

soft myoma, I got from a specimen which I helped Mr. Tait remove. Its history was that of most other such growths. Mr. Tait had diagnosed the tumor as uterine, but had half-way suspected pregnancy on account of its extremely soft, semi-fluctuating condition. After watching it, though, until the term should have been fully passed, he decided it to be a myoma, which must be removed.

Although he had watched the case for more than a year, when we had gotten the abdomen open, and exposed the tumor to view, he whispered across the table to me, "I believe it is a pregnancy still." After careful examination, we found it to be a soft myoma, involving most of the body of the uterus. An amputation at the internal os, not only saved the patient's life, but gave me a beautiful specimen. It contained no cysts of any kind, but was composed of a loose mesh-work whose interstices were filled with a fluid lymph, and from whose ultimate fibres a rapid proliferation was going on, so much, so that had I not known exactly where it came from, I would have thought I was dealing with a lymphadenoma.

As you all know, soft myomas are extremely rare, the only other one in which I ever came in contact, I removed successfully, a few months since. Like the one with Mr. Tait—the diagnosis could not be made. An exploratory incision for the relief of either a small ovarian tumor, a soft myoma, or a malignant tumor was done, and the soft myoma revealed in the wound. So extremely deceptive was the sense of fluctuation it gave, that after its removal, one of my assistants, whom I know to be a well-trained surgeon, was willing to wager almost any amount that the tumor contained a cyst. On splitting open, however, we found the same loose mesh-work, embracing many lymphatic spaces, which reminded one very much of the physical condition of a sponge. After cutting and freezing, I found much the same state of affairs as that described in Mr. Tait's specimens, the principal difference being in the presence of a greater or less number of muscular fibres distributed throughout the tumor. Many places, however, showed nothing but the myxomatous tissue, other places showed the young muscle cells of Billroth. In other places, where we had a rapid cell development, which were evidently originated from the ultimate fibres, some corpuscles seemed to be separating from these fibres and floating away in

the lymph. Others, again, seemed to be taking on a spindle shape, and going directly on to the development of new connective tissue cells, and, so far as one can tell, to the development of a young muscular fabric.*

Any one who is at all familiar with mucous tissues, can tell at a glance to what class they all belong, and I do not think it would take a great deal of microscopical training for one to catch the relationship between these tissues, and having established this, my object is almost accomplished. For it is the kinship of the parenchymæ of the endometrium and the soft myoma which adds a pathological proof of the adenoid theory of the normal endometrium. The sponge-like interstices give free room to the large amount of œdema which these tumors contain, and it is its presence that gives the deceptive sense of fluctuation which so frequently places the abdominal surgeon in uncomfortable situations. Where this œdema comes from, I think is perfectly plain.

We have known for a long time that the lymphatic apparatus of the human uterus is not very rich, and that it is the discharges through its cavity which fills the place of the large lymphatic trunks, found in the lower animals. When the endometrium begins to develop backwards into the muscular wall, as this tissue for its well being requires a greater amount of lymph than is necessary for the muscle itself, at once there begins a disproportion between the quantity of lymph contained in the uterus and its normal outlets. As the tumor grows, this inequality becomes greater and greater, the result soon being a damming back of lymph within the capsule of the rapidly growing tumor. One of the consequences of this is the formation of lymphatic retention cysts, and this, I believe, is a true history of most fibro-cystic tumors of the uterus. I have never had the opportunity of examining one of these tumors, and cannot say positively whether they embrace more than one condition or not, but am prepared to believe that they are produced by two distinct histological conditions, this being one of them, and the other I would look for in the abnormal or unusual development of some of the uterine follicles. As I have shown, the interstitial tissue of these tumors is exactly that of the endometrium, and why may it

* Here the Dr. showed a plate which, we regret, not to be able to produce.