nine hours after the operation, no hæmorrhage took place.

[For the description of and method of using Esmarch's apparatus refer to page 93, *Canadian Medical Times.*]

GYNÆCOLOGY.

CASE OF CYST OF THE LABIUM.

By Theophilus Parvin, M.D., Indianapolis.

Between three and four years since I visited Mrs.——, a lady about twenty-four years of age, married two years, pregnant for the first time, the pregnancy having advanced to the fourth month, the purpose of the visit being to operate upon a tumour situated in the left labium. This tumour was first noticed when she was eleven years old. At the accession of puberty it increased rapidly for a time, then its growth ceased until after marriage; but since that time it had been constant, until now the tumour, quite as large as a medium-sized orange, it was feared would be a serious impediment in parturition.

Upon careful examination I was satisfied that it was a cyst. A portion of the wall was exposed, the sac evacuated of a light, straw-colored fluid, and as large a piece of the wall cut out as I could and lint passed into the cavity. I was disappointed in not being able to remove a large portion or the entire cyst; but the patient was exceedingly restless, and circumstances not necessary to explain did not permit the exhibtion of an anæsthetic, and my stay at the place of patient's residence was limited to a few hours. Subsequently free suppuration occurred once or probably twice, in the cyst, but the final result I do not know.

Remarks. Labial cysts, especially such as attain the large size of the one above mentioned, are not common. Dr. Thomas, in his admirable treatise, makes no mention of the disease. Courty, the excellence of whose volume can not be too highly appreciated, briefly dismisses the affection, in company with some others, in these words: "I shall not here describe œdema, or phlegmon of the labia majora, or tumours of the dartoid sac, or encysted tumours, serous or purulent; for these diseases ordinarily do not present any peculiar indications." Churchill, on the other hand, gives quite a good description of encysted tumours, along with other diseases of the labia; but the best discussion of the subject I have seen is in Nonat and Linas. McClintock devotes a brief space to these tumours, but the largest he mentions having seen was the size of a small hen's egg. Plate XL., fig. 1 of Boivin and Duges's Atlas represents one of these tumours found by Cloquet in a woman fifty years of age, the growth being two inches and a half long and its diameter one inch. This is about the size of the tumour spoken of by McClintock.

It is hardly possible for an encysted tumour to be confounded with œdema or phlegmon of the labium. It has neither the change of colour nor the increase of sensibility of the latter, nor has it the diffiused character of the former. Its history too is different: essentially indolent, no constitutional derangement either antecedent or consequent. The tumour is in the majority of instances situated upon the left side. It is painless, and is said to be usually spherical. But this last observation I do not believe applies to the tumour when large; for in the case of Cloquet, and in that of McClintock and in my own, the swelling was much more in the shape of an egg than in that of a sphere: the larger portion, supposing the patient to be standing, projecting downward and forward. The tumour is distinguished from a hernia, as Vial has pointed out, by no prolongation sent between the ischium and vagina toward the abdominal cavity, by fluctuation, by its non-disappearance in the horizontal position, by no impulse being communicated by coughing or straining, etc.

These tumours, it is supposed by McClintock and others, "are in most, if not in all, instances, produced by obstruction of the mucous or sebaceous follicles, which exist here in such numbers, or of Duverney's glands." So far as cysts are supposed to be consequent upon obstruction of the vulvo-vaginal glands, may we not doubt the statement, since we so commonly see inflammation and abscess consequent upon obstruction.

In a recent discussion in the Philadelphia Obstetrical Society Dr. Wm. F. Jenks remarked that there were in the labia glands without secretory ducts, which by the abnormal accumulation of their contents might give rise to true "retention cysts," as they were called by Virchow. One difficulty in accepting the hypothesis of glandular obstruction or of excessive glandular activity being the cause of all these cysts is that in some instances, as in the one I have narrated, the cyst contents are so different from any normal glandular secretion.

The treatment of these cysts should only be resorted to when they are an inconvenience, a positive discomfort, and may be an injury from their size. The simplest method of treating them (it is that to which Nonat and Linas give the preference) is to evacuate the cyst with trocar and canula, then throw in a wine or iodine injection; in a word, treat it as a hydrocele.

Dissecting out the sac is not always easily done, nor is it always free from risk, as Dr. Churchill well remarks. We can incise the anterior surface of the tumour and cauterize the lining membrane or fill the cavity with lint, where the size of the growth and its extending up the vagina, as Dr. C. suggests, forbid extirpation. Upon the whole, however, the plan first mentioned will be the most expeditious and least painful, and to be preferred in the mojority of cases, though of course it is by no means the certain cure that extirpation is. I may mention also that the plan recommended is advised by Guerin in his lectures upon diseases of the external generative organs of the female (Paris, 1864). He believes, however, that the treatment by iodized injection ought not to be resorted to if the cyst extends high up in the vagina; fearing, from the great vascularity of the organ in that part, mortal accidents that have occurred from a similar injection in hydrocele of the neck.—*Am. Practitioner, Sept.*

OVARIAN TUMOURS.—OVARIOTOMY.

Dr. J. Marion Sims has recently published *(New York Med. Jour.,)* two excellent papers on this subject. In them he very briefly alludes to the past history of the operation and to the various methods which have been proposed for the management of the pedicle. For twenty years, he has advocated the plan of tying the pedicle with silver wire, and still thinks that it is the best treatment thus far proposed, though he questions whether it will not be found better in the future to apply torsion to the arteries, or else obliterate them by the enucleation of the pedicle from the coats of the cyst. As regards the results of the operation, Dr. Sims thinks that the mortality is altogether too great. He claims that the death of most of the patients is to be attributed to septicæmia. After carefully examining Mr. Spencer Wells's thirty-nine fatal cases, he considers that thirty-seven were the result of blood-poisoning, three being from pyæmia, and thirty-four from septicæmia. In all of these fatal cases, in which a *post-mortem* examination was made, a quantity of reddish serum, or grayish turbid serum or acrimonious serum was found in the peritoneal cavity. It is to these pent-up fluids that the blood-poisoning owes its origin. It seems, therefore, logical that the indication for treatment in these cases is to invent some method of draining off these poisonous fluids. As early as 1855, Dr. Peaslee *("On Ovarian Tumours,"* page 509) used intra-peritoneal injections with a view to remove any accumulation of fluid within the peritoneal cavity. Instead, however, of occasionally washing out the cavity at the top, as Peaslee proposed, Sims advises that the peritoneal cavity should always be opened at the bottom, so that the fluids may constantly drain off. This opening should be made at the lowest point, namely through the Douglas *cul-de-sac.* Here a puncture should be made, in every case, and a tube passed into the peritoneal cavity so that all effusion into this cavity may spontaneously drain off.

As showing the advantage of this plan of treatment, he gives the details of four cases in his own practice where he used this plan of treatment, he used this plan for establishing a drainage. In the first case, a sero-sanguinolent fluid began to pass off by the tube very soon after the operation. Occasionally, a little warm water was thrown into the peritoneal cavity, by the vaginal portion of the tube. The case made a good recovery. The second case also recovered. In the third case, the proper tube was not used, and the patient died. The fourth case did nicely, the drainage-tube being worn for about a month.

Great care must be taken, in these cases, that the puncture shall be made at the *lowest* part of the Douglas *cul de sac.* In washing out the peritoneal cavity the utero-vesical pouch must be carefully washed out, so that its contents (if any) shall overflow into the Douglas *cul de sac.* If care be taken in reference to these collections of fluid in the peritoneal cavity, one great source of septicæmic poisoning will be removed and the mortality which follows the operation of ovariotomy will be very greatly reduced.—*Boston Med. and Surg. Journal.*