granulations near the corners of the mouth, evidently caused by tartar on the teeth. These speedily subsided on removal of the exciting cause, with applications of nitrate of silver and interposition of dry lint.

The patient living five miles distant from my residence, I was obliged, after the first week, to entrust the occasional dressing of the wound to his son, and rather more adhesion between the new lip and gum occurred than I had intended, but a fair amount of movement of the new lip is obtained, and with an effort the mouth can be completely closed. The moustache and beard are now (October 31st) grown, and he has lost the sallow complexion before mentioned. The parts are perfectly firm and healthy, and not the least pain or inconvenience is felt. No dribbling of saliva has occurred from the commencement.

I would earnestly urge the importance of early removal, by the knife, of suspicious growths about the lips, and the fallacy of trifling with them by such injurious applications as caustics; several of the cases which have come under my notice having been thus aggravated, and a more extensive operation thereby rendered necessary. Besides, admitting that powerful caustics may occasionally eradicate the disease, I submit it as a question for consideration whether the pain, to say nothing of the annoyance and trouble of repeated applications, is not, on the whole, much greater than that caused by one rapid and comparatively simple operation by the knife, especially under the beneficent influence of chloroform.

The freedom from pain in the after-treatment of the case was very marked, and can, I think, only be attributed to the specific action of the carbolic oil on the sore parts, the patient never once complaining of the dressing of the wound. This I have noticed in other operations involving a larger extent of granulating surface.

I think it highly important also, and shall see to it in any future case, that the teeth should be carefully cleansed from tartar before or at the time of operation, as there cannot be a doubt that the healing of the wound was retarded two or three weeks from this cause, and at one time gave me some cause for anxiety.

Before concluding, I would advert for a moment to the very excellent results obtained in some cases in my own practice, and that of other surgeons, in which the whole of one side of the lower lip has been involved in the disease, where the operation has consisted in removing the part by a V-shaped incision, making another incision from the angle of the mouth about three-fourths of an inch into the cheek, and uniting the mucous membrane and the skin of the lower part with sutures, thereby greatly diminishing the strain upon the healthy half of the lip. By this process no more deformity results than after the removal of a smaller section for a less amount of disease.

February, 1873.—The patient still continues well, and without any indications of recurrence of disease; and some persons who have accidentally met him have not noticed that any operation has been performed.

Cerne Abbas.

NOTES ON OBSTETRIC CASES.

By THOMAS SAVAGE, M.D., F.R.C.S.,

SURGEON TO THE HOSPITAL FOR WOMEN AND TO THE BIRMINGHAM LYING-IN CHARITY.

THE following is a short and rather rough record of 1400 midwifery cases which have been attended by me in continuous succession, at or nearly at the full term. Of these, 1437 children were born—viz., 778 males and 659 females. Ramsbotham gives the proportion of males to females as 51.736 to 48.264 per cent. Thirty-five cases were twins and 1 triplets. Of the 1400 women, 285 were primiparæ, or about 1 in every 5. Nine maternal deaths occurred. Of the children, 1398 were born alive and 39 still-born, or about 97½ per cent. alive and 2½ per cent. still. Ramsbotham gives children born living as 96.3 per cent., and still-born 3.7 per cent. No notes have been taken of the diseases of the puerperal state, though there was the usual complement of such, as milk fever, mammary abscesses, metritis, ovariitis, parametritis (which occurred in one instance), peri-

tonitis, and the generic disease known as puerperal fever. The diseases of pregnancy were not noted. The effect of sex in children upon their being born alive or still is seen by the fact that there were 39 still-born, of which 21 were males and 18 females. A return has been published showing that they are as 140 males to 100 females. Sir James Simpson says that of the children that die in utero, and before the commencement of labour, as large a proportion are females as males; and he gives as his sixth proposition, in his remarks on Fœtal Dystocia, that of those children who are born alive more males than females are seen to suffer from the morbid states and injuries resulting from parturition.

The average duration of labour may be taken to be agreed upon by all to be longer with males than females. In this series this was not observed, except what appears from the instrumental deliveries, where there were 129 male to 91 female children. The duration of labour is also influenced by the position of the presentation in vertex cases; as, where it was occipito-posterior, of which there were 19 instances, the forceps were used 12 times (6 males and 6 females), and of the 6 born by natural efforts 1 was male and 5 female. These instrumental deliveries may be taken as a guide as to duration; for, whatever may be the views of any particular practitioner as to using artificial aid, sooner or later, in the second stage, it would always be the case that forceps would be applied in those that were the more tedious, even though in the one case they were used early, or, in the other, deferred until exhaustion had set in.

Interspersed among these 1400 cases, but not included with them, were 53 premature deliveries, with 41 male and 14 female fœtuses, 2 being twin cases. Those were called premature where the sex was easily distinguishable, but where the child was not viable—viz., at about or under the 224th day.

There is little to say of the use of ergot. In the earlier cases I used it pretty frequently, and the forceps less; but of late I have almost entirely discarded it as a means of accelerating delivery, having much more faith in the greater certainty and safety of the forceps. A case occurred recently which appeared to justify its condemnation. A woman, in labour with her eighth or ninth child, with dilated os and large roomy pelvis, was in a state of inertia; the child was distinctly felt by her immediately before her draught of two drachms of ext. ergot. liq. The uterus was almost at once set into contraction, and in about twenty minutes an asphyxiated dead child was born. Of course, these remarks do not apply to ergot as a therapeutic remedy or to its action on the uterine fibre, but merely to its administration before delivery where there is no fear or prospect of hæmorrhage, and where the application of the forceps would at once accomplish delivery.

Chloroform was rarely given in the cases that progressed satisfactorily, except at the urgent solicitation of the patient, although in many of the operative cases, where it was deemed advisable to lessen shock, it was pushed to the surgical degree. When given, it was given pure, and not mixed with either ether or alcohol. There seems to be a very general feeling in its favour in midwifery at the present time. I cannot speak personally very much of it, as I feel a little prejudiced against it, and so have not resorted to it as many practitioners do in the natural cases. I have been inclined to think that it disposes to flooding, and I know this opinion is shared by many.

The vertex presented 1366 times in the 1437 births, being, as is well known, far more frequent than any other presentation. It would seem quite impossible to diagnose the exact position of the head, according to Nægele's division, in every case of labour attended, taking them successively, though in many cases it was easily made out, and it was constantly seen that the first position was by far the most frequent—viz., with the long diameter of the head in the right oblique pelvic diameter. In many of the occipito-posterior cases it was difficult to say what caused the delay, when the vertex was at the brim, where the pains were active, and where no great disproportion existed. Of these latter there were 19, 8 male and 11 female children, forceps being used in 12 and craniotomy in 1.

The breech presented 31 times, or about 1 in 47½ cases. Dr. Meadows gives their frequency as 1 in 52½ cases. Of these 31, 24 children (10 males and 14 females) were born alive; and 7 (3 males and 4 females) were still-born. The

deaths were therefore as 1 in $3\frac{1}{2}$. Dr. Meadows gives them as 1 in $3\frac{3}{4}$. The positions, whether abdomino-anterior or abdomino-posterior, were not noted.

The feet presented, one or both, 18 times, or about 1 in 80 cases. Dr. Meadows gives 1 in $90\frac{1}{2}$. Of these 18, 11 children (8 males and 3 females) were alive, and 7 (1 male and 6 females) were still-born; the deaths were therefore as 1 in $2\frac{3}{4}$ cases. The above-named author gives them as 1 in $2\frac{3}{4}$ cases.

The shoulder presented twice, both males, alive, after version; the arm once, a male, alive, after version; the face 7 times—1 forceps case and alive, 5 naturally and alive, and 1 forceps case still-born; the funis 4 times, all still-born.

There were 35 cases of twins, or 1 in 40. Dr. Churchill gives 1 in $76\frac{1}{2}$, and triplets as 1 in 6000. Of these 35 cases 15 were both male children, 7 were both female, and 13 were male and female. This excess of twin males, and of mixed sexes being in excess of twin females, is in accordance with what Dr. Meadows gives in his manual. The delay in the birth of the second child was never allowed to go to any extent, and the forceps, bandage, and ergot were used to expedite matters in the order named. In 19 of the 35, both the children presented with the vertex, in 6 vertex and breech, in 7 the vertex and foot, in 1 both feet, in 1 vertex and shoulder, and in 1 breech and arm.

There was 1 case of triplets, in a mother eight months pregnant; the children were all male and still-born.

Of the placenta prævia cases, 8 in number, there were 2 of P. lateralis and 6 of P. centralis. Version was performed in all. Of the children 4 males were born alive, 3 males were still-born, and 1 female still-born. Three mothers died, the usual proportion of maternal deaths being about 1 in 3. One died a few hours after delivery, apparently from shock; the two others had been under the care of ignorant midwives, and were not visited until it was almost easy to say that, although delivery must be accomplished, yet it would be too great a shock to the system for the patient to rally from. Surely such instances as these are a cogent argument for giving to the very poor skilled assistance at their confinements in the shape of educated midwives. There was no difficulty in any of them in procuring dilatation of the os; should such arise where delivery is imperative, I can conceive of nothing better than the use of Barnes's bags for the purpose.

Podalic version was performed 16 times: 8 children were born alive and 8 still-born; 8 were for placenta prævia; 2 for shoulder-presentation, both children being born alive; 1 was arm-presentation, child alive; one arm and funis, child still-born; and 4 were vertex. One of these was a case of cephalhæmatoma, a large sanguineous tumour which rendered delivery by the natural process apparently impossible. The operation was performed with the left hand in all cases, aided by the right applied externally to the abdomen. In the one arm-presentation the leg first seized was the one opposite to the presenting arm; in the other cases one or other foot, as appeared most convenient, was brought down. On a future occasion I should certainly endeavour to adopt the plan recommended by Dr. Barnes—namely, that of first bringing down the opposite knee, as being the easiest and most accessible, and using the left or right hand according to the position of the child.

Of cephalic version and of bipolar version I am unable to speak.

According to Dr. Churchill, version takes place in about 1 in $220\frac{1}{2}$ cases, and foetal deaths are rather more than 1 in $2\frac{1}{2}$. In this series version was performed in about 1 in 90 births, and foetal deaths were as 1 in 2.

In 3 of the vertex presentations version was certainly performed as an alternative for craniotomy. Sir J. Simpson proposed this operation, upon the theory that, the bimastoid diameter of the head being less than the biparietal by half to three-quarters of an inch, it is easier to drag the head through the pelvis feet foremost than for the uterus to push it through; since also the uterus contracting upon the head causes the biparietal diameter to bulge out laterally, and so to render the disproportion greater; while if the incompressible bimastoid diameter be pulled through first, traction only causes the compressible biparietal to be elongated, and so renders delivery easier. The whole subject is gone into in Simpson's obstetrical works.

Perforation of the foetal head was performed three times; in 2 of these instances the head was delivered by means of

the craniotomy forceps, and in 1 cephalotripsy was had recourse to. The experience of these three cases has led me to form the following opinions: first, that the mere fact of diminishing the capacity of the foetal head does not necessarily render the subsequent delivery at all times an easy matter (in one case the child was extracted with the greatest difficulty, and the mother died of shock); and, secondly, that the cephalotribe is a most useful addition to the obstetrician's armamentarium. When the head is high up at or above the brim, with the cephalotribe applied well over the base of the skull, a few turns of the screw will crush it wholly, and then with an appropriate slight rotation it will draw it down. Dr. Hicks says that when the head is low down the cephalotribe is not so good as the craniotomy forceps or crotchet. From my experience of it in this one case, I should certainly have recourse to it again after perforation.

In these 1437 births the forceps was applied 220 times, or about once in every $6\frac{1}{2}$ deliveries; and, as regards the sex of the children, as follows—129 to males, and 91 to females. This is remarkable as showing the influence of sex in causing delay, as the same rules applied in all cases, as far as possible, as to the propriety of its use—i.e., when the second stage of labour ceased to be actively progressive. And the cases in which still-born children were delivered after forceps also show the same thing. There were 9 of these, of which 1 was a female and 8 were male infants. Three of these deaths were unmistakably due to delay; they were cases to which I was called after the head had been subjected to prolonged pressure.

There seems to be quite a change in the feelings of obstetricians in regard to the use of the forceps; while formerly, and that within the experience of our older practitioners, the forceps was used on very rare occasions. In the statistics of the Royal Maternity Charity of London for the years 1828 to 1850 inclusive—viz., twenty-three years—it was had recourse to seventy-three times in 48,996 deliveries, or about one in 670 cases; and craniotomy was performed almost as frequently—viz., sixty times. We find that, now so much relief is gained to the patient—so many children saved, especially in first cases—and also (though perhaps some may object that this should be taken into consideration) so much of the time of the accoucheur is saved by a timely and judicious use of the forceps,—all are agreed that it may be advantageously used more often than formerly. The cases where its use is indicated may be where, after the os uteri is dilated, there is delay through inertia of the uterus, from whatever cause; obstruction from very slight pelvic contraction or very slight rigidity of the soft parts, as in primiparæ; and there is no great disproportion between the foetal head and the passages. Of course I am not speaking of those cases in which all would agree in its immediate use, such as convulsions, hæmorrhage, or any complication necessitating immediate delivery. Some practitioners have, I believe, published the result of their practice showing a more frequent use of the forceps than is given in this series. I am every year more and more convinced of the advantages gained by such practice. Patients on subsequent occasions will frequently ask for its use again; and I have not seen the ill effects which are said to arise in consequence, such as ruptured perineums, lacerations of soft parts, vesico-vaginal fistula, or puerperal fever. The only case where the perineum was torn through the sphincter was a primipara, in whom the forceps was not used; and I firmly believe that in the slighter forms of laceration the perineum is less likely to be torn with the forceps than without, always supposing traction to be made in the direction of the axis of the pelvic outlet; and the same may be said in reference to vesico-vaginal fistula, for experience goes to show that the fistula is caused more often through sloughing from prolonged pressure than from injury from instruments; as Sir J. Simpson remarked, that the involuntary flow of urine generally comes on a few days, more frequently than immediately, after delivery.

One symptom, apart from exhaustion, which has influenced me as to the forceps being required, was when the uterus came to be in a state of constant contraction, so as to give no interval of ease between the pains, with the head pushed down, and not receding; the patient being in a state of pain all the time, something similar to what is often induced by giving ergot when it fails to effect the purpose for which it

was administered. The instruments that were used exclusively have been Ferguson's short straight forceps, and Robertson's long ones, with a double or pelvic curve.

In about three cases only has very great force in traction been used, nearly all the children being born very easily; so much so that I regard it, as others with greater experience have before me, that more is to be done by using judiciously the great power at our command than by applying greater force without judgment.

It is pleasant to have one's own views confirmed on this subject as was done in an able article in THE LANCET of the 26th of October of last year; the concluding paragraph of which is—"The timely use of the forceps, shortening the second stage of labour, is the great practical improvement in recent midwifery." And at a recent meeting of the Obstetrical Society, in a paper "On the Registration of Stillbirths," reference was made by Mr. Lowndes to the more frequent application of the forceps as a means of diminishing the number of still-born children.

Retention of the placenta occurred three times: in one of which hæmorrhage occurred, but not to any alarming extent; and in another the flooding was continued until the patient was on the point of sinking, but ceased on abstraction of the placenta, the cause of it all.

Convulsions occurred once only. They came on before full dilatation of the os; and there was no repetition after delivery, which was allowed to go on to conclusion by the natural efforts. I have seen, in consultation in other practices, two other cases, both of which did well, the convulsions continuing after delivery; one was subjected to venesection.

In one instance I was called to a woman who had had several children, and was said to have ruptured a blood-vessel. I found her on the ground quite dead, and surrounded by an immense pool of blood, which was ascertained to have proceeded from a varicose vein of the leg, which had given way. She was in the last month of pregnancy. After making sure of her death I made an abdominal section, and extracted the fœtus. The cord was pulsating; but I failed to establish respiration. The neighbours computed that it was about fifteen minutes from the first commencement of the bleeding until the birth of the child.

Several anomalous cases occurred, such as of incision of the os uteri for rigidity. This was in a pluripara, who always had had tedious labours, and the attendant had applied the forceps and endeavoured to extract through a rigid os, a little larger than a crown-piece, which would not give way. No other means had been adopted, such as chloroform, opium, &c. When I saw her I made two small incisions anteriorly and posteriorly through the os on a director. The head was at once brought into the world by forceps, and the patient did well. Three cases of anencephalous fœtuses were born. In one a very large amount of liquor amnii was present, so much so as literally to drown the bed. This is what has been observed in other cases, and is mentioned by Ramsbotham. One very large child was born, a male, 14 lb. weight, and 26 in. in length from vertex to end of great toe; the shoulders were so long in being extracted that it was still-born. These figures correspond to what Dr. Guy gives as maximum for children at full time, the average being 6 lb. 11 oz. weight, and 19 in. in length. A long funis was seen once, a male child. It was 39 inches, and was twice round the neck. In one case the funis was tied in a close knot about four inches from the umbilicus, but not tight enough to compress the vessels, the child being born alive. Dr. Tyler Smith says: "When the cord is long, and the amount of liquor amnii considerable, it is easy to conceive that the fœtus may, by its own movements, or the changing position of the mother, pass through a loop in the cord, and thus form a knot."

Two of the mothers had an attack of small-pox supervene, one the second day and the other the third day after delivery. Both did well. Another during her lying-in went through an attack of scarlatina, with sore-throat, rash, and subsequent desquamation. She did well.

Apology is needed for the scanty details here given. It is due to the cases having been only registered in the small compass which is allowed in Smith's ordinary Visiting-List, without at the time the slightest thought of putting them together in the shape of statistics.

Birmingham.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. THOMAS'S HOSPITAL.

CASE OF EMPYEMA OPENING THROUGH THE LUNGS.

(Under the care of Dr. PEACOCK.)

A VERY interesting case of what is generally understood to be a rare result of pleurisy—the evacuation of the fluid through the lungs—has recently been under the care of Dr. Peacock. The particulars are as follows:—

J. W—, a married woman, aged thirty-three, admitted Dec. 9th, 1872, after having been ill for two months. Her indisposition commenced with shortness of breath, pain in the left side, cough and expectoration; and she had become much prostrated and emaciated. On examining the chest, there was found to be marked dulness and absence of respiration over a considerable portion of the left side, and a loud ægophonic twang was heard with the voice at the upper level of the dull space behind. From these signs it was evident that there was effusion into the left pleural cavity. On Dec. 17th, it was stated, she had had severe attacks of coughing at intervals, and at the end of the paroxysms had expectorated a considerable quantity of matter. The expectoration was in the form of distinct masses of pus, which were free from air, but were enveloped in ordinary bronchitic sputum containing large air-bells. The patient's breath during the fits of coughing had the very offensive odour characteristic of gangrenous lung; and on examining the chest there was found to be an obscure tympanitic resonance on percussion, much resembling the "cracked-pot" sound, about the lower angle of the left scapula. With the cough, and when she drew a full breath after the fits of coughing, a cavernous sound, with some gurgling, was heard in the same situation. From these symptoms and signs it was concluded that the effusion in the pleura was in process of being evacuated through the lungs, and that there was a small escape of air into the pleural cavity. On the 20th the cough and expectoration continued, but the evidences of fluid in the left pleura were less marked, and the peculiar resonance on percussion, and the cavernous sound with the respiration and cough, could not be heard. On the 24th she still continued to expectorate the peculiar purulent masses, and there were slight signs of the entrance of air into the pleural cavity. Her general condition was, however, much improved. The following week there was but little expectoration, and a decided improvement in her general state. The signs of effusion in the pleural cavity were only slightly marked, and respiration was feebly audible over a large portion of the left side. Since that time the improvement has been steady and marked, the cough and expectoration have entirely ceased, and the respiratory sounds have returned over the whole side; and, except having some slight remains of dulness and a little contraction of the side, the patient, though still retained in the ward, may be said to be quite well.

In reference to this case Dr. Peacock remarked that he believed that cases of empyema opening through the lungs were of more frequent occurrence than was generally supposed. Indeed this was the third case which had been under his care at St. Thomas's during the last twelve months, and he had had a case also at the same time in the Victoria-park Hospital.

The first impression which he formed of the present case was that the effusion on the left side was probably the result of perforation of the lung in early phthisis, but his subsequent observations did not confirm this view, and he concluded that the empyema was unconnected with pulmonary disease of a prior date. He had repeatedly and carefully examined the chest without finding evidences of disease in either lung. The case was especially remarkable as showing that an empyema might make its way through the lung and be expectorated, although it had probably not been of