we must do this without exerting such pressure on the latter as will either provoke reaction or interfere with healthy circulation in them.

The mode of dressing I adopt is as follows:—Let us suppose an amputation of the breast. I insert a wire suture at every inch; having twisted them, I cut the wires off at about an inch from the twisted portion; when this is completed, and the edges of the wound lie nicely in contact, I lay along each side of it, and parallel with it, two large compresses of lint filled with soft cotton, taking care to get their edges under the ends of the wire: these compresses are for the purpose of making elastic pressure all along the sides of the wound, thus preventing any accumulation of blood under the flaps; and they also interpose between the skin and the cut ends of the wire sutures, and prevent chafing; over the track of the wound a wet compress can be laid, and the whole secured by a few turns of a roller, applied with moderate tightness. If there has been any dissection of glands from the pouch of the axilla, a sponge rolled in lint, or a handful of cotton, can be similarly used, to prevent accumulation of blood; and when the arm is brought to the side, sufficient pressure is made. A little ingenuity will adapt this mode of dressing to many operations. I have used it in amputations of limbs, castration, the removal of all tumours, and for the dressing of scalp wounds (omitting the stitches, or inserting as few as possible), and I have found it most useful. One advantage it possesses is, that we can easily inspect the line of wound, and sponge it clean without disturbing it: blood in the wound is the great cause of delay and danger after all operations—it prevents adhesion, causes suppuration, and tends to produce phlebitis and purulent absorption, or angioleucitis; and, as this mode of dressing prevents its accumulation, it so far diminishes the risk of operating.

ART. XVI—*On a New Sign of Post-partum Detachment of the Placenta.* By JOHN CLAY, M. R. C. S., Senior Professor of Midwifery, Queen's College; and Surgeon Accoucheur to the Queen's Hospital, Birmingham.

THE rules usually given in obstetric manuals, and text-books, for the management of the placenta, after the birth of the child, are:—to wait for a pain; or, to carry the finger along the cord to the os uteri, and, if its root can be felt, it may be fairly assumed that the placenta is thrown off, and may be easily extracted by gentle traction of the cord, with the aid of external manipulation. If these instructions be faithfully carried out,

can we rely upon the facts elicited as infallible proofs that the placenta is separated from the uterus? Pain may mislead, as it frequently arises from other causes than contractions of the uterus; and even if the insertion of the cord can be felt, it is not always conclusive on this point, as the root of the cord may sometimes be felt when the uterus is in a flaccid condition, by using moderate traction on the cord, and yet the placenta be not thrown off. Besides, the patient often lustily complains of the smarting pains caused by the frequent examinations deemed necessary to ascertain the fact; and often she positively forbids such a mode of interference.

Four years ago I was led, from these causes, to investigate the subject, with the view of improving, if possible, upon the old mode of managing the deliverance of the after-birth. I thus ascertained certain facts, from which I came to the conclusion, that a very simple sign existed by which the separation of the placenta, after the birth of the child, might be indicated; and, having tested it in upwards of nine hundred cases, I hope I may be considered to be fairly entitled to lay the results at which I have arrived before the profession.

Before dividing the umbilical cord, I always apply two ligatures, and make both sufficiently tight to prevent the occurrence of hemorrhage. If the maternal part of the cord is now examined, it will be found to be in a flaccid condition, and almost free from blood; but if it be again examined, at an interval, say from one to three minutes, it will be found to have acquired increased specific weight, and that the vessels are more or less filled with blood. The one fact may be ascertained by poisoning the cord on the fingers; the other by slightly grasping the cord near the vagina, with the thumb and fore-finger of the left hand, and, with the fingers of the right hand, suddenly compressing it, when a well-marked sense of fluctuation is perceived underneath the fingers of the left hand,—a kind of resilience similar to the feeling produced when an elastic tube filled with fluid is suddenly compressed.

When the placenta is thrown off, or sufficiently detached to give rise to a tolerably free hemorrhage, the cord loses its increased specific weight and the hydrostatic property just mentioned. These phenomena occur so invariably, that *the loss of the previously acquired hydrostatic properties of the cord after the birth of the child constitutes the sign of detachment* previously referred to.

The whole of the phenomena are manifested in three stages, viz.:—1st, a state of flaccidity; 2nd, a state of repletion; 3rd, a state of flaccidity.

If the umbilical cord be tightly grasped by a spasmodic

contraction of the os uteri, or by irregular contractions of the body of this organ, the *loss* of the particular hydrostatic properties may be delayed for a brief interval; but in a few seconds the spasm subsides, and those phenomena are produced which indicate the separation of the placenta, and that this structure may be safely extracted. These signs are not, of course, always equally marked in every case,—often requiring experienced tactile management, in order to detect their presence. When the uterus is in a flaccid condition, the phenomena are manifested in a very slight degree, but are still perfectly reliable. On the other hand, when the uterus is contracted, with some degree of firmness, on the placenta, they are so well marked that the most inexperienced may readily detect them. In cases of partially adherent placenta, the disappearance of the hydrostatic properties, after being once fully developed, and the failure to deliver the placenta by the usual manipulations, have always indicated to me the necessity for promptly adopting artificial detachment by the introduction of the hand. In twin cases, if the cord is firmly tied, I have invariably found that the signs persisted until the birth of the second child. In one case, where the hydrostatic properties disappeared, after being well marked, before the birth of the second child, I found, on examination, that the corresponding placenta was detached, and I at once removed it, which otherwise would probably have been suffered to remain. Neither mother nor child incurred any risk.

It sometimes occurs that the placenta is separated simultaneously with the birth of the child. In this instance, the first series of phenomena may be absent; and it may be prudent to wait before proceeding to extract the placenta, although it may be generally effected with safety.

The practical value of the application of these facts to obstetrics is obvious, as by merely compressing the cord in the manner previously indicated, the precise time of separation may be easily ascertained, the placenta at once extracted, and the patients thus freed from those frequent annoying examinations usually employed. The prompt delivery of the placenta, on the first efforts of the uterus, is very important, as this organ contracts then more efficiently, and the risk of hemorrhage is not so great, and it may be fairly assumed that the puerperal convalescence is not so protracted as under a more dilatory proceeding.

To students, or inexperienced practitioners, it might be a safe instruction to impart,—not to interfere in the extraction of the placenta so long as the hydrostatic properties herein defined are persistent.