

to uræmic poisoning of the nervous system, in the great majority of cases it is due to inflammation of the retina, attended with fatty degeneration.

"2. That this disease of the retina presents such distinctive ophthalmoscopic appearances as enable it to be at once with certainty recognized.

"3. That this retinal affection is found most frequently to accompany the contracting form of Bright's disease, but occasionally, also, the amyloid variety.

"4. That not unfrequently, from the insidious progress of the disease, the affection of vision is the first symptom that obliges the patient to apply for advice, and that thus the ophthalmoscope may lead to the detection of previously overlooked kidney disease; and,

"5. That, in a few cases, the diseased condition of the retina has been resolved, with restoration of function."

43. *Presumed Injury to the Ciliary Nerves from a Blow.*—Mr. R. B. CARTER read before the Clinical Society of London the particulars of a case of this, and exhibited the patient, a little boy aged 7, who had received a blow from a bat upon the right eye eight months previously. Enormous dilatation of the pupil followed the injury. The ophthalmoscope showed that the choroidal pigment around the optic nerve entrance (which formed a well-defined ring in the uninjured eye) had been scattered by the shock, and that an annulus of choroid around the nerve, and reaching nearly to the yellow spot, was undergoing atrophic changes. The inference was that the coats of the eyeball in this region had been strained and injured by *contre-coup*, and that the ciliary nerves had participated in the injury at their entrance into the globe. The dilatation of the pupil was greater than paralysis of the filaments from the third nerve would explain, and seemed to suggest active irritation of the sympathetic filaments of the dilator. There was no impairment of vision, and no paralysis of the external ocular muscles.—*British Med. Journ.*, Dec. 10, 1870.

44. *On the Causes of Failure in the Operation for Squint.*—Mr. SPENCER WATSON read, before the Medical Society of London, a paper on this subject, based upon an analysis of 103 cases of convergent and 25 cases of divergent squint. The causes of failure Mr. Watson classified under the following heads: 1. The pathological conditions were misapprehended. It had been thought to be due to mechanical obstruction to the movement of the muscles or to bands of fascia; but this was an error. In two-thirds of his cases hypermetropia was one of the conditions present; at the same time retinal changes had some influence in determining the permanent character of the squint. 2. The operation failed when improperly used. When there is eccentric fixation from any cause, an apparent squint is seen, and in such cases an operation gives rise to diplopia, and would not benefit, unless the other eye was much impaired in its visual power; or, again, squint may be apparent in cases in which one eye is very much larger than the other, from the presence of progressive myopia in one, and a normal state of the other. The cornea of the smaller eye appears nearer the inner canthus than that of the larger eye—an appearance that may mislead. 3. The tendon may be missed or divided too far from its sclerotic insertion. 4. The after-treatment may be improper, or the patient may object to a second operation, or to necessary glasses, &c. Mr. Watson held that the operation should be avoided or deferred in periodic squint, apparent squint, and squint in very young children who cannot wear glasses, and in brain cases. He further urged the use of the strabismometer, invented by the late Mr. Zachariah Laurence.—*Lancet*, Dec. 24, 1871.

MIDWIFERY.

45. *Induced Premature Labour, its true Value.*—Dr. O. SPIEGELBERG, in the *Arch. f. Gynäkol.*, 1870, I., and of whose paper we find a brief analysis in the *Centralblatt f. d. Medicin. Wissenschaften*, 1870, No. 45, expresses the opinion

that the high estimation in which the induction of premature labour in certain obstetrical cases is held is—1st. Because the question as to the true value of artificially induced premature labour in cases of contracted pelvis has never been tested by an examination of the favourable and unfavourable results, so far as concerns the safety of mother and child, or either of them. In labours occurring in females with contracted pelvis, the comparison has been made only between the results of the different procedures practised to effect delivery in the cases of labour referred to. 2d. Because, hence, the value of artificially induced premature delivery, is based upon the largest number of cases in which the infant was born alive when that proceeding has been resorted to, in place of being tested by the actual amount of lives, of mothers and infants, which survive as a general rule, in all cases of labour occurring in females with contracted pelvis. Such a course cannot be expected to lead to accurate conclusions. To endeavour to attain such conclusions, Dr. S. arranges in five tables a number of cases of delivery in persons with contracted pelvis, some of which occurred in his own practice, and part were reported by other practitioners, showing the mortality which took place in each case, as respects mothers and infants. The 1st table embraces 1224 cases of labour in females with contracted pelvis, generally. In 93.3 per cent. of these cases the result was favourable to the mother, in 6.7 per cent. she died. Of the infants, 71.2 per cent. were saved, and 28.7 were lost. The 2d table, shows the result of 271 cases in which premature labour was artificially induced. In 81.1 of these, the mother was saved, in 18.9 per cent. she died. Of the infants, 33.9 per cent. were saved, and 66.1 per cent. died; part were dead-born, and in part death occurred subsequent to birth. The 3d table embraces 587 cases of spontaneous birth in females with contracted pelvis; of the mothers, 93.5 per cent. did well, and 6.5 per cent. died. Of the infants, 64.9 were saved, and 35.1 per cent. died. The 4th table comprises 219 cases in which artificial premature labour was induced in females with contracted pelvis. Of the mothers, 84.9 per cent. were saved, and 15.1 per cent. died. Of the infants, 33.1 per cent. lived, and 66.9 per cent. died. The 5th table comprises 239 cases of extremely contracted pelvis, in which delivery occurred without the induction of premature labour. Of the mothers, 85.7 per cent. did well, and 14.2 per cent. died. Of the infants, 41.4 per cent. lived, and 58.6 per cent. died.

An examination of the tables given by Dr. S. will not prove anything in favour of forced premature labour. The cause of the unfavourable results to the mother are the sudden and forcible distending of the outlet of the womb, not yet prepared to give way before the force propelling upon it the presenting portion of the child, in conjunction with the direct injury inflicted by the operation upon the uterus. The mortality among the infants is accounted for by the fact of their premature birth, and the difficulty, under such circumstances, even when born alive, of their being reared in the families of the poor, among the females of which cases of contracted pelvis are most apt to be met with. The following are the conclusions arrived at by Dr. S.: 1. That a resort to enforced premature labour is of very doubtful propriety when the contraction of the pelvis is not under 8 centimetres. The operation should always be confined to cases in which the contraction of the pelvis is found to fall below 8 centimetres. Even then only when we have no reason to suspect, from the circumstances of former labours, that the infant may be of large size, the cranium unyielding, and the presentation unfavourable. In such cases, in which there is to be apprehended, that if delivery be deferred to the termination of the full period of utero-gestation, severe injury may be incurred by the perhaps already diseased pelvic organ. 2. Habitual dead births do not always indicate a necessity for the induction of premature labour, but of attention to its cause, which will be usually found to consist in a diseased condition of the mother, in general of syphilitic origin. 3. When the continuous death of the children is the result of maternal disease, and which cannot be prevented by any more desirable means, then, as a last resource, the induction of premature delivery must be had recourse to.

D. F. C.

46. *Prolapse of the Funis, and its Treatment by the Postural Method.*—Dr. BRUNTON read a paper before the Medical Society of London on this subject.

(*Lancet*, Dec. 24, 1870.) He reviewed the methods of treatment advocated in obstetric works, and showed that all of them were deficient in applicability and in good results, compared with the postural method, which was always applicable, the hand being the only instrument required, whilst there was no danger in its employment to the mother, as in version. Out of ten cases treated by this method by Dr. Brunton, in eight the children were born alive, and the death of the children in the two remaining instances was accounted for by special causes, one child being dead before the operation was commenced. The procedure consists in altering the direction of the internal axis or plane, which is downward and backward when the mother lies on her back, and nearly level when she is in the usual obstetric position, by placing the patient on her hands and knees in the attitude of an Eastern worshipper, so that the axis is made to pass backwards and upwards; and under these circumstances the cord can be returned by the hand during the intervals of pain, or by its own weight it slips up beyond the head. When the funis is returned, and the pains bring the head down, the usual position may be assumed by the patient. The author has not seen the postural method described in the manuals of obstetrics except cursorily, and he believed that its more frequent use would tend to diminish the infant mortality from funis presentations.

[The reader will find in the different medical journals published within the past few years abundant evidence of the value of this mode of treating prolapsed funis, which was brought into notice some years since by Prof. T. G. Thomas, of New York.—ED.]

47. *Spontaneous Inversion of the Uterus*.—Dr. J. H. TYLECOTE reports (*Brit. Med. Journal*, January 28, 1871) the following case of this: A young married woman had been attended by a neighbouring practitioner in her first confinement on October 30th, 1868. The labour was natural, except that it was followed by rather profuse atonic hemorrhage. The following day—twenty-four hours after delivery—her medical attendant was sent for hurriedly; and, when he arrived, found that, after a sudden accession of powerful expulsive pains, complete inversion and extrusion of the uterus had taken place. There was no hemorrhage, but the patient was anæmic from the previous loss, and seemed very prostrate, with rapid, feeble pulse. He immediately returned the uterus within the vagina; but, experiencing some difficulty in effecting its further reduction, procured my assistance. We put the patient under chloroform, and, without much difficulty, he succeeded in restoring the uterus to its natural position, after it had been inverted for five hours. The procedure which he adopted consisted in grasping the inverted uterus with the right hand, introduced within the vagina, exerting at the same time powerful upward pressure until the vagina was fully on the stretch, when he became sensible of the gradual recession of the tumour. Following this up carefully with my fingers, he soon found his hand occupying the cavity of the uterus, showing that its natural condition was restored. The reduction took place without any perceptible jerk. He retained his hand in the uterus for a time, and grasped it externally with his left hand until firm contraction was excited, when he cautiously withdrew the hand from the uterus, and no recurrence of the displacement took place. The patient made a good recovery, without the supervention of any inflammatory symptoms.

48. *On Prolapsus and Elongation of the Uterus*. By ROBERT BARNES, M.D., Lecturer on Midwifery at St. Thomas's Hospital.

Prolapsus of the uterus and hypertrophic elongation of the cervical portion of the uterus are now always thought of in association. Since Huguier published his views in 1859, it has become almost a general belief that true prolapsus does not exist; that it is only an apparent condition; that the real condition is always hypertrophic elongation, the cervix growing until the os appears beyond the vulva. That this is true of a large number of cases is clearly established; but it is not true to the absolute exclusion of prolapsus. Nor is it true that the discovery of the frequency of elongation of the cervix is due to Huguier. In the grandest pathological work of this century, Cruveilhier figured and described

it as of constant occurrence. Jules Cloquet also has given an accurate representation of it (*Pathologie Chir.*, 1831). Samuel Cooper, in his *Surgical Dictionary*, quotes the descriptions of Cruveilhier and Cloquet.

The use of the fingers and the uterine sound will make it clear to demonstration that the cases of apparent prolapsus uteri are divisible into two classes. In the first class the prolapsus is real as well as apparent. Enveloped in the protruded inverted vagina, the entire uterus may be felt; its whole contour may be surrounded by the fingers; and the sound, passed through the os, further determines with exactness the size and position of the organ. It is of normal size, perhaps less; and it is almost always retroverted. This form is observed most frequently in elderly women who follow laborious occupations. It is a joint product of senile atrophy of tissue and of explosive force acting upon the contents of the pelvis. As the uterus is driven down, the cervical portion, being attached to the base of the bladder, is relatively the fixed centre of rotation; while the fundus, compelled to follow Carns's curve, describes a circle round its os, so that at the outlet the fundus looks backwards.

In the second class of cases the prolapsus is only apparent. There is the hypertrophic elongation of the uterus, chiefly but not exclusively involving its neck, of Cloquet, Cruveilhier, and Huguier. This condition almost always arises during the childbearing period of life, and in women who have borne children. It is a result of chronic endocervicitis, mainly promoted, but not necessarily so, by laborious occupations. The mechanism of its formation I will explain on another occasion. The body of the uterus maintains its normal elevation and direction, or nearly so; whilst the supra-vaginal portion of the cervix, growing downwards, carries with it a reflection of the vagina, which forms the covering of the apparent prolapsus. Of course, this elongation may be met with at any stage of its progress. In the early stages, before it appears beyond the vulva, the lips of the os uteri are everted, gaping. The sound will always measure accurately the extent of the elongation. It is a remarkable fact, which I have often demonstrated clinically, that the extreme elongation is five inches—*i. e.*, exactly double the normal length of the uterine cavity. The fingers compressing the protruded portion will trace the elongated cervix as a firm cylinder, feeling like cartilage, through the reflected and thickened vagina, up into the pelvis.

The two forms of uterine disease, being essentially different in their origin and nature, demand different methods of treatment.—*Brit. Med. Journ.*, Jan. 7, 1871.

49. *Strangulation of the Uterus*.—Dr. GRAYLY HEWITT says this condition of the uterus is that in which the circulation in this organ is mechanically and forcibly interfered with, the result being acute congestion of the body of the uterus and various secondary effects. This strangulation is present when the uterus is forcibly bent upon itself, most markedly when it is bent backwards. It is a marked feature in most cases of flexion; and it is acute or chronic according to circumstances. It occurs as a necessary result of acute flexion, the arteries, but more particularly the veins, being partially occluded by the bending of the uterus. The acute pain and tenderness of the body of the uterus in such cases are due to it. The nerves are also pressed upon at the seat of the flexion. It was the opinion of the author that this strangulation of the uterus is a principal pathological element in all cases where hysterical convulsive attacks are observed; the acute congestion of the uterus determining directly, as well as indirectly, the occurrence of the convulsive seizures. Strangulation of the uterus and chronic inflammation of the uterus are intimately related and mutually co-operative in giving rise to the various sufferings present in many cases of uterine disease.—*British Med. Journal*, Oct. 1, 1870.

50. *Anteversion Pessary*.—Professor SIMPSON exhibited to the Obstetrical Society of Edinburgh (Nov. 9, 1870) an instrument which he had found useful in relieving the distress attendant on anteversion of the uterus, and made the following remarks:—

"A large proportion of the cases of this form of uterine displacement call

for no kind of mechanical treatment. A certain degree of anteversion or ante-flexion is to be regarded as the normal condition of the infantile uterus; and after the menstrual function is established, it still persists in a considerable number of women. M. Panas (*Archiv. Gén. de Médecine*, 1869, p. 274) examined 114 women with the view of ascertaining the position of the uterus, and found it straight only in about a third of the cases. His statistics are these: Uterus straight in 44; ante-flexed, 40; anteverted, 12; retro-flexed, 3; retro-verted, 3; lateri-verted, 12. He noted further that the uterus was found more habitually erect in proportion with the advance of the patient's age; and that early menstruations occurred most frequently where the uterus was still displaced, the mean age at which the menses appeared in women with straight uterus being 16.3; whilst the mean age at which they appeared in cases of flexion was 13.2. Besides these congenital cases, we find the uterus becoming displaced forwards as a result of the contraction of peritoneal adhesions, or the growth of a fibroid nodule in its anterior wall, or some morbid influence brought to bear on it during the relaxation of the puerperal period; and even in these the anteversion or ante-flexion does not always give rise to such distress as to necessitate our interference.

"Again, as is well known, the suffering associated with the displacement is often neuralgic in character, and requires for its relief the use of various nerve tonics and sedatives; or it may be inflammatory, and require the employment of antiphlogistics, etc.

"But there are yet other cases, and these not a few, where we cannot afford relief to our patients, except by the application of some mechanical support. I have seen the plan first proposed, I believe, by Dr. Moir for the treatment of retroflexion useful in cases of ante-flexion. Especially where it is associated with a marked degree of hypertrophy, I have seen the introduction of a sponge-tent straighten the ante-flected organ, and set up an absorptive action in the thickened walls. For other cases I have found the intra-uterine stem pessary, with which we are all familiar, yield the most satisfactory results; and in the case which has led to my present communication, no other means that were employed afforded any permanent relief. Various modifications of Hodge's and all other vaginal pessaries were tried for a long series of months and years; the only instrument that seemed to the patient to give any hope of ease being Dr. Graily Hewitt's. But even with it the pain in the left groin, which was her most distressing symptom, always remained acute as ever when she turned upon her side, so that she could never sleep except when lying on her back. To sit up or stand was for her an impossibility. The intra-uterine stem pessary was the only instrument that kept the uterus in such a position as to enable her to obtain the much-desired rest on the side; but, unfortunately for her, the instrument only produced its effect when it was itself kept in position by the wire frame adjusted over the pubes. So great was the relief it gave, however, that although it produced a degree of menorrhagia, she had worn it continuously for about a year and a half, till, from its pressure on the anterior lip of the cervix, it had begun partially to divide it. When she came under my care, I found that by pressing up the fundus with the tips of two fingers the pain was relieved; and in order to keep the fundus permanently supported in this position I got an instrument made, such as I now show to the Society. It is a bivalve pessary made of vulcanite, the fenestrated valves having the relation to each other of anterior and posterior, united by a hinge at their lower end, and kept apart by a slight spring. The anterior valve has a notch in its upper free border to receive and support the body of the uterus; the posterior is somewhat longer, and, by pressing upwards the posterior vault of the vagina, supplements the function of the recto-vaginal and the utero-vesical ligaments.

"In some cases where I have employed it, the instrument, as I have just described it, has proved serviceable; but in the particular case to which I have referred, I found it necessary to adapt a tube to the lower end of it, so as to allow of a wire frame passing from it to be fixed over the pubes. The lady has been wearing it for several months, with the happy result of being able to sleep comfortably on either side. She has, moreover, been enabled to move about the house, and when at the sea-coast during the summer she enjoyed open-air

exercise in the way of driving and boating, to a degree to which for sixteen years she had been a perfect stranger."

"Dr. KEILLER said that he had repeatedly shown to the Society pessaries made of gutta-percha and vulcanized India-rubber. One of these consisted of a couple of ring pessaries, which, when put together, made an instrument somewhat similar to that described by Professor Simpson. At a previous meeting he mentioned that two of Hodge's pessaries, united by the one being pressed into the ring of the other, fixed themselves. He thought it an advantage to have the rings separate. One great advantage of having the instruments made of gutta-percha is, that they can be moulded, and applied not laterally, but behind and in front. It is difficult to cure retroversion, which occurs most frequently in women who have had children; whereas anteversion is most common in virgins. It often occurs, however, in married women, and is a cause of sterility. He was of opinion that anteversion was more easily cured by Professor Simpson's instrument than anteversion. The great difficulty is to keep the instrument in position, and yet not prevent intercourse. He had operated according to the plan recommended by Marion Sims, and in one case the patient afterwards became pregnant. He thought Professor Simpson's pessary was likely to be very useful, as there was no intra-uterine stem. Dr. Keiller's experience did not quite bear out the favourable opinion entertained by Sir James Simpson as to the intra-uterine stem pessary. He thought it was of great importance to have the anteversion portion of the pessary spread out, so as to stretch the anterior wall of the vagina."—*Edinburgh Medical Journal*, January, 1871.

51. *Case of Puerperal Mania treated by Chloral*.—Mr. FURLEY made some remarks on puerperal mania before the Obstetrical Society of Edinburgh, and related the following case which he had successfully treated with chloral:—

"Mrs. W., æt. 21, a primipara, sent for the midwife engaged to attend her at 5 A. M. on the 7th of June. She had been complaining during the night of slight pains, but not sufficiently strong to warrant her in disturbing any one. Shortly before five o'clock, however, the pains became much more severe in their character, and she deemed it necessary to send for her attendant. When the midwife arrived, she found the os well dilated, and the head descending in the first position. The labour progressed quite naturally, and she was delivered at 8 A. M. The convalescence proceeded satisfactorily until the eighth day, when the secretion of milk and the lochia were very much diminished; she continued in this state for three days, when I was called in, and found her in the following condition.

"The patient was sitting up in bed with the infant on her lap, tossing it from side to side, and rolling it about. When the baby was taken from her she rose up and made for the window, and said she wanted to go out by it; her long hair was dishevelled, and was hanging partly over her face; her countenance was pale, and had an appearance calculated to arouse suspicions of albuminuria. There was no urine to be obtained for examination, and I had to trust to the look referred to. I was informed she had not slept for three days and nights. This, my first visit, was on the evening of the 18th of June. I gave the usual directions as to her being carefully watched, and ordered a dose of castor oil immediately, and half a drachm each of chloral and acetate of potassa every four hours. My reason for giving the chloral, of course, is sufficiently obvious, viz., as a sedative to the nervous system, and with a view to procure sleep. The acetate of potassa was administered to diminish the supposed condition of albuminuria, which her appearance had strongly made me think was present; and my former experience of the acetate, especially in puerperal convulsions, gave me thorough reliance on its efficacy. On the morning of the 19th, when I called, I ascertained that twenty minutes after she got the first dose of chloral she fell asleep and slept for three hours. She still talked nonsense, wept occasionally, but was much calmer than on the previous evening, and had taken tea, toast, and an egg for breakfast. The examination of the urine at least by heat did not show, as I had suspected, the existence of albumen. I ordered the chloral and potassa, however, to be continued at the same intervals and in the same quantity. The next day, the 20th, she was much

quieter—had occasionally talked rationally, and had taken her food willingly. Ordered a pint of beef-tea, and medicine to be continued. On the 21st, I found she had slept from 10 P. M. till 5 A. M., was much more rational, and had taken her food well. She occasionally tore her hair, and it being impossible to keep it in anything like order, it was removed, with the exception of a small portion in front, preserved for the sake of appearance. The same directions as to food and medicine were given. On the 22d I found that she had slept the whole night—talked rationally, answered questions coherently, was a little peevish, and wondered what had been wrong with her. On the 23d she seemed quite rational, but very weak. Ordered medicine to be given every eight hours, instead of four hours as before. On the 24th, six days after I saw her, and ninth from the invasion of the disease, she was able to be up for an hour, and was quite rational. On the 25th, 26th, and 27th, she was up the greater part of the day; and on the 28th, ten days after my first visit, when I called I found her dressing the baby, and attending to her household duties. I looked in upon her for some days subsequently. Her milk gradually returned, and she was able to suckle her child.

"I am thoroughly convinced that the chloral in this case was the agent which produced so beneficial a result, and I feel perfectly satisfied from my experience of it in this and other diseases, which I may at some future time bring under your notice, that what chloroform is to surgery, chloral will be to medicine."

"Dr. FRASER said that acetate of potassa was changed into the carbonate in the system; and as chloroform was evolved from chloral when it met with an alkali, this might account for the success of chloral in Mr. Furley's case. The acetate also keeps up the quantity of urine, which chloral tended to diminish."—*Edinburgh Med. Journ.*, January, 1871.

MEDICAL JURISPRUDENCE AND TOXICOLOGY.

52. *Strychnia Poisoning*.—The *Glasgow Medical Journal* for February last contains a highly instructive paper on this subject by Dr. J. ST. CLAIR GRAY, in which he gives an account, based upon an analysis of 143 recorded cases, of the succession of symptoms which are typical of the action of the alkaloid, and further shows that there is no symptom present in every case which can be said to be absolutely characteristic. He also describes the mode of death and post-mortem appearances, and the modes of detecting the poison, and finally points out the modes of treatment. In regard to the last topic he says: "The first procedure which ought to be adopted is the perfect evacuation of the stomach, and for this purpose emetics should be administered freely, and their action aided by the free use of demulcent liquids, as milk, gruel, or warm water; the animal temperature should be well sustained by warm applications externally, while, after the evacuation by the stomach, a mild laxative, as castor oil or magnesia, should be given. Great attention should be paid to the respiration, and should any tendency to asphyxia appear, artificial respiration should at once be begun, and continued, till respiration is properly re-established, or till it entirely ceases. Much discussion has taken place on the part of various writers on this subject as to the antidote for this poison, and there have at various times been proposed woorara, tobacco, chloroform, charcoal, camphor, hydrocyanic acid, tannin, iodine, bromine, chlorine, morphia, conia, aconite, albumen, kermes mineral, iodated iodide of potassium, lard, and, latterly, the Calabar bean and hydrate of chloral. Of these agents, those which demand special attention are woorara, chloroform, tannin, Calabar bean, and hydrate of chloral. I have at various times performed experiments with all these save tannin, but certainly from these experiments it appears extremely doubtful whether they possess any efficacy if administered subsequently to the accession of the tetanic spasms. Thus with woorara, chloroform, and Calabar bean I have frequently succeeded in retarding the appearance of the spasms, and, as I thought, in mitigating their severity when produced, but in every experiment a fatal result ensued, apparently either from deficiency or excess of the sup