times in the experience of the New York cancer hospital that the microscope failed to detect it in undoubted cases. When the diagnosis has been made early enough to find the growth limited to the uterus, there remains to the physician but one more duty—to urge the immediate removal of the organ.

TWO RARE CASES IN OBSTETRICS

*By Dr. Clouston of Huntingdon.**

I. Vaginal Thrombosis—Post-Partum—On the 17th of June last, I was called to attend Mrs. S. in confinement. Age about 35, married 12 years; had one child prematurely about 5 years ago. Labor in progress. Abdomen large, tense, impossibility to make out fœtal part, but by aid of stethoscope twin pregnancy was diagnosed. First child vertex presentation, 2nd position, natural delivery. Second child also presented vertex but occipito-posterior, and did not rotate anteriorly. Labor pains being weak and ineffective, forceps were carefully applied to head at the superior strait, and tractions made during pains. While the head was still from 1½ to 2 inches from natural outlet, which was being put on the stretch by the shanks of the forceps, I noticed the perineum suddenly give way, tearing right to the bowel. I was surprised to see such a laceration take place so early and without obvious or sufficient cause. The child was delivered without difficulty or further misadventure. Placenta came away satisfactorily, I douched out the vagina, and proceeded to repair the perineum, putting in three satures. On returning in the evening I found patient had been unable to void her urine, the right labium majus very much swollen and œdematous. I punctured the labium in several places with a needle, allowing a quantity of serum to escape, and then drew off urine with a catheter. I noticed considerable swelling about the parts, but did not make a vaginal examination. Next day the bladder was catheterized, morning and evening, the right labium and lateral half of perineum was now discolored as well as œdematous, and on further investigation I found a tense somewhat elastic swelling in the right and anterior wall of the vagina extending from the pubic ramus upwards, and in size about that of the palm of my hand. I again punctured the labium, allowing serous fluid to escape, much reducing its size, but decided to let the vaginal thrombosis alone. From the appearance of the parts I had little hope of securing union of the perineum. The patient's temperature ranged from 100 to 100½; a dose of castor oil was given, which, aided by an enema, acted satisfactorily. The temperature, however, continued to rise, creeping up to 103; discharge not foul, uterus undergoing normal involution, breasts full and hard, nipples flat, patient persistently refused to nurse children in spite of all remonstrances. So bowels were kept open by salines and belladonna, and compression applied to breasts. A portion of the mucous membrane over the lower part of the tumor showed evidence of sloughing about the 4th day, allowing the finger to be introduced and masses of foul-smelling clot to be evacuated. I syringed out the cavity with antiseptic solutions daily, removing fragments of clot and debris. The pyrexia subsided and the cavity contracted, but in spite of syringing and gentle curetting continued to be somewhat foul for some days. The sore progressed favorably, and on the 28th, or 11 days after confinement, I removed the satures from the perineum, and found good union secured by the two posterior stitches giving a functionally good perineum. On the following day patient was up, feeling well.

II. Concealed Hemorrhage—This patient was neighbor of No. I. Stout woman, aged

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