THE CANADA MEDICAL RECORD.

VOL. XIII. MONTREAL, AUGUST, 1885. No. 11.

CONTENTS.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY, MONTREAL.

Stated Meeting, May 1st, 1885.

T. J. ALLOWAY, M.D., 1st Vice-President, in the Chair.

Dr. WM. GARDNER read a paper on a case of tubercular peritonitis with encysted collection of fluid, simulating ovarian cyst.

S.B., æt. 23, unmarried, domestic servant, belonging to a remote country district north of the Ottawa River, who had lived in the city during the previous six months, was sent to me about last midwinter as the suspicion of pregnancy had arisen in consequence of extensive abdominal enlargement. She admitted a pregnancy terminating at six or seven months a year and a half previous. She could give no definite account of the date at or about which the present abdominal enlargement began, but her mistress noticed it three or four months previous. It had rapidly increased since then. The girl complained of abdominal pain; menses had been absent for three or four months; general strength, health and appetite had declined, and she had become emaciated. The tongue was red.

Examination.—The belly much enlarged; the skin below the naval presenting recent pinkish striæ, as well as old silvery streaks. Well-marked fluctuation over the whole of the anterior and antero-lateral aspects of the abdomen. Dullness on percussion over the same area. In the lumbar region (flanks) and epigastrium the bowel note present. No firm or solid part to be felt anywhere. The anterior aspect of the abdomen quite uniform. The perineum slightly lacerated and the posterior vaginal wall partially prolapsed. The uterus, measuring two inches, pressed upwards and forwards, lay immediately behind the pubes. The patient was admitted to the Montreal General Hospital and kept under observation for a few days, when it was found that she had fever of septic type, the temperature at times running very high, with profuse sweating and occasional attacks of vomiting.

Operation.—The ordinary incision for ovariotomy was made, but on reaching the peritoneum no separation of parietal from visceral layer could be made; the knife entered the collection of fluid, passing through what seemed to be a thickened, closely adherent cyst wall. The fluid was amber colored, contained flakes, and in the last portions an obvious admixture of pus. The cyst wall did not collapse as the fluid escaped, but appeared to be adherent everywhere, even to the bottom of the pelvis. Acting on this view, and with the concurrence of my friend Prof. Roddick, who was assisting, I decided to make no attempt at separation of the supposed cyst, but to drain and irrigate as affording the patient the best chance. A large glass tube was passed through the wound into the Douglas pouch, and irrigation practised every two hours, night and day. At first weak carbolized water, then corrosive sublimate solutions, and finally solutions of iodine, were used for this purpose. The general condition at once improved, and this was maintained for a period of ten days. Fever diminished and appetite improved. After