Society Proceedings.

MONTREAL MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, January 25, 1895.

DR. G. P. GIRDWOOD, PRESIDENT, IN THE CHAIR.

Large Interstitial Uterine Tumor with great Development of the Uterine Wall and Moderate Increase of the Uterine Cavity.—Dr. WM. GARDNER contributed this specimen and said that it appeared to belong to the variety of myoma, designated as lymphangiectodes; and, roughly speaking, was composed of intersecting bands or filaments of pearly white tissue bounding spaces containing a clear straw-colored fluid.

The case was interesting from its rarity, its rapid growth, its consistence as felt through the abdominal wall, and otherwise in some respects presenting difficulties in diagnosis. The patient was aged thirty-two, and married eight years, sterile, menstruation regular till three or four months ago, the flow being copious and painful. Otherwise her complaints were of pain in the left lumbar region and in the legs, and of abdominal enlargement. The patient said that previous to a year ago there was scarcely any enlargement. The abdominal tumor resembled much in feel and in other characters the gravid uterus of seven months, presenting at intervals the painless contractions so valuable a sign of pregnancy, as insisted upon by Dr. Braxton Hicks. The fact, however, that this sign is occasionally met with in the softer varieties of uterine tumors, was demonstrated by the late Dr. Matthews Duncan. This consistence of the tumor and marked purplish discoloration of the genitals, with pigmentation of the linea alba, and areola about the nipples, had given rise to the suspicion of pregnancy; a suspicion which was shared by a member of the profession. The operation was done a fortnight ago, and the method chosen was supravaginal amputation after ligature of the ovarian and uterine arteries, and intraperitoneal treatment of the stump. The recovery had been absolutely witho ut unfavorable symptoms.

Cholecystenterostomy from the use of Murphy's Button.—Dr. SHEPHERD at a meeting held September 21st, 1894, reported a case of cholecystotomy in which a fistula remained, and he stated then his intention of doing a cholecystenterostomy should the fistula not close within three months. She returned to the hospital November 28, 1894, looking well and healthy, and having gained considerably in weight. She, however, said the continued discharge of the bile was unbearable, and asked that an operation be performed for relief. So, on December 3rd, she was placed under ether, and an incision was made a little internal to the first one, and the fistulous opening thus avoided. The gall-bladder was seen attached firmly to the abdominal wall. On examining the site of the supposed gall-stones found at the last operation in August, he came down on a large mass, the size of an orange, which apparently involved the head of the pancreas and duodenum. Being convinced that the case was one of malignant disease, and that all measures for relief could only be temporary, it was decided to unite the gall-bladder to the colon by means of a Murphy button, the duodenum being fixed and not easy to get at. The button was introduced without much difficulty, the purse string suture being first applied; owing to the thickness of the gall-bladder, there was some puckering, and it was difficult to get the folds to lie flat. The thinness of the colon was remarked, and the button when pressed home could be seen distinctly through the walls of the gut, so a few Lembert's sutures were introduced. As the patient had malignant disease, it was not considered very important to close the fistulous opening, as it was felt that this would gradually diminish in size when there was free communication between the gall-bladder and the gut. On dropping back the bowel and gall-bladder the parts seemed to lie quite comfortably without tension. The abdominal wound was now closed with two layers of sutures.

The patient went on excellently well for three days, very comfortable, with no pain and no discharge of bile from the fistulous opening. On the evening of December 6th, she complained of chilliness, and bright red blood began to ooze through the fistulous opening which led to the gall-bladder, and large clots of blood could be squeezed out. The bladder was packed with iodoform gauze, but in a few hours the blood began to force its way through the abdominal wound, and the pulse began to fail, so it was decided to reopen the wound and examine the source of the hæmorrhage. On opening that, however, the parts were free from any peritonitis or sepsis, but there was a considerable amount of clotted blood in the abdominal cavity in the neighborhood of the stomach, besides a quantity in the gall-bladder. On examining the anastomosis, it was seen that the button had cut through the gall-bladder, and from this cut there was free bleeding. There was no gangrene of parts in contact with the button. The button was immediately removed and the wound in the colon and that of the gall-bladder sewed up. In the latter, owing to its great friability, this was a difficult matter. Blood still came, and so the gall-bladder was packed with iodoform gauze and the wound closed as the patient was getting much weaker. Next morning the dressings were found to be soaked with blood