

5th. He can now read large print, and, excepting a slight appearance of mist which surrounds all objects, his sight is as good as formerly. The left pupil now contracts sluggishly when stimulated, but it is still somewhat larger than that of the sound eye. The congestion of the tunics has disappeared.

He is discharged.

All who have had much experience in ophthalmic diseases will be aware that it is very common for cases similar to the above to terminate in permanent blindness of the injured eye. In this instance, the man, in all probability, owes the restoration of his sight to the treatment adopted, and another case is afforded in support of the practical rule, that, when blindness or impaired vision result from concussion of the eyeball, the rapid and free exhibition of mercury should never be neglected.

MIDWIFERY.

59. *Case of Arm-Presentation successfully conducted without Turning.*—It has been an axiom in obstetrics to turn in every case of arm-presentation where turning is practicable. Dr. R. G. MAYNE records (*Lond. Journ. Med.* Oct. 1852) the following case in which he departed from this rule, and with a happy result.

"On the 20th June, 1852, I was summoned to attend Mrs. H. on occasion of her first accouchement, and reached her house at six o'clock A. M. She was of sallow complexion, a small, lean figure, and thirty-six years of age. She had had pretty smart pains since four o'clock P. M., of the previous day, and the membranes had given way, with considerable discharge of the waters, an hour before my coming. I found her walking about her bedroom, her progress arrested every now and then by regular and evidently powerful uterine contractions. After a little while spent in persuading her to submit to examination, I ascertained that the os uteri was dilated to the extent of a half-crown piece, and that the case was one of arm-presentation, my finger-point at once encountering several objects, which gradually became distinguishable into the fingers of a minute left hand, resting in close contact with the acromial portion of the shoulder of the same side, and the broad surface of the corresponding scapula. The occiput, and the back of the child, were thus directed to the abdomen of the mother; its head above, or resting upon her right ilium, as she lay, in the usual posture, on her left side.

"The discovery was far from agreeable, having particular duties to attend to for the day, which the nature of the presentation, the stature, aspect, and age of Mrs. H. allowed little expectation of my being able to perform. The pains continuing vigorously recurrent, I did what I could to promote dilatation by repeatedly passing the finger, with some slight degree of pressure, round and within the tense rim of the os uteri, during the contractions. By seven o'clock A. M. such progress had been made, that the child's hand and greater portion of the forearm had entered into the vagina, the upper, or humeral portion, and arm proper itself, being detained by the cineture, formed by the cervix uteri, binding down and hindering the passage of the elbow.

"In accordance with early precept and past practice, I contemplated the operation of turning as the orthodox expedient to be adopted, and commenced by introducing the fingers and thumb of my left hand, conically packed together, into the vagina, which, from the rigidity of parts, would admit no more, even after some perseverance. I persisted in trying to urge my way, though every movement—even of a finger-joint—provoked a more energetic resistance. I also made some attempts to push the child's hand and arm up into the womb, with the view of securing greater facility in preparing for the contemplated operation of turning; but each expulsive effort sent them forth again as before. Could nothing be done to alter this state of things? This question presented itself over and over again, as with all my efforts I could make no progress towards foot-version; and I resolved to try.

"The idea of the practicability of returning the arm, and of exerting a repres-

ing force upon a part of the presentation, according to circumstances, so as to convert the case into one of natural labour, had formerly occurred to my mind when engaged on one or two similar occasions, and I had then endeavoured to act upon it, but found, to my disappointment, that matters resumed their faulty condition so soon as such endeavours ceased. In those cases, however, the protrusion of the hand and arm was much more complete, when I was first called to them, and had existed for a longer period, than in the present instance. Here, there were circumstances of one kind which seemed favourable to the prosecution of the idea; thus, the presentation had but partially entered or dipped into the cavity of the pelvis, and, as yet, the hand and part of the forearm only had escaped beyond the constricting band of the cervix uteri. But there were also others, as the discharge of the liquor amnii about two hours before, the patient being a primipara, her constitution and age, which inclined to the reverse. The latter considerations, however, were equally inauspicious as to any facility to be hoped for in performing the operation of turning; and, therefore, with my hand firmly wedged in the vagina the while, I, after repeated though hasty and anxious deliberation on all these points, decided on the propriety of making a persevering effort to alter the character of the presentation.

"Having quite failed in carrying my hand beyond the second joints of the fingers and thumb, every endeavour to do so causing painful and loudly complained of increase of the contractions, I extricated my thumb altogether from its confinement, by which the fingers were now enabled to pass in a flattened form of the metacarpus, as far into the passages as the junction of the thumb with the fingers at its first joint would permit. By this means, I pushed the child's hand and arm (in reference to the position of the mother) *back*, or (in relation to the erect posture) *up* towards the fore part of the body of the womb, till they rested above the pubic portion of the pelvis, to which point my own fingers also reached, and steadily retained them there, by uninterruptedly bearing upon the latter, or rather upon the arm proper, a little above the elbow, for one hour and a quarter. During this space, the pains, which were uncompro-misingly withstood, so far as they could affect the arm and parts against which it was urged, regularly recurred, and slowly advanced the labour, so that the descending presentation began to press uncomfortably on my already cramped fingers.

"The woman had for some time complained of my *pushing back the child* at every pain; and, in no gentle tones, now ordered me to desist altogether, at least for a time. Her friends, impressed with some alarm by her vociferations, added their remonstrances to the same effect. Therefore, having carried out my intention as far as was possible, I withdrew my hand, resolved to abide the issue, without any further active interference. Leaving her to herself for a short time, in which several pains occurred, I was much gratified and encouraged, upon a digital examination, in finding that the arm had not again descended, and that the labour was making perceptible progress. Deriving relief and confidence from these two facts, yet conceiving that whatever course the case should take, I might now safely leave for an hour, in order to fit myself for the day's engagements, I retired at half-past eight A. M.

"At half-past nine A. M. I again saw my patient, and really felt overjoyed to find a perfectly natural presentation. At ten minutes past ten A. M. I delivered her of a well-formed male child at the full time, with only a slight swelling of the left hand and forearm, who is yet alive, if not to *tell* the tale, at least to afford evidence of the practicability of acting successfully upon my idea. The mother, in common parlance, had not a bad symptom; and is now in her accustomed health."

60. *Supposed Extra-Uterine Abdominal Pregnancy; Natural Delivery.*—It is ever wise not to be hasty about operating, and especially not to have recourse to the Caesarian section before it is clearly shown that the patient must sink if this formidable operation be not performed. Here is a case which gives this rule a world of strength.

A woman, twenty-nine years of age, was admitted on the 18th of April, 1832, into the Hôpital Beaujon, at Paris, under the care of M. HUGUET. The prac-

and directed towards the os uteri, where it was held steadily. After exhausting the tube, the other extremity was placed in the warm water. The stream immediately began to flow with considerable force against the os uteri, and continued until the whole contents of the vessel had been discharged. Two gallons of cold water were then poured into the vessel, and discharged in the same manner. The time occupied by the whole douche was from twenty minutes to half an hour, the patient only complaining of discomfort when the hot and cold currents first began to run. During the after part of the day she complained of dysuria and occasional pains in her back.

Sept. 2d.—One P.M. The douche was again applied in the same manner and quantity.

She had labour-pains from half-past twelve until four. At nine o'clock, the douche was repeated. Two o'clock P.M.: Has had irregular uterine pain since the douche in the morning. On examination, the os uteri was felt dilated to the extent of half a crown. Douche repeated. Nine P.M.: Had considerable uterine pain for half an hour after douche. Douche repeated.

4th. One A.M. Has had powerful uterine pains since last douche, and the child was born about half-past one A.M., or about sixty-four hours after first application of douche.

"The time," Dr. Smith remarks, "between the first application of the douche in this case, and the completion of delivery, was less than frequently occurs in cases of puncture of the membranes. But it has been objected to the douche, by those who have used it on the Continent, that some women are less susceptible of its influence than others, and that the susceptibility of the same woman varies in different pregnancies. I suspect this variation may be obviated by performing the operation, when the time can be selected, at the eighth or ninth catamenial date, and by increasing the energy of the douche by the alternation of temperature."

62. *Induction of Abortion in the Vomiting of Pregnant Women.* By MM. Dubois and Stoltz.—During a recent discussion at the Académie de Médecine, M. P. Dubois stated the results of his experience in relation to obstinate vomiting in pregnancy. In proof that this is oftener a more dangerous occurrence than is usually supposed, he stated that, in the course of thirteen years, he had met with twenty cases in which it has proved fatal. That obstinate vomiting is but the exaggeration of the natural sympathetic vomiting of pregnancy, and not due to any special lesion, is proved by the facts that at the autopsies nothing is found, and that when the process of gestation becomes arrested, whether spontaneously or artificially, the vomiting is ordinarily put an end to, although the woman may not be delivered until several days after, of a dead child, and may yet die of the effects of what she has already undergone. M. Dubois refers to several cases in which the women, apparently at the point of death, were saved by the spontaneous death of the fetus, this being expelled only some time afterwards. In respect to the question of how far artificial interference is attended with the same result, he furnishes notes of the four cases in which he has employed it. Three of these died and one recovered—this last being added to other cases on record, making the number of recoveries he is aware of certainly seven, and probably nine. In all the cases, however, whether fortunate or not, the vomiting was suspended by the operation. The difficulty is, indeed, to fix the period at which this should be resorted to; for it is the natural desire to delay this as long as possible, which leads to the fatal result—the woman dying, in fact, from the exhaustion and prolonged abstinence which the vomiting has induced, prior to the operation for arresting it being undertaken. M. Dubois lays it down as a rule, never to perform it when the signs of extreme exhaustion are present, as evidenced by considerable loss of vision, cephalalgia, comatose somnolence, and disorder of the intellectual faculties. On the other hand, we should also abstain from operating when the vomiting, though violent and frequent, still allows of some aliment being retained; when the patient, though wasted and feeble, is not obliged to keep her bed; when the suffering has not yet induced intense and continuous febrile action; and when other means still remain untried. In the first case, we

should not save our patient, but perhaps accelerate her death, and bring discredit on the operation; while, in the other, we should sacrifice a pregnancy that might have gone on to the full time. It is, therefore, the intermediate period that should be chosen, and this is characterized by the following signs: 1. Almost incessant vomiting, by which all alimentary substances, and sometimes the smallest drop of water, are rejected. 2. Wasting and debility, which condemn the patient to absolute rest. 3. Syncope, brought on by the least movement, or mental emotion. 4. A marked change in the features. 5. Severe and continuous febrile action. 6. An excessive and penetrating acidity of the breath. 7. The failure of all other means. But even within this period, which is of variable duration, the opportune moment must be chosen. This seems to have arrived, when the inefficacy of the most approved treatment has been proved, when fever is found to persist, and the debility and wasting of the patient are making sensible progress. The attendant should now declare that the operation is indicated, leaving to the patient and her friends the duty of deciding upon its adoption.

Professor Stoltz, of Strasburg, has published a highly interesting communication upon this subject, in which he also states his belief that vomiting during pregnancy is much oftener fatal than is usually supposed. He relates four cases, from among others, that have come under his own notice. In three of these death occurred, and life was saved by the operation in the fourth, although the case seemed hopeless. M. Stoltz lays great stress upon the operation being performed *in good time*, because, if we wait until the effects of the sympathetic reaction constitute in themselves a serious disease, the evacuation of the womb does not induce a cessation of these, and may, in certain cases, even hasten death—life, so to say, hanging upon a thread. It is undoubtedly difficult to say, *when* the moment has arrived that we can no longer hope for benefit from nature or therapeutical agents. But may not the same observation be made with regard to many important surgical operations? It is true, that neither spontaneous nor artificial abortion always saves life in these cases; but the former usually occurs only when the woman's powers are hopelessly exhausted, and the pain and discharge consequent on the delivery may expedite her end—the same result not being infrequently seen in severe fever. Some practitioners have expressed themselves very feelingly against sacrificing the child in these cases; but there is a great inconsistency on the part of those who do so, and who still advocate the operation in the case of narrow pelvis. A woman who has undergone artificial abortion for obstinate vomiting, may hereafter (and these cases mostly occur in primiparæ) give birth to a living child, which can never be the case in one who has so narrow a pelvis as to call for the induction of abortion rather than of premature labour.—*Brit. and For. Med.-Chirurg. Review*, Oct. 1852, from *Gazette Médicale de Paris*, No. 23.

63. *Stethoscopic Sign of Separation of the Placenta*.—In our number for July, 1852, p. 263, we noticed a supposed stethoscopic indication of the separation of the placenta pointed out by M. Cailliant. Prof. Simpson, of Edinburgh, in a communication to the Edinburgh Obstetrical Society (Jan. 14, 1852), gave various reasons for dissenting altogether from the explanation of the sound offered by M. Cailliant. Dr. Simpson believes the sound is produced by the mere physical compression of the placenta, as it is being expelled from the uterus; and it could be imitated with a placenta, after its expulsion from the body, by pressing the placenta through an aperture such as that of the cervix uteri.—*Monthly Journ. Med. Sci.* August, 1852.

64. *On an unavoidable Uterine Hemorrhage*.—M. DEPAUL read an elaborate paper upon this subject at the Académie de Médecine, in which he defended at great length the views held by MM. Stoltz and Dubois, upon the tardy development of the lower segment of the uterus. Our space admits only of the notice of some of the more practical parts of the paper. M. Depaul is of opinion that the attachment of the placenta to the lower segment of the uterus is of much greater frequency than those authors admit who have only noted the cases in which it has been found inserted over the orifice itself; and he considers Lacha-

pelle's statement, that the majority of cases of uterine hemorrhage occurring after the sixth month are due to faulty insertion of the placenta, to be correct, when so understood. He does not regard the *diagnosis* of the occurrence by the thickness and softness it imparts to the lower segment of the uterus, as being so easy as stated, when the cervix is long and closed. Nor is the absence of *ballotement* at all conclusive, as he has perceived it in several of these cases. He considers that the hemorrhage oftener shows itself in the course of the eighth or ninth month, than in the sixth or seventh, as stated by some. Even when the cervix is effaced, and the os opened, experienced persons have sometimes mistaken coagula, or excrecences of the cervix, for the placenta. M. Depaul considers that the *prognosis* as regards the mother has been exaggerated, and that with due care the mortality, stated by Simpson at one-third, might be much diminished. It is more serious when the placenta is inserted over, in place of near, the orifice, and in the earlier period, when the cervix is hard and closed. He agrees with La Chapelle that more than half the children are lost, especially when it is considered that many of those born alive are so before their time, and exhausted by the disturbance of the placental communication.

In the *treatment* of these cases, (1.) when the hemorrhage is slight, and the os closed, and no uterine contractions are present, he recommends the employment of the usual general means to arrest hemorrhage, such as posture, opiates, acidulated drinks, &c., and small hemostatic doses of ergot. When (2.), with the same conditions of the uterus, the hemorrhage is great and increasing, besides the above means, he advises plugging the vagina. This may act by favouring the coagulation of the blood, and the obliteration of the vessels left open by the detachment of the placenta; and by hastening the advent of labour and the dilatation of the orifice. This last end is not always attained; for cases have occurred in which the plug has been applied for twenty-four or thirty-six hours, with the effect of arresting the hemorrhage without producing any modification in the cervix. When, in spite of the plug, the bleeding still continues, in part internally, and in part externally, and the woman appears in any danger, we should rupture the membranes; and if such partial emptying of the uterus is not attended with prompt improvement, delivery should be forced, even if multiplied incisions of the cervix uteri are necessary for this purpose. When (3.) the hemorrhage is slight, and has commenced at the full period of pregnancy, or when repeated hemorrhages have induced premature labour—a certain degree of dilatation being present—if the loss is very moderate, we may order rest and other general measures, and give ergot to hasten the labour. When the dilatation has become considerable, we should rupture the membranes, especially if the hemorrhage, without being great, has been of long continuance or frequent repetition, so as to have materially damaged the health. The same course is justified in the interest of the child, the life of which will be risked by its prolonged detention in the uterus after a considerable separation of the placenta. It is in this case that obstetric auscultation becomes so useful; and when this shows the child's life to be in danger, the forceps, or version, should be had recourse to, even when the dilatation is not so great as in other cases would be deemed desirable. When (4.) the os is more or less dilated, and the hemorrhage too serious to admit of temporizing, if the membranes are still intact, the dilatation not being quite complete, these should be ruptured, and the ergot given in preference to using a plug. M. Depaul has, however, the greatest objection to perforate the placenta itself, at the risk of inflicting injury on some vessel that might prove fatal to the child. Even in central insertion, whenever possible, he detaches an edge of the organ to get at the membranes. In central insertion, too, he would employ the plug as a dilator. On account of the danger the child incurs, he likewise objects to Simpson's plan of prior detachment of the placenta. When, in spite of the discharge of the waters, the hemorrhage continues, or the child's life is found to be endangered, we must deliver; and, in these cases, the somewhat forcing delivery is preferable to the employment of the plug, lest even a moderate amount of uterine hemorrhage prove too much for the exhausted powers of the woman, or a too long delay prove fatal to the child.

It is an error to suppose that the woman is always safe when delivery has

been accomplished; for she sometimes sinks from subsequent hemorrhage. This occurrence is explained by the special vascular distribution at the lower segment of the uterus, and the less disposition this part has to contract. To secure due contraction, the ergot is the best means; and perhaps it should always be given in these cases immediately after delivery.—*Brit. and For. Med.-Chirurg. Review*, Oct. 1852, from *Bull. de l'Académie*, vol. xviii, pp. 849-874.

65. *On the Continuance of Lactation during the Progress of Diseases.*—Dr. RÜSER states that the results of his observation during thirty-two years, have quite convinced him that the routine practice of desiring mothers to discontinue suckling when they become the subjects of serious disease, is erroneous, the ill-effects of the milk upon the infant having been ridiculously exaggerated. He has already called the attention of the profession to this matter, in an essay on typhus, published ten years since, and all subsequent experience has only confirmed him in his views. He objects to the cessation of suckling for any other cause than local inflammation of the breast, the resolution of which it may prevent, and the cessation of the secretion, which, however, is often due to the neglect in continuing to apply the child: and he cites cases in which the continuance of the child to the breast, in apparently hopeless affections, was attended by the best results. He remarks upon the inconsistency in arresting a secretion which is so powerful an agent in abstracting the proteine-compound from the blood, while, at the same time, by exciting other excretions, and employing various antiphlogistics, we endeavour to diminish the fibrinous and albuminous elements of the fluid. The effect of suppressing pathological secretions in causing or aggravating disease is admitted, and yet we suppress a normal one, which is exerting an important derivative action on existing disease, and has established the habit, on the part of the system, of requiring such a drain. In the various epidemics of typhus witnessed by Dr. Rüser, he has found the continuance of suckling, while the milk remains, of great service in the prevention of bronchitis and pneumonia, which are the usual causes of death; and in inflammatory diseases, he recommends the practice even when collapse has occurred. Even when a woman is suckling much beyond her time, the child should not be taken from her during an attack of inflammation.

Dr. Rüser strongly objects to the advice so commonly given to women suffering from, or threatened by *tubercular disease*, to abstain from suckling. He regards it as one of the best of preservatives, as also a means of prolonging life when cavities are formed; and he states that he is in possession of many cases justifying this opinion. Suckling, too, pursued within normal limits (which vary in different women, but average nine months), is always advantageous in pure neuroses, including hysteria itself. In the same way is the numerous class of affections benefited dependent on a stasis of the blood, and marked by chronic inflammatory action, and the generation of adventitious productions.—*Brit. and For. Med.-Chirurg. Rev.* Oct. 1852, from *Froriep's Tagesberichte*, &c. Nos. 441 and 446.

66. *Epidemic of Puerperal Gangrenous Vulvitis.* By M. CHAVANNE.—During the early part of the cold January of 1850, several of the puerperal women at the Charité of Lyons were attacked, three or four days after delivery, with vomiting and diarrhoea, or with febrile paroxysms and abdominal pains, or slight hemorrhage. These symptoms were followed, in twenty-six cases, by lassitude or prostration, and lowness of spirits, and by the development of œdematous redness of the vulva. In a few cases, the disease did not extend beyond this stage, active febrile symptoms becoming, however, developed; but in the great majority, pulsatious plates, resembling Delpech's pulposus form of hospital gangrene, formed on the interior of the vulva and vagina, closely adhering to the mucous membrane. Although their extension became limited in a day or two, they were not separated by the inflammatory process until the end of the first week, or during the second; small, superficial, suppurating wounds being left at the points they occupied, which usually soon healed up, though occasionally degenerating, and becoming covered with the same pulsatious mass. In four of the twenty-six cases, the disease extended to the uterus,

and the patients died, having presented all the symptoms of intense puerperal fever, the gangrenous condition of the uterus becoming complicated with peritonitis. No cause could be assigned for the development of the epidemic; both the general sanitary conditions of the establishment, and the prior state of health of the patients, having been satisfactory. In twenty of the cases, the labour was natural, the forceps, however, having been applied eight times; and while the affection seized some of the patients who had very easy labours, others of the inmates, whose cases required active interference, entirely escaped. Besides the four cases above mentioned as having proved fatal, three others of the twenty-six died from metro-peritonitis, without extension of the gangrene. The other nineteen recovered, the gangrene usually soon yielding to tonic regimen, and the local use of the strong muriatic acid. A very similar epidemic was observed at Lyons in 1815; and another of the same character has been recently witnessed in Paris.—*Brit. and For. Med.-Chirurg. Review*, Oct. 1852, from *Gazette Médicale*, No. 16.

MEDICAL JURISPRUDENCE AND TOXICOLOGY.

67. *Infanticide, and what may be confounded with it.*—The frontal and parietal bones are the only ones which Dr. WEBER (*On the Strength of the Skull*) has seen fissured and fractured by the act of parturition. According to the greater or less extent of the fracture, and particularly the distance of separation between the edges of the injured bone, so is the amount of injury to the vessels of the locality of the fracture. Rupture of small ones always occurs, as is proved, by the most delicate fissure being indicated by a red streak. The periosteum is generally elevated by extravasated blood, and there are marks of suppuration from effusion into the cellular tissue of the scalp. In these cases, internal cephalæmatoma may occur. But the extravasations here alluded to must be distinguished from those which follow rupture of the longitudinal sinus, and of the larger cerebral veins. It is true that both forms may be present; but, according to Dr. Weber, the latter are not the consequences of the fracture, namely, "a too violent forcing of the bones over each other." BENNET, after referring to the fissures and fractures, dwelt on at some length by the former writer, remarks that "in the cranial bones of new-born children clinks are sometimes observed running from the surface for several lines deep into the bone, generally in a somewhat oblique direction. Their origin we cannot explain, as, from the yielding character of the bone, we are unable to produce them in the corpse by stroke or pressure."—*British and Foreign Medico-Chirurg. Review*, July, 1852.

T. R. B.

68. *Whether a Blow on the Head, producing Fracture of the Skull, ever causes Immediate Death.*—Dr. LENTE, in a communication on the Statistics of Fracture of the Cranium at the New York Hospital (*New York Journal of Medicine*), after analyzing 117 cases, of which 21 recovered and 96 died, remarks: "In no case did death follow the receipt of the injury, until after the lapse of some hours, even in the most desperate cases; nor does it appear to be possible for an ordinary blow on the head, producing fracture of the skull, to cause immediate death. In a recent criminal trial of great interest, it will be recollected that at one stage of the proceedings it was much discussed whether a blow upon the head with an ordinary weapon capable of inflicting death could produce this result instantaneously. Many eminent surgeons were examined, and the general impression was that the thing was exceedingly improbable, if not impossible, and the question was thus decided."—[See this *Journal* for April 1852, p. 579.]

Professor F. H. Hamilton, of Buffalo, in his table of Fractures of the Cranium, the cases amounting to 33, of which 21 recovered and 12 died, according to the reporter, arrives at a similar result.—*Buffalo Medical Journal*, September, 1852.

T. R. B.