CLINICAL NOTES IN SURGICAL PRACTICE.

DIAGNOSTIC DIFFICULTIES IN PELVIC SURGERY.

NOT very long ago I heard an abdominal surgeon, whose reputation is beyond reproach, say that when he was younger he could always make a diagnosis before the abdomen was opened, but as his experience grew greater he did not feel quite so sure in every case. About the same time I heard an equally good surgeon, when speaking of pelvic tumors, remark, that with our present knowledge of pathology we ought to be able to say with certainty what will be found before the abdomen is opened.

With two statements so diametrical I may be excused if I present the clinical history of a few cases in which there were unusual symptoms, or in which some of the usual symptoms were absent or masked by unusual conditions, to show that diagnosis before incision is often difficult.

Case 1.—Mrs. S., aged thirty, married, two children, personal and family history good, had no miscarriages, menstruation regular; her last menstrual period, which had just been completed when I saw her, was normal in amount of discharge and length of time. She never had any attack of acute pain in the pelvis, but for some time she had experienced a feeling of weight and a dragging sensation, with some shooting pains down the back of the thighs. Her general health was somewhat impaired, her features had an anxious pinched look, and her skin was rather pale. Bimanual examination revealed a large doughy tumor, well rounded off, occupying the left pelvic region, and extending across somewhat towards the opposite side. The tumor could be distinctly felt in the hypogastric and left iliac regions. The uterus was pushed to the right side and closely packed against the pubic arch. The sound entered it to the extent of three inches and with it *in situ* the fundus could be made out behind and above the pubes. Incision was made, and on examination the dome of the tumor proved to be the pelvic peritoneum, raised up and covered with portions of the sigmoid flexure, its mesentery on the inner side entering into the formation of the serous coat of the tumor. It was a pelvic hæmatocele. The abdominal wound was closed at once and the hærmatocele freely opened by an incision through the vagina. About two pints of tarry fluid escaped by this route, and after a period of four weeks she returned home.