

diseases, which, when allowed to proceed uninterrupted, can only be relieved by the aid of an operation. Nothing indeed can be more reprehensible than the fact of some surgeons presuming to despise a knowledge of physic. Such a sentiment is fraught with evil in the education of youth, and highly pernicious to society.

In concluding these observations on the subject of surgical operations, it may be thought that I have been too tedious; but due attention to, and minute acquaintance with, everything relative to this subject, will be of the greatest use to you in future practice, for there is no author to whom I can refer you, who has treated, in so comprehensive a manner, on these points, as their importance appears to me to merit. Indeed, I am fully persuaded that many of those operations which are every day perfectly well performed, and which, nevertheless, prove unsuccessful, owe their want of success entirely to inattention to the previous and subsequent treatment of the patient, and to a disregard of those peculiarities of individual temperaments, constitution, and system, which I have endeavoured to point out in the preceding lectures.

ON THE INFORMATION AFFORDED BY
THE STETHOSCOPE
IN DETECTING THE PRESENCE OF
FŒTAL LIFE.

By THOMAS M'KEEVER, M.D., *Master of the Coombe Lying-in Hospital, Dublin.*

THE possibility of our being enabled, through the medium of the stethoscope, to decide respecting the vitality of the fœtus during its intra-uterine portion of existence, has been altogether denied by some practitioners, while by others it has been received with no slight degree of hesitation. It therefore becomes desirable that the matter should no longer rest on loose and unsatisfactory grounds, but that it should, as far as possible, be established on the solid basis of fact and experiment. This, it is obvious, is a question, not of mere speculative interest, but one of considerable practical utility, particularly as regards the discrimination of abdominal tumours, the result of pregnancy, from those occasioned by ascites, diseased ovary, and a variety of morbid causes. Respecting its influence on the management of tedious and laborious labours, I am willing to admit that too much stress has

been laid on the audibility of the fœtal heart as a guide in the employment of instruments. In such cases it is obvious that recourse is had to such formidable expedients, not altogether with reference to the infant, but with the distinct view of securing the life of the parent, which we conceive to be endangered by the further continuance of the parturient efforts. Thus, we shall suppose a case of no very unfrequent occurrence, namely, where a pulseless, putrid, umbilical chord becomes prolapsed before the head. Here we have a positive certainty of the death of the infant; yet if the labour advance favourably, and the constitution of the patient do not appear to suffer, the mere duration of the process beyond a certain number of hours, would not, I conceive, warrant interference. Instruments, however ingeniously contrived, however dextrously applied, are still an evil, and are only to be thought of with the view of meeting one of still greater magnitude. At the same time I feel satisfied that cases of hemorrhage, convulsions, &c., will occasionally present themselves, where, in consequence of the information furnished by the stethoscope, an earlier interference, either by the forceps or the lever, would be justifiable, than if we were deprived of that mode of ascertaining the life of the fœtus.

In puerperal convulsions, a recurrence of the fit most commonly proves fatal to the child; but if satisfied from the pulsations of the fœtal heart that it still lives, and that the passages are dilated to their full extent, the pelvis being at the same time well formed, and the bulky part of the head sufficiently advanced, it is our bounden duty to expedite delivery, provided, of course, such means be employed as are consistent with the safety of the mother.

Having premised these few observations, I beg to submit to the profession the following cases illustrative of this curious and interesting subject. They are extracted from the ward-book of the Coombe Lying-in-Hospital; and have been witnessed by Mr. O'Hara, the resident assistant, as well as by a large class of intelligent pupils. In some rare cases I should observe, that notwithstanding the utmost care and attention, no pulsation whatever could be detected in the fœtal heart, and yet the children have been born alive. This was probably in part owing to the large quantity of liquor amnii with which the fetus happened to be enveloped,—partly to the position the fœtus may have assumed in the uterus,—and, in some cases, perhaps, to its having been in a state of torpidity, such as we fre-

quently observe to occur among many of the lower animals.*

Case 1.—Eliza Canna, admitted July 3, 1833, in labour with her first child. Waters not yet discharged; pains slight; placental soufflet diffused over right iliac and lumbar regions; foetal heart 130; heard distinctly in left umbilical region; pulse of mother 90.

Twelve hours after admission:—Waters have gradually drained away; head has entered pelvic cavity, with face towards pubis; funis prolapsed at anterior part of os externum. Child born alive.

Case 2.—Mary Grant, admitted July 4th, her first child. Membranes unbroken; placental soufflet in right iliac region; foetal heart 120, right umbilical region; head has not yet entered pelvis; os uteri slightly dilated; pulse of mother 80. Infant born alive after twelve hours' labour.

Case 3. Eliza Tynan, admitted July 4th. Waters unbroken; placental soufflet very indistinct in *both* iliac regions; foetal heart 136, can be distinctly heard in right iliac region; pulse of mother 86. Child born alive.

Case 4.—Betty Agar, admitted July 6th, in labour of her sixth child. Waters unbroken; labour pains slight; head has not yet entered pelvis; neither placental soufflet nor foetal heart can be detected. Infant born alive.

Case 5.—Mary A. Dunne, first child, admitted July 6th. Placental soufflet right umbilical region; foetal heart left; iliac fossa beating 136; pulse of mother 90.

Case 6.—Sarah Ryan, admitted July 10th. Third child. Seven months pregnant; seized with labour pains the preceding evening; waters unbroken; os uteri not dilated. Says she felt infant move this morning; placental soufflet very distinct in left iliac region; foetal heart 128, below and to the right of umbilicus. Child survived the birth some hours.

Case 7.—Margaret Johnston, admitted July 20th, her sixth child. Liquor amnii not discharged; foetal heart right umbilical region 130; pulse of mother 96; placental soufflet could not be heard. Child born alive.

Case 8.—Mary Darkinson, admitted Aug. 13th, in labour with her first child.

Membranes unbroken; foetal heart 120, very distinct in right iliac fossa; placental soufflet midway between left spine of ilium and umbilicus; pulse of mother 82. Child came to the world alive in first position.

Case 9.—Eliza Ryan, admitted Aug. 15th, her first confinement. Waters not discharged; slight uterine pains; foetal heart about three inches below umbilicus, in direction of linea alba, beating 140; placental soufflet could not be heard in any position. Child born alive.

Case 10.—Catherine Doyle, her sixth child. Os uteri fully dilated, membranes entire; head has entered brim of pelvis; examined most carefully in every position, but neither placental soufflet nor foetal heart can be discovered. After four hours delivered of a living male infant.

Case 11.—Biddy Cassidy, admitted May 4th, in labour of her second child. Os uteri dilated to about the size of a shilling; foetal heart 130, heard distinctly over pubis, and in a direct line from that to umbilicus; placental murmur dull in right iliac fossa. Child delivered alive in second position.

Case 12.—Catherine Thompson, admitted April 29th, in labour of her second child. Os uteri high up, and but slightly dilated; placental murmur indistinct in both iliac regions; foetal heart between right iliac fossa and umbilicus. Delivered in about twelve hours of a living male child, which came in second position.

Case 13.—Mary Cooke, admitted April 30th, in labour of first child. Waters discharged several hours; head pressing on perineum, posterior fontanelle being placed towards left foramen ovale; foetal heart distinct between right iliac fossa and pubis; placental soufflet in left iliac fossa. After a few pains delivered of a living female infant.

(From my Private Case Book.)

Case 14.—Mrs. C., Patrick's Close, the mother of several children. Has been affected for the last eight months with cough; pain of right side; profuse expectoration; light perspirations, and extreme emaciation; becoming more feeble every day. During last two months she has observed a progressive enlargement of the abdomen, extending from below upwards, but is not conscious of any feeling of motion.

Examination with the stethoscope, assisted by Mr. O'Hara; placental soufflet cannot be detected in any position; foetal heart heard distinctly in left iliac fossa, about 130; pulse of mother 110. She

* How long the foetus in utero can survive the absence of pulsation in the umbilical chord, has not been satisfactorily ascertained. I have assisted at one case of breech presentation, with prolapsed funis, where no pulsation whatever could be detected for fifteen minutes, yet the child was born alive. Was the circulation interrupted in this case?

sunk gradually, but no examination of the body could be obtained.

Case 15.—A lady, who had contracted a private marriage in the north of Ireland, came up to town, and requested my advice under the following circumstances:—The menses have been suppressed for the last six months, and about two months since she observed slight enlargement of the abdomen, which has continued to increase, so that it is now quite apparent. She was sick occasionally in the morning at the commencement, but now enjoys better health than she has done for some time. The mammae are slightly distended, but the areola round the nipple has not undergone any alteration. Is not conscious of any feeling of motion.

Examination with the stethoscope.—Fœtal heart exceedingly distinct in right iliac fossa; placental murmur on left side about two inches below umbilicus. This lady has since been confined with a daughter, which she is now nursing.

68, Marlborough Street, Dublin,
Aug. 21st, 1833.

PROFESSIONAL REMINISCENCES.

By SAMUEL GOWER, Esq., Surgeon,
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DYSURIA FROM DEFORMITY AT THE GLANS PENIS.

A CASE once fell under my care, in which there existed a long unsuspected mechanical obstruction to the exit of the urine, owing to an adhesion of the prepuce to the glans penis, accompanied by some degree of constriction of the os urethræ. The former, as I am inclined to believe, was partially, if not entirely, the result of a casual complaint, from which the patient suffered three or four years before he came to me. From this period he dated an aggravation of his sufferings from dysuria. He had from infancy been a sufferer from the same cause, so that there must have been more or less of congenital malformation. He applied to me, in the first instance, for medicines to relieve dysuria. From such remedies as I prescribed for him from time to time, he good-naturedly professed to derive benefit, though from the nature of his case this must have been a misstatement. It was not till after some time that I proposed an examination, and ascertained how mat-

ters were. He had been elsewhere for medicines before he came to me, which did him as little good as mine. The urine came away either *stillatim*, or in a minute uncontinuous stream, through a straw-like and tortuous aperture, which would not admit the passage of the smallest probe. The os urethræ itself was not discoverable. The prepuce which, on a superficial view, presented a natural appearance, was found inwardly adherent to the glans. Having detected the cause thus far, I recommended an operation, to which he submitted. Having pulled back the prepuce, and caused it to be kept on the stretch, I passed a lancet through the centre, with the same movement cutting through the prepuce on one side, and then proceeded to remove the other portion. From ten to twelve ounces of urine flowed away in a full stream immediately after the operation. This had not been purposely retained, as he always had been compelled to employ a great length of time in partially emptying the bladder in the manner before described. A piece of bougie was kept in by tape, to prevent subsequent maladhesion. The impediment was thus removed by a species of inward circumcision, of which no outward and visible sign remained after the parts had healed, and the painful condition from which he had suffered for years, was thus in a few seconds finally relieved. A portion of the lip of the orifice of the glans was sliced off with the excised portion of prepuce, but the cohesion of parts rendered this inevitable, and no ill consequence ensued. Either death from diseased or ruptured bladder, or the formation of a fistula vesicaria, or other intractable complaint, would have terminated, in all probability, this case of dysuria, had it been unrelieved. I met many years ago with an instance of this species of fistula of fourteen years' standing, in which the urine oozed away from fifty or sixty openings in the perineum.

PHYMOSIS.—DISEASED SINUSES.

I have had opportunities of remarking the extreme necessity of operating, in certain cases, for phymosis,—an incidental complaint which may generally be subdued without it. I have witnessed examples of its existence to a considerable extent in children, as the result of congenital elongation and tenseness of the prepuce. I was once witness to a case of phymosis attendant on venereal disease, in which the glans penis was absolutely sloughing away—its substance dissolving, as it were, into pus—for want of one of the simplest operations in surgery. Maladhesions and diseases of many kinds arise

* Some other papers thus entitled were published in former volumes of THE LANCET.