

of this caso, here ceases, no doubt now being entertained of its charner. After a second and a third tapping, the poor girl gradually got weaker and weaker, her only comfort the oblivion produced by anodynes; and on the 15th of February she died.

The day following, assisted by my friend, Mr. Druitt, we made a post-mortem examination. The upper portion of the body was extremely emaciated, but, owing to slight œdema of the lower extremities, this appearance was not general. Abdomen greatly distended, and marked by enlarged veins; it measured in circumference fifty-eight inches. About a gallon of fluid was drawn off by the trocar, previous to making a free incision, after which, nearly a pailful of brain-like matter rolled out. This had been contained in a cyst, which extended from the pubis to the ensiform cartilage, and from the left to the right hypochondrium; in some parts, the walls of the sac were more than an inch thick, and of a fibro-cartilaginous consistence; the anterior portion adhered firmly to the abdominal parietes, the upper being formed by the inferior surface of the liver; that organ was bailed with the contents of the sac, and became inoculated, several small cysts, filled with medullary sarcoma, having formed in its substance. There were, also, many isolated cysts, varying from the size of a hazelnut, to that of a pigeon's egg; formed in the walls of the cyst; these had no connection with each other, or communication with the general cavity. The uterus was found imbedded in the lower portion, or base of the cyst; no trace of the ovaries could be met with; the bladder was small, but not affected by disease.

62. *Use of Auscultation in the Treatment of Labours.*—The *Dublin Quarterly Journ. of Med. Sci.* for August last, contains an interesting memoir on this subject, by Dr. McCARTOCK, the materials for which were collected by him in the wards of the Dublin Lying-in Hospital, whilst he was assistant in that institution. The following aphorisms contain the chief points of practical interest contained in this memoir.

1. Where the fœtus is alive, the sounds of its heart may be always detected at some period of the labour, by any one of ordinary proficiency in obstetric auscultation.

2. The precise region of the abdomen in which the fœtal heart is heard, affords auxiliary evidence of the position of the child in *utero*, but can never be relied on alone for determining this point, or supersede the necessity for vaginal examination.

3. In presentations of the lower extremities, whether it be breech, foot, or knee, the fœtal heart is usually heard most distinctly in the vicinity of the umbilicus of the mother.

4. Conclusive auricular evidence of the existence of twins *in utero* is only to be drawn from the inequality in the number of the beats of the two fœtal hearts, and not merely from any difference as to their respective positions.

5. If, in the course of a tedious or difficult labour, the fœtal cardiac sounds, from having been distinct and clear, gradually become feeble and obscure, and ultimately inaudible, even with every precaution against deception; under these circumstances, their absence is entitled to rank as positive evidence of the child's death; but without the previous successive examinations this conclusion would be destitute of any positive character.

6. In cases where ergot of rye has been given to hasten delivery, auscultation of the fœtal heart is the only certain way by which we can know when the medicine is commencing to exert an injurious influence upon the child; consequently, the stethoscopic indications are alone entitled to confidence for determining the exact time when the state of the fœtus calls for, and justifies interference.

7. In cases simulating rupture of the uterus, the persistence of the fœtal heart's sound is a strong proof against the occurrence of the accident, and the more advanced the period at which they are audible after the setting in of bad symptoms, the more conclusive is the evidence that rupture has not taken place; whilst, on the other hand, the sudden cessation of the fœtal pulsations, where they had been distinctly audible a short time previously, would strongly corroborate other existing symptoms of laceration of the uterus.

8. After an attack of puerperal convulsions in the seventh or eighth month of

pregnancy, where labour has not immediately supervened, the prognosis should be very much regulated by the state of the fœtus; for if it be proved by the stethoscope that the child is alive, we may venture to hope that gestation will go on undisturbed (unless the convulsions recur); whereas, if the child has been destroyed, its expulsion will take place, most probably, in ten or fourteen days from the date of the convulsive attack.

9. No certain conclusion regarding the state of the fœtus can be drawn from the characters of the placental sinistlet.

10. In cases of bleeding before delivery, observation of the placental bruit may supply useful diagnostic information, by pointing out the part of the uterine to which the after-birth is attached, and thereby showing whether the hemorrhage be accidental or unavoidable.

11. Auscultation of the heart in still-born children more accurately acquaints us with the state of the child's vital powers, than any other source of information, and is, therefore, well deserving of employment in all such cases.

63. *Spontaneous Rupture of the Uterus from thinness of the Parietes.*—Mrs. — was taken in a labour, I believe at her full time. The labour appeared to be going on naturally, when suddenly symptoms of great depression occurred, accompanied with vomiting and extreme tenderness of the abdomen, and the patient sunk rapidly, dying a few hours after the first accession of the dangerous symptoms. On examination after death, there did not appear to be any malformation of the pelvis, or disproportionate size of the child. She had borne several children, and her labours had been natural, though rather lingering. The cause of the rupture appeared to be, that one-half of the uterus, as the foetus increased in size, merely dilated, but did not increase in thickness as it should have done, so that whilst the cavity of the uterus was of the size it ought to have been in pregnancy, the substance of the walls of one-half was little thicker than brown paper, the substance of the other half being of the proper thickness. It appeared, therefore, when labour came on, that the part of the uterus which was thus prematurely alienated had been unable to resist the tension, and had given way. Nothing was discovered to account for this want of nutrition. The patient had generally enjoyed tolerable health. The true nature of the case, though suspected, was not ascertained till after death.—*Lond. Med. Gaz.*, Oct. 1847.

64. *A new method of bringing on Premature Delivery.*—The German journals contain the account of a new method of inducing premature labour, where required, as practised by M. COHEN, of Hamburg. That physician has been led to employ the subjoined method from noticing the power of injections into the uterus, in developing contractions of that organ; and as the pregnant uterus is in a condition apt to contract, he thought injections might be efficaciously used, and that without danger, to bring on delivery, in those cases where it is necessary the foetus should be expelled before the full term of pregnancy.

In the carrying out of his plan, M. Cohen has used a common small syringe, holding from one ounce and a half to two ounces of liquid, and furnished with a canula eight or nine inches in length, about one-eighth of an inch in diameter at its extremity, and curved like a female catheter. The patient is placed on her back, and the pelvis slightly raised. Two fingers are then passed into the vagina as far as the posterior lip of the uterus, in order to guide the canula, which is introduced between the anterior wall of the uterus and the ovum. The free extremity of the syringe is now lowered so as to allow the canula to glide under the pubic arch until it penetrates about two inches into the uterus, and at this point the injection is begun. The fluid is injected slowly and gently, taking care so to raise the syringe that the extremity of the canula may not rub against the wall of the uterus, and to vary its direction whenever any obstacle occurs to the escape of the liquid; the syringe is also withdrawn by degrees. Ten minutes afterwards, the woman may get up and walk about. If at the end of six hours there is no sign of approaching labour, the operation may be repeated.

Dr. Cohen has used for injection tar-water, which fluid he has also employed to diminish excessive secretion from the uterine surface. The author gives a case in which he resorted to this plan of injecting with success, it was one of