is still the view of many people even in America, including some Judges and Reverends, who fail to realize that the actions of a drug in the human body are definite chemical combinations and physical reactions, selective for certain tissues, and becoming more clearly understood and formulated with each succeeding year. As Prof. Cushney says, "The action of drugs is quantitative and not qualitative; the activity of living matter may be changed, but the form which the activity assumes is unchangeable."

In other words you can quicken or retard the action of the heart, by giving the proper drugs in the proper way, but no drugs will make the heart do anything but pump blood through the arteries and veins. The Chinese idea, and that not uncommonly held even in America, is that certain drugs have the power to go to certain organs, and by the exercise of some mysterious and transcendental force, drive out any disease which may affect these organs. This is the superstition to which the patent medicine men appeal, with their "kidney-cures," "liver-cures," "lung-cures," and all the long list of cures over which so much printer's ink has been shed, and so many landscapes disfigured. We are quite ready to laugh at the absurd notions of the Chinese, but a trip from New York to Philadelphia by daylight, between almost unbroken rows of signboards whose staring colors proclaim the virtues of this or that "cure" will show how large a proportion of enlightened Americans are still, through an unreasoning habit of mind, pretty much on the same level mentally as the "heathen" at whom we laugh.

As to actual conditions in China, they are about what one would expect where over-population produces a fearful struggle for existence, where ignorance leads to constant infraction of nature's laws, and where there is only denser ignorance available to relieve the suffering which results from the struggle and the law-breaking. Needless to say, the Chinese medical profession contributes little or nothing to the actual betterment of conditions; indeed its efforts could be more properly put on the debit side of the account, for the few drugs of value within the scope of its knowledge are so generally misused, and its practice is so full of useless and even brutal maltreatment, that not a little of this sum total of misery must be laid to its charge. Even the best of them, "graduates" of the "Imperial Medical College," are the merest ignorant empirics. Dr. S. Wells Williams, for years the Secretary of the American Legation at Peking, with unequaled opportunities for observation, says of this "College": "There are nine main divisions in Chinese medicine. . . . A professor of each of these classes is attached to the Royal Family, who is taken from the (Imperial) Medical College at Peking. But he has no greater advantages than he could get from his own reading and practice. No museums of morbid or comparative anatomy exist in the country, nor are there any lectures or dissections; and the routine which old custom has sanctioned will go on till modern practice, now rapidly taking its place, wins its way." China can usually show the oldest examples of any form of abuse or fraud, and here is the oldest example of the "diploma factory" for physicians, now fortunately all but extinct in America. Its graduates have a parrot-knowledge of an appalling array of huge tomes, but in the words of a rustic philosopher, "It is better not to know so much, than to know so much that ain't so." As Remusat said of them: "In place of studying the organization of bodies, they undertake by reasoning to determine how it should be: an aim which has not seldom led them far from the end they proposed."

If this is true of the best that China can produce, the court physicians of the Emperor, it is not hard to appreciate the attainments of the average Chinese medical man, and to understand the results of his practice. There are the "needle-doctors," whose entire armamentarium consists of needles of different shapes and sizes, and whose entire training it is to learn the three hundred and twenty or more places into which a needle may be thrust to "let out the disease." The writer has repeatedly seen old festering sores and even destruction of the eye or the knee-joint as a result of such punctures. Then there are the men who use caustic chemicals or the red-hot iron for all forms of disease. There is a Chinese treatise on the use of the cautery which fills seven volumes. Then there are the absurd and useless remedies handed down for ages as of sovereign efficacy. A classic example is a treatment for eye disease. "Put half a chicken over the eye as a poultice, and eat the other half." There is some ground for the Chinese proverb, "The ordinary physician is a murderer." Fortunately for China, its leaders now realize the defects of the old system, and are doing their best to introduce Western medical science. The relatively few Chinese who have been trained according to Western ideas in Government and Missionary medical schools are in great demand among all classes of the population; and the influence of the old-style physician of China is daily lessening among his own people.

The writer does not wish to be charged with overestimating the influence of Chinese practitioners in America. They are a fad of which the good people of Los Angeles, Boston, and Brooklyn will soon tire: as with theosophy and kindred delusions, these cities will always welcome "some new thing." But in behalf of the credulous woman and the defenseless child who suffer by these follies, the truth should be given at least as much circulation as the falsehood, even if somebody loses money thereby.

SARCOMA OF THE UTERUS.*

By EMMET RIXFORD, M. D., San Francisco.

Sarcoma of the womb is commonly regarded as a comparatively rare tumor and as a consequence has received very little attention from clinicians until within recent years. While cases of "recurrent fibroids" had been observed and recorded and which were doubtless sarcomatous, the first case to be designated sarcoma of the womb was reported

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by Carl Mayer in 1860, a polypoid sarcoma of the uterine mucous membrane of which the diagnosis was verified by Virchow. In 1867 Veit got together three cases, and in 1871, according to Senn, Keegar based an investigation of sarcoma of the uterus on nine cases reported up to that time. The statistics of Gurlt showed that of 2,649 uterine tumors 1571 were diagnosticated as carcinoma, 883 as fibro-myoma and only 2 as sarcoma, i. e., 1 sarcoma to 1228 uterine tumors or 1 sarcoma to 785 carcinomata. Roger Williams in England found only 8 sarcomata in 4115 uterine tumors or 1 in 514.

Recent statistics, however, show a very different frequency. Geisler in the Frauen Klinik at Breslau put the relative frequency of sarcoma to carcinoma as 1 to 50, and Veit, gathering together the material in the clinic of Halle for 17 years, found 40 sarcomata to 1493 carcinomata or 1 to 37.1. Krukenberg found 1 to 47.5 in the University Frauen Klinik at Berlin. We therefore may assume that the estimated frequency of the diagnosis of sarcoma of the womb compared to that of carcinoma is approximately 1 to 40.

It is probable, however, that even these figures underestimate the relative frequency of sarcoma of the womb, largely because of the difficulties in diagnosis and because statistics are very apt to include cases which have not been subjected to thorough microscopical examination by competent pathologists. Veit asks the question how often is the diagnosis of inoperable carcinoma of the cervix made on clinical grounds alone, and he calls attention to the fact that the resemblances of sarcoma to carcinoma in this region are so great as to make differential diagnosis difficult; moreover it should be remembered that mixed forms of carcinoma and sarcoma occur in the cervix uteri as well as alveolar sarcoma which may readily be mistaken for carcinoma.

My own personal cases in private practice, with systematic microscopical diagnosis, show a much greater frequency than the above figures would indicate although the number of cases is too small to warrant anything very definite being predicated concerning their significance. I have performed hysterectomy in five cases of sarcoma of the womb and during the same period have removed fibromyomata in sixty cases and carcinomata of the womb in twenty, making the relation of sarcoma to uterine tumors in general 1 to 17, and of sarcoma to carcinoma 1 to 4.

A full bibliography of sarcoma of the womb up to the year 1908 is to be found in Veit's Handbuch der Gynaekologie, Third Edition, with exhaustive discussion on the anatomy and histology by R. Meyer and the clinical considerations by J. Veit of Halle.

To the pathologist sarcoma of the womb is of particular interest because the tumors frequently consist of non-striped muscle, the tumor being a malignant leio-myoma and the question has given rise to much investigation and debate as to whether the muscle cells in the tumors are essential parts of the malignant neoplasm or merely the result of growth of muscle cells infiltrating between the bundles of fibrous tissues in the round celled or spindle celled forms of sarcoma. It would appear that the preponderance of opinion is in favor of the former view—(Mallory).

Between the pure leio-myoma and the spindle celled sarcoma lie transitional forms in which the proportion of muscle cells to spindle cells varies from one extreme to the other. Again different parts of the same tumor will present different histological characteristics.

Of the sarcomata of the wall of the uterus, most, if not all, have their origin in pre-existing fibromyomata as shown by many observations of small sarcomatous areas found within typical fibro-myomata, a fact which is of the greatest clinical significance.

There is much confusion in nomenclature arising from the curious mixture of forms of mesoblastic tumors found in the womb. There have been described in addition to the forms mentioned, myxosarcoma, lipo-sarcoma, alveolar-sarcoma, angeio-sarcoma, etc., etc., the matter being further complicated by degenerative processes. Following Meyer it would be preferable to limit the use of the word myo-sarcoma to designate a mixture of myoma and sarcoma, i. e., two individual tumors coexisting and in the same way carcino-sarcoma, angeio-sarcoma, etc., designating the sarcoma in which muscle cells predominate as myomatous sarcoma and that in which spindle cells predominate as fibromatous sarcoma and intermediate forms as myo-fibromatous sarcoma.

Cases have been recorded of multiple sarcomata within the uterine wall: tumors varying in size from that of a pea to that of a walnut in the same womb. A condition difficult to account for unless by metastasis, but the very occurrence of which argues strongly against partial hysterectomy in favor of total.

To the clinician the chief interest in sarcoma of the womb is in the clinical problem of making the diagnosis at a time when operative removal may be efficient as well as in the operative procedure indicated. In this connection it should be said that the malignancy of these tumors varies greatly. Some of them may exist a long time and grow to immense size without forming metastases, while others form metastases comparatively early. Olshausen removed a sarcoma of the uterus the size of a man's head, and Terrillon reported one said to have weighed 20 kg. The largest tumor of my personal cases weighed seven pounds.

Sarcoma of the womb is of much lower degree of malignancy than carcinoma in the sense of the tendency to the formation of metastases and to local recurrence after operative removal, but on the other hand it commonly grows much more rapidly and undergoes necrosis and breaks down under infection more readily and by infiltration, hemorrhage, and sepsis, destroys life quite as surely and much more rapidly than carcinoma.

The disease is not confined to any period of life. Cases have been reported as occurring in children under 5 years and in women over 70. The greatest period of frequency, however, is between 40

and 60. In the five cases here reported the ages at time of operation were 61, 40, 41, 35 and 56.

Excluding from present consideration the rare but exceedingly malignant *sarcoma botryoides* which appears in grape-like masses hanging from the cervical canal, sarcoma of the womb occurs clinically in two principal forms, the one developing in the wall of the uterus and the other in the mucous membrane, the first resembling fibro-myoma in its clinical and microscopical aspects, the other being difficult to distinguish from carcinoma, especially if diffuse and affecting the cervix.

It is not always possible to differentiate the wall sarcoma from mucous membrane sarcoma, especially in the later stages when symptoms such as bleeding, discharge, pain and pressure ensue, for they are common to both. In the earlier stages the mucous membrane tumors sometimes give symptoms more or less characteristic of their site.

There are no characteristic symptoms of malignancy, though persistent hemorrhage and cachexia in the absence of sufficient hemorrhage to account for the anemia and weakness are so regarded, but these are late rather than early symptoms. There will always be cases in which the sarcoma is discovered to be such only after removal of the tumor under the diagnosis of fibro-myoma, the practical meaning of which is simply to widen the indications for operative removal of fibroids.

On the part of the mucous membrane there are no characteristic symptoms even when the tumor originates in the mucous membrane—bleeding in the form of increased menstrual flow, continuous oozing in the interval occur also in subinvolution, chronic hypertrophic endometritis and in polyposis, but sudden tremendous hemorrhages such as are common with polypi are said not to occur in sarcoma. However, in one of the five cases here reported this very form of hemorrhage did occur and so severely that the patient was practically exsanguinated when she consulted a physician for the first time.

Retention of the bloody fluids by reason of the tumor obstructing the cervical canal may occur and to an extreme degree—five quarts in one case and in another an hematometra of fifteen litres was found. Pyometra occurs occasionally in the presence of infection with obstruction.

Most of the following are late symptoms, but they are of value in making evident the necessity for haste in operative removal of the tumors: failure of an apparent myoma to shrink following the menopause, recurrence of bleeding after the menopause, development of cachexia and weakness in the presence of myoma, ascites in the presence of myoma, rapidly growing or in softening myoma and when a polyp recurs after removal (all polypi removed should be carefully examined microscopically. [Veit].

In diffuse sarcoma of the mucous membrane nothing short of total hysterectomy is indicated and in wall sarcoma of the body of the womb resembling pedunculated fibroids, total hysterectomy is preferable to partial, for the pedicle is most often sarcomatous and cases have been reported in which the disease recurred in the cervix after supravaginal amputation.

In cases of infection and sloughing of the intra-uterine tumor or in the presence of pyometra a two-stage operation is preferable—emptying of the uterus and removal of necrotic parts of the tumor may be performed through the vagina and after some weeks either vaginal or supra-pubic hysterectomy, with preference for the latter.

Most text books discussing fibro-myoma of the womb have more or less to say about the disappearance of such tumors at the menopause, by atrophy, calcification, etc., so that it is common to encourage a patient the subject of myoma and who is entering the menopause to wait for a time to see if the tumor will not shrivel or disappear. It is dangerous advice and should be given only with the greatest caution and with the necessity of systematic examination impressed upon the patient. The development of a sarcoma in one case of fibro-myoma in which such advice is heeded will overbalance the operative risk in many cases in which the fibro-myomata might have atrophied if not molested. In one of my five cases I gave such advice but within four weeks the tumor had so increased in size as to demand removal, and it was afterwards found that even before operation a number of metastases had formed. Probably operation a month earlier would not have forestalled mestastasis, as this tumor seemed particularly malignant.

Without doubt patients with fibro-myomata, especially if approaching the menopause, should be examined at regular and frequent intervals to detect any increase in size, change in character especially softening, increase of tenderness, increase in menstrual flow, bleeding recurring after the menopause, the occurrence of a foul discharge, etc. In the presence of any of these symptoms the interior of the womb should be investigated with a curette and the aid of the microscope should be sought or else an hysterectomy be performed. In fact, in my opinion the indications for operative removal of fibro-myoma should be increased rather than curtailed, that the doubts may be on the other side.

All tissues removed in hysterectomy and especially in myomectomy should be subjected to a most searching microscopical examination by a competent pathologist, and if sarcomatous tissue be found the whole womb with the adnexa should be extirpated, because even when the abdomen is opened it is often impossible to say from the appearance of the tumor whether it is simply a congested, inflamed, or degenerated fibro-myoma or a sarcoma.

Of the five cases whose histories are appended, two were in patients who had passed the menopause and all were of the type resembling fibro-myoma. Two grew from the fundus of the womb as more or less pedunculated tumors, evidently having originated in the uterine muscle and grown outwards through the peritoneum, and three projected into the dilated cavity of the womb. In two of these latter, bleeding was severe. In the two tumors projecting from the fundus of the womb there was

but slight increase in the menstrual flow. In one case in a woman of 56 who had long since passed the menopause and thought herself in perfect health, there was no bleeding whatever until the patient received a fall, when a few drops of blood appeared calling attention to the tumor, although at that time it was of the size of the five months' pregnant uterus and was widely necrotic within. The three tumors which projected into the cavity of the womb were more or less necrotic on their surfaces and one of them was deeply necrotic and infected.

Case 1. Mrs. J. A. P., age 61. July, 1902. Had 4 children, the last 20 years ago. Patient was well until the age of 47 when menstruation began to be too profuse. Shortly thereafter it became very irregular and ceased until the age of 59 when flooding again came on. The attack was repeated after 2 months and recently the hemorrhages have become much more frequent. Several hemorrhages during the last week and slight continuous oozing. Patient has had very little pain, has frequent desire to urinate but has some difficulty in emptying the bladder. Is growing weaker though appetite is good. Never noticed the tumor in abdomen, simply thought abdomen was a little prominent. Has had severe leukorrhea for a number of years. During past few years discharge has increased, it has been foul smelling and acrid, patient being obliged to use douches continually.

Status: Very anemic, nervous woman past middle age. Abdomen protuberant, containing a large, round, soft tumor with pear-shaped projection to left of the middle line. Vulva excoriated from irritating discharge. Vagina short and atrophied. Cervix atrophic. Two fingers enter cervix readily and surround large, soft, intra-uterine tumor. Very offensive odor of dead tissue. Discharge profuse. With probe, which entered 8 or 9 inches, it was possible to make out the attachment of the tumor to be chiefly on the left side and very broad. Manipulation caused considerable bleeding, controlled by ergot. Haemoglobin 30%. Leukocytes 2,400. Polys 84%. Reds 2,536,000. Urine negative. Temperature 99° to 100°. Pulse 100.

Diagnosis: Sub-mucous myoma uteri undergoing necrosis and infected.

Operation: Because of the necrosis and evident infection it seemed best to remove the tumor per vaginum. The vagina readily stretched to admit the hand and the cervix did also with slight cutting. Tumor tissue to the amount of six pounds was removed by the hand, scissors, and volsellum forceps. Hemorrhage was not severe and was easily controlled by irrigating with hot water. Uterus was tamponed with gauze and it remained firmly contracted. Duration of operation one hour. Convalescence without incident.

The pathologist, Dr. Osmers, reported the tumor to be a spindle-celled sarcoma.

Second operation after 3 weeks. Patient having gained much in strength, although the hemoglobin was only 40%, the discharge being no longer foul, vaginal hysterectomy was performed. The tumor being too large to be delivered, both uterine arteries were ligated and the uterus split antero-posteriorly and removed in halves. Convalescence normal and patient left hospital at the end of two weeks.

Five years later patient was reported as being in perfect health.

Case 2. Mrs. S., age 40. April, 1907. One child age 14 years. Several miscarriages and with one of these had chills and fever and was in bed several weeks. Present trouble first noticed 3 weeks ago. Sudden headache, chills, not referable to any known cause. Took physic and next day had pain in the pit of the stomach, whence it went to left groin. Her physician, Dr. Magnus of San Francisco, found a large, hard tumor of the womb extending upwards into the left groin. Slight fever. Menstruation regular, normal in amount, and painless.

Status: Strong middle aged woman, apparently in good health. A pedunculated tumor connected with the womb extending upwards and to the left, the size of one's fist, markedly tender. No discharge.

Operation: Median incision. Pear-shaped tumor size of one's fist, somewhat larger at upper extremity than at its attachment to the fundus, covered with very large dilated blood vessels. Tumor soft, nodular, was thought to be malignant. Therefore a pan hysterectomy was performed. Normal convalescence. Patient left hospital at the end of three weeks.

On examination the pathologist reported the tumor to be spindle-celled sarcoma.

Four years after operation patient was reported in good health.

Case 3. Mrs. M. B., age 41. Sept., 1905. Patient had always enjoyed good health. Had three children, the youngest 9 years of age. Menstruation always regular but generally painful. Five months ago noticed hard mass in the lower abdomen unaccompanied by symptoms. Three months ago there was slight pain and patient consulted her physician, Dr. Henry Gibbons Jr. One month ago patient was referred to me in consultation. From the patient's account of her symptoms the pain did not seem very severe. Patient was not sure that the tumor was any larger than when it was first discovered 4 months previously. There had been no hemorrhage and not even any increase in the menstrual flow. No discharge.

Status: Well nourished middle aged woman apparently in perfect health. Tumor of the womb reaching well above the pubis, irregular in form like multiple fibromata, freely movable. Advised waiting a while until symptoms should arise warranting operation or the tumor should show a tendency to grow.

During the following month patient began to be very uncomfortable. Menstruation during this month more profuse than formerly. A good deal of pain because of expulsion of blood clots, it lasted 8 days. Recently has had increasing pain in the back and the right side sometimes radiating down thighs. States that the back would apparently ache more when she was in bed than when up and about. Got some relief from lying flat on the abdomen, but recently the tumor became too large to permit this. She therefore lies first on one side and then on the other and is so uncomfortable that she gets little sleep. Bowels regular. Urination a little more frequent than formerly. No evidences of pressure on bladder.

On examination tumor was seen to have very markedly increased in size. It was still fairly movable.

Operation: Median incision. Tumor not adherent, readily lifted out of the pelvis. Nodules whitish, surrounded by areas of redness with large blood vessels. There were two hard lymph glands the size of beans palpable in the right broad ligament. Over the iliac vein on the right side a rosette-like tumor 1½ inches in diameter on the peritoneum, freely movable over deeper tissues. This was apparently a metastasis and was excised. Complete pan hysterectomy was then performed. Convalescence without incident. Patient out of bed at the end of second week.

During the third week of convalescence patient complained of several tender points in her scalp. On examination these were evidently metastases. Patient then admitted that she had noticed them even before operation. Under chloroform several of these tumors were excised. They were slightly elevated and red around the borders. Microscopical examination showed them to be similar to the uterine tumor. Patient left the hospital and a month later showed a great number of metastases in dif-

ferent parts of the body. One in the spinal canal soon caused paraplegia and patient died about 9 weeks after operation. Microscopical diagnosis by Dr. Ophüls, fibro-sarcoma of womb.

Case 4. Miss M. B., age 35. March, 1910. Referred to me by Dr. Canney. Has always been strong and a hard-working woman. The first symptom calling patient's attention to the pelvis was a severe hemorrhage from the uterus. Bleeding was profuse and lasted for 3 or 4 days. Dr. Canney found a large pelvic tumor within the uterus which bled profusely upon the slightest touch.

Status: Tall, large Swedish woman. Intra-uterine tumor about the size of 6-months' pregnant uterus. Cervix thin, dilated by tumor. Tumor soft and elastic, bleeding readily, attached to womb by very broad peduncle. Hemoglobin 45%. Temperature 100°. Pulse 120.

Clinical diagnosis: Sarcoma of the womb.

Operation: Because of the low hemoglobin and the presence of decomposing blood in the vagina and the uterus it was thought that two stage operation was less hazardous. Cervix split in middle line. Vaginal outlet incised sufficiently to admit the hand posteriorly. Tumor pulled out with forceps and scissors. Moderate bleeding. Uterus packed. Wound in cervix sutured, also wound in peritoneum. On the second day of convalescence there was a sharp rise in temperature, otherwise convalescence was without incident.

Microscopical diagnosis by Dr. Ophüls, spindle-celled sarcoma of uterus.

Four weeks later hemoglobin 50%.

Abdominal hysterectomy. Right tube and ovary absent. Small round tumor size of an egg low down near the cervix on the left side posteriorly. Because of the apparent extension of tumor into the left broad ligament, wide dissection was made, removing the whole mass between the iliac vein and the uterus except the ureter, which was isolated for about 3 inches. Peritoneum closed completely with catgut sutures by drawing the broad ligaments together and suturing them to the anterior wall of the vagina and the base of the bladder and covering bladder flap in the center. Patient strained a great deal during the operation, requiring the use of many pads to hold the intestines back, which fact may account for subsequent adhesions. Convalescence without incident.

At the end of three weeks patient left the hospital, having had hemaboloids and Blaud's pills. Hemoglobin 60%. Patient became well rapidly and gained in weight and strength and was able to perform her duties as a domestic.

About 8 months after operation patient was suddenly seized with severe vomiting and distress. A surgeon called in during my absence advised immediate operation for intestinal obstruction, but patient determined to wait until next day. About 12 hours after the beginning of the pain patient went into a sudden collapse and died in a few hours.

The abdomen was opened and extensive necrosis found of the small bowel, which was matted in the pelvis.

Case 5. Mrs. M., age 56. Feb., 1912. Referred by Dr. Hirschfelder. Menopause 8 years ago. Has always been a remarkably strong, healthy woman. Never sick in her life. Three months ago had slight attack of cystitis which yielded to medical treatment. Two or three weeks ago cystitis returned. One week ago had a slight fall followed in a few hours by a slight showing of blood in the vagina. Dr. Hirschfelder found a uterine tumor.

Status: Large stout woman, vaginal outlet very small. Uterus palpable above the pubis. Cervix high up. With much difficulty a curette was introduced into the womb and with it several pieces of soft tissue were removed.

On microscopical examination they proved to be necrotic and their structure was not to be made out. The fixity of the tumor, the bleeding following the fall, the necrosis within the womb, strongly suggested malignancy.

February 8th, 1912—Operation: Vagina and interior of cervix painted with tincture of iodine. Supra-pubic pan-hysterectomy performed. There was considerable bleeding from pelvic veins torn in separating attachments in the pelvis.

Microscopical diagnosis by Dr. Ophüls, spindle-celled sarcoma of the uterus.

Convalescence without incident. October 1st, patient continues perfectly well, no evidence of recurrence.

Discussion.

Dr. W. W. Beckett, Los Angeles: I have not very much to add. I believe that the frequency of sarcoma of the uterus is much more frequent than we realize, largely because of the difficulty of making the diagnosis clinically between sarcoma and carcinoma and the lack of making thorough microscopical examination of the tumors removed. I believe now that I have removed sarcomata of the uterus which I have supposed at the time were carcinomata. I am now keeping very close records of these cases. I have only had two cases of primary sarcoma of the uterus. The other cases I have had have been degeneration from fibroid tumors. In all of these cases I think we should do a total supra-pubic hysterectomy, the same as we would go into the axillary space for a malignant tumor of the breast. I do not believe it is possible to do as clean a vaginal operation as we can do suprapubically. If we make a large incision and put the patient well in the Trendelenberg position and dissect out all the glands and adnexa of the uterus we will cure many of our patients. I think by all means that we should go suprapubically in these cases, lay the abdomen well open and clear out the pelvic cavity as thoroughly as possible. I would also make a plea for early removal of fibroid tumors of the uterus, as many in time become malignant, and if we wait until they are clinically malignant it is too late to save our patient.

Doctor Rixford, closing discussion: I have very little to add to what has been said except that if the diagnosis of sarcoma of the womb has been made, the choice of route whether vaginal or suprapubic for the hysterectomy is a matter of decision on the part of the surgeon for the particular case in hand. The usual indications for abdominal hysterectomy applying to malignant disease have little meaning here for these sarcomata do not form metastasis by way of the lymph stream so that there is no meaning in the decision to make a wide dissection of the neighboring lymph glands. If one metastasis is found one may be sure there are others in the body and that the patient is doomed. Vaginal hysterectomy would be less dangerous than an abdominal in cases of necrosis of the tumor with infection and this condition often obtains in these large sarcomata. In the case mentioned in which I gave the advice to the woman with the fibroid to wait until after her menopause who returned four weeks later with the tumor greatly enlarged, I removed the tumor suprapubically and found when the abdomen was opened a single metastasis on the free surface of the peritoneum. There was no enlargement whatever of the lymph glands in the neighborhood. A few weeks later many metastases were found in the scalp and in various parts of the body; one in the spinal canal caused intense suffering and probably was the immediate cause of death. The points I wish to emphasize particularly are the necessity of systematic and thorough histological examination of all fibroids removed by the surgeon and this by a competent pathologist; the "best friend of the surgeon" is not the peritoneum but a competent pathologist. I would urge the widening rather than a curtailment of the indications for the operative removal of fibroids, especially as the menopause approaches and would be very guarded in advising patients with fibroids to wait for the menopause.