

Forehead.—Inclination of the frontal line; gradations from receding to prominent or bulging. Prominence of the frontal bosses. Height: gradations from very little to very great; usually measure. Width: same gradations. Degree of prominence of the superciliary arches. Degree of prominence of the frontal sinuses.

Face generally.—Shape: long and narrow, short and broad, &c.; lozenge-shaped. Asymmetry (see measurements). Proportion between the forehead and the lower part of the face. Inter-ocular space: abnormally large or small.

Nose.—(1) Shape: (a) concavity of the root—size of; (b) general shape of the ridge. Cave; rectilinear, convex, cave-sinuuous, rectil.-sinuuous, vex-sinuuous. (Bertillon); and (c) inclination of the lower edge. (2) Dimensions (to eye): (a) height (root to the nostril attachment)—gradations, little to great; (b) projection, same gradations; (c) width (between wings); and (d) large or small, in proportion to face. (3) Peculiarities, as tapering, thick, bilobed, shape and formation of the nostrils, deviation of the nose, &c.

Lips.—In profile; height of the upper lip; little, medium, great; relative prominence of the lips; thickness of: thin, thick, "blubber." Upper protuberant; lower pendant; median furrow of upper accentuated; pouting or compressed (permanent or habit).

Mouth.—Pinched, gaping, normal; corners elevated, depressed, horizontal.

Cheek-bones.—Prominence of.

Chin (in profile).—Inclination of: receding, medium, projecting. Ball of: absent, medium, large. High, medium, low.

Eye.—Palpebral fissure: little or much slit, horizontally; little or much open, vertically; direction of fissure, horizontal, oblique; Mongolian characteristics. Upper lid: covered, uncovered, patient looking forward; drooping. Balls: sunken, protruding. Eyebrows (Bertillon): heads near, distant, united; low, high (middle eyebrow to the centre of the eyeball); rectilinear, arched, oblique (and direction, if last); short, long; narrow, wide. Hairs: scanty, abundant; long, short; blonde or dark. Eye-lashes: long, short; abundant, scanty, or absent. Iris: general colour of, flecks on, chromatic asymmetry, coloboma, &c. Eye anomalies: strabismus, nystagmus, &c. (Refractive errors probably constitute a special study.)

Ear.—Maximum length and breadth. Length of implantation. Length from the nose-lip angle to the upper and to the lower limit of implantation. Insertion: perpendicular, oblique. Separation from head: in whole or in part. Clinging to head: in whole or in part. Supero-posterior contour: acute, square, round. Helix (regarded in three parts, anterior, superior, and posterior): small, medium, large, absent, flat. Helix: open, intermediate, adherent; regular, rumpled. Fossa of: shallow, deep; broad, narrow; Darwinian nodosity, or tubercle present. Antihelix: convex, concave, intermediate (on vertical sagittal plane); superior division of: accentuated, medium, *nil*; any peculiarity of its branches; fossa of: small, large; deep, shallow. Antitragus (general direction of): horizontal, intermediate, oblique; edge of: rectilinear, projecting, intermediate; everted, intermediate, erect; small, medium, large. Tragus: large, medium, small; posterior edge bifurcated. Concha: small, large, deep, shallow, traversed. Lobule: square, intermediate, gulfed; blending, intermediate, separated; channelled, dimpled; elevated, intermediate; small, medium, large. Mobility of ear (volitional).

Hard palate.—Cast if possible (saving of time to take several different cases at one sitting. The casts can be detached from the moulds and shaped subsequently). General observations *re* shape of vault and of alveolar margin. Note cleft.

Soft palate and uvula.—Arches of the former symmetrical. Uvula: size, shape, whether bifurcated, and whether deviating to one side when the palate is raised.

Tongue.—Any peculiarities in size and form.

Teeth.—Large, small, irregular, deformed, misplaced, projecting. Diastema, numerical augmentation of, &c. Note great development of the superior central incisors with small lateral incisors (or absent).

General contour of the head.—Prognathic, naso-prognathic, orthognathic. Lower jaw prominent.

Fronto-nasal profile.—Rectilinear, angular, parallel (or nearly so), semilunar.

Occiput.—Flat, bulging.

Skin.—Anomalies of, such as naevi, pigment spots, albinism, colouration of.

Hair.—Amount on head, face, trunk, and limbs. Premature greyiness; excess of local growth; coarse, fine; straight, wavy, curly. Glabrous chin and cheeks in men. Growth on unusual parts. Asymmetry in growth at any part. Low growth on forehead. Colour of hair: black, coal-black; dark brown, chestnut; yellow, flaxen; red (auburn).

Nails.—Abnormalities of.

Limbs.—Congenital contractions, paralyses, atrophy, luxations and joint anomalies; abnormalities in size or appearance (as feminine types in men). Form of hands, feet, and digits; excess of digits. Note size of great toe and dimensions of space between it and second toe, with unusual mobility of first.

Body generally.—Giantism, dwarfism, asymmetry. State of breasts and genitalia. Buttocks asymmetrical. Femininism, masculinism. Infantile traits. Deviations of spine, chest-conformation, &c.

(b) Physiological.

Anomalies of motor function.—Tremors, tics, nervous muscular movements, &c.

Anomalies of sensory functions.—Deaf-mutism; in some subjective examination will be possible—as to hyper-, an-æsthesia, neuralgiæ, migraine, &c.

Anomalies of speech.—Stammering or defective speech; character of voice.

Miscellaneous.—Incongruity between age and appearance; left-handedness; state of circulation.

(c) Psychical.

If alienation, nature of; or other abnormality, as eccentricity, moral delinquencies, egoism, imperative ideas, excessive emotionalism, mysticism, hysteria, epilepsy, intellectual or other precocity. Note facial expression. Note evidences of degeneration in history, family and personal, including evidence of anomalies in sexual life of patient

(impotence, sterility, perversion, menstrual anomalies), and dispositions to diseases.

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Carmarthen.

A CASE OF CHRONIC INVERSION OF THE UTERUS REDUCED BY AVELING'S REPOSITOR.¹

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CHRONIC inversion of the uterus is one of the rarest of its morbid conditions. Acute inversion is so rare that it occurred but once in 190,800 labours at the Rotunda Lying-in Hospital, Dublin, and not once in 250,000 labours at Vienna. But for acute puerperal inversion to become chronic it must remain unreduced, the patient must survive the danger of a speedy and fatal termination which this involves, and involution must take place. So excessively rare is such a sequence of events that a specialist may see tens of thousands of gynecological cases without meeting with a single instance. Hence no man can accumulate much personal experience of the treatment of chronic inversion, and it is important that every case should be published.

A woman, aged 24 years, was admitted into the Hospital for Women and Children, Leeds, on April 11th, 1899, complaining of "flooding." She stated that she was delivered of her second child on Oct. 4th, 1898. The labour was difficult and tedious and chloroform and the forceps were used. Five days after labour she had bearing-down pain and a tumour presented at the vulva which she supposed to be "something which had to come away" and she tried to get rid of it by straining. The medical attendant was now summoned. He informed me that he reduced the inversion completely without anæsthetic and with no serious difficulty, passing his hand into the uterus. He also told me that at the labour there was neither traction on the cord nor post-partum hæmorrhage. After the reduction the patient had no further pain and he had made no further examination. She was free from the bearing-down pain but she had a good deal of leucorrhœa which was somewhat offensive. At the end of three months from that time she had four days' normal menstruation and at the end of the fourth month she had a week of excessive loss. On March 31st she began to "flood" and continued to lose profusely till she was admitted to the hospital. She consulted her medical man, who examined her and advised her to enter the hospital.

On admission the patient was very anæmic, but was fairly well nourished. The vagina was occupied by the inverted uterus. This felt like a polypus hanging from the cervix by a narrow pedicle. On making traction on the tumour it could

¹ A paper read before the Leeds and West Riding Medico-Chirurgical Society on May 5th, 1899.

be drawn outside the vulva and then all trace of the os was obliterated. On bimanual examination—recto-abdominal and recto-vaginal—the cup of inversion could be easily felt with the appendages passing out of it. The surface of the tumour was soft and vascular, the mucous membrane being somewhat tumid and bleeding very easily. The patient was ordered iron and antiseptic vaginal douches. On April 17th an attempt was made under ether to reduce the inversion by taxis. Various expedients were tried unsuccessfully, and it was decided not to persist in efforts at rapid reduction but to rely upon continued elastic pressure. On April 25th Aveling's repositr was applied in accordance with Dr. Aveling's directions. The cup employed had a diameter of one and a half inches and it held its place well without any packing. On the next day the uterus was unreduced and the instrument was re-applied. On April 27th after 51 hours of application the fundus was found to have gone up. The cup of the repositr had followed the fundus and was firmly grasped by the cervix. The attempt to remove the repositr caused so much pain that ether was again administered and the repositr was withdrawn by tilting the cup and using a blunt curette as a button-hook. It was now found that there was still partial inversion of the fundus which felt exactly like a polypus within the os internum. On making steady digital pressure on the tumour and counter-extension on the cervix with three pairs of vulsella, reduction was easily completed. A No. 20 Hegar was passed into the uterine cavity which now measured three and a half inches. The cavity was well washed out and was packed with iodoform gauze for 24 hours. For two or three days there were slight rise of temperature and some abdominal tenderness, with some discharge of an offensive nature from the endometrium. On May 5th the uterus measured two and a half inches and the patient was practically well, but the discharge continued to be offensive for some days. The inversion was thus reduced after 29 week's duration. The amount of pressure used was about three pounds. The general condition of the patient on leaving the hospital was much improved.

The history of this patient bears out the statement that if a case of inversion survives the stage of involution it may give little trouble till menstruation is re-established and then it causes danger from "flooding." Details of the history of onset are wanting. Spontaneous inversion seems to have taken place. Probably the reposition made was not quite complete and relapse occurred by subsequent uterine action.

The diagnosis of such a case of complete inversion is easy if one remembers to make a diagnosis. But the inverted uterus bears such a close likeness to a polypus that some operators have cut it off first and made their diagnosis afterwards. But the diagnosis of *partial* inversion must, I am convinced, be exceedingly difficult in some cases. When in my case the uterus was half reduced it was exceedingly difficult on bimanual examination to recognise the cup of inversion, and if I had not seen the uterus completely turned inside out I should have found it very hard to distinguish it from a case of polypus uteri with partial inversion, and I am not surprised to read that very competent men have sometimes mistaken the one for the other.

There can be no doubt that *the* treatment for chronic inversion is sustained elastic pressure. There seems to be a growing opinion that amputation of an inverted fundus or panhysterectomy for the same condition is hardly ever necessary. Dr. Aveling's repositr seems to be the very best instrument for the purpose. Dr. G. E. Herman goes so far as to say that it has not been known to fail and that an inverted uterus ought never again to be amputated. How far such a universal negative can be sustained I cannot venture to say, but it is certainly one of the triumphs of surgery that a condition which at one time was considered incurable except by amputation is now capable of such successful treatment that the only question is whether the mutilative operation is ever justifiable.

If in case all other methods of reduction fail I think that a trial should be made of Küstner's operation. As I cannot find a clear account of this in modern English textbooks a brief abstract of Küstner's description may be interesting. He has performed it, so far as I know, but once. It was then successful in a very obstinate case. 1. He made a transverse incision through the posterior vaginal cul-de-sac into the pouch of Douglas. 2. He inserted his index finger, sought for adhesions, and tried to reduce the inversion but unsuccessfully. 3. He made an incision in the middle line from the surface of the posterior wall of the uterus right

through to the peritoneum, using as a guide the index finger inserted into the cup of the inversion. The incision began four-fifths of an inch from the extreme fundus, was four-fifths of an inch long, and ended four-fifths of an inch from the os externum. 4. He then found it easy to reduce the inversion. 5. By vulsellum forceps he forcibly retroflected the uterus and drew it into the vaginal incision so as to enable him to suture the uterine wound from the peritoneal side. 6. He then closed the vaginal wound. The patient did well. This operation seems worthy of trial if necessity arises.

In regard to the literature of the subject I have found the most valuable contributions to be the following: 1. Dr. John Green Grosse's classical essay.² Such an essay as this, so exhaustive, luminous, and scholarly, it is a treat to read. The illustrations are excellent. 2. Observations on this subject in Dr. Matthews Duncan's Clinical Lectures. 3. Dr. Aveling's lecture,³ containing directions for the use of the repositr. 4. Küstner's paper.⁴ 5. Dr. Galabin also gives some useful hints in his "Diseases of Women."

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THE X RAYS IN PROGNOSIS OF PULMONARY TUBERCULOSIS.

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IN October of last year a short paper by me was published in THE LANCET on the use of the x rays in diseases of the chest. I there pointed out that the x rays might possibly be found useful in prognosis in cases of pulmonary tuberculosis. The following case which has recently been under treatment in the hospital is, I think, worthy of record.

A schoolboy, aged 11 years, was admitted into the City of London Hospital for Diseases of the Chest, under the care of Dr. Harrington Sainsbury (who has kindly given me permission to make use of the notes of the case) on Oct. 17th, 1898. There was no family history of tubercle. The patient had had a cough for about a year, which had become worse during the last six months. Expectoration was slight; there were no hæmoptysis and no night sweats. He had been wasting for the last three months. His evening temperature was 103.4°F. The physical signs before admission were as follows. There were dulness to percussion, tubular breathing with whispered pectoriloquy, and fine consonating râles at the apex of the right upper lobe. The left apex was apparently free. The following skiagram (Fig. 1) was taken before the patient's admission to the hospital. It shows massive consolidation of the apex of the right upper lobe, but gives no evidence of cavitation which the physical signs led one to believe existed. Although the left apex on auscultation was apparently free, the skiagram shows distinct evidence of commencing consolidation in that position. The patient remained under observation 12 weeks in the hospital. The treatment consisted in the administration of cod-liver oil and creasote in gradually increasing doses up to 40 minims of the latter with iron and arsenic. The general health of the patient improved somewhat while in the hospital. The temperature gradually fell during the first three weeks to nearly the normal level, but never quite reached it, the evening temperature always being slightly above 99°. The patient gained six pounds in weight. The physical signs indicated some clearing up of the right apex; the physical signs being *nil* at the left apex. The skiagram (Fig. 2) is from the chest of the same patient after his discharge from the hospital. From a therapeutical point of view it is very disappointing. It shows a steady progress of the disease downwards in the left upper lobe and also in the right lower lobe, notwithstanding the auscultation signs on the left side remained negative.

It is in cases such as this that I think the x rays will be found useful in prognosis. The patient is still under observation as an out-patient, and is in spite of treatment

² Transactions of the Provincial Medical and Surgical Association, vol. xiii., et seq.

³ Brit. Med. Jour., 1876.

⁴ Centralblatt für Gynäkologie, 1893.