

over the neck and front of the chest, and the breathing, half-laboured, half-panting, wheezes in agony of distress. Many such cases occur in the practice of every physician of experience, who will be able to confirm this fact, that proper treatment removes the exaggerated secondary consequences induced by the inflammation, and restores the patient to the same, or even to a better condition than that in which the inflammation found him. Improvement, however, continues but for a short time; a fresh accession of inflammation occurs with its attendant consequences; treatment again removes it; again does it recur, and again it is subdued by treatment; and thus, with alternations of fresh accessions and improvements, is the patient worried, until at length one such attack overwhelms him in irretrievable ruin.

The history, the nature, the reason, afford but a gloomy prospect in affections of the right side of the heart. With few, very few, exceptions, they arise and progress steadily unto death. They do not kill suddenly, because the right heart does not supply the blood necessary for the due maintenance and innervation of the nervous system, but they kill none the less certainly by the secondary effects which they produce in every organ, every tissue of the body.

(To be continued.)

THE INDUCTION OF PREMATURE LABOUR.

By CLEMENT GODSON, M.B.,

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IN proportion as the induction of premature labour gains more general recognition as a means of ensuring, under certain circumstances, the safety of both mother and child, it becomes more incumbent on obstetricians to determine which of the various methods that have been devised promises the best results to the individuals whose welfare is primarily involved.

That great differences exist in this respect cannot, I think,

attended by no greater risk than spontaneously occurring premature labour, its induction would be far more frequently undertaken than it is at present, saving the mother the sufferings of a severe labour, and resulting in the birth of a living child instead of a dead one.

That the operation may be undertaken under such favourable conditions I now venture to submit.

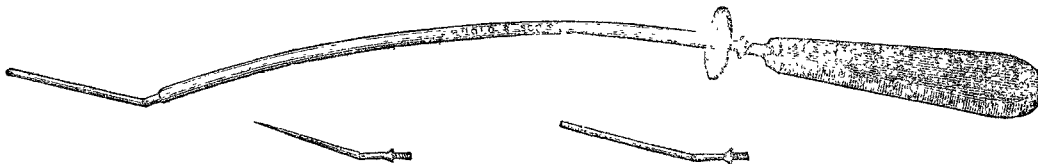
The means I advocate operates by surely and safely coaxing the uterus into an action which only differs from natural labour in being artificially initiated, and which is maintained and completed under all the conditions of labour spontaneously occurring at a corresponding stage of pregnancy.

Each of the methods in general use is, according to my experience, more or less formidable, in virtue of the amount and the kind of the manipulation which it involves. Most of them are practised in such a manner as to force on too hurriedly the uterine contractions; and that which consists in the evacuation of the liquor amnii stands self-condemned, as depriving the womb at the very outset of the all-important dilator provided by nature.

My mode of procedure consists in insinuating, night and morning, between the cervix uteri and the membranes, sponge tents of gradually increasing size, the first and each succeeding one being as large as the parts will admit. On removing each tent, and before replacing it by another, a warm douche, containing Condyl's fluid, is administered. I have found the use of one, two, and three tents to be sufficient, and have never had occasion to employ more than four.

The instrument by means of which the tent is placed in position is made for me by Messrs. Arnold, of West Smithfield. It is shown in the accompanying illustration, and will be found fully described in THE LANCET of April 2nd, 1871. It entirely obviates the use of the speculum, and being provided with what is equivalent to an universal joint, it enables the tent to be pushed, without extraneous guidance, between the cervix and the membranes, taking of itself the readiest path presented to it. For the same reason the membranes run no risk of puncture. The tents themselves are short, rounded at the extremity, and perforated to facilitate adaptation to the instrument.

The apparatus and the mode of its application are so simple, and so free from inconvenience and danger, that its



be doubted; and it is quite certain that the reputation of the operator will in a considerable degree depend upon the amount of risk and inconvenience which attends the procedure he habitually adopts. It also appears to me that, were it admitted that labour prematurely induced need be

use causes in practice little or no anxiety on the part of the patient, and, until labour sets in, she moves about without pain or inconvenience, regardless of the presence of the tent.

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A Mirror

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

UNIVERSITY COLLEGE HOSPITAL.

EXTENSIVE FRACTURE OF THE BASE OF THE SKULL;
COMPRESSION; DEATH.

(Under the care of Mr. MARSHALL.)

IN the present volume (page 597) we recorded three cases of fracture of the base of the skull, followed in a few days by paralysis of the facial nerve. In the sub-joined case the lesion was much more extensive, and was speedily followed by compression and death. The compression was evidently due to pressure exerted on the brain

by extravasated blood, as no depressed fragment of bone could be detected. It is also interesting to note the co-existence of the symptoms of concussion and compression, the latter however greatly predominating. The autopsy afforded a full explanation of all the symptoms present during life.

Frederick S—, aged thirty-seven, on Sept. 26th fell on his head from a height of fifteen feet. On admission, a quarter of an hour after the accident, his condition was as follows:—The respirations were forcible, and divided by a distinct interval. He was totally insensible. The right eyeball was prominent; subconjunctival hæmorrhage and distension of the upper lid; pupils equal, dilated, and insensible; pulse 80, and of moderate strength. There was complete paralysis of the extremities; slight bleeding from the nose, but none from either ear; extensive extravasation of blood beneath the scalp, across the line of the coronal suture, and in each temple. The respirations became separated by gradually lengthening intervals till the patient died, about fifteen minutes after admission, the pulse continuing to beat some time after cessation of respiration.

The laboured respiration pointed to some pressure on the pons Varolii and the medulla oblongata. The interval