eruption existing in the same individual will therefore establish no contradiction to the views here laid down, but will serve rather to demonstrate their truth, and will be especially acceptable to those who are interested in following up the natural history of syphilitic disease.

One other point requires comment. I have stated above that a few of the pimples, those which were the last to subside, presented in their summits a small collection of white-coloured pus. The occurrence of a sero-purulent fluid or pus is a common character of the lichenous pimple when the eruption is severe or has lasted for a long time, and when the pus dries up it forms a scab of some thickness, and occasionally on the fall of the scab there remains behind a trifling degree of ulceration. I apprehend that the existence of sero-pustules on the summits of the papules of syphilitic lichen may in some instances have been mistaken for vesicles, and the purulent formations for pustules; but both the vesicles and the pustules of syphilis are vesicular and pustular from the first, and not solid pustules at their origin, as was the case with these.

I may further remark, that I have never seen pus or a purulent secretion in the summits of lichenous papules, excepting in cases like the present, where mercury has been unnecessarily or injudiciously given, or where the person while taking mercury has been exposed to the influence of cold.

CASE OF UTERINE HÆMORRHAGE FROM PURPURA, AND AN EFFECTUAL MODE OF ARRESTING THE FORMER IN ALL CASES.

By JOHN LYELL, Esq., Surgeon, Newburgh.

The following case, as illustrating a mode of practice, adopted by me for many years, in that most terrible of all the casualties of childbirth—uterine hæmorrhage, will, I trust, find a place in your columns.

Mrs. L—— consulted me on the 8th of December last; she was in the beginning of the eighth month of pregnancy; felt very feeble, with a weak, quick pulse; had pains in her limbs, so as to render her lame in walking, and was marked, in various parts of the surface, with livid blotches of purpura, varying in size from a shilling to the palm of the hand.

On applying the stethoscope, what has been termed the placental souffle was distinctly audible in the right iliac aspect of the uterus, but the fœtal heart could not be heard. She had been sensible of the fœtal movements for a few weeks after quickening, subsequent to which period all maternal impressions of fœtal life had ceased. The child evidently was dead, and the purpura and ill health probably dependent on that death.

As the state of pulse and other symptoms precluded general bloodletting, I prescribed laxatives with quinine and iron; the purpura, however, went on increasing; by the 12th, the gums had commenced bleeding, and continued to ooze out rather freely, in spite of all local styptics, so as to keep her incessantly spitting for two days and nights.

On the 14th, labour commenced, but the pains were feeble and distant, so that the os uteri dilated very slowly. The gums now gradually ceased to bleed, but a discharge instead of dark fluid blood took place per vaginam, which increased in quantity as labour went on; and at last, getting somewhat alarming, I administered ergot to expedite delivery. The presentation was normal; satisfactory uterine action took place, and in less than an hour after administering the ergot, a blighted fœtus of apparently five months was expelled; the placenta soon after followed, remarkable only in extensive fibrinous deposit on its maternal aspect. The uterus having properly contracted under the special stimulus of the ergot, and hæmorrhage to any appreciable extent having ceased in a short time, I left the patient in a hopeful condition. Some hours after, however, I was called again hurriedly, as she had sickened and become alarmingly ill; I found her pale, faint, and almost pulseless, evidently, to the least practised eye, prostrate from the loss of blood. There were very few clots, but the bed under the patient was soaked with blood, which continued to escape by a ceaseless and considerable stillicidium from the external parts. Still, the uterus felt well contracted and normal in size, the hæmorrhage evidently depending, not on the adynamic condition of that organ, but on the purpuric quality of the blood itself, which thus found means of escape from its whole internal surface, where healthy blood would have been restrained in its flow.

To prevent further loss of the vital fluid, and arrest the progressively fatal tendency of the case, I re-adjusted the circular roller with increased padding, so as firmly to compress the uterus from above, and then applied the long bandage with a properly shaped sufficient compress in the perinæum, so as to afford counter support to the organ below, when escape of blood from without being impossible, and its collection within equally so, it is almost superfluous to say that the patient ceased to get worse; in a short time began to get better; and now, ten days after delivery, is doing well. The long bandage I slackened within twenty-four hours, and in another like period removed entirely.

What I have here designated the long bandage consists simply of a stripe of stout linen or calico, fully two yards in length, and about a foot broad; a slit is made in mid-breadth near the one end, through which the patient's head is passed, when the bandage rests on the shoulders; the long end is passed down the back, and brought up between the thighs, to meet and partly overlap the short end in front, to which it is pinned or tied. From this arrangement, it is obvious that with the shoulders as a counter-point of support, any amount of pressure can be applied to the perinæum, and through the medium of a compress to the uterus itself. The organ thus compressed within the cavity of the pelvis, without the possibility of blood escaping externally, or collecting to any appreciable extent internally, uterine hæmorrhage becomes at once effectually arrested, at least, so I have found in practice, for many years. I had recourse to it at first from the disagreeable nature and comparative inefficiency of the tampon, which I have ceased to use for fifteen years or more.

A descriptive paper on the use of the long bandage I transmitted to Professor Simpson, was read by that gentleman to the Obstetric Society of Edinburgh, some time ago; but the above case being one in which most, if not all other means, even comprising electro-magnetism, would have been of no avail, as uterine contraction was not deficient, I have thought it proper to bring the subject more prominently before the profession. The long bandage has the advantage of being always at hand, a recommendation not possessed by several other means, including electro-magnetism; and if I may be allowed to speak of it from experience, it is perfectly efficient for the arrest of uterine hæmorrhage, either post-partum or from other causes. The abdominal pad I have generally formed of a common bed-pillow, or flannel petticoats; and the perinæal, of soft handkerchiefs or towels, made into an ovoid form, like the half-closed hands placed together. When the compresses of proper size are applied, the woman seems as large as at the full period of utero-gestation.

I trust your readers will excuse me for being thus minute, as the subject is a most important one, the means recommended exceedingly simple, in accordance with the recognised rules for the arrest of hæmorrhage in general, and perfectly efficacious, so far as my experience goes.

February, 1850.

DISLOCATION OF THE PHALANGES.

By A. D. DUNSTAN, Esq., Surgeon, Holmes Chapel.

In the night of February 15th, 1849, whilst house-surgeon to the Middlesex Hospital, I was called to see a woman, who, just previously, had fallen in the street, and dislocated the metacarpal phalanx of the thumb of the right hand, on to the dorsum of the metacarpal bone. Reduction was easily effected in the following manner:—

A nurse steadying the elbow to the side, I raised the hand so as to bring the points of the fingers as near as possible to the coracoid process, (*i. e.*, supination of hand and flexion of hand and forearm.) Supporting the hand with my own right hand, and the metacarpal bone with the ends of my fingers, I bent the luxated bone with my left hand, over the end of, and at a right angle to, the metacarpal bone; then, with my thumbs on the head of the phalanx, pressed it firmly downwards towards the palm, and whilst continuing the pressure, quickly raised the distal end of the finger to a straight line with the metacarpal bone; in doing so, the phalanx slipped into its normal position; the whole process being accomplished most readily, and almost without pain, so that the patient was agreeably surprised when she found her thumb "set right."

There was no treatment necessary subsequently, save keeping the thumb quiet for a day or two.

A few weeks after this, a carpenter applied at the hospital, having dislocated the metacarpal phalanx of the forefinger backwards. This was reduced by the same method as the former, and with ease to myself and patient.

The last case I had was that of a boy thirteen or fourteen years old, who fell whilst running, and received a compound

dislocation backward of the same phalanx of the ring finger, and simple dislocation of that of the middle finger.

These were reduced as the other cases.

For this plan of treatment I am indebted to Mr. Wormald and Mr. Vincent. The former gentleman pointed out the position I have described of the hand and arm, as most completely relaxing all the extensors and flexors of the thumb. The mode of reduction is that taught by Mr. Vincent at St. Bartholomew's, and since published in his valuable "Surgical Observations" pp. 39, 40, where he shows that the chief difficulty in reduction "is in the lateral ligaments, which usually remain entire, but are altered in direction." "If these ligaments are entire, the phalanx that is dislocated lies over, and parallel to, the other, and the lateral ligaments are now at right angles, instead of being in the same line as the bones, and any power to draw the bone in the line of its axis must only press the bones most closely together," and would consequently be useless.

He cites cases in which extension failed, but "reduction was effected without any pain and with the utmost facility," when the mode by flexion was adopted.

Holmes Chapel, Cheshire, 1850.

PECULIAR CASE OF DISLOCATION.

By HUGH THOMSON, Esq., Greenock.

A. H——, aged thirty-five, by trade a sawyer, on the morning of the 25th of January last, whilst walking upon a log over his sawpit, slipped, and fell into the pit, and sustained an injury of the left leg, in consequence of which he was unable to walk home without assistance. On examining the limb about two hours after the accident, the only thing remarkable to be seen was an unusual prominence of the head of the fibula, which I found to be thrown forwards upon the anterior and outer aspect of the tibia. I endeavoured to replace it by pressure with the fingers, but without success, until I directed the leg to be flexed upon the thigh, so as to relax the biceps muscles, when the bone immediately slipped back into its place with an audible crepitus, and the part, at the same time, assumed its natural appearance. A compress and bandage was applied, and rest enjoined. A slight effusion took place into the knee-joint, which subsided in a few days, and the patient was able to resume his work in a fortnight.

Greenock, March, 1850.

Foreign Department.

Treatment of Ascites by Injections of Iodine.

Dr. Leriche, of Lyons, has published in *L'Union Médicale* a paper, wherein he strives to establish that idiopathic ascites may be cured by purely surgical means. He asks: "Why should injections of iodine into the abdomen be more dangerous than the same injections into the tunica vaginalis, or other synovial cavities, since the anatomical identity between the peritonæum and these membranes admits of no doubt?" The author starts by quoting two cases of penetrating wounds of the abdomen which were perfectly cured, and infers that iodine injections are less trying than such wounds. He condemns the free use of purgatives and diuretics advocated by Cullen and Brown, and commends the attempt at cure by a substitutive inflammation, in spite of the opinions of Frank and Grisolle, who reject the practice. A case is then cited where repeated injections of a decoction of Peruvian bark, after evacuation of the fluid accumulated in the abdomen, were followed by the happiest and most lasting results; and M. Velpeau, who is rather favourable to attempts of this kind, is quoted at length. From the passages of the "Médecine Opératoire" of that author, extracted by Dr. Leriche, it appears that the first trials of this method were made by Brenner; Warrick followed him, injected Bristol water with success, and failed with red wine and tar-water; Hales advocated the introduction of two canulæ, so that the fluid injected by the one might escape by the other; Heurmann and Bossu gave their support to abdominal injections, but had few imitators until Broussais mentioned two successful cases obtained by the vapour of wine. MM. L'Homme and Gobert used the same means in two cases, and the patients recovered perfectly. Yet M. Velpeau thinks that such cases are not sufficiently clear to authorize a like practice; he holds, as shown by two autopsies, that the cure is effected by the agglutination of the parietal layer of the peritonæum to the abdominal viscera, and asks whether we are in prudence and humanity justified in thus imitating the process of nature? M. Jules Cloquet has mentioned a case of congenital hydrocele, where the alcoholic fluid, injected into the tunica vaginalis, penetrated into the abdomen without giving rise to unpleasant symptoms. M. Roosbroeck, of Louvain, has tried the injection of nitrous oxide gas into the abdomen, this idea being suggested by the diuretic and diaphoretic properties of this gas. Two men and one woman were subjected to this treatment with advantage; and M. Broussais used it on a patient, who was so exhausted beforehand, that it appeared surprising to see him survive the operation a whole week. Dr. Leriche, having thus given an historical sketch of this method, according to M. Velpeau's book, adds: "The first case of iodine injections into the abdomen which has come to my knowledge is one of Dr. Dieulafoy: he employed them three different times on the same patient, who quite recovered. I have myself used these injections in several cases of ascites, and was perfectly satisfied with the results, and so convinced of their innocuity, that I tried them in a case of ascites resulting from cirrhosed liver; and though the effusion eventually returned, I did the patient no harm by two operations." Two cases of complete success are then quoted by Dr. Leriche—one relates to a girl of seventeen, whose abdomen measured thirty-eight inches in circumference over the umbilicus. After evacuation the following injection was thrown in:—Tincture of iodine, one ounce; iodide of potassium, one drachm; water, eight ounces. The patient did not experience any pain; the abdomen was well kneaded; about four ounces were allowed to escape again, and a bandage was put on. The case was very successful, yet we cannot help thinking that the author, in a subsequent paragraph, rather oddly ascribes the ascites of this girl to pleuritis, which, by contiguity of tissues, had spread to the peritonæum in a latent form. The second case is that of a woman, thirty-eight years of age, who had ascites after a sudden check to the flow of the catamenia; the abdomen measured forty-eight inches; the fluid was evacuated, and the same injection as above thrown in. The irritating liquid was brought into contact with the whole abdomen by handling its surface, and almost the whole allowed to flow out again. The patient, from whom about nine pints of greenish-yellow and adhesive serum had been drawn, recovered perfectly; she was seen six months after the operation, and complained of no return of the effusion. It should be mentioned that the injection caused but very little pain.

Twin Birth—Abnormal Disposition.

Drs. Sagot and d'Hurtebise have recently published in *L'Union Médicale* the following extraordinary obstetric case. A healthy girl of twenty married about five months ago, and almost immediately after marriage, she felt the first symptoms of pregnancy. Gestation went on in a regular manner up to three months and a half, but at that period the abdomen took rapidly a development and a tension of a morbid character, and the legs begun to swell. At four months and a half, the abdomen was enormously stretched, much more so than is usual on the ninth month of a natural pregnancy; there was fluctuation, and the œdema of the legs became considerable, though neither the face, arms, nor superior portion of the trunk were swollen. When the fifth month had been reached, the patient no longer felt the child, intermittent pain in the loins set in, no serosity; not a drop of blood escaped; the os uteri began to dilate, and the head of the fœtus presented at the brim. The expulsion was very rapid; the child had the dimensions of a fœtus of four or five months; it was dead, and from the colour of the skin it might easily be perceived that death had taken place several days before. The umbilical cord was thin, about the size of a quill, and the passage of the child had been unaccompanied by any blood or serosity, in fact, not a drop had escaped. The mother's abdomen was, however, as distended as before, the placenta was not appearing, and by the finger the cord might be felt communicating with a smooth, soft, and fluctuating membrane. The examination being carried further, the membrane burst, and a tremendous gush of a yellowish serosity took place. No less than from eight to ten quarts escaped. The abdomen fell in considerably, pains came on, and a second child was soon born; it was a little larger than the first, and the umbilical cord was enormous, knotty, and at its fœtal insertion, as big as a man's thumb. A little blood escaped with the placenta; the latter was voluminous, of an oval shape, separated by no groove or division, and received the insertion of both cords, which, however, were implanted at some distance from one another. The patient was soon well, and the œdema entirely