except under exceptional circumstances occurring in disease, where such a dose might be injurious. Such a dose might probably set up inflammation of the kidneys, but he did not think it would produce peritonitis. He thought the defendant was justified in concluding that the irritation of the kidneys was due to turpentine, and that this irritation might have aided the death; but he did not think such irritation had produced peritonitis, although he could well understand how a man who had not studied the subject thoroughly might come to the conclusion that it had set up peritonitis, and give that as his honest opinion, while a man who had gone into the subject would not have done so. He had always been accustomed to insist very stringently upon the dangers of a medium dose of turpentine, like one or two drachms, and upon the necessity of giving very small doses or large ones.

Mr. Winch: Do you mean to say that a large dose is really safer than a medium dose?

Dr. Lauder Brunton: Certainly.

Mr. Winch: Then the cause of death on the certificate should be "under-dose?"

Dr. Lauder Brunton: No, it is not from an under-dose, because two teaspoonfuls may be absorbed into the system, whereas a larger one would pass out through the bowel and not be absorbed. He thought in the circumstances he would have taken precisely the course pursued by Mr. Stubbs. He would not have put the words "given by another doctor," unless suspicion of having given it was likely to fall upon himself.

Dr. Job Collins agreed with Dr. Lauder Brunton, but thought it possible that turpentine, being of great power when applied to the skin or mucous membrane of the intestine, might be a contributory cause of peritonitis by producing enteritis. He thought the case one which called distinctly for a post-mortem examination, as they were perfectly in the dark at the present time.

Mr. Justice Day characterised it as a very serious case indeed, as there could be no doubt that if the defendant had maliciously intended to injure the plaintiff by accusing him of causing the death of a patient by incompetence or negligence in the exercise of his profession, he had accused him of that which was likely to lead to his ruin, and consequently had inflicted a grievous injury in any point of view. After the judge had reviewed the facts of the case at some length, the jury found for the plaintiff, and awarded damages to the amount of £200. Judgment was given in accordance with the verdict, and a certificate allowed for a special jury, costs following in due course.

Correspondence.

"Audi alteram partem."

THE OBSTETRIC BINDER.

To the Editors of THE LANCET.

SIRS,—As a practitioner who has attended over 2000 cases of midwifery, and having paid perhaps more than usual attention to the binder, I wish to make a few remarks on a subject which I see has caused some discussion at the Obstetrical Society's meeting. In the first place, I noticed that the remarks passed at that meeting were favourable to, and nothing was said against, the use of the binder.

The binder, as commonly used, consists of a strong broad piece of diaper, a towel, or bolster-slip, or one of the shaped binders. A pad is very often placed over the uterus first, and pressure made upon this with the binder in a direction downwards and backwards. It is applied (or should be) after the expression of the placenta, and not, as I have frequently seen, directly after (or even before) the birth of the child. The only cases in which the binder should be used during labour are those occurring in women with pendulous abdomens, a condition in which the child is carried, to use a midwife's term, "forward." It may then be applied in the earliest stages, and drawn tight during each pain until the head engages the brim, when it should be at once removed. To apply it after the birth of the child and before expulsion of the after-birth is bad practice, as it is perfectly useless, and one cannot compress the uterus to express the placenta through a strong binder. Now comes the question, Why is the binder applied after labour? The answers are: (1) To counteract sudden lowering of the intra-abdominal pressure, and to assist the

involution of the abdominal parietes; (2) to compress the uterus; and (3) to comfort the patient. With regard to answer No. 1, as Dr. Herman remarks, the application comes too late to counteract intra-abdominal pressure; and does support assist, or is it necessary to assist, involution? When we see immense tumours or organs removed over which the skin and soft parts have been greatly stretched, and where no pressure is afterwards applied or could be borne, and observe how quickly the parts resume their normal appearance, and after witnessing involution after labour in animals, I think we may safely say that the abdominal parietes will involute without any pressure being brought to bear upon them. 2. Compression of the uterus. This may be divided into two kinds—viz.: (1) Temporary compression for the first few hours to prevent relaxation; and (2) continuous and increasing pressure during the whole of the lying-in period. With the first of these I entirely agree. I think that steady pressure on the womb for the first twelve hours is decidedly beneficial. As to the second, let us glance for a moment at the condition of the parts directly after the conclusion of labour. The uterus has contracted to the size of a small cocoanut. It is heavy, its sinuses being filled with coagulated blood. The ligaments, sacro-uterine especially, are greatly relaxed. The vagina is patulous and relaxed. Now, what effect will the *continuous* pressure of a binder, in a direction downwards and backwards (I see Mr. Duke of Dublin, in a letter to THE LANCET, recommends the pressure after labour to be applied downwards), have upon the uterus in its present state? It will change its normal direction, one of slight anteversion, into one of slight retroversion and prolapse, bringing the heavy uterus with its relaxed ligaments into the line of a vagina the walls of which are unable to support it. What more likely to cause permanent prolapse than this? Gynaecologists well know that the anatomical position of the uterus, and its relation to and the condition of the vaginal walls, are safeguards against prolapse. I have emphasised the word "continuous" by italics, as that is where I consider the danger lies; the medical man is so careful, and the patient so particular to have the binder tightened to the fullest bearable extent, to improve the figure. I think a great proportion of cases of prolapsus uteri owe their origin to this treatment. (3) As regards the comfort of the patient. A great deal of this may be put down to habit and fancy. The woman has always been taught that a binder is necessary, and looks for it, and therefore fancies she feels better for it. German women recover quite as well as English, and the binder is unknown to them. The "pendulous belly" I do not consider to be owing to non-binding, but to the fact of too early getting up, before involution of the abdominal walls is complete.

In conclusion, I consider the binder may be of use in (1) the earliest stages of labour occurring in women with "pendulous bellies"; (2) as a temporary support after labour (say, for twelve hours). It is detrimental if (1) applied before expression of the placenta, or (2) continuously after labour. Should a binder be imperatively demanded, I would suggest cutting out a circular piece of it, of which the centre would be midway between the umbilicus and pubes, thus leaving the uterus free from pressure. I also consider the prone position, as soon as the patient can bear it, occasionally will relieve the passive hyperæmia which is apt to occur in the long-continued dorsal position.

I am, Sirs, yours faithfully,
Marple, April, 1890. HARRY BURTON, M.R.C.S., L.S.A.

"CARDIAC DISEASE IN PREGNANCY AND LABOUR."

To the Editors of THE LANCET.

SIRS,—Having read Mr. Edge's article on the above subject in your issue of March 8th, I should, like the author, be glad to see the opinions of some authorities on the views therein enunciated.

The object of the paper seems to be to advocate the adoption of two new rules for the treatment of cardiac disease in women—(1) In unmarried women forbid marriage, and (2) in pregnant women induce abortion at the third month. It does not clearly appear whether the author deduces these radical suggestions from the result of the case he reports, or whether he simply uses that case as a text on which to base his advocacy of that plan of treatment. But in either event it is evident that his whole contention for the adoption of these sweeping rules is based on two assumptions:

(1) that in the reported case treatment during labour was powerless to avert the fatal result, and (2) that labour will be found to be thus inevitably fatal in so high a proportion of women suffering from cardiac disease as to render it advisable to prevent the possibility of its occurrence in these cases.

Now, without stopping to inquire what proportion of such cases come under notice early enough for the application of this treatment, let us come to the point at once and ask, Is either of these assumptions justified? For if not, then clearly the very foundations of the argument are unsound, and any conclusions built upon them must fall. With regard to the first, I would ask, Were all reasonable precautions taken to reduce the danger from labour to a minimum? Was every effort made to avert the fatal result? Mr. Edge himself supplies to both these questions an answer in the negative; for if we compare the treatment actually adopted with that which he tells us should be followed in these cases, we find that a number of most important measures were omitted. In the first place, we find that the case was entrusted to "the care of a trained midwife," and apparently the surgeon only attended on information being sent to him that the patient had become "suddenly worse." Was this the proper time for him to attend? Having anticipated danger in the second stage of labour, ought he not rather to have been in attendance from the commencement of that stage, so that even if no preventive measures were taken, at least the approach of danger might have been promptly recognised and *immediately* met by appropriate treatment? Then, again, it would appear from the report that respiration continued after the heart had ceased to beat. Under these circumstances should not the hypodermic injection of ether, or other treatment directed more especially to the cardiac failure, have been preferred to, or at least combined with, artificial respiration? Mr. Edge advocates anesthesia by chloroform or ether, hastening the labour by forceps or turning, and cupping or venesection should the heart's action fail; yet none of these measures, except hastening the labour, and that only when too late, seem to have been employed. When we thus see how altogether incomplete was the treatment adopted, I think we may be allowed to doubt whether the fatal result must be regarded as having been inevitable. But even supposing that in this case it was so, there still remains the question whether this occurs in a large enough proportion of cases to justify Mr. Edge's sweeping contention that no woman the subject of cardiac disease should be allowed to give birth to a viable child. With regard to this question I would ask, Is not the treatment of labour which he himself advises in these cases when the pregnancy is allowed to proceed, and which (with the possible exception of cupping and venesection) is, I believe, that usually adopted—is not this method of treatment sufficiently safe to render altogether unjustifiable the proposed treatment by prohibition of marriage or induction of abortion?

Mr. Edge, as a scientific hospital surgeon, appeals to authorities for judgment on his views; I, as one of the humble race of general practitioners who, not having the same opportunities for personal research, have to look still more to authorities for guidance, would like to support his appeal.

I am, Sirs, yours truly,

Blackpool, March, 1890.

ARTHUR BAXENDELL.

HYDERABAD CHLOROFORM COMMISSION.

To the Editors of THE LANCET.

SIRS,—I telegraphed yesterday to request you to omit the *Pioneer* article altogether from the Chloroform Report, as it has been pointed out to me that the passage—"Syme's successors have disregarded his teaching," &c., might reasonably be held to refer to Sir Joseph Lister or Mr. Annandale. On page 518 of Spence's *Surgery* the following passage occurs: "The state of the pulse should be ascertained before beginning the inhalation, and carefully watched throughout." Caird and Cathcart's "Surgical Handbook" says, "Reflex inhibition of the heart through the vagus might cause death" (page 11); and under the heading "Dangers and Cautions," "secondly, *cardiac*—syncope, or complete cardiac failure." Neither Sir Joseph Lister nor Mr. Annandale was thought of when this teaching was alluded to, and I can only express my deep regret that the phrase, which is susceptible of misinterpretation,

should ever have been allowed to appear in connexion with the report.—I am, Sirs, your obedient servant,

EDWARD LAWRIE, Surgeon-Major.

Hyderabad, Deccan, March 27th, 1890.

MEDICAL OFFICERS OF SCHOOLS' ASSOCIATION AND INFLUENZA.

To the Editors of THE LANCET.

SIRS,—The annual general meeting of the Medical Officers of Schools' Association will be held on Tuesday, April 29th, at the rooms of the Medical Society, 11, Chandos-street, at 3.30 P.M., when a discussion on Influenza will be opened by Dr. E. Symes Thompson. The following are the chief points which will be submitted for consideration:—Is influenza merely catarrh in an epidemic form? Does occupation or exposure modify the access or course of the disease? How does the disease affect communities, especially schools? Is it contagious? What is the incubation period? Is segregation desirable or possible? Does one attack secure immunity? Relapses and repeated attacks; association of the disease with measles &c.; classification; treatment. In the belief that the subject is one worthy of attention, and that it would be useful to collate the large amount of evidence which must now be in the possession of many observers with respect to the points already noted especially, the Council of the Association desires to extend a cordial invitation to all medical men who are interested in the question and who may be willing to attend or take part in the discussion.

We remain, Sirs, faithfully yours,

ALDER SMITH,

April 12th, 1890.

CHAS. EDWD. SHELLY, } Hon. Secs.

THE INQUIRY IN REGARD TO METROPOLITAN MEDICAL CHARITIES.

To the Editors of THE LANCET.

SIRS,—As your readers know, the Government have expressed their readiness to appoint a Select Committee of the House of Lords to make inquiry with regard to all hospitals and dispensaries and charitable institutions within the metropolitan area for the care and treatment of the sick poor, which possess real property or invested personal property in the nature of an endowment of a permanent or temporary character, and with regard to the amount of accommodation provided out of the rates, and the management thereof. A large number of members of the profession signed the petition which has led to this investigation.

I am desired to request you to allow me, through your columns, to ask your readers, especially those who are engaged in general practice, if they would furnish, for submission to the Select Committee, evidence in regard to such defects of our existing charitable medical system as have come to their knowledge, and more particularly explicit evidence in regard to cases in which persons have without justification claimed on charitable grounds the honorary services of the medical or surgical staff at hospitals and dispensaries when they were in a position to pay the ordinary fees. It would be of service also if they would give evidence in regard to cases in which the ailments were of such a trivial character as to make attendance at a hospital or dispensary unnecessary. I should add, perhaps, that a circular on this subject is being sent to the members of the profession who signed the petition.

Communications in regard to this letter should be sent to me at the address given below.

I am, Sirs, your obedient servant,

C. S. LOCH, Secretary.

Charity Organisation Society, Central Offices, 15, Buckingham-street, Adelphi, London, W.C., April 16th, 1890.

GENERAL HOSPITAL, NOTTINGHAM.—The annual meeting was held on the 9th inst. A satisfactory feature of the report, which was read and adopted, was a substantial reduction in the expenditure on account of each patient from £5 11s. 10d. to £4 13s. 11d. The financial position showed a total of cash in hand of £1007 6s. 3d. There had been a very considerable falling off in the subscriptions.