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THE MIMICRY OF PREGNANCY BY FIBROID AND OVARIAN TUMORS.

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In examining a patient under forty-five years of age, with a pelvic tumor, every cautious observer invariably takes pains to assure himself: *first,* that the tumor is not purely a physiological one, that is to say, that it is not a pregnancy pure and simple; and *second,* when a tumor is undoubtedly present, that it is not complicated by pregnancy. Nevertheless, in spite of these precautions, mistakes do sometimes occur even in careful hands, and for this reason, I have thought that it may prove profitable to review some of these cases occurring where, to my personal knowledge, large tumors have been mistaken for an advanced pregnancy by competent observers.

I shall not include the numerous instances in which friends or relatives have brought me young women with enlargements of the abdomen under the impression that they indicated pregnancy. I have still, however, the painful recollection of one of my Philadelphia patients, about the year 1887, a girl in the neighborhood of twenty, with a uniformly enlarged abdomen the size of an eight months' pregnancy. She came under my care in the utmost distress of mind in consequence of the gossip of her associates, who insisted that she was pregnant, and she appealed to me in order to secure relief from her natural burden. There was no difficulty in diagnosis, and I removed a large ovarian cyst. Her convalescence was complicated by an exfoliative cystitis, followed in a few days by a shrieking mania, in consequence of which she was sent, as soon as her condition permitted, to the Pennsylvania State Insane

Asylum, where she died a couple of years later of pulmonary tuberculosis.

There are four classes of cases in which error in the diagnosis of pregnancy in consequence of mimicry has occurred.

(a) Those in which there has been a pregnancy, and no tumor.

(b) Those in which pregnancy has been complicated by a tumor.

(c) Those in which there has been a tumor, but no pregnancy.

(d) Those in which there has been neither tumor nor pregnancy.

My present intention is to cite briefly several striking instances illustrating in an instructive manner the mimicry of pregnancy, with particular reference to cases of hard abdominal tumors with ascites, in which a mistake in diagnosis is peculiarly liable to be made.

The first case occurring in my own practice, was a woman in Philadelphia, about the year 1885 whom I had had under treatment at my office for several months for painful irregular menstruation and pelvic pain which I attributed to a sub-acute pelvic peritonitis with adhesions. The pain at last became so aggravated that I took her into my private hospital, and opened the abdomen only to find normal appendages and a normal uterus three months pregnant. She fortunately recovered from the operation, and bore a fine child at term. Inexperience here misled me, and the fact that the woman had been more or less constantly under my treatment for some months threw me off my guard, so that I committed the error of accepting the first diagnosis as a permanent one, and therefore neglected to review the diagnosis and thoroughly reinvestigate before operating. I regret to say that this fact places me under the stigma of having omitted to adopt all necessary and proper precautions before forming an opinion, the commonest source of error in the group of cases we are now considering.

An extraordinary, and yet by no means unparalleled instance of this kind, came under my observation in the Episcopal Hospital in Philadelphia about the year 1883. The patient, a mature woman in her early forties, had just immigrated to America, and she blamed the recent sea trip for a persistent amenorrhea. She entered the hospital complaining of a large abdominal growth, which the general surgeon palpated many times, and pronounced to be a large fibroid tumor of the uterus. He set the day for doing a radical operation, at that time a most hazardous and almost necessarily fatal venture; at the appointed time he arrived with his interested colleagues, bustling with excitement over the prospective hysterectomy, only to be met at the hospital door by his resident, who cheerfully greeted him with the embarrassing news: "Doctor, the tumor has been born! It was a lusty infant."

Dr. E. Paget Thurstan of Perth, Western Australia, reports a case of this kind (*Lancet*, Aug. 6, p. 322). The patient believed herself four months pregnant, and milk was present in the breasts. A tumor of irregular outline could be felt above the pubes; the os was high up, patulous and apparently torn by previous labor. A hard round freely movable mass could be felt on the tips of the fingers with another irregular mass behind it. A diagnosis of pregnancy with pedunculated fibroid was made, and three days later the patient aborted suddenly, after which both the tumors disappeared at once.

Another case is reported by Routier (*Bull. et Mém. de la Soc. de Chir. de Paris*, Nov. 21, 1899, reviewed in epitome, *Brit. Med. Jour.*, April 7, 1900). A diagnosis of interstitial fibroid was made by Psaltoff of Smyrna in a case of persistent menorrhagia. On beginning a hysterectomy it was found that the gravid uterus had been opened. The abdomen was closed and abortion occurred in a few hours, after which the patient rapidly recovered.

I do not pause to refer to a number of similar errors already well known to the profession, committed by prominent surgeons.

My own next personal experience, in which the diagnosis presented some unusual difficulty, falls under class (c), that is, a tumor but no pregnancy. About eight years ago, I opened the abdomen of a maid servant about forty years of age, with the expectation of removing a fibroid uterus, but when the uterus was exposed, I found it so soft and fluctuating and so uniformly distended, and in every way so exactly resembling a five months' pregnancy, that I felt convinced I had made a blunder and at once desisted from further operation, and closed the wound. I did not lay stress on the history, thinking the woman might have deceived me. The event failed to justify my expectation, there was no pregnancy and when the abdomen was subsequently reopened by a distinguished colleague in order to remove the ovaries to check the further growth of the mass, he failed for some unknown reason to find them, and insisted that I must have removed them at the previous operation. This opinion was expressed without any intention of injuring me, but it almost involved me in a law suit. I have naturally been unable to get the patient to come back to me after such a blunder.

Dr. Stone of Washington had a similar case in which the abdomen was opened, the tumor handled and a diagnosis of pregnancy made. The abdomen was closed and the patient sent to the Lying-in Department. Dr. Fry examined her two months later and decided she was not pregnant, after which she was operated on and a fibroid uterus removed.

Another case of my own was one in which there was extreme suffering, keeping the patient abed, and a softening of the right uterine cornu in the fourth month of pregnancy. I examined the patient most carefully under ether anesthesia and found what I took to be a distinct tumor at the right uterine cornu and a pedicle apparently about 2 centimeters in length connecting the tumor, with the firm, hard, slightly enlarged uterine body to the left. I took particular pains in this entire examination, as I was desirous to exclude what I have repeatedly noticed, a softening of one cornu or one half of the uterus during the earlier months of pregnancy, while the rest of the organ remained hard. On opening the abdomen I found the soft boggy large right uterine cornu of an otherwise normal uterus, with a thin translucent spot about 4 centimeters in diameter, near the fundus. The abdomen was closed and the patient aborted *per vias naturales.*

The group of cases to which I especially desire to call attention are those which, like the others just cited, belong under the third head, and which present a remarkable mimicry of advanced pregnancy on account of a simulation on the part of the tumor of the form of the child's body, a much rarer form of mimicry than the equable enlargement of a fibroid uterus.

In recent literature, Montgomery (Text-Book of Gyn., p. 581-2) has called attention to the close simulation of pregnancy which may arise from a fibroid tumor of a peculiar form when in association with ascites. The two figures given in his work are reproduced here. (See Figs. 1 and 2.)

Dr. H. J. Boldt (*Amer. Jour. Obst.,* vol. 27, p. 715) cites a case in which there was a large abdominal tumor reaching above the umbilicus. A diagnosis of pregnancy with ovarian cyst was made. The operation, and later the post mortem examination showed that there was no pregnancy at all. Two such myoma cases are given in the second volume of my Operative Gynecology (Vol. 2, figs. 486 and 515), and I will briefly repeat them here for the sake of completeness.

In one instance the form of the tumor so exactly resembled that of a child lying in a transverse position that my resident thought the case was one of advanced uterine pregnancy on account of the distinctness with which the infant's body, head, and limbs could be felt, directly under the abdominal wall. The head lay in one iliac fossa with a distinct neck and shoulder and a body attached. Even a rudimentary arm was not wanting, as will be seen by consulting the figure. A correct diagnosis was made after carefully considering the history, and examining bimanually under ether, and discovering the organic

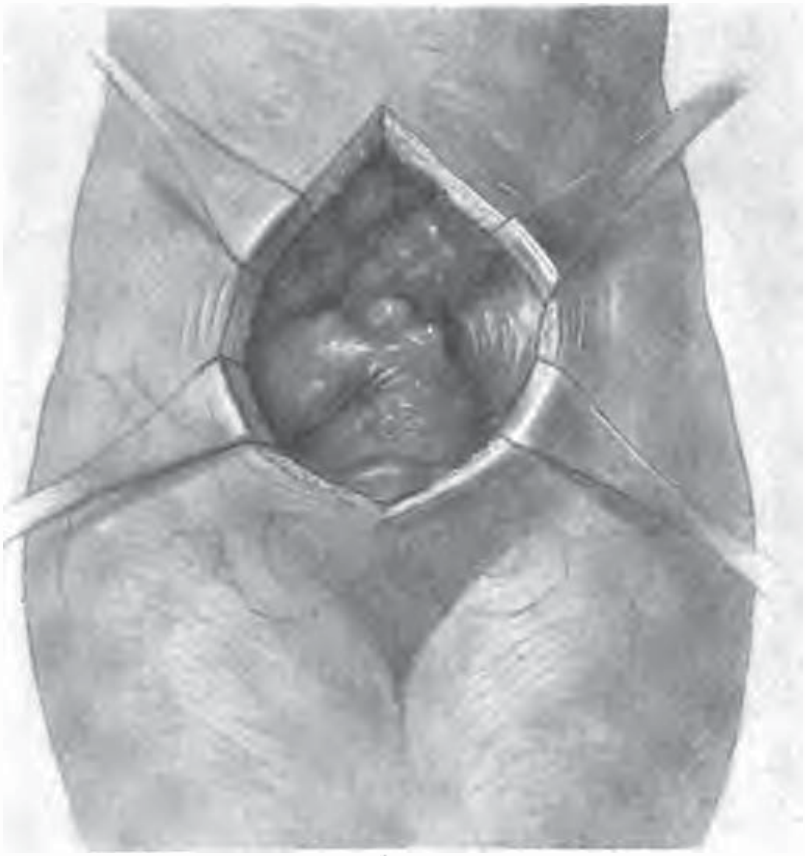

Fig. 1. A myoma which, from the associated ascites, has been mistaken for pregnancy.

Fig. 2. Tumor shown after removal.

connection between the enlarged nodular fundus and the cervix. (See Fig. 3.)

The second case presented a remarkable sign which was calculated to mislead on a first examination. The nodular myomatous uterus filled the pelvis, and on its summit were two fibroid tumors. Three unusual circumstances here conspired to produce a wonderful mimicry of a sign

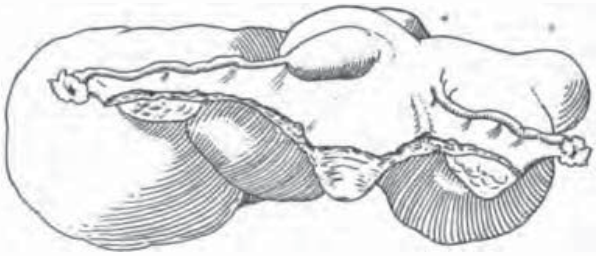

Fig. 3. A tumor, simulating pregnancy.

Fig. 4. Two fibroid tumors on the summit of a nodular myomatous uterus, simulating pregnancy.

most suggestive of pregnancy. One of the tumors was spherical in form and just the size of the head of a seven months fetus. This mass lay well to the front and a little to the left, and was attached to the uterus by a short pedicle, while above it several large omental vessels plunged into the substance of the tumor; furthermore, the growth was separated 2 to 3 centimeters from the abdominal wall by a layer of ascitic fluid.

Upon making sudden pressure at this point the fingers encountered a firm round body which instantly left the fingers, *returning in a moment and striking the fingers a gentle blow, producing a perfect ballottement.* (See Fig. 4.)

Another one of these remarkable cases was that of B. S. (Gyn. No. 6272), aged 36, who had a large nodular fibroid uterus rising as high as the umbilicus and complicated by nephritis, cardiac disease, appendicitis, and pelvic peritonitis. She had also an ascites sufficient to make her girth at the umbilicus 103.5 cm. The tumors projected from the pelvis up into the abdomen and were covered by a layer of ascites: *a typical ballottement was obtained through the abdominal walls upon striking the tumor a sudden blow through the fluid and causing it to recede; in a moment it returned and gave a gentle tap to the waiting hand.* There was no other point in the case simulating pregnancy. The patient recovered from a hystermyomectomy and removal of the appendix to die six months later from her other chronic ailments.

Another case of this sort was one in which two large carcinomatous ovaries associated with ascites, were mistaken by several surgeons for an advanced pregnancy.

The patient, Mrs. B. (San. 1898), came under my care in February, 1900. She was 32 years old and had been married for seven years; she had had one child 5½ years before, and an early miscarriage 4½ years previously, seven months before she came under my care, after a previous history of perfectly regular menstruation, she ceased to have any further flow. She was examined shortly before I saw her by two surgeons of international fame who were so certain that she was pregnant that she came to me with a full wardrobe of clothes made for the expectant infant. She felt in doubt herself on account of the dissenting opinion of another prominent surgeon, Dr. W. W. Keen of Philadelphia. She had felt no signs of life, had had no nausea, and no enlargement of the breast, but was fully conscious of a definite enlargement of the lower abdomen, which had become decidedly more prominent in the last two months.

I examined her Feb, 19, 1900. She was a woman somewhat above the average size, and as she lay on her back, the abdomen was stout but flat for an advanced pregnancy and in the lower abdomen one could distinctly feel rounded nodules which might either be the bosses of a tumor or the prominences of a child's body. In the right iliac fossa, on making sudden deep pressure, a rounded mass was felt like a child's buttock; on striking this a blow, it was felt to depart from the fingers and then to return again. The yielding of this

part of the mass was marvelously like a seven months' child floating in abundant liquor amnii. The mass extended transversely across the lower abdomen, but could not be felt so distinctly on the left side. It is important to note that it persistently kept one position and could not be rotated, and was quite tender on pressure. The whole configuration of the growth, however, was a remarkable imitation of a child in a transverse position.

Percussion in the flanks yielded a dull tympanitic note which changed to clear tympany in altering the position of the patient while keeping the finger in the same place, showing the presence of free fluid in the abdomen.

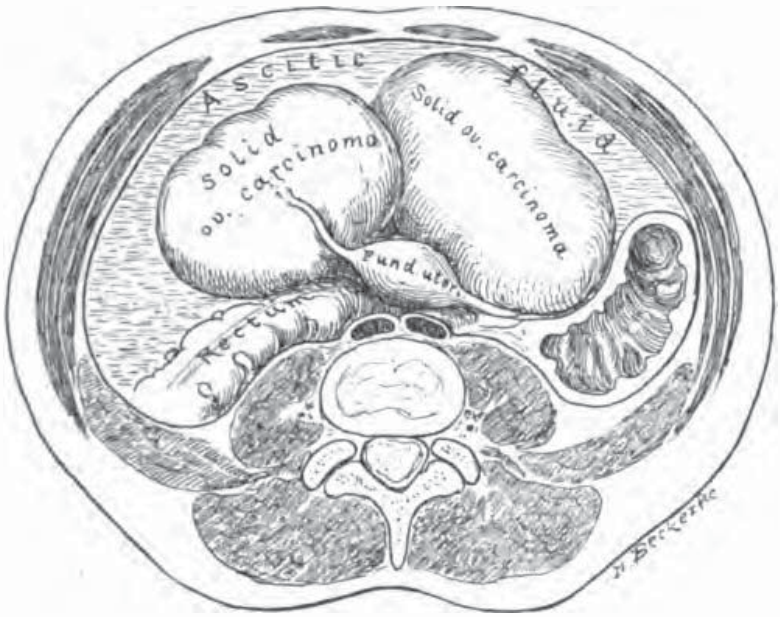

Fig. 5. Carcinoma of the ovaries, simulating pregnancy.

The vagina presented the deep purple color of pregnancy, but there was no edema or softening of the tissues, and the lacerated cervix was hard. Some hard masses were felt back of the cervix and bimanually there seemed to be a distinct organic connection between the mass filling the lower abdomen and a multinodular mass occupying the position of the uterus.

The evidences for pregnancy in this case which had misled two competent observers were, the age of the patient, the sudden complete cessation of menstruation, the gradual, steady enlargement of the abdomen, the mimicry of the fetal ovoid floating in amnioniotic fluid, even down to the sign of ballottement, and the discoloration of the vagina.

The evidences against pregnancy were the flat abdomen, the presence of fluid in the flanks, the flat breasts, the absence of fetal heart sounds, the fixed position of the mass resembling the fetus, the absence of movements, the hardness of the cervix, the hard masses felt by the vagina, and the close attachments of the tumors to the cervix or uterus.

I operated Feb. 20, 1900 and found dense nodular carcinomatous tumors of both ovaries and about 2800 cc. of clear straw colored fluid; I found also an atrophic peritonitis and infiltration of the omentum. Both ovaries were removed and the fluid evacuated, the patient recovered to die the following June from extensive metastases. (See Fig. 5.)

The next case which came under my observation was one in which a fibroid uterus was mistaken for a normal pregnancy by an eminent consultant previous to my visit on Christmas day, 1900.

The patient who was 45 years of age, passed through one pregnancy and had had a miscarriage 15 years ago; she had noticed a progressive enlargement of her abdomen since the preceding August, since which time she distinctly felt fetal movements in both sides of the abdomen exactly like those noted in her former pregnancy; these movements were so distinct that they could sometimes be felt with the hand. She had suffered in July and August from indigestion and nausea not, however, like the typical morning sickness; since that time she had had excellent health and a good appetite and had noted no loss in weight or strength. The abdomen had enlarged gradually as in a normal pregnancy. I found an enlargement of both breasts with prominence of the veins and easily expressed a whitish secretion from the nipple. During the summer she had had a severe attack of pain in the right side requiring the use of morphin. She was examined at this time by a physician who thought that the uterus was about three or four months pregnant.

The menstrual history was one of regular flow until June when there was a prolonged period lasting three weeks; the flow had also been regular since that time.

The abdomen measured 101 cm. at the umbilicus, half way below the umbilicus it was 110 cm. The distance from the symphysis to the umbilicus was 21cm. and from umbilicus to sternal notch 20 cm. In place of the umbilical depression there was a slight prominence. The adipose pannicle was about 4½ cm. thick and showed numerous striæ; there was a slight injection of the left superficial veins, the abdomen was rather flattened and bulging in the flanks and evidently occupied by

a tumor filling the lower abdomen from the umbilicus down. There was no *linea nigra.*

The tumor in the lower part of the abdomen was about the size of a child's head entering the superior strait. It could easily be pushed up but returned at once to its first position. There was a corona of resonance surrounding the whole mass extending from one anterior superior spine to the other above the umbilicus.

The vagina was relaxed, its anterior wall marked by broad, thick transverse rugæ. There was a definite injection simulating the discoloration of pregnancy. No vaginal portion of the cervix could be felt, but in its place there was a little dimple in the vaginal vault to the right. Above the vaginal vault there was a tumor filling the superior straight, just about the size of a fully developed fetal head. When this was displaced upwards, there was an immediate transmitted movement felt in the position of the cervical orifice. The rest of the mass of the tumor could not be distinctly outlined. No fetal heart sounds could be heard.

The points in favor of a diagnosis of pregnancy in this case were: *First,* the gradual increase in the size of the abdomen; *second,* the history of nausea in the early months; *third,* the well defined sensations of fetal movement, recognized by the patient who had already borne one child; *fourth,* the presence of a tumor filling the lower abdomen the size of a uterus at term; *fifth,* a rounded body the size of a fetal head entering the superior strait, easily displaced and returning at once to its primitive position; *sixth,* the changes in the breasts, swelling, slight pain, enlarged veins and secretion; *seventh,* the discoloration of the vagina. I might add that these signs and the general good condition of the patient, which precluded the notion of the presence of a tumor in her mind, induced a conclusion which was strengthened by the opinion of two physicians.

A careful bimanual examination through the rectum and abdomen showed that the mass was a bunch of fibroid tumors growing out of the body of the uterus, associated with some ascites.

At the operation, Jan. 5, 1901, an incision 17 cm. long was made through the thick abdominal walls, exposing a tumor 17 x 14 cm. extending from the fundus down towards the pelvic floor and rising from the anterior face of the uterus. The uterine cornua were separated 6½ cm. and there was a slight rotation from right to left. There were two masses just below the fundus 2½ to 3 cm. in diameter. On the left side was a hydrosalpinx and dense adhesions about the ovaries and tubes. The fundus of the uterus was thrown back into a retroflexion as well

as lifted up in ascensus, throwing the large tumor anteriorly prominently above the symphysis.

The enucleation was effected by grasping the tumor on the right and left side respectively with museau forceps while bisecting and drawing it up at the same time.

The tumor proved to have a deep extension into the pelvis making its entire length 17 cm.

The case of Mrs. C. A. H. (No. 8, 227), age 41, white, widow, admitted to the Hospital Oct. 15, 1900, is also interesting in this connection. Married at the age of thirty and never pregnant, one year before, she had had some abdominal pain more marked on the left side. In February, 1900, she detected a slightly tender mass as large as a cocoa-nut in the left lower abdomen; this had grown more rapidly during the past few months until it filled the abdominal cavity.

I found, on examing her, an abdomen the size of a seven to eight months' pregnancy, but a little more bulging at the sides and somewhat flatter.

The *linea nigra* was well defined. Palpation showed that the tumor was fluid containing a hard round body which yielded perfect ballottement in the fluid. There was also a slight discoloration of the vagina. The cervix was hard.

As pressure was made on the mass to the left a movement communicated to other masses on the opposite side resembling the small parts of a child could be detected.

The percussion note in the flanks was tympanitic.

On incising the peritoneum there was a free gush of fluid, clear at first but afterwards bloody. When the fluid had escaped the mass felt to the left came into view and proved to be a cystic tumor. Over it coursed a leash of vessels in a membrane 8 cm. long and 5 to 6 cm. in width, binding the tumor down and connecting it to the bladder and at the same time dragging up the vertex of the bladder. The under surface of the tumor was attached to an omental strand and beneath it on the left side were intestinal adhesions. The tumor was filled with an opalescent fluid. The distance from the symphysis to the adhesions of the bladder was 20 cm.

The pedicle of the tumor, 5 cm. long, was found twisted from right to left, 360 degrees. There were adhesions to the fimbriated edge of the right tube. The appendix was free, but injected at the tip and bulbous; it was apparently beginning to form adhesions to the tumor.

Diagnosis: Large left ovarian cystoma with about 2 liters of bloody

ascites from an incipient peritonitis, due to a twist in the pedicle from right to left. Small myomata uteri.

Operation: Abdominal incision, evacuation of fluid. Cystectomy.

Result: Uneventful recovery.

This case was most interesting as it presented another rare combination imitating an important sign of pregnancy which is much relied upon, namely, the presence of a round firm body felt through a layer of fluid, capable of displacement, and, after displacement, of return to its first position.

We had further a firm body at an opposite pole, shown to be connected with this mass, and also a discoloration of the vagina. The most remarkable feature of this case was the extraordinary tongue like adhesion which straddled the two major cysts, sinking into the sulcus between them and holding them down in the fluid.

Dr. John S. Pyle, Canton, Ohio, records a case of this kind in which it was impossible to state positively that pregnancy did not co-exist (*Medical Record,* April 9, 1898). The patient, who was thirty-six years old, noticed an enlargement of the abdomen soon after marriage. The breasts increased in size, the areolar rings became deeply pigmented, and a milky fluid made its appearance. A diagnosis of pregnancy was made by two physicians, but as they disagreed about the date, no further consultation was sought until twelve months after the date of the first symptoms. The abdominal enlargement was found to be very irregular. The growth extended markedly to the left, and was nodulated, some of the protuberances being as large as a fist. A digital examination showed a hard mass in the pelvis continuous with that in the abdomen. A diagnosis of fibroids was made, but it was impossible to exclude pregnancy. On operation, the entire uterus was removed, and proved to contain numerous centers of fibroid development throughout its entire walls, and a large developmental hypertrophy of the muscular substance of the organ. The patient made an uninterrupted recovery.

My next case, from the Obstetrical Department under the supervision of Dr. J. W. Williams, which falls in the class (b), pregnancy complicated by a tumor, is interesting in that while akin to those already described it presents some points of unusual difficulty in the diagnosis.

The patient who was pregnant and near term had a myomatous uterus carrying fibroid nodules of such sizes as to impress the examiner, whose report follows, with the idea that there was a twin pregnancy.

J. M. Out-patient Department, Obstet. No. 323.

The patient was first seen by one of the staff of the Johns Hopkins

Hospital Out-patient Department one week before her confinement, at which time she was having abdominal pain and thought herself to be in labor.

The pelvic measurements were the following: Intersp. 22 cm., Intercr. 23.5 cm., Bitr. 27 cm., diameter of Baudelocque 19.75 cm.

At this visit no vaginal examinaton was made and hence the conjugata diagonalis was not measured.

On palpating the abdomen many hard nodules, some of which were movable, were felt on both sides of the median line. Similar nodules were felt at the upper pole of the uterus. At the lower pole a round hard body about the size of the fist was felt. This was just above the pelvic brim and ballottable and was thought to be an unengaged fetal head.

Fetal heart sounds could be heard with about equal distinctness at points just above and just below the level of the umbilicus on the left side of the abdomen. The rate of the beats was the same above and below the umbilicus, *viz.*, 128 per minute.

The multiplicity of small parts and the large size of the abdomen caused a strong suspicion of twin pregnancy. From the absence of pains during the visit and from the fact that a fetal head could be felt above the brim of the pelvis, it was evident that labor either had not begun or was in a very early stage so that the vaginal examination was postponed.

At the confinement, one week later, examination of the abdomen before the birth of the child revealed the same condition which was noted at the first visit. By vaginal examination the cervix was found to be almost completely dilated. A fetal head was felt engaged in L. O. I. A. position. Little less than two hours after this examination a small male child, weighing 6 lbs. was expelled and the placenta was expressed from the vagina by pressure upon the fundus uteri ten minutes after the birth of the child. Even after delivery of the placenta the body of the uterus was quite large and on palpation numerous nodules resmbling fetal small parts were felt towards the mid-line and on the right side of the abdomen. On the left side of the abdomen there was a smooth resistance suggestive of the dorsal plane and behind the symphysis was a spheroid body rather freely movable and to the touch almost indistinguishable from a somewhat small fetal head. Although no fetal heart could now be heard, it was thought that the uterus contained a second child. After waiting an hour, during which time there were occasional pains with contractions of the uterus, the hands being carefully sterilized, a vaginal examination was made. Two fingers

were passed into the canal of the cervix and it was only when the uterine cavity was thus found to be empty that it was discovered that the nodules felt through the abdominal walls were uterine myomata and not parts of a second fetus.

The child was puny and after birth became somewhat asphyxiated on account of stoppage of the larynx with mucus.

There was nothing worthy of note during the puerperium.

The simple citation of these histories to which doubtless all of my colleagues could add from their experience, teaches us, then, that a serious and a mortifying error in diagnosis may be made unless great care is exercised; we learn from these facts that a busy physician is often apt to rely upon one or two of the prominent signs of pregnancy but rarely found with tumors.

The following elements enter into these cases as misleading:

1. The patient may be very fat making it most difficult to palpate and percuss an abdominal enlargement with precision.

2. The vagina may present a more or less characteristic violet discoloration.

3. The cervix may be soft.

4. The breasts may be enlarged, painful, and may contain fluid.

5. There may be a cessation of menstruation with more or less nausea.

6. The *linea nigra* may be well defined.

7. There may be a regular enlargement of the abdomen more or less closely corresponding to the calculated period of pregnancy.

8. The mass may closely resemble a fetus in the abdomen presenting a head, body and limbs.

9. The subjective sensation of movements may be a prominent, and to the patient, a factor decisive beyond argument as to the existence of a pregnancy.

10. A perfect abdominal ballottement may be present.

If the mimicry of pregnancy can be so remarkable how, then, are we to make a differential diagnosis?

A diagnosis can always be made by a thorough examination which pays close attention to all the important signs of pregnancy.

First and foremost, the fetal heart sound is always absent, and the pulsations in the tumor will not be mistaken for a fetus if the observer is careful to notice that they are synchronous with the radial pulse. This sign by itself is decisive.

In the second place, even taking the list of mimicking signs given above, no one case presents them all, and the omission of one or other

of the usual important signs should put the observer at once on his guard. For example, it is a most suspicious fact when the menstruation has continued through the supposed pregnancy, and I find that physicians treat this sign too lightly, telling the patient that they know of a number of instances in which menstruation has continued. This contradicts my experience.

Again the presumption is strong against pregnancy when there is an unaltered hard cervix and the burden of proof rests heavily on him who assumes the contrary.

A more careful examination for ascites, as distinguished from fluid in utero, will reveal it in most cases if the areas of dulness are marked out in four postures, erect, lying dorsally, and on right and left sides.

A recto-abdominal bimanual examination under a brief anesthesia of gas will always clear up the diagnosis and reveal the uterine tumors or the small uterine body with ovarian tumors.

Lastly, a better knowledge of abdominal palpation in advanced pregnancy will almost always avoid error in diagnosis.

Other factors which often help in the diagnosis of these mimicking cases are the age of the patient and the length of time the tumor is known to have existed.

The absence of the regular enlargement of the womb, or the non-occurrence of labor, running weeks or months over the calculated time.

The existence in a single woman of an intact hymen.

In all instances of error which have come under my notice the mistake would not have occurred if a thorough examination had been made, using an anesthetic if necessary, and paying attention to all the signs of pregnancy.

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