active condition during lactation, that this points to the high nervous tension of the ganglionic systems which is an essential factor in the reflex resultant which I am endeavouring to prove. Again, the fact of movements of the head causing almost coincident palpitation of the cardiac region points conclusively to the sympathetic influence at work in the whole excito-motor system. I am therefore of opinion that the eclampsia in the cases I have related was due to shock and not to diversion of blood or of nerve force. Now I have arrived at the following conclusions: given a very rigid cervix and a high tension of nerve force we may have convulsions occurring during labour, and that when these two factors are present it is possible to anticipate from sudden stretching of the unyielding parts conveying through a nervous system in such a state as I have mentioned a reflex influence on the brain proper causing shock and resulting in eclampsia. *En passant*, to strengthen my argument, I am wishful to refer to an analogy which, although very limited in degree, I consider applicable to the intention of the paper, and I therefore introduce it. I allude to sickness. Dr. Barnes places ovario-uterine vomiting under the category of convulsions. We are all of us well aware of the old nurses' proverb of a sick labour being a safe one, and we also know as a fact that it is usually coincident with the passage of the globe-head through the cervix, and therefore a safe one, because the convulsion explodes in the gastric organ. I had almost forgotten to draw attention to the two other cases, and refer these to the same category as Mrs. P——'s as to cause and effect, and I have said that the resultant is due to the reflex shock conveyed to the brain from the stretching of a rigid cervix either at will or by the head of the foetus passing through it. And now I have arrived at a very important part of the subject—viz., the treatment of such cases as I have related. I shall consider it as an axiom that no practitioner should enter a lying-in room without chloroform. This is the sheet anchor in such emergencies as I have been discussing. And I go as far as to assert that its presence at hand is as essential, and probably more so, than ergot.

I have attempted to show that I have produced one form of eclampsia puerperalis by mechanical stretching of the cervix uteri without any poisoned state of blood. I shall consequently arrange my method of treatment under two heads: First, the preventive or forestalling; secondly, the immediate. I will commence with venesection, which I must discard as coming under either class, preventive or immediate. It may possibly be of service in relieving subsequently the comatose condition which in vascular temperaments arises from arrested circulation due to a relaxed reactionary condition of the vaso-motor system following the shock. But in two out of the three cases mentioned in this paper the system was anything but replete—in fact, the reverse—although the third case was not so hypernotic as to demand bleeding. Drawing your attention to my previous syllogism—viz., that given a rigid cervix and a certain explosive standard of the nervous system, I say there is every probability of eclampsia resulting, and on these grounds I think I may justify my belief in basing the *modus operandi* of treatment by using such means and administering remedies which are known to relax the tissues in question and reduce central nervous irritation. And amongst the preventive class I will take the following: belladonna, opium, bromide of potassium, chloral, and chloroform. Chloral has the combined effects of reducing the central nervous irritation as well as relaxing the tissues. Bromide of potassium acts more directly on the structure of the tissue of the cervix itself. When ordered as a preventive, I prefer giving the two drugs in combination. As to the immediate treatment when the paroxysm is going on, chloroform must be our sheet anchor. No recognised anæsthetic acts quicker, unless it be nitrite of amyl, the virtues of which I have no experience of. The former must be pushed to the surgical extent, and repeated as often as there is a recurrence of the eclampsia. After a time the patient remains in a more or less comatose condition, which may continue for some hours, or even days, without being fatal. The pulse and other general indications must be our guide as to whether we should use the lancet or not. We must use our discretion. I need not give any caution as to the necessity of avoiding all peripheral irritation, such as dashing cold water over the face, sinapisms, &c., which methods to check convulsions were rife in days gone by on account of their supposed restorative action, but which in

enlightened scientific periods have been proved by the highest of obstetric authorities to act quite in the reverse manner. One word as to the forceps, and I am well aware of the fact of my trespassing on dangerous ground when I say I should forbid the use of them unless the head is pressing on the perineum free of the cervix, and then will be the time and not before when we should seek instrumental aid.

Brighton.

ABSTRACT OF PAPER ON PERICHONDRITIS OF THE LARYNX.

By F. DE HAVILLAND HALL, M.D., F.R.C.P.

AT the meeting of the British Medical Association in Leeds, after the reading of the above paper, the following points were submitted for discussion:—1. Is there such a disease as primary laryngeal perichondritis? 2. Are there any characteristics by which the laryngeal perichondritis of tuberculosis, of syphilis, and of cancer can be differentiated? 3. The occurrence of laryngeal perichondritis in enteric fever. 4. The causes of the dyspnoea. 5. The prognosis. 6. The treatment of laryngeal perichondritis.

Evidence in favour of the occurrence of primary laryngeal perichondritis was adduced, but the author laid stress on the difficulty of excluding the possibility of the perichondritis being of a secondary nature. In the diagnosis of the different forms of secondary perichondritis much difficulty was at times experienced. The presence of tubercle bacilli in the secretion from the larynx, pale and puffy swelling of the epiglottis and arytenoids, the occurrence of ulceration in the inter-arytenoid fold, and the existence of apical mischief in the lungs, spoke for the tubercular origin of the disease; the absence of pain, extension of ulceration from the pharynx, a history of past syphilitic manifestations, and the effect of full doses of potassium iodide were the chief points to be noted in syphilitic cases. In perichondritis of malignant origin, a thickened and infiltrated condition of the thyroid and cricoid cartilages and surrounding tissues, and the occurrence of hæmorrhage from the larynx, were the chief diagnostic points. Microscopic examination might be of use. The cause of the perichondritis of enteric fever was attributed to defective nutrition rather than to any specific inflammatory process. The absence of symptoms was stated to be a marked feature of typhoid perichondritis. (Edema of the larynx, immobility and median position of one or of both vocal cords, abscess, impaction of the necrosed cartilage in the glottis, collapse of the cartilaginous wall of the larynx, and, finally, in the more chronic cases, stenosis from cicatrization, were mentioned as the causes of the dyspnoea in laryngeal perichondritis. The prognosis in this disease was always a gloomy one; in the primary and limited variety, however, it was more hopeful. Of secondary perichondritis, the traumatic and syphilitic varieties were the most hopeful, though, in the latter, stenosis, as the result of cicatrization, usually occurred. In cancer the occurrence of perichondritis accelerated the end by exhaustion from the profuse suppuration. Typhoid perichondritis was a very grave complication.

Functional rest and the use of ice-bags, or Leiter's coil externally and ice internally, were enjoined for the treatment of the disease at the outset. (Edema should be treated by the application of cocaine and scarification, abscesses should be opened, and necrosed cartilage should be removed by the laryngeal forceps. Early tracheotomy was advocated, and subsequent dilatation by Schroetter's method practised. Allusion was made to the plan originally suggested by Dr. Duncan Gibb of splitting the thyroid and removing dead structures. This plan has been recently advocated by Dr. Sajous, and its employment in suitable cases was recommended.

OLD STUDENTS' DINNERS.—At the annual dinner to be held at St. Mary's Hospital Medical School, on Wednesday, Oct. 2nd, the chair will be taken by Dr. Broadbent, in place of Dr. Lees, who is unavoidably prevented from being present.—At St. Thomas's the annual old students' dinner will be held in the governors' hall of the hospital on Oct. 1st. Dr. Harley will preside.