

CASE 61.—*Rupture of Perinæum, complete; twenty-six years' duration; operation; cure.*—W. B—, aged forty-one, admitted into "The London Home" on October 1st, 1858. Mother of six children; was delivered of her first child twenty-six years ago, and since then has suffered from much bearing-down and general lowness. She hurt herself about nine months ago by lifting a heavy weight; it was followed by severe flooding. She has been in hospitals for eleven weeks together, but has had nothing done beyond injections and rest. On examination, I found the perinæum torn up through the sphincter, of which only a few fibres remained.

Oct. 4th, 1858.—I performed my usual operation, using iron wire sutures instead of twine.

7th.—The deep sutures removed; some ulceration.

At the end of a month she was discharged with a firm and sound perinæum, and perfect control over her bowels.

Remarks.—This case was one of the mildest form, and, therefore, the most amenable to treatment. It will be observed that she suffered from bearing-down and general weakness—a frequent effect of loss of perinæum, even where the sphincter is not entirely torn through.

CASE 62.—*Rupture of Perinæum, complete; five weeks' duration; operation; cure.*—E. B—, aged thirty, admitted into "The London Home" on Dec. 27th, 1858. She had her perinæum completely ruptured with her first child, and her case is fully reported as Case 40 of the series (see THE LANCET, August 29th, 1857). Taking into consideration her general make and the extremely large size of her first child, I recommended her to have labour induced at the seventh month, but she would not consent, and allowed pregnancy to proceed to the full period. She was delivered by her ordinary accoucheur on Nov. 22nd, 1858, of a large male child, and notwithstanding every care and precaution her perinæum again gave way. Examination showed that the rupture had extended through the sphincter, and that the bowel was more deeply torn than usual.

Dec. 31st, 1858.—I performed my usual operation, but, owing to the depth of the rent, had much difficulty in getting the edges into apposition.

Jan. 2nd, 1859.—Deep sutures removed; there appears to be a small escape of flatus through the vagina; the parts look healthy.

6th.—Superficial sutures removed.

12th.—Parts healing nicely. There is, however, a small recto-vaginal fistula. This was touched with acetum lyttæ.

Feb. 1st.—Fistulous opening much smaller. Again touched with acetum lyttæ. Soon after this, the opening was nearly closed, and the patient had a good perinæum.

Remarks.—It will be seen that this was a second rupture, and it was foretold on account of the conditions of the outlet. I have seen this patient lately, and she says that occasionally a little flatus escapes through the opening, but never any fæces, and that she has perfect control over the bowels. She fears she is again pregnant, and I have advised that she be delivered at seven and a half months.

CASE 63.—*Rupture of Perinæum, complete; nine weeks' duration; operation; cure.*—H. B—, aged twenty-three, admitted into St. Mary's Hospital, under my care, on Oct. 2nd, 1858. Was delivered by forceps of a dead child, after a labour of three days, a midwife attending. So soon as she got about, she had constant bearing-down and very imperfect control over her bowels. On examination, the perinæum was found lacerated, and the anterior two-thirds of the sphincter torn completely across.

October 6th.—I performed my usual operation, using wire instead of twine.

8th.—Deep sutures removed.

14th.—Wound perfectly united; bowels opened.

Nov. 6th.—Discharged perfectly cured.

Remarks.—This case is one of ordinary complete rupture, and was cured in one month by the usual operation.

CASE 64.—*Rupture of the Perinæum, complete; operation; cure.*—S. P—, aged thirty-one, admitted into St. Mary's Hospital, under my care, on November 26th, 1858. Has eight children. The last labour was of two days' duration, and terminated with instruments. Some days after delivery she found she had no control over her bowels.

On examination, I found the perinæum torn through, and the anterior fibres of the sphincter gone. A mucous band assisted in forming the anal circle.

Dec. 1st.—I performed the usual operation.

3rd.—Deep sutures removed.

7th.—Interrupted sutures removed. The greatest part has healed. The part which had not healed by first intention

granulated, and the patient was perfectly cured in a month from the day of operation.

Remarks.—This case is one of ordinary complete rupture, and it will be seen that all did not heal up by first intention, and yet did so by granulation. This is almost always the case, and is a practical fact which should not be forgotten in the treatment of these cases.

CASE 65.—*Rupture of the Perinæum, complete; operation; cure.*—M. M—, admitted into "The London Home" on Jan. 22nd, 1859. She was delivered of her first child five weeks previously. She was three days in labour, and the child, a large male (living), was extracted by instruments. Mr. Godfrey, of Herne Bay, when summoned to her, found one arm through the anus, and the vertex presenting. So, of course, the perinæum gave way, and the rent extended into the rectum. She has never been able to retain her motions since.

Jan. 21st.—I performed my usual operation.

Feb. 3rd.—Deep sutures removed. The parts looked flabby and unhealthy, and had not united.

Under the use of opium and decoction of bark, with nitric acid, her health much improved. The granulations became healthy, and gradually filled up the perinæum; the two surfaces united, and ultimately formed a perfect perinæum. She was discharged perfectly cured in a month.

Remarks.—This case is one like the last, where granulation finally filled up completely the parts, and resulted in a good perinæum. This patient has continued well ever since.

CASE 66.—*Rupture of the Perinæum, complete; operation; cure.*—C. E—, aged twenty-six, from Ruthin, admitted into "The London Home" March, 1859. When confined of her first child she was in labour two days and a half, and it was terminated with instruments. Her bowels acted on the third day, but she had no control over the sphincter, and has been unable to retain her urine since. Five weeks ago she was confined of her second child, and feels better in herself, but has no more control over her bowels.

On examination, I found complete rupture of the perinæum through the sphincter, but not extending far up the bowel.

March 17th.—I performed my usual operation.

18th.—Parts look well, but she feels poorly and sick. Ordered decoction of bark with dilute nitric acid.

19th.—Deep sutures removed.

23rd.—Superficial sutures removed; going on well.

April 4th.—Had an attack of rheumatic fever. This was treated with bicarbonate of potass and iodide of potassium. It very much delayed her convalescence, but ultimately she left with a good perinæum and perfect control over her bowels.

Remarks.—I found that this patient was attended by a midwife, whose ignorance allowed the case to be prolonged two days and a half before she applied for medical aid.

CASE 67.—*Rupture of the Perinæum, incomplete; vaginal rectocele; thirteen years' duration; operation; cure.*—Mrs. D—. The perinæum was ruptured in labour up to, but not through, the sphincter. Since then she has had constant bearing-down and difficulty of defecation. The os uteri was enlarged and ulcerated.

March 18th, 1859.—I performed my usual operation, assisted by Messrs. Nunn and Philip Harper.

She progressed most satisfactorily, and about a month after the operation was perfectly cured, and from being unable to walk about is now an active pedestrian.

Remarks.—In this case the perinæum had been torn up to the sphincter, and simply a skin union had taken place for about an inch from the anus, so that, on making a casual examination, anyone would believe that her perinæum was entire. On more careful examination, it was soon found that the protruding tumour was the rectum pushed into the vagina, and then through the labiæ, because the support of the true perinæum was lost. The distress of these cases is very great, and as they can be easily cured by a plastic operation, it is evident that the sufferer should have the benefit of modern surgery.

(To be concluded.)

AN UNUSUAL CIRCUMSTANCE ATTENDING A CASE OF MIDWIFERY.

By W. THOMAS, L.R.C.P. EDIN., &c.

ON Sunday, the 12th ultimo, at six A.M., I was called to Mrs. —, whom I had attended already in eight confinements, and who was then in labour with her ninth child. She had been ill nearly all the preceding night, and on my arrival, I

found the pains effectual, the presentation natural, the os uteri freely dilating, and with every appearance of a speedy delivery. And such, indeed, was the case; for in the course of half an hour it was accomplished; but, strange to say, both the fœtus and the placenta, which came away with it, were enveloped in a complete and impervious sac, that I had to rupture in order to disengage them.

The case terminated favourably, neither mother nor child suffering in any way whatever. There had been considerable sickness of the stomach and vomiting during pregnancy, and even up to the period of labour, casualties to which she had not been subject on former occasions. Had these anything to do with the separation and expulsion of the membranous envelope in its entirety?

I do not know whether any of my professional brethren have met with such a case, but I have never done so during an active practice of thirty-seven years, a considerable portion of which has been that of midwifery.

Pembroke Dock, Feb. 1860.

A Mirror OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla est alia pro certo noscendi via, nisi quam plurimas et morborum et dissectionum historias, tam aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.*, lib. 14. Proœmium.

ST. BARTHOLOMEW'S HOSPITAL.

CHRONIC HYDROTHORAX OF THE LEFT SIDE, WITH DIS-
PLACEMENT OF THE HEART TO THE RIGHT, IN A
SAILOR; SLIGHT BENEFIT FROM TREATMENT.

(Under the care of Dr. FARRE.)

INFLAMMATION of the pleural serous membrane, with its consequences and termination, is a subject of not less importance and extent than diseases of the lungs themselves. Of pleuritis and its concomitant pneumonia we do not now purpose to speak, but we wish to draw attention to the serous effusion within the chest known as hydrothorax, and the manner of remedying it. Of this consequence of pleurisy we present three examples, showing its chief diagnostic signs.

In a patient recently under Dr. Farre's care, a question arose as to the best means of getting rid of the fluid, which had been present for nearly nine months, and was still serous in its character. (The particulars are given below.) The patient was a young sailor, who appeared healthy, notwithstanding the serious thoracic inconvenience. He had no dyspnoea, but complained of shortness of breath, which, in fact, was the only distressing symptom.

The absence of dyspnoea in such cases is referred to by many writers, and amongst others by Andral; and several instances are on record of individuals with extensive pleuritic accumulations, who have gone about their daily avocations, and have been, moreover, enabled to do some heavy work, without any inconvenience. Yet this can be for a time only, as sooner or later some change must ensue of a serious nature. In regard to the amount of dyspnoea present from the effusion, it varies in most patients, but it is generally severe in acute cases,—at any rate, in the commencement of the disease.

Dr. Watson remarks, in his "Lectures on Physic," that "In some patients, the dyspnoea never ceases to be urgent from first to last; and these are apt to prove fatal cases. In others, the respiration is very much impeded at first; then the difficulty of breathing diminishes; and at length it ceases, long before the fluid is re-absorbed. In others, again, by some unaccountable idiosyncrasy, the respiration remains at all times very facile, both at the outset and during the progress of the disease."

The system generally would seem then, after a while, to

accommodate itself to the inconvenience caused by the presence of the fluid. In the treatment of such cases as these, there are two methods which arise for consideration—namely, absorption by means of internal remedies, (such as produce a diuretic and purgative effect,) and paracentesis. The patient, under all circumstances, gets the trial of the former firstly, and if their results are unsatisfactory, recourse is had by some physicians to the latter. It is this latter which is the question of importance. Is tapping of the chest to be performed, unless there are some urgent symptoms present which require it? If we are guided by the same rules which actuate its choice in ascites, not much hesitation is required to come to the conclusion that it should not be resorted to in chronic cases of hydrothorax, unless life is in jeopardy, which will be shown by the severe and urgent dyspnoea present, and the great interference with the central circulation, as characterized by its particular symptoms. In such a patient as Dr. Farre's, whose compressed lung had most probably now accommodated itself to its peculiar situation, it is most likely that tapping would have afforded no very great amount of relief, and besides there was the risk of converting a simple serous effusion into a complicated empyema. There are two patients in the same hospital at the present time, whose chests are being frequently washed out for empyema, the lung in each having shown no disposition to expand. The operation, therefore, was not contemplated in the following case, because the man was slightly benefited by treatment, and for the other reasons we have mentioned. No doubt he will be able to follow his employment, which is not a heavy one, for a considerable time without inconvenience.

It is quite possible that by making a valvular opening into the chest, and using a trocar that will not admit any air, the fluid might be drawn off in small quantities with advantage, and we are aware that such is occasionally practised in urgent cases where the effusion has followed acute pleuritis. The chronic do not offer such favourable grounds for hope. In the urgent dyspnoea from this cause, tapping the chest has been performed as far back as the time of Hippocrates.

On referring to Maclean's work on Hydrothorax, published fifty years ago, we find that he strongly recommends a combination of digitalis, squills, calomel, and crystallized tartar—remedies which are employed with benefit to the present hour. The indications of cure which he pointed out, and which are still applicable to this disease, are the restoration of the lost or impaired action of the absorbents, determination of blood to the kidneys, lessening inordinate exhalation, and the removal of weakness in other organs.

For the notes of this case we are indebted to Mr. E. Strickland, clinical clerk:—

Thomas N—, aged twenty-six, was admitted into Radcliffe ward, under the care of Dr. Farre, on the 19th of January last, for effusion into the left side of his chest, and inability to lay on his right side since May, 1859. This patient is a rather healthy-looking man, and of moderate condition, by occupation a sailor; he has been to sea for thirteen years, and states that he has always been very healthy—in fact, he does not remember ever being ill previous to this attack, which he says came on last March. He states that while on board of his ship he got very wet, and had to remain in his wet clothing, which he thinks is the cause of his present illness. The first symptoms were cough and spitting of a white, frothy mucus. The surgeon of the vessel treated him for this; but he gradually got worse, the breathing became short, with a piercing pain in the left side. This took place in May. Then he was taken to Malta Hospital, and remained there three months; but he gradually got worse, so that he was sent to England—viz., to Enfield, where he was attended by a medical gentleman, and improved under his treatment; but was advised to come to this hospital to save further expense. He now complains of weakness and shortness of breath, but is quite free from pain.

Physical signs.—Dulness on percussion in front on the left side; absence of the respiratory murmur; behind, dulness; slight vesicular breathing in the upper lobe of the left lung, and in the interscapular region, which may be heard a little lower by the side of the spinal column; puerile breathing on the right side; resonance nearly natural, with the exception of the posterior part of the chest, which is due to the heart being pushed to the right side; its pulsation or impulse most distinct in the right mammary region; vocal vibration absent, or nearly so, on the left side, natural on the right. The chest is thirty-six inches round in the mammary region, and thirty-five inches and a half round the chest over the lower part of the sternum (scrobiculus cordis); about half an inch difference in the two sides—left side half an inch greater; the left side immovable when he breathes, and bulges the intercostal spaces on a level