations were
made for operation, and I did not see the patient again until she
was under the anaesthetic and the abdomen prepared.
Immediately I was struck with its appearance, asked for a stetho-
scope, and satisfied myself as to the foetal pulsations and the
presence of the mammary secretion. I was enabled to con-
gratulate the anxious husband, who came to hear the result of
the operation, on the unexpected happiness that awaited him.

Such a mishap teaches us in diagnosis the value of the axiom,
"Take nothing for granted or on hearsay." It has always to be
remembered that in the case of abdominal swellings and pelvic
effusions or collections of fluid, the conditions are often transitory,
and signs which are clear and unmistakable when an examination
is made, may not be present even after a comparatively short
time has elapsed. Thus the most painstaking medical man may
find himself confronted with a completely altered state of things
when the patient comes for further advice, should no examination
have been made in the interval. Serous cysts rupture and are
absorbed, collections of blood disappear, effusions and exudations
which may have been hard and extensive, soften and become
purulent, or are reduced in size, so that but slight evidences of
their occurrence remain; cysts sometimes grow rapidly, and assume
unexpected proportions; displacements, adhesions, and fixations
also occur, either as consequences of any of these pathological conditions or changes, or as fresh complications. All this is true of the adnexa. In the uterus, small interstitial myomata both appear and grow rapidly. Recent adhesions will alter its position, as will effusions, and, as in a case I intend to quote, even the emptying of the bowel and bladder prior to an examination may reveal a small pelvic tumour not discoverable beforehand. Cervical erosions take often but a short time in making their appearance, and what is an erosion to-day may after a few months have assumed the character of the pre-cancerous stage. What we are doubtful of as malignant to-day, we may not hesitate to pronounce so in a few months. An erosion and follicular degeneration with an endometritic discharge will frequently escape detection by digital touch, but would be revealed by a proper examination by the speculum. More particularly have we to be careful of any influence on our exercise of caution by the statement or history of a patient. Take, for example, the case of a wealthy patient consulting me in order to support proceedings for nullity of marriage on the ground of impotence. The hymen was intact, she was in perfect health, and most nervous lest I should injure her in any way by examination. The accident of placing my hand over the pubes saved me from an awkward blunder. I proceeded to carefully investigate her condition, and satisfied myself that she was pregnant,—a conclusion which she continued to indignantly deny the possibility of, as long as the outward manifestation permitted her to do so. Mentioning the case induces me to emphasise the known fact, that an intact "folding" hymen is compatible with the birth of a child at full term, and consequently must only be taken as evidence inter alia of the "virgo intacta" state.

Speaking of the sudden appearance or disappearance of tumours, it is not necessary that they should be "phantom" tumours for this to occur. Only recently, I was sent a patient with a considerable swelling in the right lumbar region. I found a large mobile kidney, with hydronephrosis. I explained the position to the patient, and wrote my view to her medical attendant. She went home, and within a few days, while making up her mind as to interference, the swelling began to disappear, and when I saw her shortly after there was nothing save an ordinary and not very mobile kidney to be detected. This, of course, is not an uncommon occurrence, and is easily explained by some temporary ureteral blocking, but, as in a case which happened before, may shake a patient's confidence in one's opinion.

I removed a polypus from a lady who thought she was pregnant. On seeing her, I discovered the polypus slightly protruding from the os uteri. The following day, under ether, I proceeded to remove it, and could detect no growth. Examining the uterus with a sound, I failed to detect anything in its cavity, and came to the conclusion that, as sometimes occurs, the polypus had been
extruded with uterine pains, and that its pedicle had given away. A few days subsequently she again visited me, complaining of the same symptoms. The following day I dilated the cervix, and removed a pear-shaped polypus with a long pedicle which was attached to the fundus, and which must have retracted under the anaesthetic, the sound in exploration passing round it.

At the Gynaecological Society I showed a pedunculated submucous fibroid, removed from a uterus that had not long before been curetted by an obstetric physician. Haemorrhage, pain, and considerable anaemia continuing, I saw the case; and, on dilatation of the uterus, determining to explore and re-curette if necessary, I found the polypus within reach of my finger, and removed it. The curette had been carried round the pedicle of the polypus.

I once lost the confidence of a patient through failing to realise that a persistent pain in the gluteal region and thigh was due to the pressure of a not very large myomatous uterus. The lady was subject to gout and rheumatism, to which I attributed the pain. I showed at the Obstetrical Society a fibromatous uterus and adenomatous ovary removed from the same patient. The pain in the hip and lameness had been the only symptoms complained of, and had absorbed the attention of the medical adviser, and for these she consulted me. I discovered the fibroma, but did not realise the condition of the ovary until operation, when it was found to be the size of an orange and jammed down into the pelvis at the left side. The symptoms completely disappeared after operation.

A few years since, I exhibited a pure fibroma of the ovary, removed from a young patient who had for some time been suffering from anaemia and amenorrhoea with persistent sickness. After a careful abdominal examination, I discovered nothing to explain the symptoms, and advised a Weir Mitchell course. A few days subsequent to this, I discovered to my surprise a small movable tumour in the left inguinal region. Placing her under an anaesthetic the next day, the bladder and bowel having been emptied, I found that the tumour had quite disappeared from its position, and now lay in the pelvis in front of the uterus, requiring a vaginal examination for its recognition and isolation. In the ascent of the full bladder, the tumour had been raised above the pelvic brim.

I have not alluded to another not uncommon yet most serious error,—that of mistaking the earlier symptoms of appendicitis for inflammation of the adnexa and pelvic peritonitis. I have seen some fatal errors arising from this mistake, with the consequence that perforation occurred from a fulminating appendicitis before any operation was proposed. At the same time it is well to bear in mind the possible occurrence of some form of ovaritis or salpingitis, side by side with the appendical inflammation.

1 I shall again refer to undetected intra-uterine polypus as a cause of aggravated dysmenorrhoea.

2 Trans. Obst. Soc. London, vol. xl. p. 154.
Perhaps no pathological change reaches such an advanced stage
without discovery, as malignant disease of the uterus. This may be
due either to neglect in making a careful examination, as the
disease is not necessarily attended by pain, and the other character-
istic symptoms of cancer, or to the malignant changes gradually
taking place in that which has been previously looked upon as a
benign growth. It is not uncommon to find an advanced carcino-
matous cervix discovered for the first time through the haemor-
rhage which it causes, while malignant disease of the bod} of the
uterus can often only be determined after dilatation, and re-
moval of portions of the tissue for examination. Our increased
knowledge of the pathology of the adnexa has proved how much
more frequently than was supposed, morbid changes in the ovaries
and tubes are either of a carcinomatous, sarcomatous, or papillo-
matus nature, while endotheliomatous and gyromatous changes,
undiscoverable before operation, are occasionally found.

To illustrate the impossibility of arriving at a complete diag-
nosis, even in such an apparently simple case as a uterine myoma,
I may refer to a tumour recently removed by me, in which
I gave an opinion for operation, in consequence of the increas-
ing size of the tumour, though the patient’s general health was
not affected in any marked degree. The operation had been pro-
nounced as one not of absolute necessity. On operating, the
growth was found to consist of two distinct tumours, but intimately
connected. The upper contained the uterus, the lower solid mass
filled the pelvis. In the centre of the former was a large bed of
necrosed and degenerating tissue, surrounded by a zone of cal-
careous tissue, to be discovered only by section of the growth.
The uterine cavity was filled with mucoid discharge, and was
greatly dilated, as were also the Fallopian orifices. The condition
is well shown in Plate VII. Death from septicaemia or other
consequences of the necrotic change must have been the result in
such a case, had the tumour not been removed.

I have not included in this comparatively brief summary of our
gynaecological pitfalls, those into which we are liable to be led by
ectopic gestation occurring at any time during pregnancy. These
every surgeon is familiar with. I operated quite recently in a case
in which I had no certainty from the symptoms as between a hydro-
salpinx, pyosalpinx, or ectopic gestation. The fluctuating tumour
I felt posterior to and behind the uterus almost filled the space of
Douglas. By colpotomy I found the right ovary enlarged and cystic,
the Fallopian tube crossing the space, and the cyst principally at the
left side. Examination proved that it was none of the conditions
that I suspected, but a cyst of the mesosalpinx (Plate VI., Fig. 2).

The few instances that I have here given of the dangers that
beset us in making a diagnosis, establish the need there is for
extreme care in the first examination of a case. It must, however,
be admitted that if, as is absolutely necessary in a large propor-
tion of cases, anaesthesia be availed of, and the bimanual method of examination, by the vagina and rectum, in the dorsal position, be adopted, the rectum and bladder having been previously emptied, most risks of blundering will be avoided. Such an examination includes the judicious use of the sound,—though resort to it is less necessary when the finger becomes more educated and those precautions I have referred to have been taken. But no matter how exhaustive be our inquiry into the antecedents and history of a case, or how searching be the investigation of the abdominal and pelvic viscera, there still remains a balance of conditions, the nature of which can only be ascertained by abdominal exploration or colpotomy.

CLINICAL RECORDS.

CASE OF CEREBRO-SPINAL FEVER—PURPURIC VARIETY.

By William Frew, M.D., Physician, Kilmarnock Infirmary.

On several previous occasions I have drawn the attention of the profession to the occurrence of this disease in Scotland, and have no doubt but that, were its members made more familiar with the signs and symptoms of it, many more cases would be recognised. Lately in this district I have seen several well-marked cases. Of these, three were seen in consultation with professional brethren, who had recognised their true nature before I was called in, and the others have occurred in my own practice. The latest of these having exhibited the features of the disease in its most malignant form, I have thought it desirable to place it on record.

The victim was a healthy girl of 8 years and 4 months, who had not suffered from any of the usual diseases of childhood, and never had any ear trouble. On the morning of Thursday, 8th March, she was found in bed extremely ill. I saw her at once, and was much struck with her appearance. She was tossing about uneasily, and moaning loudly as if in great distress. She had a dazed and stupid look, and although she evidently heard and comprehended to a slight extent what was said to her, she was quite unable to give any verbal answer. Her face exhibited a deathly pallor, but somewhat livid; the eyes were sunk and vacant-looking when opened, the extremities cold, the pulse thin, very rapid and weak, and her breath had a peculiar feter. But what above all added ghastliness to her appearance, was a copious purpuric eruption over the face, legs, and arms,—a very few spots only occurring on the trunk. The spots were chiefly pinhead in size, but here and there a few had coalesced and formed distinct patches. Spots were noticed on the conjunctivæ and gums. She had been vomiting into a basin which had been set on a chair at the bedside; and although there was nothing that could be termed a haematemesis, some of the contents looked dark, like coffee grounds. It was observed that she had passed her urine in bed.