who write from the point of view of the consulting surgeon. In dealing with the subject from the standpoint of the general practitioner I can endorse the impression that is now gaining ground—i.e., that it is much more common than has hitherto been supposed. I find it to be among women perhaps the commonest affection, with the exception of dyspepsia, to which they are liable. If those cases in which movable kidney gives rise to no symptoms are included, it is, in my experience, the commonest affection of all; but I can say nothing statistically upon its prevalence, for I seldom examine for it unless the symptoms are suggestive of its presence.

Reading.

TWO CASES OF UTERUS SEPTUS, AND THE EFFECTS OF THIS CONDITION UPON LABOUR.

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CASE 1. — A married woman aged thirty-seven was confined on Feb. 14th, 1891, at the General Lying-in Hospital. Labour was natural, the child was living, and the placenta was expressed without difficulty. Fifteen minutes after delivery I was asked to see her on account of continued hæmorrhage and collapse, coming on after expression of the placenta. On putting the hand on the abdomen I was at once struck by the peculiar shape of the uterus, the right half being much larger and reaching at least three inches higher in the abdomen than the left, and the fundus having a marked antero-posterior depression. On vaginal examination the finger impinged upon a median antero-posterior septum extending from within one inch of the os externum to the fundus. On the right side of this septum two fingers passed easily into a large cavity, from which some adherent membranes were removed; the placental site was examined, and was found to be situated partly upon the septum. On the left side the finger passed with difficulty into a long narrow cavity lined by thick soft decidual membrane, of which quite a handful was peeled off with the finger. There was no vaginal septum. The hæmorrhage ceased after the removal of the decidua, and the patient made a good recovery. For permission to use the notes of this case I am indebted to Dr. G. E. Herman.

CASE 2. — The patient was a married woman aged thirty-six. I was asked by Mr. Sutcliffe of Clapham to see this case. Labour having been very prolonged, he was called in to see her, applied the forceps, and extracted a living child with great difficulty; no abnormality had been noticed during the application of the forceps. Afterwards the uterus remained enlarged, and the temperature became high, varying between 103° and 100° F. until the sixteenth day after her confinement, when I saw her for the first time. At this time the fundus uteri was situated two inches above the level of the umbilicus, the left side extending much higher than the right, and there was a distinct antero-posterior depression at the fundus in the middle line. On examination, the finger passed within the os uteri and impinged upon the firm edge of an antero-posterior septum at the level of the internal os uteri, which extended to the fundus. There was no trace of a vaginal septum. On passing the whole hand into the vagina the finger could be introduced on the left side of the septum into a cavity two inches and a half in length, whose walls were rough; the placental site was found to be in this cavity and situated at the fundus, but no debris or clots remained. The finger was then withdrawn and passed with great difficulty on the right side of the septum into a cavity two inches long; this was found to be lined with soft decomposing decidua, which was peeled off with the finger. There was a very offensive discharge. Both cavities were washed out with iodine solution, and the patient recovered completely but slowly.

Remarks. — The first patient had had two children and one miscarriage; the second had had six children and one miscarriage. Neither had given birth to twins, nor had anything abnormal been detected in their previous labours, although the first patient had always been confined in the hospital. On examination of the literature relating to this abnormality, after excluding doubtful cases and those of uterus bicornis, I can find only thirteen cases in which

an account of the labour is given. Of these five died—viz., two from peritonitis due to decomposition of retained decidua in the unimpregnated half of the uterus, one from septic peritonitis, one from rupture of the uterus, and the fifth died undelivered, owing to the small size of the os uteri of the impregnated half. In four cases the placenta was retained and adherent, but recovery occurred, although one suffered from peritonitis. In two frequent abortion occurred, with menstruation during pregnancy in one of these; and abortion occurring on one side, with pregnancy going on to term in the other half of the uterus, at another time. This is the only case in which twin pregnancy is recorded. In the remaining two cases labour was always normal, although pregnancy occurred seven times in one and five times in the other. A vaginal septum was present in two cases only out of the thirteen. From this record it will be seen that the chief danger arising in connexion with this malformation is that which was present in the two cases above recorded—namely, the retention of decidua in the unimpregnated half of the uterus and the resulting risk of decomposition and septic peritonitis. Next to this comes retention of the placenta and consequent post-partum hæmorrhage. It is curious that twin pregnancy should be so uncommon, and likewise abortion. Labour is not unusually prolonged as a rule. In one case menstruation was shown to occur from both sides of the uterus simultaneously. The rarity of the existence of a vaginal septum is also noteworthy.

The Chase, S.W.

GASTROSTOMY IN ONE STAGE.

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THE history of the operation of gastrostomy is clearly divided into two eras, that before and that since the practice advocated by Howse of undertaking the procedure in two stages. Previously the mortality was almost prohibitory; subsequently it has been greatly reduced, and is now variously estimated at from 30 to 70 per cent., the correct mean probably approaching to something like 50 per cent. for all operators. The reason that the mortality still remains so high is undoubtedly the late stage of the disease at which the operation is put into practice, for the simple exposure and attachment of the stomach to an abdominal wound would

A, Method of passing the ligatures in the stomach. 1, Glass tube. 2, Rubber tube with clip. 3, 3, Sectional view of glass rods over which the ligatures are tied. 4, Interior of the stomach. 5, Abdominal wall.

very rarely be fatal in a healthy subject. Jacobson, giving his own experience of nine cases in 1891, says that "in three patients the operation was asked for too late." Treves says: "One thing is certain, and that is, the operation is usually carried out too late." All surgeons of any experience in this matter say the same, and yet the prospect of systematically operating earlier in the disease seems to be remote, as this