

gave rise to a very great deal of anxiety. I found that in most cases this arose from the carelessness of the nurses, for it was almost impossible to get them to understand what a clean catheter really meant, and I had to resort to the expedient of having the instrument, when not in use, always kept in a basin of water. If this simple precaution was properly attended to, my patients always escaped inflammation of their bladders; but even with the most scrupulous injunctions, a case of cystitis would occasionally occur. I therefore use the catheter now as little as possible, and my patients are always encouraged to pass water for themselves as soon as they can. Owing, however, to some reflex influence, arising doubtless from irritation of the nerves of the pedicle, they are sometimes quite unable to pass water for several days after the operation, and then the catheter must be employed with the precautions I have already indicated; and if it is to be used, let me urge the absolute necessity of these being attended to.

Another danger in this matter is to be avoided—one which is occasionally overlooked—over-distention of the bladder. I remember being told on two consecutive days, at each of my visits, by one of my most intelligent nurses, that a patient was passing her water all right. She was an extremely nervous patient, and the complaint she made of pain at first did not attract my attention; but at last I examined the bladder, and found it completely distended, although the nurse had informed me that she had passed a quantity of urine only a few minutes before my visit. The fact was that what she had passed was the mere overflow, and probably the patient's bladder had been distended for forty-eight hours. Thus, upon the slightest complaint on the part of the patient in the region of the bladder, a careful examination should be made. Fortunately in the case I have alluded to no harm ensued, but every consultant knows how frequently we are called in to see cases where the bladder has been allowed to remain over-distended for many days after a labor, and too frequently this is followed by terrible disasters.

For the treatment of cystitis arising from the use of a foul catheter, or from over-distention, I know of nothing equal to the injection into the bladder of a tepid solution (five per cent.) of hyposulphite of soda, and the administration every eight hours of a soluble pessary containing three or four grains of extract of belladonna.

The after-course of a case of ovariectomy is subject to many rude checks, which alter its history very much from the fortunate career supposed in the preceding pages. There are many dangers in the path of every patient submitted to this operation,

and there are many indications of their approach, but none so trustworthy as those derived from a close observation of the patient's temperature-curve. It should be the invariable practice of the surgeon to have temperature and pulse observations of his patient made night and morning for a few days before the operation, and afterward these ought to be repeated every four hours for at least ten days. Nothing has been to me more instructive than a comparison of a group of such charts; and I have repeatedly seen grounds for a prognosis in a case by the comparison of its temperature-range with those of former cases. It will almost invariably be found that, immediately after the operation, the temperature falls considerably. I have seen it do so as much as two degrees, indicating the risk the patient has to run in the form of shock. To obviate this being carried to a dangerous extent, it is always well to place hot water bottles to the sides and feet, and, if depression be severely marked, to administer a diffusible stimulant. By far the best is an enema of diluted champagne, with a little brandy. It is generally necessary to administer a small dose of morphia—one-third or one-fourth of a grain—immediately after the operation, by suppository, and by this I believe shock may be warded off in great measure, and the after-sickness prevented.

From the twelfth to the twentieth hour after the operation, the temperature slowly rises, unless the patient succumb to the shock; or, in the still rarer condition, where the operation has had to be undertaken on an emergency due to cyst-inflammation or an attack of peritonitis, in which case the temperature falls. In a case of the latter, where I operated with a temperature of nearly 40° Centigrade, it fell in twenty-four hours to 37°.

After the recovery from shock, the patient generally breaks out into a gentle perspiration, and this should be slightly encouraged, and the temperature may vary from 36.8° Centigrade to 38.5° without giving rise to any alarm. If it rise, however, above the latter point, especially if accompanied by an increased pulse frequency, dry tongue, pain, and inflation of the abdomen, green vomiting or hiccup, and anxious face, the access of peritonitis, in some form or other, may be taken for granted. The treatment of this must vary very much according to the circumstances of each case.

Vomiting and distention used to be, as I have said, an invariable indication of an ultimate fatal issue. In the old days of the clamp, when we saw these symptoms come on accompanied, as they always were, by the unmistakable expression of face, we knew only too well that our efforts had been in vain. Now it is extremely rare to see either of these symptoms of an extent

sufficient to give rise to much anxiety. We do see sickness, and sometimes it is green and bilious, and we occasionally have some little distention, but they very rarely cause us any trouble. For the treatment of the sickness, I find the most effectual remedy to be a small dose of sulphate of magnesia, thirty or forty grains in tepid water, repeated every other hour or every hour until the bowels have moved, or two and a half grains of calomel given every three or four hours until a similar effect is produced.

The distention is nearly always started in the transverse colon, and shows itself first at the scrobiculis cordis, which, after an ovariectomy, is usually concave. I look at every visit at this point, and teach all my nurses also to watch it carefully, and as soon as any distention is visible, a tube is passed into the rectum at intervals of two or three hours, and left in a short time to enable the flatus to escape. If either of these symptoms advance to any alarming extent, I use still more active measures to get the bowels moved, because I always find that as soon as a motion has passed they rapidly disappear.

If, at the time of the operation, it has been thought necessary to follow the plan of drainage, as introduced by Koeberle and Keith, a little extra care must be taken with the case. I have now had considerable personal experience of this method, and I am quite satisfied from the cases in which I have used it, and from what I know of Dr. Keith's work, that there will occur every now and then a severe case in which it will be found absolutely necessary to employ it. The tubes we use are made of ordinary glass, formed somewhat like a test-tube, with an overhanging lip with which they may be secured by one of the sutures against the possibility of falling inside. They vary in size and length, having a diameter of from three-fourths of an inch down to one-fourth of an inch, their length being from three to six or seven inches. In some of my operations upon the liver, I have had to use them a good deal longer; but for an ovariectomy this length will generally be found quite enough—in fact, it will rarely be necessary to use them more than four inches long. For at least half its length the tube is perforated with small holes through which the fluid drains into it from the cavity of the pelvis. Just before closing the wound, the tube is placed with its bulbous end down into the cavity of the pelvis, care being taken, of course, that it is placed behind the uterus, and that it does not interfere with a loop of intestine. Very soon after the wound is closed, it will be found that the serum drains from it, and the amount of fluid which, in the course of a very short time, will drain in this is simply amazing, for Dr.

Keith has shown me three huge bottles containing an aggregate amount of probably ten or twelve pints drained from one patient.

Now, whether it is or is not necessary to drain this large quantity away is not yet a settled question. I believe that a tube placed in a healthy peritoneum could be made to drain away an indefinite quantity, for there is no doubt that the peritoneum, being a huge lymph-sac, is constantly passing lymph either through the intestines outward or from the outer wall in toward the intestines. The direction of this lymph-stream is not known, nor, indeed, do we know anything about its physiology; but the facts of pathology are alone sufficient to determine its existence. My own view about drainage is that it will be useful only where some addition to this lymph-stream is made greater than the outlet can carry away. The fact that I have been so successful in my own operations without drainage makes me think it probable that I have unconsciously substituted purgation for drainage; for, on looking over my records, I find that in very many of the cases where Dr. Keith would have drained I have purged. This would make it seem as if the intestines were to a large extent the outlets of the drainage stream; but it will remain for some time an open question which of the two channels, the drainage-tube or the intestinal canal, will prove the better vehicle.

Dr. Marion Sims' proposal to drain every case by means of a tube passed from the abdominal cavity into the vagina was one which did not meet with any very favorable reception, and I feel quite sure that even in Dr. Keith's hands, where drainage of a reasonable kind is resorted to, the cases will become fewer and fewer; but still there can be no doubt the drainage will largely assist in relieving the strain upon that absorbent power of the peritoneum.

Dr. Keith, after fastening in the tube, places over it a wide sheet of very fine rubber-cloth, through which the end of the tube passes, and by the aperture in which it is firmly grasped; some carbolized sponges are then wrapped up in this cloth, and in this way a very ingenious absorbent dressing is formed, which prevents the fluid, as it drains from the tube, soiling the bed-clothes. Every hour or two the nurses squeeze the sponges dry, or replace them by fresh ones, and this is continued as long as the fluid is tinged red, sometimes for nearly a week. I employ a much simpler method. I merely apply two or three absorbent pads over the tube and change them when necessary.

The convalescence of a patient from an ovariectomy may be interrupted by any of the very many causes and accidental

complications common to all surgical operations, but these are found to be very greatly diminished by the increased care we now bestow upon the hygienic arrangements of our hospitals. Thus, formerly it was not an unusual thing to see a patient die eight or ten days after an operation from an attack of pneumonia, just the same as sometimes occurs in large hospitals after amputations; but in the admirable building of the New Infirmary at Edinburgh, Dr. Keith has already performed quite a large number of operations with splendid success; and but a few days ago he told me, I think, that there he had done some twelve or thirteen consecutive cases successfully without any of the Listerian or so-called antiseptic precautions.

Once or twice, after the removal of very large tumors from elderly women, I have seen a short, rapid cough set in, rapidly increasing in severity, and killing the patient in about thirty hours. What had occurred there was, I believe, perfectly analogous to the suffocative catarrh of old age. The expiratory muscles, perhaps chiefly the diaphragm, from long want of use, had become atrophied, and, missing their *point d'appui* in the tumor, were unable to carry on the process of expectoration of mucus.

Occasionally we have the occurrence of tetanus after ovariectomy, just as we have it after every other surgical operation. Only once has it occurred in my practice, and the patient recovered, probably because I did nothing at all to her, but left the disease entirely alone. It is not a subject upon which therapeutical experiments have produced any satisfactory results, and, therefore, I think the less its victims are interfered with, the more likely they are to get well.

Another nervous lesion I have seen occur twice after ovariectomy, and in both cases it has proved fatal, and several other operators have told me that they have had a similar unfortunate experience. I refer to a paralysis, or what appears as such, of the muscular coats of the intestine. The abdomen distends rapidly with gas, and when examined after death, nothing is found but the distention. In both of my cases there was nothing like peritonitis. I tried many things to relieve these cases, including galvanism and puncture of the intestines, but without benefit.

Great stress used formerly to be laid in all abdominal operations upon the necessity of keeping the bowels from moving, and it was formerly my practice to take pretty active measures to prevent them acting for ten or twelve days. This practice I have now entirely given up; and should there not arise any need for purging my patient, I let matters alone, desiring the

nurses to give her an enema of warm water as soon as she expresses any desire to have a motion, and to repeat this every three or four hours until it is effectual.

I have so far only made casual allusions to cases of exploratory incisions and incomplete operations. It is very difficult, indeed, to lay down definite instructions upon this matter which would be of much assistance to the beginner. Of course, in a mere exploratory incision, made, let us say, for the purpose of ascertaining whether the tumor is malignant or not, no special difficulty will be experienced. In my own cases they really are but open tapplings; that is to say, now-a-days, when we know there is a quantity of ascitic fluid marking the outline of the tumor, instead of tapping with a trocar, I simply make an incision with a knife, large enough to admit my finger. I empty the cavity, and, with my finger and my eye, I can generally satisfy myself upon the points where I require information. This sort of operation is nothing more than a tapping, and has no more risk, so that I hardly class it amongst the list of exploratory incisions. What I mean by the latter term is when I open the abdomen by an incision big enough, perhaps, to admit my hand in order to determine whether the particular tumor can or cannot be removed. Here there are one or two dangers with which the inexperienced operator must be acquainted, and which are not always to be avoided even by the most experienced. Thus, in a soft uterine tumor, which may very closely resemble an ovarian cystoma, it may very often happen that the bladder is pulled with it right up out of the pelvis, and the surgeon's knife may go through the bladder before he recognizes it. This has three times happened to me, but I have always carefully stitched the viscus up, and no harm has resulted from the accident. Whenever, in an exploratory incision, the bladder is found pulled up and spread over the front of the tumor for a considerable distance, the proceeding may at once be brought to a conclusion, for it may be regarded as perfectly certain that the tumor cannot be removed. Another danger is in opening the capsule of a very vascular tumor, for it is often a matter of the greatest difficulty to arrest hemorrhage from such an incision; and when the tumor looks very vascular, and is probably uterine, let me strongly urge the operator, whose experience is not very large, to be very cautious how he touches it, unless he is prepared to proceed with and complete its removal. It is at this point that the great question arises; how to direct an inquirer upon this difficult path I do not know, unless it be to advise him that, before he engages much in abdominal surgery, he had better see a good deal of it in the practice

of some one else; for the success of an operator is to be marked not only by the number of successful operations he has performed, but also by the diminution of those he has left incomplete. When and how to complete the removal of a tumor in which there are grave difficulties can be learned only by experience, and, as I have elsewhere said, in my own earlier practice I too often left an operation unfinished which riper experience would have enabled me to complete. Let me here repeat once again my advice that the surgeon should most carefully consider what he is about to do before he turns an exploratory incision into an incomplete operation; but, after having once determined the tumor to be a fit one for removal, let him proceed as speedily and as surely as he may, attending carefully to the precautions I have already laid down, and, once having put his hand to the task, let me say it will be wiser for him not to turn back, but proceed to finish the work he has undertaken.

A most remarkable case was narrated in a paper communicated to the Medico-Chirurgical Society of Edinburgh, in May, 1874, by Dr. Mathews Duncan. In this paper Dr. A. C. Campbell, of Dundee, described a case of cystic tumor of the kidney, simulating ovarian disease. The patient, aged forty-nine, a mill-worker, had a tumor for about eighteen months in the left flank, as large as a man's head, with fluctuation, and with symptoms of ovarian disease. On exposure of the tumor and insertion of the trocar, nothing came, as the contents were like porridge. The tumor was therefore laid open, and two pints of the stuff cleared out. Both ovaries were perfectly healthy. It was found that the tumor was an altered kidney; it was, therefore, removed. The patient made a tedious, but complete recovery. About forty ounces of urine were passed daily.

As a fitting conclusion to this chapter I place a list of one hundred and one consecutive operations for the removal of ovarian and parovarian tumors, performed without any of the Listerian details, and forming, as may be seen from the dates, my most recent experience. The table shows what seems to me the best method of recording cases. The letters "H" and "P" mean that the cases in the respective columns were in hospital or in private practice. "R" means recovery, and "D" means that the patient died. Of the hundred and one cases there were only three deaths.

SERIES OF ONE HUNDRED AND ONE CONSECUTIVE OPERATIONS, WITH THREE DEATHS.

No.	Residence.	Medical Attendant.	Age.	M. or S.	Disease.	Operation, Removal of	Date.	Hosp.	P.	R.	D.
1	Malvern	Dr. Weir	64	W.	Cystoma.	Left ovary	1880. Nov. 1		P.	R.	
2	Feckenham, Worcester	Dr. Leacroft	50	M.	"	Right ovary	Nov. 20		P.	R.	
3	Hednesford	Dr. Marsh Stiles	41	M.	Parovarian cyst.	"	Dec. 2	H.	P.	R.	
4	Coventry	Dr. McVeagh	21	S.	Cystoma.	Left ovary	Dec. 7	H.	P.	R.	
5	Stratford-on-Avon	Dr. Gill	42	S.	"	Right ovary	Dec. 21		P.	R.	
6	Hambleton, Worcester		56	M.	"	Right ovary	1881. Jan. 4	H.	P.	R.	
7	Baddesley, Warwick	Mr. S. F. Palmer	49	M.	"	Right ovary	Jan. 5		P.	R.	
8	Llanbedr, Merioneth	Dr. Williams	49	M.	"	Right ovary	Feb. 2	H.	P.	R.	
9	Birmingham	Mr. H. Bracey	15	S.	"	Right ovary	Feb. 2	H.	P.	R.	
10	Brierly Hill	Dr. D. Arcy Ellis	41	M.	"	Both ovaries	Feb. 5		P.	R.	
11	Dyffryn, Merioneth	Dr. C. Williams	49	S.	"	Left ovary	Feb. 7		P.	R.	
12	Chesterfield	Dr. Booth	32	S.	"	Left ovary	Feb. 14		P.	R.	
13	Birmingham	Mr. Raffles Harmar	48	M.	"	Left ovary	Feb. 17	H.	P.	R.	
14	Leominster	Dr. Barnett	23	S.	"	Left ovary	Feb. 19	H.	P.	R.	
15	Nuneaton	Mr. R. B. Nason	56	M.	"	Left ovary	Feb. 27		P.	R.	
16	Wootton-under-Edge	Dr. Forty	25	S.	"	Both ovaries	March 2		P.	R.	
17	Leicester	Dr. Cox-Hippisley	31	M.	"	Both ovaries	March 3	H.	P.	R.	
18	Harbury, Warwick	Dr. Lattey	63	M.	"	Both ovaries	March 9	H.	P.	R.	
19	Lancaster	Dr. Cassidy	56	M.	"	Right ovary	March 9		P.	R.	
20	Solihull	Dr. Page	22	S.	"	Both ovaries	March 12		P.	R.	
21	Wolverhampton	Dr. Walton Hamp	21	S.	"	Left ovary	March 16	H.	P.	R.	
22	Ashby-de-la-Zouch	Dr. Betts	43	W.	"	Right ovary	March 26		P.	R.	
23	Cannock	Dr. Moses Taylor	38	M.	"	Right ovary	April 2	H.	P.	R.	
24	Birmingham	Dr. Bailey	30	M.	"	Left ovary	April 9	H.	P.	R.	
25	Cradley	Dr. Standish	29	M.	"	Left ovary	April 29		P.	R.	
26	Nottingham	Dr. Huthwaite	47	M.	"	Right ovary	May 7		P.	R.	
27	Lichfield	Dr. Bastable	36	M.	"	Right ovary	May 7		P.	R.	
28	Birmingham	Dr. Cox	57	M.	"	Right ovary	May 19	H.	P.	R.	
29	Darlaston	Dr. Cameron	40	M.	"	Both ovaries	May 21		P.	R.	
30	Malvern	Dr. Weir	48	M.	"	Right ovary	June 15		P.	R.	
31	Aston	Mr. Lawson Tait	31	M.	"	Left ovary	July 4	H.	P.	R.	
32	Wellington, Somerset	Dr. Edwards	22	S.	"	Both ovaries	July 5		P.	R.	

SERIES OF ONE HUNDRED AND ONE CONSECUTIVE OPERATIONS, WITH THREE DEATHS—(Continued).

No.	Residence.	Medical Attendant.	Age.	M. or S.	Disease.	Operation, Removal of	Date.	Hosp.	P.	R.	D.
33	Walsall	Dr. G. Sharp	39	M.	Cystoma.	Left ovary	1884. July 6	H.	P.	R.	.
34	Ashby-de-la-Zouch	Dr. Betts	34	M.	"	Both ovaries	July 7	.	P.	R.	.
35	Derby	Dr. G. Copestake	35	W.	"	Both ovaries	July 13	.	P.	R.	.
36	Alfreton, Derby	Dr. J. J. Bingham	48	M.	"	Right ovary	July 28	.	P.	R.	.
37	Birmingham	Dr. D. Nelson	38	M.	"	Right ovary	Aug. 2	.	P.	R.	.
38	Chirk	Dr. Aylmer Lewis	17	S.	"	Left ovary	Aug. 2	.	P.	R.	.
39	Birmingham	Mr. Lawson Tait	40	M.	Parovarian cyst.	"	Aug. 8	H.	P.	R.	.
40	Derby	Dr. Rice	18	S.	Cystoma.	Right ovary	Aug. 22	.	P.	R.	.
41	Sutton-in-Ashfield	Dr. J. J. Bingham	25	M.	"	Both ovaries	Aug. 24	H.	.	R.	.
42	Worcester	Dr. Coombes	52	M.	"	Left ovary	Sept. 3	H.	.	R.	.
43	Adderbury, Oxon.	Dr. Colgrave	46	M.	"	Right ovary	Sept. 5	H.	.	R.	.
44	Horne Suckley, Worcester	Dr. Woodward	51	M.	Parovarian cyst.	"	Sept. 12	H.	.	R.	.
45	Bilston	Mr. Lawson Tait	35	M.	"	Left ovary	Sept. 13	H.	.	R.	.
46	Birmingham	Dr. Kenny	30	M.	"	Right ovary	Sept. 20	H.	.	R.	.
47	Llاندulas, North Wales	Dr. Turner	48	M.	Parovarian cyst.	"	Sept. 24	H.	.	R.	.
48	Birmingham	Mr. J. R. Harmar	63	W.	Cystoma.	Right ovary	Oct. 15	.	P.	R.	.
49	Wolverhampton	Mr. S. F. Palmer	57	S.	"	Both ovaries	Oct. 21	H.	P.	R.	.
50	Ombersley	Dr. Roden	63	M.	"	Right ovary	Oct. 28	.	P.	R.	.
51	Wolverhampton	Dr. Scott	34	M.	"	Right ovary	Oct. 29	.	P.	R.	.
52	Rugby	Dr. McKenzie	44	S.	"	Both ovaries	Nov. 1	H.	P.	R.	.
53	Swansea	Dr. Rawings	40	M.	"	Right ovary	Nov. 1	H.	P.	R.	.
54	Machynlleth	Dr. Pratt	63	M.	"	Right ovary	Nov. 11	H.	P.	R.	.
55	Birmingham	Dr. Nelson	39	M.	"	Both ovaries	Nov. 19	H.	P.	R.	.
56	Birmingham	Mr. Hall-Wright	22	M.	"	Left ovary	Nov. 22	H.	P.	R.	.
57	Derby	Mr. Curgenven	50	W.	"	Right ovary	Nov. 30	H.	P.	R.	.
58	Denbigh	Dr. Turnour	53	M.	"	Right ovary	Dec. 7	H.	.	R.	D.
59	Warwick	Dr. Tibbits	55	W.	"	Left ovary	Dec. 16	H.	.	R.	.
60	Kingswinford	Dr. Thomson	57	M.	"	Right ovary	Dec. 19	H.	.	R.	.
61	Llاندulas	Dr. Wolstenholme	25	M.	"	Left ovary	Dec. 24	.	P.	R.	.
62	Dudley	Mr. Lawson Tait	46	M.	Parovarian cyst.	"	1882. Jan. 11	H.	P.	R.	.
63	Birmingham	Mr. J. R. Harmar	32	M.	Cystoma	Left ovary	Jan. 17	H.	.	R.	.
64	Birmingham	Mr. Leach	25	M.	Parovarian cyst.	"	Feb. 17	H.	.	R.	.

No.	Residence.	Medical Attendant.	Age.	M. or S.	Disease.	Operation, Removal of	Date.	Hosp.	P.	R.	D.
65	Birmingham	Dr. Drury	37	M.	Parovarian cyst.	Left ovary	March 3	.	P.	R.	.
66	Derby	Dr. Carter Wigg	64	W.	Cystoma.	Both ovaries	March 8	.	P.	R.	.
67	Bromsgrove	Dr. Wood	42	M.	"	Right ovary	March 10	.	P.	R.	.
68	Birmingham	Mr. Hollingshead	58	M.	"	Right ovary	March 15	H.	P.	R.	.
69	Tipton	Dr. Hickin	39	M.	"	Both ovaries	March 17	.	P.	R.	.
70	Whitchurch	Mr. Groom	64	W.	"	Both ovaries	March 19	.	P.	R.	.
71	Bootle	Dr. Young	27	M.	"	Both ovaries	March 23	.	P.	R.	.
72	Nuneaton	Mr. Nason	29	M.	"	Right ovary	March 23	H.	P.	R.	.
73	Derby	Dr. Carter Wigg	52	M.	"	Both ovaries	March 24	.	P.	R.	.
74	Birmingham	Mr. Lawson Tait	29	S.	"	Right ovary	March 25	H.	P.	R.	.
75	Birmingham	Dr. Madden	33	M.	"	Right ovary	April 5	H.	P.	R.	.
76	Birmingham	Mr. Waterson	17	S.	"	Right ovary	April 6	.	P.	R.	.
77	Birmingham	Mr. Hollingshead	42	M.	Fibroma.	Left ovary	April 7	.	P.	R.	.
78	Birmingham	Dr. Edginton	38	M.	Cystoma.	Both ovaries	April 13	H.	P.	R.	.
79	Cheltenham	Dr. Simmons	50	W.	"	Both ovaries	April 13	H.	P.	R.	.
80	Walsall	Dr. Oliver	28	M.	Parovarian cyst.	"	May 3	.	P.	R.	.
81	Leicester	Dr. Marrott	26	S.	Cystoma.	(?) Removed	May 5	H.	P.	R.	.
82	Birmingham	Dr. J. W. Taylor	67	M.	"	Left ovary	May 6	.	P.	R.	.
83	Birmingham	Mr. Leach	45	M.	"	Left ovary	May 9	.	P.	R.	.
84	Bilston	Dr. Smith	40	M.	"	Left ovary	May 12	.	P.	R.	.
85	Leicester	Dr. Cox-Hippisley	48	S.	"	Both ovaries	May 15	H.	P.	R.	.
86	Lichfield	Mr. J. Clay	28	S.	"	Both ovaries	May 16	.	P.	R.	.
87	Longton	Dr. Dawes	56	W.	"	Both ovaries	May 17	H.	P.	R.	.
88	Wednesbury	Dr. Blackwood	49	M.	"	Both ovaries	May 18	H.	P.	R.	.
89	Birmingham	Dr. Hickenbotham	48	M.	"	Both ovaries	May 23	H.	P.	R.	.
90	Sunderland	Dr. Dixon	38	S.	"	Both ovaries	May 27	H.	P.	R.	.
91	Dudley Port	Dr. Price	34	M.	"	Left ovary	May 30	H.	P.	R.	.
92	Stonehouse	Dr. Walters	27	M.	Dermoid cyst.	Parovarian cyst.	June 7	H.	P.	R.	.
93	Birmingham	Mr. Lawson Tait	27	S.	"	"	June 7	H.	P.	R.	.
94	Birmingham	Dr. Bull	54	M.	Cystoma.	Both ovaries	June 24	H.	P.	R.	.
95	Birmingham	Dr. Hickenbotham	18	S.	"	Left ovary	June 29	H.	P.	R.	.
96	Bickenhill	Dr. Quirke	50	S.	Parovarian cyst.	Left ovary	July 10	H.	P.	R.	.
97	Birmingham	Dr. Drury	22	M.	Cystoma.	Left ovary	July 21	H.	P.	R.	.
*98	Coleshill	Dr. Jones	38	M.	"	Left ovary	July 28	H.	P.	R.	.
99	Willenhall	Mr. Harthill	33	M.	"	Left ovary	July 29	.	P.	R.	.
100	Llanrwst	Dr. Jones	54	W.	Fibroma.	Left ovary	Aug. 5	.	P.	R.	.
101	Birmingham	Mr. Lawson Tait	29	S.	Cystoma.	Left ovary	Aug. 5	.	P.	R.	.

H means hospital case. P, private case. R, recovery. D, Death. \* By an error of copyist case 98 was omitted in list published in Brit. Med. Journal, October 28, 1882.