AN ADDRESS ON THE SURGICAL ASPECT OF IMPACTED LABOUR.

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Mr. President and Gentlemen,—I feel much the honour you have done me in asking me to deliver your annual oration, but when I first received the communication from your secretary I had, as usual, much difficulty in the selection of a subject of which to speak, for although the triumphs of abdominal surgery are always fresh, yet the constant repetition of points as to which the minds of most men are made up is apt to pall upon the taste. At the same time there are many points upon which it is impossible to make up one's mind till those who supply the material on which to form a judgment have taken us into their confidence, and till, by outside criticisms, we have been led into a correct line of practice.

I have first of all to observe that the progress of modern abdominal surgery has influenced surgery in general throughout its entire extent, a fact which may be abundantly illustrated, but which will be shown in one striking instance, namely, that the use of short ligatures in utero is distinctly the result of the practice arrived at first within the abdomen, and completely established only within the last ten or twelve years. You must have seen, as I have, the tedious manoeuvres formerly in use which necessarily accompanied the use of the long ligatures, causing much anxiety to the patient and much pain to the surgeon. I have not only seen these ligatures, but I have had the pleasure of being present when a patient was saved by the introduction of the short ligature, and I am not ashamed to say that, as a result of the practice of Dr. Haldane and others, I have preserved a number of cases which otherwise would have been destined to a fatal termination.

In the third division of the practice of medicine, obstetrics, the prospect of the interference on the principles laid down by abdominal surgery is less striking; but even here it is to be hoped that our progress will not be without effect. The medical and obstetric person, who practises the cutaneous or opening method of cases in which I, who practise purely as a surgeon, is but little of obstetric work, and, save for the incidental occasional conduct of a case in which there could be any question as to the possibility of relieving a parturient woman by an opening through the abdominal wall, my association with obstetrics is absolutely negative.

I come before you this evening to risk a question before a body of men likely to give me suggestions distinctly trenching upon the department of practice with which I have just confessed myself as having nothing to do. It is certainly more than twenty years since I have seen a case of normal labour, and I ask your indulgence, therefore, if, upon purely obstetrical grounds, I should make a slip. I have done my best to bring myself up to date upon the matter by the consultation of all the authorities within my reach, but notwithstanding what knowledge I have, as far as he is in full association with its object. My purpose in this new inquiry is to examine whether our methods of dealing with impacted labour are not capable of improvement. I of course am not speaking about impactions that can be relieved by the forceps or by turning, but of the instances to which the interference is due to some deformity of the pelvis, or similar cases of an extreme kind. Such cases are met with in remote districts of the country, where the accurate measurements of pelvic diameters, as recommended by skilled obstetricians, are not practicable. It might be possible, under favourable circumstances and in highly-skilled hands, to say, before labour has begun, or during the early stages of the process, that the diameter of the pelvis is, or is not, less than three inches, but, as a matter of fact, such a pronouncement is not within the skill of the ordinary practitioner; and, moreover, in the great bulk of the cases of which I am about to speak, labour has been advanced, and the only means left to relieve the obstinate efforts at relief, so that an accurate measurement and knowledge of the real condition of the pelvis may become impossible; or they might, by the previous experience of the patient, by the knowledge of the fact that she had a previous impacted labour, which required the most serious means for overcoming the obstruction, have a knowledge which would guide them in the proper treatment of the case. If by any reason they came to the conclusion that the least diameter of a given pelvis was not less than three and a half inches, the authorities were agreed that it was now in all probability the safe way to withdraw the obstetrician, and if not less than three inches then podalic version would be successful. When, however, they came upon cases, more especially when they were unexpected, where the diameters of the pelvis were restricted below this, the difficulties became greater and greater.

I am not here to speak to skilled obstetricians, nor indeed am I prepared to accept their verdict upon the point, for ninety out of a hundred men who had to make their living by extending the practice of midwifery are not skilled obstetricians, are not under the influences in which they have kept obstetricians, their skilled knowledge of the art could be maintained. They did not live with the full association and stimulus of hospital appointments and teaching engagements, with all the resources of skilled aid, and the most recondite costly appliances at their disposal. The knowledge of obstetrics in the hands of women could maintain their high level of the science of the obstetric art, but with the majority of practitioners, the conditions of their life rendered this impossible. I find that the skilled obstetricians speak with authority on the one side as they themselves occupy it, I venture to say, generally useful person, the general practitioner, and upon his decision, I think the future practice of obstetrics upon this vexed question must depend, whether it should remain what it is or whether it should be allowed for the better.

I have to point out that impacted labour may arise in one of two ways: first, that impaction may be due to causes intrinsic to the fetus, such conditions being very rare and for my purpose, they may be almost dismissed. Within this class is comprised hydrocephalus, a very rare condition; distension of various parts of the body or of the generally; anasarca—one of the very rarest—or perhaps distension of one kidney from obstruction of the ureter, resulting in enormous hydropnemonia. So rare are these cases that it is indeed hardly worth while speaking of them even in the universal condition. In the majority of instances the impaction results from causes intrinsic to the mother. We have therefore to deal with two groups of cases, one infinitely small and exceptional, so small as to be practically undeserving of attention—and that group might be dismissed with a remark that if the diagnosis were made of the true cause of impaction, the destruction of the child is a matter of necessity, for no one would advocate surgical interference with the mother on account of a fetus subject to any of the diseases or deformities I have just alluded to. I therefore pass on to the consideration of impaction due to extraneous causes of the mother, and I say it is necessary here to mark out into subdivisions all cases in which the line of practice would be distinctly divergent, possibly not so much in the course to be followed as in the reasons for the proceeding which would have to be adopted. Thus the impaction might be due to cancer of the cervix or vagina, conditions in which there could be no doubt as to the propriety of interference with the mother and not with the child, for the reason that the mother was suffering from a disease which had already doomed her to a certain death whilst that organ was not in any way dangerous. Consequently it would be far greater to be concerned with it than with the mother, if there be any choice of opposing interests.

You know, of course, as a matter of history, that embryolica in such a condition for the mother is a very risky and a very deadly operation.

Next we come to the most important class of cases of impaction, where the difficulty arises from pelvic deformity, tumours of the uterus, or of the ovaries; generally speaking, indeed, the most frequent cases of impactions due to conditions in the mother. Here, again, there is a qualification which almost subdivides the

1 Delivered to the Southampton Medical Society.
line of treatment to be followed, not as a matter of choice, but as one of necessity, and that is as to whether you know the exact condition of the mother before labour has advanced to the position of impaction. If you are a skilled obstetrician and can assign the precise condition which will be found, your gifts will undoubtedly be a means but not an absolute knowledge of the condition of the patient in a previous labour, you will be still better able to elect the line of treatment which will be most to her interests. If you know, for instance, from your own experience or from knowledge received from your patient or her medical attendant, that the first labour has been terribly protracted, and had to be terminated at last only by eversion of the child, your desires would be certainly considerably lessened to have the conduct of the labour in any case, but such information would be very useful to enable you to make use of one alternative which, without that previous knowledge, would never enter into your mind—you would in fact have no alternative— these are, however, by no means uncommon, for not a year passes in which I do not see cases of such damage to the maternal tissues resulting in dreadful facial and urinary fistulae after long impacted labour, that I feel sure, in the interests of humanity, some reconsideration of our position is called for. I never get into conversation with a practitioner advanced in life, and with prolonged experience, from whom I do not gather in conversation that he has met with a number of such cases, the great majority of whom die.

On the other hand, I have been strongly impressed with the belief that the facility with which a perforator will relieve the head of a child of its contents, so that its diameter may be reduced half an inch to an inch, together with the reduced sense of the so-called difficulty with which modern skilled in obstetrics has induced us to regard the life of the child, has led to the perforator being more frequently used than it ought to be.

In conversation with a practitioner some forty or fifty miles from Birmingham, who had reached his three score years and ten, but had not lived a day, and had been a general practitioner, who had not lived quite six years, there, that he had, in that short experience, effectually employed the perforator no less than seven times. He cannot help thinking that in this instance—and my experience in this direction is not confined to it as unique—there was displayed a far too slight regard for the interests of the child.

In discussing the rules for our practice at this point we bring in discussion the treatment of impaction at some point or other within the pelvis where the diameter is below three inches, perhaps below two and a half. In such a case, according to Simpson, the induction of premature labour would be indicated, but this would certainly not apply to the case of a primipara, for I assume that the Western doctors are called in to women already well advanced in labour, or in whom at least labour has begun before they know anything at all of the complication which they are to overcome, where they find, in fact, the impaction already taken place in face of greatly reduced pelvis.

It is clear, of course, that where a previous knowledge of the condition has existed, the choice of induction of premature labour is one which ought to be fairly discussed, and probably, in the majority of instances, accepted; but in those instances where this is not the case, the good regulation practice, according to the books and the teaching of the schools, leaves nothing but the adoption of an evicerating operation for the destruction of the child; and it is possible also that doubt may be expressed even in cases where the notice has been given, and where the induction of premature labour may be adopted, for authorities differ upon the value to be placed upon this proceeding, even to the extent of a rendering of its mortality from 5 to 60 per cent. If the mortality be found not to exceed 5 per cent., I think there is nothing to be said against it, but if it approximate anything towards 60, I cannot make it my practice. In cases of premature labour the mother must be so advanced as to come within range of the induction of abortion at the third or fourth month in order to remove all risks of the necessity for eviceration. Upon this point, therefore, we may with justice narrow down the theme on which I was to discuss, and that is when a practitioner is faced with a case of impacted labour at the full time, in which he has had no previous knowledge of the possibility of complication, in which efforts at delivery by long forceps and podalic version are evidently unlikely to prove effectual, or actually have done so on trial, what is to be done?

The routine treatment advised by authorities is that of eviceration. I propose to offer the alternative, which I think has greater and stronger arguments in its favour, and it is to test the validity of these arguments by the opinion of men who have the best means of examining it. For the sake of the interested reader I have collected a number of cases from the reports of cases in the literature where I have appeal to my professional brethren who are in general practice under such circumstances as to relieve them from the charge of being skilled obstetricians; for I do not think the skilled obstetrician ever has the experience or the knowledge which justifies his coming to the fate of his profession. I am perfectly certain that his verdict would be one that could not be applied to the general practice of obstetrics throughout the country.

But passing on to discuss the operations at present in vogue, I have to enumerate eviceration, generally beginning with perforation of the head or one of the large cavities of the body, and removing the child piecemeal. As I have seen this operation performed, and had in one or two instances in my early life to perform it myself, I cannot imagine anything more repulsive and horrible. It is open to a great many objections, as in the first place it involves the investment of a considerable amount of money in an extensive and costly armamentarium, which usually lies rusting in a corner year after year, until the rare occasion presents itself for its use. Such an armamentarium must necessarily be possessed by comparatively few men, and there would be always a tendency, as I have already illustrated, for timid men to resort to the destructive operation under less severe conditions than altogether justified it. The operation is a difficult, complicated and delicate one, occupying in the majority of instances a very long period of time and involving the most prolonged and painful efforts in the worst cases where it is most required, great bruising and injury to the maternal passages; it involves of necessity the death of the child, and, finally, it leaves the mother, if she recovers, exactly where she was, to undergo a similar risk again.

As an alternative to such an operation, I have to offer a modification of our old friend the Cæsaract section; but it must be borne in mind that there is great difficulty and no small danger by reason of the constant want of precision in modern nomenclature concerning operations. The operation as at present known by that term...
consists in principle of the preparation of an artificial channel between the womb and the living mother for the delivery of the infant. The original meaning of the operation was restricted to the removal of a living child from a dead mother, and the conditions of the operation were stringently limited by the canons of the Catholic Church. It was the duty of the obstetrician to wait till the mother was dead before performing the operation. In the interests of the child being in eminent danger from any cause, it was imperative to have the child baptised as long as indications of life remained in it; and it is well known that the canons of the Catholic Church lay a far greater stress upon the duty attached to preserving the child than to the use of part of the ethical code of modern obstetrics. Whether we have rightly or wrongly deplored from this is a matter for individual opinion; but I am strongly disposed to believe that we have too little considered the cogent arguments of the fathers of the Church, through which have descended the Christian doctrines for many centuries uninterruptedly.

A large number of new operations have been suggested as modifications of the Cesarean section to which the names of persons have become unfortunately attached, but in none of these, with one exception, is there any detail of a new kind of sufficient importance to be lifted into the position of a particular item of nomenclature. None of these details, with the exception of the one about which, I am about to speak, have proved of sufficient importance in practice to justify us in believing that they are in any way essential to success. The great majority of proposals are simply encroachments upon one or another of the sections of the old method, as, for example, after the method of Porro, which in my experience and in my belief will revolutionise the art of obstetrics in those conditions in which the relations of mother and child are of the most serious kind.

In the old Cesarean section, no matter whether applied to the living or the dead mother, as has been the case with Porro, his proposal is to perform a Cesarean section, and then to remove the uterus by a simple process of amputation, and this constitutes a most essential difference to all other proposals. The difference may best be expressed by figures, for it seems to me that in cases operated upon by the adoption of Professor Porro's principle, the mortality need not exceed 5 or 6 per cent., whilst we know that the Cesarean section gives a mortality of no less than 90 or 95 per cent. Sydney Smith used to say that no one ought to perform the operation of Cesarean section unless he was infallibly certain that it was a very good thing to be a baby. It is now shown that the operation was never successful unless it was performed by a cow, an allusion to the fact that in cases in which accidentally a cow had ripped open a pregnant uterus, several recoveries had taken place, whereas hardly a patient was known to have recovered even when the operation was performed by a special surgeon.

The reasons for the want of success attending the performance of Cesarean section are not far to find. In the first place, the operation has to be performed in the great bulk of instances by men who have had no kind of special training, not only in abdominal surgery, but in surgery generally. Most of the operations fall to the lot of men in outlying districts, and this was undoubtedly a factor of great importance in the consideration of the mortality. The cases were not operated upon in their earlier stages, but only, as a rule, after a tremendous amount of insectile hemorrhage had taken place; it is one of the deadliest perils a woman has to undergo. You all know very well that there is no region in which the inflammatory process is so uncontrollable as in the parturient uterus. So strongly have they been impressed with this point that they will not undertake in the treatment of the so-called puerperal fever, removal of the suppuring uterus as probably the only treatment which we shall apply of a truly satisfactory kind.

When we open the bodies of women who have died after confinement from inflammation of the uterus, we find a suppurating peritonitis, which is only a feature of the case. The real trouble is that the enormous venous sinuses of the uterus are filled with decomposing and putrid blood. This would therefore of necessity constitute a large element in the mortality of the old Cesarean section. Removal of the uterus would obviate it. Finally, the removal of the uterus would entirely relieve the patient from the risks of again being placed in a similarly dangerous position. This question, of course, is an ethical one upon which considerable difference of opinion may be expressed, but it is true that on the one hand we have a means of relieving a patient for the time, and on the other hand a means of permanent cure, we are bound to accept the method of permanent cure instead of one of mere temporary relief. My thesis is therefore contained in this question: Whether, when you have before you a case of impacted labour arising from causes which you have been unable to ascertain beforehand and in which neither the forceps nor turning are available for relief, it will not be better to put all evacuating operations on one side, and proceed to remove the fetus through the abdominal wound of the mother.

Arguments for such a proposal must, of course, be largely statistical, and are apt to be made more or less misleading for the simple reason that mere statistical returns cannot comprise the whole history of the cases, and the most paltry set of results may be apt to be drawn from the statistics. It must therefore, to be of any value, comprise a very large number of instances in order that they may be qualified, or they must consist of a small number in which the conditions are most rigidly defined; in fact, the total record must be so comprised as practically to state what it would be. It would thus be nonsense to consider in the same group cases in which impaction had been found beforehand, and those in which amputation of the pregnant uterus had to be performed upon patients only after a tedious suite of useless efforts of other kinds. In the former state, the patient was in a very serious state of obstruction, and in the latter there would be a risk of an immense mortality. In the latter series, it was the mauling previous to the surgical operation and not the operation which killed the patient.

We might, therefore, draw some conclusion from the material which is available. In this way all statistics of the kind are liable to mixed qualifications; but even qualified as they have to be, we may draw some conclusion from instances where statistics of a very extensive kind are obtainable. Thus, according to Ramsbotham, the simple application of the long forceps was mortality of 30 per cent.; and in the forms of podalic version, with all his advocacy of podalic version, could not claim to be more successful.

All the modern authorities on craniotomy are nearly agreed that this operation has a mortality of at least 20 per cent., and this would probably be very much emphasised if we had to consider all of the cases in which the operation was really necessitated by a small pelvic diameter, and had to be carried out to the piecemeal removal of the child. Even the mortality of the induction of premature labour is said to approach nearly 15 per cent. for the mother, whilst for the child it is certain that no more than half a chance is given; but even these statistical statements are, I think, only one side of the question. In forceps application the mortality of the fetus is well known to be about 1 in 7 or 8, whilst in turning it is 1 in 3 or 4. In craniotomy, of course, the child dies practically to the extent of 100 per cent. In craniotomy, the mortality for the child is almost nothing, certainly not 5 per cent. as against premature labour, in which half the children are lost, and the question therefore narrows itself down to the diminution of the mortality for the mother.

I am perfectly well aware that the ethical view upon this question will be immensely modified by the accident of the particular school in which any particular writer has been brought up. Upon such a question every man is entitled to have his own individual opinion, but it is hardly fair to put that opinion into a pronouncement from a school unless there be a semblance of critical authority to back it. The old discussion between the application of the forceps and the operation of podalic version was an illustration of this. When it was discussed between the Dublin school and the London school, it is well remembered how fiercely this battle was fought, and upon the point chief of the right of the child to a consideration when the mother was in danger. The teaching of the Dublin school was, of course, strongly
tinctured with the teaching of the Catholic Church, whilst that in Edinburgh was not less strongly coloured by the school of Calvin.

Authorities dating from Rome hold very stringent views in respect to the propriety of saving the child if possible, and I have to urge views promulgated by a church which was one that had given the matter a special and distinct consideration and is entitled to respect from an ethical point of view. One result of the discussion that I am speaking of between Edinburgh and Dublin was an effort of compromise—which, like most compromises, was highly unsatisfactory—under which a rule was adopted that the obstetrician was to wait till the death of the child before proceeding to an eviscerating operation. The only result of this could be the certainty of destruction for the child and the enormous increase of the hazard for the mother. Per-secutively I am disposed to endorse the view that the child is eminently entitled to serious consideration, and I think that there has slipped into our training a lamentable tendency to disregard the rights of the child.

I would not go so far as to say that the child has equal, rights with the mother, but certainly its life ought to be the subject of a far more serious consideration than is at present given to it. This is one of the reasons why I have taken upon myself to advocate an operation which involves vastly less risk to the mother, and of which there is a thoroughly good chance of life to the child. My thesis is that eviscerating operations ought to be entirely discarded in favour of amputation of the pregnant uterus, except in the small and exceptionally insignificant group of cases in which the impaction is due to causes intrinsic to the child, and where, almost without exception, variety is the order of the day.

Given or as the case may be deformed or diseased fetus is really a quantité négligeable. I believe that the simplicity and more of the mothers and also that the child has been affected, and the absolute prevention of the recurrence of the terrible disease, or renders more cumbersome and less intelligible the instruments required for its performance. The less elaborate and complicated the instruments are, and the less tedious and difficult the manoeuvres, the greater the chance of any surgical proceeding becoming popular as well as successful.

I would therefore urge the introduction and the adoption of all the numerous instruments which are wanted to make up the paraphernalia of the scientific obstetrician, while he would inevitably have at hand the few simple instruments required to perform the operation for which I am now arguing that it ought to be substituted for all the destructive and mutilating operations on the fetus in impacted labour. In enumerating what is required, let me first of all say that they are what you may carry in your pocket case: two or three pairs of catch forceps for arresting bleeding points, a small sharp scalpel, a sharp point pair of suture-noodles, some silk, a piece of India-rubber drainage tube, and two needles of steel wire, and none better than the ordinary stocking knitting needle can be found. If you wish to be very scientific, you may add a serre-nœud such as was originally invented by Koeberlé, as modified by Bantock or myself, but it is not in the least degree necessary.

The first step in the operation is the abdominal incision, four inches in length, involving first the skin and then the muscles down to the sheath of the rectus, all of which ought to be divided by a sharp knife at once; then the tendon of the oblique muscular layer is divided, the uterus is drawn aside, the posterior layer of the uterus is now lifted up by two pairs of forceps and divided between them. The extraperitoneal fat is treated similarly, then the peritoneum raised again by two pairs of forceps, a slight notch being made between them; and the moment these are made, their entanglement is at once removed. No director is required, nothing but an observant pair of eyes, lightly-applied forceps, and a delicately-applied, sharp-cutting knife. The finger is then introduced into the peritoneal cavity, and the relations of the uterus and bladder are exactly ascertained. The peritoneum is then opened until the full extent of the incision is taken, and the cut edges of the peritoneum are seized on each side by a pair of forceps and are pulled severally to the respective sides. No better retractors can be employed.

The piece of India-rubber drainage tube about eighteen inches or two feet long is now held as a loop between the fore and middle finger of the left hand, and is by that means slipped up over the uterus and pulled down over the cervix, passing the fingers behind the cervix to see that coils of intestine are not included in it. One hitch is then made on the tubing when it has been so far drawn down as possible, and it is pulled as tight as is consistent with safety. The second hitch may be made in it, but what is far better, an assistant keeps the tube on the strain, so that the one hitch will be quite enough to effect the most efficient clamping. A small hole is then made in the uterus, just large enough to admit the finger; if it is possible, the position of the placenta may then be ascertained; if not, the right forefinger follows its colleague, and between the two, by gentle rending, an aperture is made in the uterus, and the leg of the child is seized. The foot is then carefully delivered feet first, and this, despite all the authorities to the contrary, is by far the best proceeding; less blood is lost, and it requires but very gentle manipulation to relieve the head.

As soon as the foot is removed, the placenta is sought for, and removed similarly; the uterus itself, being then completely contracted by this time, is pulled out of the wound, and the elastic ligature is tightened once more, and finally arranged round the cervix, and the second hitch is applied. The main details of the operation are now completed; all that is required is to pass the needles through the flattened tube and through the uterus, and out at the other side, forming a St. Anthony cross or two parallel bars to support the weight of the uterus and the stump, and to keep it outside the wound. A complete toilet of the peritoneum is then performed, and the abdomen is closed by the anterior vesical cul-de-sac; stitches are passed in the ordinary way to close the wound accurately round the uterine stump.

The uterus is now removed close down to the needles and strangulating rubber tube, so as to leave a little tissue above. It does not then become necessary to having all the demands for such an operation as this—indeed, I deprecate the introduction of any complicated detail into such an operation as this—indeed, I deprecate the introduction of any detail into any operation—which in the least degree tends to complicate its per-
MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, &c.

THE ECBLIC ACTION OF PENNYROYAL.

From what Dr. Marshall states in the Journal of March 8th it appears that the therapeutic action of pulegium as an emmenagogue is very imperfectly known. The drug is used very freely by many married women to hurry on delayed periods. One lady told me that she always kept a supply, and took large doses if the menses did not come on. She was much distressed to find that the drug failed to have the desired effect on the occasion I saw her, and added: "My sister-in-law takes it regularly when she passes her time, and invariably finds the period to come on in three days." I made some inquiry regarding the practice, and find that among many classes it is recognised as a tolerably certain abortifacient, and esteemed as less hurtful than aloes, safflower, cantharides, ergot, eelenterum, croton oil, black hellebore, squills, or even borax. At the same time it is very questionable if any of these drugs can be regarded as absolutely certain to interrupt gestation. Given a healthy embryo in a healthy and normally placed uterus, it is by no means easily injuriously affected. But if by causing irritation or congestion of the uterus an early abortion is once procured, it is very probable that the process may be repeated indefinitely. I cordially agree with Dr. Marshall's suggestion that greater precautions should be enforced regarding the sale of such drugs.

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ON MUMPS.

During the present epidemic of influenza, I do not read in the medical journals that it has had any influence upon the parotid glands (mumps). In my practice I have had numerous cases of Russian influenza, four of which at the end of a week have terminated in parotiditis. In one case that I was called into in the latter stage of the disease, one gland suppurated; the others rapidly yielded to salicylate of quinine. I gave the salicylate of soda in a mixture, and the quinine in milk in alternate doses.

Some cases of Russian influenza that I have treated have left a persistent cough, with pain between the fourth and fifth ribs on the right side; the region of the pain could almost be covered with the tip of the finger; over the region I have applied a liquid blister, and the patients have found great relief in Burroughs and Wellcome's tablets of chloride of ammonium.

Hull.

THOMAS JACKSON, M.D.

FÉCAL EXTRAVASATION INTO THE PERITONEAL CAVITY.

Between two and three years ago a case of this nature occurred in my hospital practice. An elderly woman suffering from a large mass of rectal cancer was admitted into the London Hospital for obstruction. Her abdomen was much distended, her face pinched, and pulse tachycardic. Operation being urgently needed, and as our house-surgeon, Mr. Haslip, was anxious to have one of these cases, I superintended while he operated. The sigmoid was pulled out as far as we could get it, the patient turned on her left side, and after packing sponges on either side of the gut, this was opened, and the contents flowing into a porridge while the abdomen was much gasessated. By some accident the gut partially slipped, and liquid feces ran freely into the peritoneal cavity. The opening in the bowel was then temporarily plugged, and the peritoneum well washed and cleansed, and the gut secured in the manner I usually adopt.

This contrivance was so otherwise excellently executed operation had no ill effect, as the patient made a rapid recovery, and left the hospital much relieved. This case shows that temporary contact of feces with the peritoneum is not necessarily harmful, and Mr. H. Cripp's instructive case goes still further, as it demonstrates the tolerance of the peritoneum to the contact of feces for some hours. The cases also teach another important practical lesson, and one which I have inculcated for several years, namely, that in inguinal colotomy, or sigmoidostomy, as I prefer to call it, the gut should be opened at once, as this can usually be done without risk of extravasation if the bowel be pulled out and the patient placed on the left side before opening the bowel. I have adopted this plan in several cases with entire success. The relief demanded in these extreme or late cases is so urgent that it is well to know how to avoid peritoneal extravasation, and also how to deal successfully with it should it occur.

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H. A. REEVES.

URETHRAL CALCULUS ATTACHED TO AN OLD LITHOTOMY SCAR.

R. G., a Mussulman boy, aged 13, had had lateral lithotomy performed on November 25th, 1851. He was admitted into the Bhawan Hospital on February 15th, 1860, with a recurrence of calculus. On passing a sound, a calculus could be detected in front and below the neck of the bladder, and on examining the perineum a large amount of cicatricial tissue was found to exist in connection with the old lithotomy scar, causing an enlargement of about the size of a pigeon's egg. At the deepest part of this tissue the calculus could be felt. A lithotrite was passed in the hope of pushing the stone into the bladder and crushing it there; but as only a portion of it was dislodged I performed lateral lithotomy; by this means I removed a portion from the bladder, the remaining fragment I have to disperse in the peritoneum. For the sake of description, the stone may be said to consist of two portions, namely, one measuring half an inch, ascending from the scar tissue upwards and backwards, and joining the second or horizontal portion, which bears a mould of the perineum, about three inches in length, and the vertical and lateral diameters being about one-third of an inch. The weight of the calculus is 26 grains.

Edwardebad, Punjab.

L. J. PISANI, Surgeon, I.M.S.

The Chair of Surgery in the University of Halle, left vacant by the death of R. von Volkmann, has at last been filled up by the appointment of Prof. Mikulicz von Königberg. It is said that Professor Brammann will probably succeed Professor Mikulicz von Königberg.