opened, and had been discharging ever since. About the same time that matter formed, the right knee became "enlarged and stiff," and the leg flexed on the thigh; so that from that time he has been unable to walk at all.

On admission, he was found to be a scrofulous-looking boy, but fairly nourished. The left hip-joint presented the characteristic appearances of advanced morbus coxæ; the thigh was flexed on the pelvis, and fixed in that position; there was extreme wasting of the muscles of the buttock, and the head of the bone could be felt to be displaced and lying on the dorsum of the ilium. The thigh was shortened to the extent of an inch. On its outer side were two sinuses, running upwards in the direction of the joint, and leading down to carious bone. The ends of the tibia and femur on the right side were much enlarged. The knee was semiflexed, and ankylosed in this position. There was no cough, and the chest-sounds were natural. The urine was healthy, and contained no albumen.

On the 16th of April excision was performed in the ordinary manner by the longitudinal incision behind the trochanter. The head was found resting on the dorsum of the ilium, much diseased, the cartilages having vanished, and the bone being eroded and softened. The acetabulum was also much diseased, and a piece of bone, the size of a hazel-nut, was lying loose in the cavity. The limb was put up on an interrupted long splint.

The boy went on well after the operation, and the wound soon began to heal. On the 20th of May both the original sinuses were closed, and the wound was quite healthy. The splint was now removed, and extension made by a weight and pulley, the limb being supported by sand-bags. In the beginning of July the wound was all healed, except a minute sinus, which discharged a little thin sero-purulent fluid. He was allowed to get up, having been fitted with a leather splint. He was discharged on the 3rd of August, and sent home again into the country. There was then about an inch of shortening. The ends of the bones were firmly united, and there was free movement in every direction. He could walk on the left leg with the help of two crutches. In consequence of the disease in the left knee he was unable to put this limb to the ground.

Medical Societies.

OBSTETRICAL SOCIETY OF LONDON.

WEDNESDAY, NOV. 4TH, 1868.

DR. HALL DAVIS, PRESIDENT, IN THE CHAIR.

DR. T. B. HAY, Mr. E. Fletcher (Melbourne), and Dr. G. R. Playfair (Agra) were elected Fellows.

The discussion on the papers of Dr. Tilt and Dr. Meadows, on "Irritable Uterus" and "Flexions of the Uterus," adjourned from the October meeting, was resumed by

DR. ROUTH, who said that if he understood Dr. Tilt's paper accurately, it went to prove that the disease called irritable uterus by Gooch was very infrequent nowadays. Experience proved that abnormal complications existed in many of these cases; but while admitting this, it could not be doubted that the amount of complication often bore no relation to the amount of pain endured. And just as in an ordinary attack of tic-douloureux of the eye there was copious flow of tears and redness of the conjunctiva, not unlike inflammation, so it was possible that the uterus might be red and apparently inflamed, and yet this after all be only a simple tic of that organ. Such cases might still be cited as instances of irritable uterus. As bearing on the etiology of displacement, he would say that there were three varieties:—1. Those produced by inflammatory or other complications of surrounding parts—i.e., those retained by adhesions; these formed about 2 per cent. 2. The congenital, the percentage of which could not yet be determined. 3. The acquired, which might be met with either in an active state, with inflammatory or congestive symptoms, or in a quiescent state after all these had subsided. As regards anteversion, he believed it to be a more common affection than generally supposed, but, fortunately, often quiescent. It should be remembered that the normal position of a child's uterus, and also in early puberty, was one of anteversion; and in later life a fat omentum, heavy and loaded intestines, &c., might induce this flexion quite apart from any inflammatory disorder of the uterus itself. With respect to retroflexion, he would say that, given a healthy pelvis and healthy ligaments, retro-

flexion was impossible; but what did occur was this—the round ligaments and the ligaments of Douglas were both especially relaxed; the lateral less so. The points of support superiorly being thus removed, the organ was disposed to fall on one side or the other, and when top-heavy through inflammation or congestion of the fundus, this tendency was increased, and with this predisposition, a sudden accident, a jump or a fall, often proved an efficient exciting cause of retroflexion. If he was right in these views, it followed clearly that until the congestion or inflammation was at least partially subdued by treatment no permanent good could result from the use of instruments. Now, he had seen several cases of women who had been treated by Hodge's pessaries, and Dr. Hewitt's modifications of them, and were still uncured, and suffering intense pain from them, and who only got well when the complications had been overcome. And in these cases, where retroversion was accompanied with pain, inflammation, or congestion of the organ, nothing but depletion combined with absorptive remedies did good, especially the former; and whether accomplished by leeches, scarifications, or the hysterotomy, it was a necessary preliminary measure to the use of instruments. There was one variety of retroversion in which the pain in the fundus was most acute, but with little or no actual congestion or inflammation of the organ, the pain in this case being reflected from the ovary, which on examination would be found tender and inflamed. To treat this was to cure the disease, and reduce the case to one of simple retroflexion.

DR. SAVAGE said that this antagonism between practitioners so eminent as Dr. Hewitt and Dr. Meadows plainly showed that all opinion about uterine displacements was lamentably unsettled. He thought, therefore, that a reconsideration of the normal relations of the female pelvic organs with the pelvis might do something towards a more creditable uniformity of opinion. Dr. Routh had alluded to three ligaments of the uterus, but there were others, and those more essential, or what would become of Dr. Hewitt's vaginal base of support for his pessaries? The utero-pelvic cellular tissue, which enclosed the pelvic organs, had properties eminently fibro-elastic (muscular also in many parts of it), and was an integral part of the pelvic uterine system. The function of this tissue could be inferred from the following experiments on the dead body. Draw forcibly on the cervix with a vulsellum. The strain will be seen to begin with the utero-sacral portion where it divides to give passage to the rectum: thence it passes on to the broad ligaments; cut through these and the uterus comes down about an inch. In short, it is necessary to divide the pelvic cellular tissue before a notable displacement can be effected. Or to the vulsellum attach a weight, with the body in the sitting position. The weight must be heavy and the time long before the uterus appears at the vulva. Remove the weight, and the elastic property of the tissue, even in the dead body, causes the organ to retire. Cut through the broad ligaments close to the womb and the organ falls helplessly in all directions. If backwards, fix the neck, and there will be retroflexion (supposing the neck to be weak enough to bend); release the neck, and the back deviation is retroversion. He believed that there was always some prolapsus with retroversion. Owing to the presence of the rectum and bladder the cellular attachments of the vagina are limited to its sides, and this is why the vagina contracts not as a cylinder, but as a flat tube; the upper half being fixed, dilatation and contraction for the most part affect the lower half only, which must fall or rise in this to-and-fro relation with the former. No pessary, one excepted, can do much more than keep the womb out of the vagina. Then how account for the comfort attending their use? They ease the strain on the cellular tissue, which begins forthwith to regain its healthy tone. Aggravated cases of prolapsus of long standing are again and again held up, permanently reduced after the perineal operation; but should this tissue have lost its elasticity the best artificial perineum would be sure to give way. Hodge's was the best pessary, because in shape it corresponded with that of the contracted vagina, and with it the lateral vaginal action was unhindered, and the series of curative processes referred to permitted. It was a marital consideration which led to Hodge's curious modifications of the pudendal end of his instrument, and another authority still more considerate had cut off this end, and substituted india-rubber. It was regrettable to hear proclaimed far and wide pretensions to originality for what were in reality very unessential modifications. Of internal uterine pessaries, the record as a rule had been one of disaster. But, at the same time, he wished it to be understood that, in condemning intra-uterine pessaries, he did not include that of Dr. Hewitt, because he had had no experience in its use.

Dr. BRAXTON HICKS suggested that in this case, as in many others, between the two extreme views propounded, a large amount of intermediate truth existed, which was quite overlooked. He considered that for practical purposes cases of retroflexion were to be divided into four classes, which however ran into each other at every degree. In the first class he would place cases of congenital retroflexion, where no pain had existed previously, and those in which, the flexion having occurred a long time before, all pain had completely gone off, every resisting part having accommodated itself to the change. It was impossible to say how many cases existed of this class, because, as they suffered nothing, they did not apply for advice, but the state was observed in looking for other troubles. In the second class, the retroflexion was *in transitu*; the supporting tissues were not yet fully stretched, so that when any straining or quick action of the body ensued, the parts were put on the stretch, and pain was produced. To this class the largest amount of relief is given by mechanical support. In the third class he would place those cases where to the retroflexion a state of congestion, hypertrophy, and tenderness, more or less severe, was added. If these cases were handled roughly per vaginam, or with the sound, no doubt much mischief might ensue; but if the uterus could be replaced by the postural mode, or even by the sound gently used, then, the uterus being free from concussion against the sacrum, and the tension being taken off the ligaments, great relief would be obtained. The organ could be kept in position by Hodge's pessary, the action of which was not so much to push the fundus up, as to keep the os uteri so far backwards that the retroflexion could not recur. In the fourth class he would include all those cases where the uterus was reflected, and either tied down by adhesions, weighed or pushed down by heavy tumours, or with a very tender ovary, &c., where the use of mechanical support would be generally more distressing than a means of relief.

Dr. BARNES believed that simple retroflexion was a cause of real and serious distress in many cases. He found that congenital retroflexion was more frequent than it was supposed to be by Drs. Routh and Hicks. Cases of severe suffering in single women due to it had come under his care. A year ago he was asked to see a young lady who had long been suffering from obstinate constipation; there being pelvic distress, he was requested to examine. There was decided retroflexion. The body of the uterus, turned back in the hollow of the sacrum, pressed like a ball-valve upon the rectum, impeding defecation; and after a time the intestines, from being constantly distended, had become paralysed. A Hodge's pessary gave quick relief, and gradually the uterus rising into its place, the intestines regained power. It was therefore certain that inflammation or other disease of the uterus was not necessary to the production of retroflexion. A most common cause was childbirth or abortion. In many cases where he had been called in to treat secondary puerperal hæmorrhage, he found retroflexion, and when the retroflexion was relieved, the hæmorrhage commonly stopped. After labour, if involution were retarded, and the patient got up too soon, the uterus was apt to roll backwards, and if not rectified at the time the retroflexion became chronic, and various disorders ensued. To restore the body of the uterus to its place Hodge's pessaries answered admirably. He concurred in what Dr. Savage had said about bringing out modifications of Hodge's pessary under new names. Hodge himself had made various forms. The one thing to remember was the principle. It was a lever, and must be made to float with the vagina. It should not be fixed. A common fault in the pessaries was that they were made too large, so as to stretch the vagina, which was destructive of the principle of the pessary. He thought that Hodge's pessary could often be used advantageously whilst there was inflammatory complication. By supporting the uterus in its due relations, the hyperæmic condition of the body was relieved by the freedom afforded for the return of the blood from the engorged vessels. It was by no means illogical to treat the epiphenomena, the consequences of the disease, first. It was a fallacy to disregard these, and to limit our attention to the presumed cause. In most conjunctures in medicine we were compelled to treat the secondary complications. Indeed, it was only by observing and removing them that in many cases we were enabled to trace back and to discover the primary disorder.

Dr. SQUIRE wished to protest against the use of the hystero-tome as a means of depletion in these cases; injurious and dangerous results he had known to follow its adoption. Ovarian irritation also would subside under other remedies than leeching and blistering, if the use of alcohol were prohibited. In-

volution of the uterus was greatly aided by lactation, and retarded by alcohol, the use of which ought to be limited where lactation is not carried on. He could not consider the puerperal state as a disease of more than a week's duration, though careful management was necessary for at least a month longer.

Dr. PRIESTLEY said that he recollected the time when uterine flexions were denied a place in uterine pathology by some authorities, and even now eminent practitioners were not in accord as to their frequency and importance; indeed he was informed by Dr. Greenhalgh that so eminent a teacher as Dr. Churchill, of Dublin, had never as yet met with antelexion in the unimpregnated uterus. He quite coincided with Dr. Barnes in reference to the frequency and severity of the local symptoms sometimes associated with retroflexion as their direct cause. He could indeed testify that within his experience retroflexion of the unimpregnated uterus had been productive of very grave symptoms. Uncontrollable chronic vomiting had in some cases been a prominent feature. In another case, in which he had ascertained by examination that there was acute retroflexion of the uterus, the patient had for some years been suffering from what appeared to be progressive paraplegia, until she lost almost entirely the power of walking. The use of a Hodge's pessary gave great relief; the patient began soon to walk little by little, and was now gradually regaining the use of her limbs. In this case there were no symptoms distinctly pointing to uterine derangement, and the womb was not in the least degree morbidly sensitive to touch. When patients experienced pain in the pelvis in connexion with uterine flexions he felt confident that it was not always due to some superadded congestion or inflammation of the uterus—that it did not, indeed, always proceed directly from the uterus itself. In a lecture published some years ago he had pointed out that the cause of the attendant suffering was often to be found in the condition of the ovaries. In the cases where the results were felt in distant organs, pressure caused by the displacement could not account for the symptoms, but they were probably due to reflex effects upon the nervous system. He had no hesitation in recognising the classification suggested by Dr. Hicks. In treatment he pursued an eclectic course, dealing with each case in accordance with its own peculiar features. With respect to depletion as an occasional treatment, he preferred that moderate amount which would be just sufficient to relieve the congestion present rather than the frequently repeated and larger bleedings alluded to in the discussion, and he could not regard depletion alone as a remedy for the displacement. In conclusion, he could bear willing testimony to the value of Hodge's pessaries in suitable cases.

Reviews and Notices of Books.

Army Medical Department Report for 1866. Vol. VIII.
London: Harrison and Sons, for her Majesty's Printers.
1868.

[FIRST NOTICE.]

THE Blue Book of the Army Medical Department for 1866, just issued, is a very good one, and contains many excellent papers; it is, on the whole, the best that has yet appeared. On turning over its pages, the reader at once perceives that a change has been made in the arrangement of its materials. Instead of being divided, as formerly, into three distinct sections—the Statistical, Sanitary, and Medical,—the two former have been incorporated; and those contributions which detail the history of an epidemic or describe the topography and sanitary aspects of a particular station, or those which specially treat of medical and surgical subjects, have been grouped together in an appendix at the end of the volume. The reader is referred, by means of a foot-note, to the papers contained in this appendix, whenever these afford additional information bearing upon the health of the troops. We think the authorities at Whitehall-yard have done well to recast their volume, and that they have already effected a considerable improvement. We would suggest that the Statistical Tables and the Abstracts of Meteorological Observations should be transferred to the end of the volume. In their present position they are apt to mislead the reader into the supposition that the appendix consists of these tables, whereas it contains some of the