later, and about nine months after she had had another child. The uterus then could be clearly differentiated from the fibroid, because it was pushed down into the pelvis and was retroverted, the cervix pointing forward, whilst the fundus could be felt behind. From the anterior wall, there was now projecting a hard growth which could be moved to some extent over the body of the uterus, and which extended upwards nearly to the umbilicus. The nodular outgrowths previously felt were markedly larger than before. I opened the abdomen, and then found that the growth in front was connected with the uterus by a broad pedicle, but, as there were largish nodules in the uterine wall at different points, there was nothing to be gained by merely removing the upper mass, and therefore I performed hysterectomy. In the course of two years, then, of which nine months had been occupied by pregnancy, this growth had not only increased at least four-fold in size, but had become extruded by the muscular action of the uterine walls right out of the organ and upon its anterior surface. Pregnancy itself had not been interfered with thereby, neither had parturition been interrupted.

If, on the other hand, the fibroid growth more nearly approaches the uterine canal and pregnancy then takes place, there is a constant and increasing tendency to the occurrence of a miscarriage, because the pressure of the increasing muscle-wall outside the growth tends to force it into the uterine cavity, and once it has bulged into that canal the tendency will still go on to its complete extrusion. In such a case, the larger the growth, and the more it involves the uterine passage, the greater will become the struggle between itself and the contained fœtus; each striving to obtain greater space for its own development. I have known pregnancy in such cases, especially when the tumour was small, progress to full term; but if the growth be at all large, there is a constant tendency for it to develop in the uterine canal, and therefore, to set up by its presence as a foreign body not only pressure on the growing fœtus, but also sufficient irritation in the surrounding walls to excite muscular contractions, and therefore, sooner or later, the expulsion of the fœtus. Although this sequence of events is obvious, there is reason to believe that the condition is one which is frequently overlooked as a cause for the occurrence of miscarriage; whilst the presence of a fibroid is a still more common cause, I believe, for frequent and profuse losses after labour. I have, for example, not infrequently seen patients who have been sent to me for more or less exhausting and continuous hæmorrhages, either following labour or after a miscarriage, for which there existed no obvious cause; but, on examination, I have found the cavity of the uterus dilated by a larger or smaller fibroid polypus. I recall one case especially of a lady who had been under the care of two well-known specialists, both of whom had carefully curetted her uterus for such losses, but without bringing about any cessation of the hæmorrhage. Had I seen her first, it is probable I should have adopted the same treatment with the like want of success; but, warned by the previous results, I sufficiently dilated the cavity to thoroughly explore it, and then found a large fibroid growth dependent by a long pedicle from the fundus. I removed this with a wire *écraseur*, and she had no further trouble.

Finally, there is a class of case which deserves most careful attention, in which necrotic and degenerative changes take place in the fibroid subsequent to labour. The pressure of the contracting uterus upon the growth, it may be, cuts off its blood supply, or by the mere pressure causes necrosis of its substance. At any rate, the following case is typical of several which I have seen. A lady, aged forty-two, whom I had treated on several occasions for hæmorrhages caused by a fibroid growth in the posterior wall of the uterus, had a child at full term, and for a short time appeared to be progressing quite favourably. About three weeks afterwards, she had a shivering fit, and her temperature rose to 103°, then fell, and finally began to rise and fall regularly between 102° and 100°. She began to have considerable and increasing pain, first in the back, then all round the pelvis and abdomen. I was called in to see her, and found the uterus enlarged, extreme tenderness and fixation of the posterior wall—in which the original growth was embedded—in Douglas's pouch. It was evident that acute septic changes were taking place. She was losing flesh fast; her skin was dry and hot; her pulse varied from 100 to 120; her tongue was furred; there was no uterine discharge, and I, therefore, diagnosed degenerative changes in the uterine fibroid, and advised hysterectomy as soon as possible. This was performed, and with some difficulty I separated the uterus from dense adhesions in Douglas's pouch, lifted up the organ, and removed it. We then found that the whole of the posterior wall was involved in a fibroid growth, the size of a cocoa-nut, which was breaking down into grumous material. The capsule was intact, although the broken-down matter extended to within a quarter of an inch of its surface. The day after the operation, her temperature and pulse were normal, and she made an uninterrupted recovery.

It is a golden rule, and one which probably everyone who has much experience of these cases will endorse, that degeneration in a fibroid tumour demands the removal of the whole growth as speedily as possible. Formerly, these cases were temporised with, and often when operation was at last undertaken as a sort of forlorn hope, the patient was found to have drifted into a condition of septicæmia.

(To be continued.)

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