AN ADDRESS ON SOME SUBJECTS IN OBSTETRIC MEDICINE.

*Delivered before the Obstetrical Society of London, on Wednesday,
January 3rd, 1877.*

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GENTLEMEN,—To-night we terminate another session and mark another year in the age of the Obstetrical Society. The past year has not been uneventful, and several contributions have been brought before the Society of more than passing interest.

At the very beginning of the session, Dr. Routh brought before the Society an instance of the Removal of a large Fibroid Tumour of the Uterus by abdominal section. The case was interesting in several respects, and specially so in the way that hyperpyrexia following the operation was successfully controlled by the use of an ice-bath. Five days after the operation, the temperature rose to 105 and 106 deg., and other grave symptoms accompanied this increase of temperature. The patient was then placed bodily in an ice-bath, and kept in it for three-quarters of an hour, after the plan recommended in cases of acute rheumatism with perilous rise of fever-heat. The temperature sank under this treatment to 100 deg., and shortly afterwards to 97 deg., while consciousness returned. A second rise of temperature a week later to 104 deg. was treated in the same way, with a like result; and the patient, after being tapped by the vagina and relieved of intensely fetid pus which had gravitated into the retro-uterine *cul-de-sac*, eventually recovered. The results which have hitherto attended the attempts to remove fibroid tumours of the uterus by surgical proceeding have not been very encouraging. With the exception of one other successful case by Mr. Bryant in an early volume of the *Transactions*, I believe Dr. Routh's is the only instance of recovery after removal of a large uterine fibroid by abdominal section recorded in the proceedings of this Society. A considerable number of like operations have been undertaken by Dr. Atlee, Dr. H. R. Storer, Mr. Spencer Wells, Professor Koeberle, and others, in various parts of the world; but of these more than two-thirds of the patients died—a much larger proportion than after ovariectomy. The treatment of fibroid tumours of the uterus is no doubt one of the problems of the future. Fibroid tumours are much more frequent in women than ovarian tumours; but fortunately they are, in the majority of instances, of much slower growth and attended by less grave symptoms in progress, and the ultimate results are less threatening. By far the largest proportion of fibroids, when once discovered, are most judiciously treated by non-interference surgically. The discomforts may be relieved by appropriate remedies; the hæmorrhage, if occurring, can be controlled by rest and styptics; and a prospect may be afforded that, with the arrival of the climacteric, activity and inconvenience will subside. There are, nevertheless, some cases which are attended with such persistent and alarming hæmorrhage, or with pain and inconvenience from the bulk or position of the tumour, that the practitioner would be only too glad were it possible to look forward to an operation for its removal with no greater fear of a fatal issue than appears from the latest results of ovariectomy. Enucleation of the tumour by the vagina, in all its modifications, is a most hazardous proceeding. The large plexuses of veins and the erectile character of the tissues surrounding the womb in the true pelvis eminently predispose to phlebitis, diffuse cellular inflammation, and blood-poisoning; so that a simple incision into the cervix is attended with more risk than a similar incision elsewhere, and the danger increases with the magnitude of the operation. The peril is always enhanced by the difficulty experienced in preventing the retention of septic matters in the neighbourhood of the wounded surfaces, and their consequent absorption. A case in illustration of this subject was reported to the Society by Dr. Thomas Chambers.

When improvements in surgery obviate this source of danger to the patient, we may possibly procure more favourable results than heretofore. The history of ovariectomy has taught us that the fears formerly entertained concerning the great sensitiveness of the peritoneum, and the danger incurred by wounds of this membrane, were greatly exaggerated. It has further taught us that much greater danger is incurred by its contact with septic matters produced by wounds, than by exposure to the outer air. In the case of the major proceedings, when we have a choice between the two, the index of experience, indeed,

seems pointing somewhat in favour of abdominal section rather than of operation *per vaginam*, as being more manageable in its after-treatment, and giving a better chance of recovery. The experience of Péan, of Kœberle, of Hegar, of Spencer Wells, and others, indicates a distinct advance in this direction. Dr. Thomas Keith of Edinburgh, one of the wisest and most conservative of modern surgeons, told me recently he believed that, when all the details had been as carefully mastered as in ovariectomy, it would become a much less hazardous operation to remove large fibroids by abdominal section, particularly if the cervix uteri could be utilised as a stump, as recommended by M. Péan.

Mr. Wells informs me that he has recently removed a pedunculated tumour of the uterus by abdominal section from a patient who was bed-ridden from the discomfort it produced, and that she recovered without an adverse symptom. Such semidetached tumours are, no doubt, the most favourable for removal; but commonly they are just those which give least annoyance and least call for operative interference. It should be remembered that all operations which involve the laying open of the peritoneal cavity rank with the capital operations of external surgery. In their gravity and risk of life, they are beset with perils at every step, and they should not be undertaken without very adequate reasons.

The discussion which arose on Dr. Meadows's communication concerning the Diagnosis of a Nulliparous Uterus, and the specimens illustrative of the subject exhibited by Drs. Braxton Hicks and Edis, afford sufficient proof—if such proof were necessary—of the desire which exists to reduce the results of observation to a scientific and precise basis. Investigation has not yet enabled us to speak with any degree of certainty concerning the *post mortem* differences which exist between a nulliparous and a multiparous uterus; but the points dwelt upon by the various speakers on this topic deserve the careful attention of the medical jurist in the future. The arching of the fundus of the uterus, the relative size of the organ, and the fissured condition of the cervix, conjoined with other signs, afford only some presumptive evidence of pregnancy, if certain sources of fallacy be guarded against. But if it be true, as asserted by Dr. John Williams, that the condition of the blood-vessels during pregnancy is so changed as to leave a permanent alteration in their walls which may be henceforth recognised on section, a further sign of undoubted importance may be added to the evidences of previous delivery.

The same praiseworthy desire to solve some of the scientific problems of gynecology appeared in the respective contributions of Dr. John Williams on the Mechanical Action of Pessaries, and of Dr. Braxton Hicks on the Cause of Uterine Displacements.

Two very interesting papers have been contributed during the session by members of the profession who do not practise obstetric medicine, and to whom therefore the Society is specially indebted for these additions to its *Transactions*. Mr. Hutchinson, the distinguished surgeon, has brought forward a series of observations on Diseases of Sheep incident to Parturition and on the "navel ill" in lambs. These form an interesting contribution to the study of comparative parturition and its diseases. Dr. Langdon Down contributed an admirable paper on the Obstetric Aspects of Idiocy. The paper of Dr. Langdon Down, as well as those by Mr. Godson and Dr. Cooper Rose, have brought prominently before the Fellows a question of great practical importance to them in the exercise of their vocation, viz., the frequency with which forceps ought to be employed in ordinary midwifery practice. A sort of revolution may be said to have taken place in the views entertained by medical practitioners on this subject. At one time, the forceps was used but rarely in proportion to the absolute number of deliveries. In 1850, Dr. Churchill computed that the forceps was employed by British practitioners only about once in 362 labours. In France and Germany at the same time, the forceps was used with more than twice this frequency, and the maternal mortality was considerably higher than in Great Britain, while the number of children saved was only about a half per cent. more. Anterior to that period, the short forceps was almost exclusively used. Dr. Collins, who was master of the Dublin Lying-in Hospital for seven years from 1826, taught that the forceps was quite inapplicable in difficult labour, unless the child's ear could be reached with the fingers, showing that he only used short forceps, and this only in the easiest cases. Nearer our own time, Dr. Robert Lee, who had one of the largest consulting midwifery practices in London, and is still living, always objected to the long forceps as a dangerous instrument. The result was a large proportion of craniotomy cases, and a sacrifice of infant-life which we now believe might have been spared.

With the advance of time, and a more accurate knowledge of the statics of parturition, of the dangers which beset both mother and child when pressure is over-prolonged in the maternal passages, and a better appreciation of the mechanical action of the forceps, as well as

the possession of improved instruments, the forceps has gradually come to be used with greater frequency and at the same time with happier results, and many craniotomy cases have been avoided by the employment of long forceps. During Johnston and Sinclair's term of office in the Rotunda Lying-in Hospital, Dublin, the forceps was employed in about one to every sixty deliveries, and some practitioners use it with still greater frequency. Dr. George Johnston, in his report of the Rotunda Hospital for the year ending November 1875, states that the forceps was employed about once in every nine cases. These figures, however, only bear on a limited number of deliveries. The danger now is lest the forceps should be used with mischievous recklessness, and without due consideration of all the issues involved. Allusion has been made in debate more than once to the fact that Dr. Hamilton of Falkirk had, mainly from the timely use of forceps, been able to publish two successive series of cranial deliveries, one of 600 and another of 750, without losing a single child; and the propriety has been mooted of applying forceps as often as once in every five cases. I am bound to say that, guided by somewhat extended and varied experience, in London, in the country, and in a densely populated manufacturing town, where deformity of the pelvis was not unfrequent, I can see no valid reason for such constant recourse to instrumental interference. Unfortunately, the effect of suggestions of this kind is not always foreseen in all its consequences. Medical practitioners in town and country are led to believe that, because these doctrines are seriously discussed before the Obstetrical Society of London, they are the more advanced views of eminent obstetricians on the subject, and, unwilling to be behind their contemporaries in matters of practice, hasten to adopt them. An eminent surgeon recently informed me that he had within a short time been called in to repair serious lacerations which had been produced by the use of forceps; and, on inquiry, he found that the patients had been only two and four hours respectively in labour from its commencement before instruments were employed, and, so far as he could learn, there had previously been no urgent or threatening symptoms.

With our present knowledge, I think it may be fully conceded that, when the forceps is required, and it is employed by experienced and skilful hands, it will do less harm to the mother than long continued pressure of the presenting part on the maternal structures, and further, that its timely use may be the means of saving infant life. Excluding the cases in which complications occur, and where, for safety of the mother or child, delivery must be completed at the earliest possible period, the difficulty is to know *when* to interfere in each individual instance. Although we know that danger to both mother and child increases with the duration of labour, yet it is obvious that time alone cannot be taken into account. One patient may encounter greater peril from severe or continued uterine contraction against rigid structures in two hours than another patient in six hours, and a variety of matters have to be weighed before concluding that instruments are necessary. Obstetric practitioners in remote and isolated localities are perhaps not always in the best condition of mind for weighing nicely these various considerations. Wearied by long journeys and night-watching, distracted by demands for their services in different places at the same moment, they require all the moral support which authorities can give them in favour of patience and prudence. One who has experience and dexterous hands may have large success from the frequent and unnecessary use of forceps, but the absence of misadventure by no means proves its necessity. Another, endeavouring to imitate, may produce a series of disasters. One corollary we may deduce from this, that all practitioners in midwifery should be thoroughly instructed in the mechanism of natural and morbid labour, and in the use of instruments. To use forceps with the greatest dexterity, it is probably best to adhere to one form, and that the long forceps, because it will answer for all forceps cases, and the hands thus grow familiar with its form and curves. The next point is to determine *when* the forceps should be rightly applied in a cranial presentation, and how to strike that just balance between too long a delay on the one hand, and too hasty an interference on the other. The rule should be, not as Dr. Collins propounded it, in past years, "wait until nature is absolutely exhausted", but rather see what nature can effect, and then supply the deficiency. To interfere when all is going on favourably, although it may be slowly, is to do away with all those safeguards, so far at least as the mother is concerned, with which nature has surrounded the parturient processes. More especially, it is apt to interfere with the full and perfect contraction of the uterus after delivery, and the gradual and progressive dilatation of the maternal canals which tends to prevent their laceration. There is no doubt a safe middle path between the two extremes of practice. Whenever the head is arrested in its progress through the pelvis, and there exposed to such pressure as to raise apprehension either for the maternal structures or the child's cere-

bral circulation, the skilful hand may proceed at once to deliver. When the head lies at the floor of the pelvis, and the passages are dilatable, there may be less hesitation in deciding on this course, even when the indications are somewhat doubtful, because the operation is simple, and generally easily performed. When the head is arrested at the brim, the operation is more complex and difficult, and greater care must be taken in forming a decision. Especially is this care necessary when the os uteri is imperfectly dilated; because, although experience has taught us that the long forceps may, in emergency, be applied before the os is fully dilated, it must at least be *dilatatable*, or it will oppose obstinate resistance to efforts at traction, and may be severely lacerated.

The history by Dr. Galabin of two cases of delivery, in which labour was impeded by extensive Malignant Disease of the Cervix Uteri, has, for the second time, raised the question whether Cæsarean section should not in these cases be performed, instead of some operative proceeding *per vias naturales*. An opinion was expressed during last session that it would be better in all cases to have recourse to Cæsarean section. In this opinion I cannot concur, nor do I think that obstetrical authorities generally will endorse it. In some cases of undoubted malignant disease of the cervix uteri, where the affection is limited, no interference at all may be required, and, even where disease is more extensive and involves both labia uteri, it is surprising sometimes to see what Nature will effect in overcoming the obstacle without serious detriment to mother or child. In other instances, again, some artificial dilatation, or one or more incisions into the lateral margins of the os uteri, may be all that are required to favour delivery, and this is far less hazardous than the capital operation of Cæsarean section. When malignant disease is so advanced that deposit is thrown out into the adjacent structures, and such impediment exists to delivery by the natural channels as to forecast grave laceration of the maternal parts, and possibly evisceration of the fœtus as well, then timely abdominal section probably becomes the more conservative operation, and affords a better chance both to mother and child.

The Society will still have in fresh recollection the interesting communication by Mr. Jessop of Leeds on a case of Extra-uterine Foetation for which Abdominal Section had been performed. This, I believe, is the first of the kind occurring in Great Britain in which the lives of both mother and child were saved, although, as pointed out by Dr. Wiltshire, Keller of Strasburg has related nine cases in which four of the mothers recovered and seven children were saved.

There can be no doubt that Mr. Jessop and his colleagues exercised a wise discretion in electing to remove the fœtus by abdominal section in the case reported; for the mother's life was in jeopardy, and yet there was evidence that the child was alive. But I ventured to remark during the discussion that the recital, marvellous though it was, on account of the perils surmounted, could not be taken as a justification for like interference when no such imminent peril to the woman is present. There can be no uncertainty about the grave position in which a woman is placed who is the subject of extra-uterine foetation in any of its forms. During the whole progress of gestation, there is the ever present danger of rupture of the containing sac, and the subsequent internal hæmorrhage and collapse. If this catastrophe be avoided, intercurrent peritonitis is rarely absent, with all its forms of functional derangement and suffering. Later, comes the inconvenience and peril, in many instances, of spontaneous suppuration after the death of the fœtus and its slow extrusion from some forced outlet. Fortunately, extra-uterine foetation is not very common, but cases occur with sufficient frequency to give most medical men in large practice an opportunity of encountering an example from time to time, and every experience tending to better and more successful treatment is to be welcomed. Hitherto, the weight of experience has been overwhelmingly on the side of postponing an operation until foetal life is extinguished, and the suppurative process is well advanced. Dr. Campbell, who wrote a standard work on *Extra-uterine Foetation* in 1842, collected a sum of fifty-one operations. The accounts of all are not very complete; but, of thirty cases (as I understand the figures) in which gastrotomy was performed or the breach dilated after suppuration had set in, twenty-eight patients recovered. He gives twelve cases of gastrotomy performed after the suppurative process was well advanced, in which ten were successful; but, of nine women operated on during the existence of foetal life or soon after its extinction, the whole died. Dr. Parry of Philadelphia has, during the last year, published a volume on the same subject, which brings out later results from a much more extended series of cases. In twenty cases of primary gastrotomy, the maternal mortality was 70 per cent., or 17.35 per cent. greater than when the cases are left to nature, and the infantile mortality was 60 per cent. On the other hand, in thirty-six cases of secondary gas-

trotomy performed some time after full term, not including those in which the operation was merely to assist the efforts of nature, the mortality was only 38.88 per cent. The conclusion is irresistible that, as a rule, so long as the vascular and nervous excitement inseparable from the progress of gestation are present, it is unwise to interfere, and that an operation is more likely to be successful after the puerperal state has subsided.

Dr. Parry believes the most prudent course, when the patient is not in immediate peril, is to wait until suppurative is fully established, and then enlarge any opening made by nature to evacuate the contents. As Mr. Jessop very justly pointed out, every rule must have its exceptions; and, if urgent signs of danger present themselves at any time during the progress, they must be met by attempts at a remedy which, under other circumstances, should be avoided.

In the two last cases which I have seen, there has not even been a clear history of suppurative established. In both instances, the children died towards the term of gestation; became encysted, and afterwards gradually shrivelled *in situ*, the mothers recovering so entirely, that only some limited swelling remained as evidence of the pre-existing large tumour. As this is not an uncommon termination, it is an additional reason for not exposing the patient during the period of pregnancy to the serious risk of abdominal section in the expectation of a possible danger in the future which may never arise.

But, if it be better to abstain from interference generally during the progress of extra-uterine foetation, there are additional and urgent reasons for not entertaining the suggestion which was made during the discussion on Mr. Jessop's paper, that we should open the abdomen in cases of early tubular pregnancy, with the view of removing the tumour, as in ovariectomy.

It is true that Fallopian pregnancy is a particularly dangerous form of extra-uterine foetation; that gestation rarely advances beyond the third month without rupture and collapse; but, in these cases, no parallel can be drawn with cases of ovarian disease, as the excitement of pregnancy renders all operative proceedings more hazardous. Moreover, the diagnosis of tubular foetation is, in the majority of cases, so obscure until actual rupture takes place as, in the present state of our knowledge, to be almost impracticable.

As an illustration of the difficulty in diagnosis, I may mention that, not long ago, I saw a patient whom I believed to be the subject of extra-uterine foetation, and whom I recommended to return to her ordinary medical attendant, a man of much experience, that he might watch her progress, and be ready for any emergency which might arise. A few weeks later, her medical man brought her back to me. He was now in much anxiety, because foetal movements had become very distinct; and he thought, although the patient seemed quite well, that some operation ought to be performed to save her from untoward consequences later. I advised him not to interfere, and he then asked my sanction for another opinion—a point I readily conceded—as he proposed to take his patient to a surgeon of great reputation for the treatment of abdominal tumours. To my surprise, the second opinion so far differed from mine, that it was clearly in favour of the case being one of normal pregnancy, and not extra-uterine at all.

Eventually, however, the term of gestation was passed and the foetal movements ceased. Then, without serious symptoms, the child became converted into an apparently innocuous mass, slowly shrivelling and diminishing until but little indication of its previous existence could be detected at a later period.

When rupture of a tubular foetation has actually occurred and the patient is in the face of a deadly peril, it then becomes a question whether it might not be justifiable to cut down upon the locality for the purpose of removing the offending mass from the cavity of the peritoneum. In such circumstances, we meet a desperate case by a desperate remedy; but no spirit of adventure, no desire for fame as operators, should induce us to expose a patient to so serious an operation as is here contemplated, on the mere assumption of a fact which may in reality have no existence.

I venture to speak strongly on such matters as these, because I take it to be one of the duties of your President to moderate between views which may seem to be extreme, and to attempt to try them by a judicial standard. I frankly own myself attached to a conservative exercise of our rapidly improving branch of the medical art. At the same time, I am most anxious not to take a reactionary part in opposing any useful innovation. I render all honour to the pioneers of progress, but I desire in advancing to keep a fair equipoise; and I hold that, when we are entreated with such important issues, we ought to prove each step of progress, and not be led away by an *ignis fatuus* which may end in fatal disaster.

When I observe an almost feverish anxiety, well intentioned though it be, to interfere before the emergency has distinctly arisen; or, in the

course of affections like pelvic hæmatocele, for example, where the natural tendency in a large proportion of cases has been indubitably proved to be towards a favourable termination, I am forcibly reminded of the exclamation of a great statesman in reference to the meddling policy of a political opponent, "Why cannot you leave it alone?" I desire it to be understood that these remarks do not apply to exceptional cases in which peril or inconvenience is great, and where it is obvious some attempt commensurate with the evil must be made to abate or remove the difficulty. When such an occasion presents itself, it must be met courageously and fearlessly; but I believe it requires higher mental training to watch patiently and wait, than to act when the necessity for action comes.

In Mr. Lawson Tait's case of Vesico-vaginal Fistula cured by operation after a series of unsuccessful attempts, which might well have appalled the most enthusiastic of surgeons, the Society had an opportunity of learning what may be achieved by indomitable perseverance, and of deducing the fact that scarcely any case is so bad but may be repaired if both skill and patience are untiring.

Other interesting matters, it may be recollected, have been brought before the Society, and some new instruments have been exhibited. Notably, a new blunt hook by Professor Lazarewitch of Russia; an ingenious thermo-cautery invented by Dr. Paquelin of Paris, exhibited by Dr. Oscar Prevôt of Moscow; and the beautiful apparatus for transfusion, demonstrated in action by Dr. Roussel of Geneva. Concerning the question of transfusion, I may inform the Society that the Committee appointed on this subject has reported to the Council that twelve meetings have been held, and many instruments have been presented and examined. The Committee suggested that a physiologist should be appointed to carry out a series of experiments on animals; and for this purpose the Council have granted a sum not to exceed £50.

Since last January, we have received intelligence of the decease of three honorary foreign Fellows; and we have to mourn the loss of six ordinary Fellows, whose names must regretfully be erased from the Society's list.

The names of deceased honorary Fellows are Professor Tracy of Melbourne; Professor Channing of Boston, United States; and Professor Simon of Heidelberg. I must crave your indulgence while I say a few words concerning the lives and labours of each of the remarkable men who were chosen by this Society to rank as honorary Fellows.

Dr. Richard Thomas Tracy of Melbourne, Australia, died on the 7th of November, 1874; but intelligence had not been received of his decease when I delivered the annual address last January. From obituary notices in the *Australian Medical Journal* and in the *Medical Times and Gazette*, we learn that Dr. Tracy was born at Limerick in Ireland, on the 19th of September, 1826; and was educated at the Limerick County Infirmary and at Trinity College, Dublin. During his pupillage, he volunteered as an assistant medical attendant during the famine fever, then desolating Ireland, and almost succumbed to an attack of that disease caught from a patient. Having passed the College of Surgeons in Ireland in 1848, he visited the hospitals of Paris; and eventually went to Glasgow, where he became Resident-Surgeon to the Hospital for Cholera. Cholera was then rife in Glasgow. The hospital contained seven hundred beds; and for four months, during the prevalence of the epidemic, he never left the hospital. In 1849, he took the degree in Medicine in the Glasgow University; and, being disappointed in a negotiation for a share of a practice which he purposed to acquire in London, he determined to go to Australia. After various adventures at the gold-diggings and elsewhere, he settled in Fitzroy, Melbourne; and, in that as yet imperfectly organised colony, began to develop his resources. He became not only a prominent medical practitioner, but took an active part in all social matters—in the building of the church, and in the enrolment of volunteers. He avoided politics, but became a magistrate for the local bench, and officer of health for the district. In 1855, he started, in conjunction with Dr. John Mound, a lying-in hospital and infirmary for women and children; and somewhat later he took part in the formation of a medical society and the publication of a medical journal. His natural energy, his perspicacity, and his sound judgment, would have given him a leading place in any branch of the medical profession; but he inclined especially to the cultivation of obstetric medicine, and earned so much success and prestige in this department that he became the leading authority in the new country. His contributions to obstetrics were always of the most practical kind, and showed him so thorough a master of his art that, when a Medical School and University were instituted at Melbourne, he was chosen by common consent lecturer and examiner in Obstetric Medicine. In 1871, he was elected a honorary Fellow of this Society as a representative scientific gynaecologist in the antipodes. He contributed a paper to our own *Transactions*, and

made a communication to the Royal Medical and Chirurgical Society on Ovariectomy. He was the first to perform ovariectomy in Australia; and, coming to England in 1873, he watched the operations of Mr. Spencer Wells with the greatest assiduity. At this time, he was in failing health; and returned to Melbourne in April 1874, knowing that his fate was sealed and quite resigned to it. He died seven months later, of malignant disease of the mesentery; and, at his funeral, the whole town of Melbourne went into mourning for him. *The Argus* newspaper of the date said, "he was a chief among the people, who had lived a honoured life and left a cherished name behind him".

Dr. Walter Channing of Boston, United States, who died on the 27th of July, 1876, at the age of ninety, was a Nestor in his profession. The particulars of his career have been chiefly gathered from an obituary notice in one of the Boston newspapers, signed with the initials "T. W. H.," and from the *Boston Medical Journal*. He was one of a remarkable family, and his personal fame was in a manner overshadowed by his eminent brother, the Rev. William E. Channing, a great American preacher, with whom his identity was often confused. It is recorded of the subject of this memoir that, in answer to an inquirer at his own door, he said that he was not the Dr. Channing who preached, but the one who practised. Dr. Walter Channing was for a long period the recognised head of Obstetric Medicine in New England. He was the first Professor of Obstetrics and Medical Jurisprudence in Harvard University, an office which he held for nearly forty years. He was besides associated with Dr. Jackson, of American celebrity, in charge of the Massachusetts General Hospital from its commencement. He received its first patient, and held office in it for twenty years. Besides various contributions on Obstetric Medicine, some of which are to be found in the library of this Society, his most important work was entitled *Etherisation in Childbirth Illustrated by five hundred and eighty-one Cases*. This volume was regarded in America as the standard work on the subject. Dr. Channing was one of the first, if not the first, in his own country to use ether in childbirth; and I well recollect his enthusiasm on the subject in writing to Sir J. Y. Simpson in the early history of anaesthesia. Besides his devotion to obstetrical science, Dr. Walter Channing was a keen naturalist, and was one of the founders of the Boston Natural History Society. He was a prominent supporter of the anti-slavery movement, the temperance movement, the peace movement, and of the efforts for the prevention of pauperism. Regarding himself as a citizen as well as a physician, he spoke and wrote on a variety of domestic topics; and in the Boston Library is a long list of his numerous writings. He seems to have had an impulsive and ardent disposition, great fertility of mind, and a large fund of wit and humour. His life, like his mind, was crowded with divergent activities, and he was always ready for a new interest. He outlived nearly all his contemporaries. His final illness was without suffering, and his death painless.

Professor Gustav Simon of Feidelberg was born at Darmstadt in 1824. He graduated at Heidelberg in 1847; and was nominated extraordinary Professor at Rostock in 1861. He then became known to the scientific world through a remarkably learned work on *Excision of the Spleen*, a book in which every case to be found in ancient and modern literature where the spleen was accidentally or intentionally removed is recorded and criticised with the greatest acuteness. In 1867, he was transferred to Heidelberg, and remained Professor there until his death, which took place on the 28th of August, 1876. While in Heidelberg, he occupied himself with gynaecology as well as general surgery; and in summer he gave lectures on this subject, which were largely attended by foreigners attracted by his reputation, as well as by practitioners and students of his own country. His work on *Vesico-Vaginal Fistula* was remarkable for the demonstration it gave of the superiority of silk over wire sutures, the utility of which had been before so much dwelt upon. This gave the first impulse of returning confidence in organic as opposed to metallic sutures; and, conjoined with the proofs he gave of the good results of the suture without the use of the catheter, may be said to have given an entirely new aspect to this operation. The dispensing with the use of the catheter after closing vesico-vaginal fistula was received as a startling innovation by almost all our own operators; but subsequent experience has, I believe, proved that the retention of a catheter may, in many cases, be avoided, and that, in others, its occasional use only is required. Simon is said to have operated for the cure of vesico-vaginal fistula two hundred and fifty times. He was the first surgeon who successfully extirpated the kidney for disease. The patient submitted to the operation in 1869, and, according to the last accounts, was still living. Other innovations due to Professor Simon were a mode of examining the interior of the bladder by rapid dilatation of the urethra, and a mode of exploring the interior of the pelvis and abdomen by the introduction of the whole hand and part of the forearm into the rectum. Mr. Spencer Wells,

who knew Simon well, and to whom I am indebted, as well as to Dr. Tuckmann, for some particulars of this sketch, assures me that, under his guidance, he was enabled to reach the kidney by this way of examination. I do not attempt to enumerate all his works. His contributions to Clinical Surgery were very numerous; and his originality and industry marvellous. In the opinion of very competent authorities, few men have done so much good work for surgery in general, and gynaecology in particular. His memory has received a graceful tribute in a warm eulogy by Dr. Braun in the *Berliner Klinische Wochenschrift*. Dr. Braun says: "He was one of the most famous, as well as the most dexterous, operators in Germany, and possessed all the qualifications for this in the highest degree. Belonging to no school, he became everything by his own zeal and by his own strength. All who knew him recognised his open honest character, and his singleness of purpose. All who personally came in contact with him, were they patients, pupils, acquaintances, or friends, all felt themselves irresistibly drawn towards him, and to all such his memory will be imperishable." In 1870, Simon began to feel symptoms which must have been the precursors of his last illness; and in 1875 he thought it prudent to retire for a time from his duties as Professor. On the day preceding his death, he had been feeling unusually well, but was seized with dyspnoea in the evening, and was so distressed that he begged to have tracheotomy performed. This apparently gave him some relief, but it was only temporary, as he passed away without any great struggle on the night of the following day. A necropsy proved that he had died of aneurism of the ascending aorta. His death caused great sensation in Germany; and a stately funeral, attended by a multitude of mourners, testified to the great esteem in which he was held by all classes. On his death-bed were found the proof-sheets of a book, which has since been published, *On the Treatment of Surgical Diseases of the Kidneys*.

The names of the deceased ordinary Fellows are Frederick Augustus Stutter, M.D., Farnboro' House, Upper Sydenham; Fred. Turton, Atlow House, Wolverhampton; Henry Harding, M.D., 18, Grafton Street, London; Sir John Cordy Burrows, J.P., F.R.C.S., Old Steyne, Brighton; Thomas Taylor Griffith, F.R.C.S., Consulting Surgeon to the Wrexham Infirmary; and William Sudlow Roots, F.R.C.S., F.L.S., Surgeon to the Royal Establishment at Hampton Court, an original Fellow of the Society.

All these names have rendered some service directly or indirectly to gynaecology according to their sphere or opportunity, and while living desired to participate in the advantages shared by the Fellows of this Society. Sir John Cordy Burrows of Brighton and Mr. Griffith of Wrexham were notable characters in their respective localities, and were so esteemed for their public as well as their professional services, that their townsmen observed a general mourning on the day of their funerals.

Notwithstanding these grievous losses, the Society is undoubtedly in a most active and flourishing condition. The number of Fellows now exceeds seven hundred, and no less than eighty-two ordinary Fellows have been elected during the past year. As an indication of the attractive character of its proceedings, I may state that, sometimes more than one hundred Fellows and visitors have been present at the meetings, and the average attendance at each meeting during the session has been nearly seventy. The successful *conversazione* given by the kind permission of the President and Fellows in the Royal College of Physicians, was attended by medical practitioners from all parts of the country. Especial thanks are due to the *Conversazione* Committee for their exertions on that occasion, and particularly to the honorary Secretaries and Dr. Grigg for bringing together so large and interesting a collection of instruments and works of art.

The demand for the *Transactions* has been so considerable that the Council have ordered twice the former number of copies to be printed, and the financial condition, notwithstanding all that has been undertaken during the year, is, as the Treasurer's report shows, most satisfactory. It only remains for me, in retiring from the Chair, to which through your favour I was elected two years ago, to acknowledge my profound sense of the advantage I have gained in presiding over a Society possessed of so much vitality. The earnestness which pervades its proceedings may need at times some control, but it is at least a sign of health and vigour, and I have distinctly felt its influence as an incentive to renewed exertion. I have to thank the Society very cordially for the way in which it has facilitated the conduct of business, and the responsive manner in which it has respected the decisions of the Chair. To the Council and other office-bearers I have to acknowledge my indebtedness, and more especially to the honorary Secretaries and Treasurer are my thanks due for important aid on all occasions.

In taking my leave, I must warmly congratulate the Society in

having secured for its next President so distinguished a representative of obstetric medicine as Dr. West. Dr. West's name is as familiar with us as a household word, and it is respected throughout the world where gynaecology is cultivated. To our new President I am personally indebted for the most unselfish services, during a period of severe illness and anxiety, which any one brother physician can render to another, and its recollections of these is always vividly before me. I can only say that, had I known Dr. West could have been persuaded to accept the Presidency of the Obstetrical Society at any earlier period, I would gladly have postponed my term of office until I could have had the advantage of his example and precept as my predecessor.

CASE OF ACUTE ARSENICAL POISONING FROM THE USE OF GREEN PAINT.

By JOSEPH FARRAR, L.R.C.P. Ed., Bradford.

A YOUNG man, aged 22, was taken very ill on the night of December 13th, 1876, with vomiting and purging, accompanied with pain in the abdomen of a colicky character, and so severe as to be best expressed by the word excruciating. Along with these conditions were great weakness and quickness of pulse (120), faintness, paleness of the face, pinched features, but with the eyelids somewhat red and puffy, and cold clammy perspirations of an intermittent nature. The tongue was raw-looking, with portions of its upper surface denuded of epithelium, sore to the touch, and somewhat enlarged in size. There was no lead-line along the gums.

For a few weeks previously, he had been ailing from an attack of enteric fever, attended towards its termination with congestion of the lungs, and he was now, during convalescence, amusing himself by making large Christmas cards, etc., which he painted with colours chiefly of a bright green; and not being aware of the subtle nature of the paints, and not being much accustomed to their use, he exercised none of the usual precautions adopted by the artisans of the trade to prevent the entrance of the materials into the system. On the contrary, his habits were such as to present the most favourable conditions for these poisonous substances to find their way into the economy; he neglected to wash his hands before meals. Beneath his finger-nails had accumulated large quantities of material, and he was in the habit of holding the brushes between his teeth; besides which, he worked long and energetically, without much intermission, in a room small and heated, which would be greatly improved if it could be ventilated. The green paint shown me was marked "*Poison, Scheele's Green*".

By way of treatment, the patient had a sinapism applied to the seat of pain, followed by linseed poultices as hot as could be borne. Internally, an astringent, containing tincture of opium, was given every hour so long as the diarrhoea and pain lasted, with half an ounce of brandy; the latter to be given more frequently if the faintness continued. His food was now to be chiefly milk, ground-rice, beef-tea with bread-crumbs, etc., administered in small quantities, frequently repeated.

The patient's condition at once improved. The vomiting and purging ceased, and, by next day, the astringent was stopped. Pain in the abdomen was still, however, complained of for six or seven days, its presence being intermittent, and the paroxysm often very severe, to allay which it was necessary to administer anodynes. After the second day, a mixture of iodide of potassium was given, with the view of eliminating any portions of lead which might also have been present in the system, from the handling of the other paints, etc. The patient is now recovered from the more immediate effects of the poison; his bowels, tongue, appetite, etc., normal, though weakness is still complained of, and slight feelings of uneasiness in the abdomen.

REMARKS.—The above is another in the long list of cases arising out of the use of arsenical colouring matters, and it suggests the question whether the manufacturers, or the vendors of such dangerous substances, should not issue with each portion sold, printed instructions regarding the subtle character of the poisonous material, and the great care necessary to be exercised during its manipulation. It is not sufficient to print the word "*poison*" on the containing vessel, as is evidenced by this case. As a rule, the green colours most pleasing to the eye, whether in paints, wall-papers, or other articles, are those containing arsenic as their colouring ingredient; a body which, though the very best as regards effectiveness, etc., is yet the very worst as regards its danger to those who happen to be within its influence.

CASE OF INTRATHORACIC TUMOUR (LYMPHO-SARCOMA) WITH SECONDARY DEPOSIT IN THE SUPRARENAL CAPSULE.

By BYROM BRAMWELL, M.B.,

Physician and Pathologist to the Newcastle-upon-Tyne Infirmary; Joint-Lecturer on Pathology in the University of Durham College of Medicine.

WILLIAM JONES, aged 30, labourer, was admitted into the Tynemouth Union Workhouse on October 28th, 1872, complaining of shortness of breath on exertion, cough, great emaciation, and debility.

Previous History.—Seven years ago, he had three or four small chancres, which were not followed by secondary symptoms. With this exception, he did not know what a day's illness was until January of the year in which he was admitted. He at that time caught cold while blasting rock in a cold damp tunnel, which was often full of gunpowder-smoke. He began to cough and spit; the expectoration at times was streaked with blood; he rapidly lost flesh, and, in the middle of April, was obliged to give up this work. He thought his cough was brought on by the inhalation of the gunpowder-smoke. He had been working off and on as a labourer until five weeks before admission. For the last five weeks, he had been confined to bed.

Condition on Admission.—His general appearance at first sight would lead one to suppose that he was suffering from renal dropsy. The face was puffed and swollen, especially about the eyelids. On more careful examination, it was seen that, instead of the characteristic pallor of Bright's disease, the face had somewhat of a dusky hue; the neck, too, was swollen, chiefly on the right side, above the clavicle. The slightest exertion made him, he said, "wonderful short of breath". He had a frequent short hard cough; the expectoration was scanty, consisting chiefly of saliva; his voice was husky; he spoke in a whisper. He complained of a dull boring sort of pain, much worse when he lay on his right side, between the superior internal angle of the right scapula and the spine. He was extremely emaciated; he said he used to be very stout and muscular. The right pupil was considerably larger than the left.

Respiratory System.—On inspection, the upper part of the thorax, anteriorly, was seen to be swollen; the clavicles did not stand out; there was pitting on pressure over the swollen part. Several large veins were seen coursing over this part of the chest; the right brachiocephalic vein was distended and stood prominently out. The left side of the chest did not expand even on full inspiration; the movement of the right side was normal. The left side, at the level of the nipple, measured during expiration an inch more than the right. Vocal fremitus was absent over the lower half of the left chest. On percussion, there was dullness anteriorly over the whole of the left chest; the dullness was absolute from an inch below the left clavicle. Transversely, the absolute dullness extended on the one side as far as the right border of the sternum; on the other, over the lateral region of the chest. Posteriorly, there was absolute dullness over the lower two-thirds of the left lung; over the upper third, the percussion-note was much impaired, the resonance being greatest in the suprascapular region and close to the spine. Together with the dullness, there was a feeling of great resistance. On the right side, anteriorly, there was absolute dullness over an area of the size of a hen's egg, about the second right costal cartilage. There was impaired percussion from the right border of the sternum to within two inches of the right nipple. Over the rest of the right chest, the percussion-note was, if anything, hyper-resonant. On auscultation, there were tubular breathing and increased vocal resonance over the upper third of the left lung, back and front. Over the lower two-thirds, the respiratory murmur and vocal resonance were absent. In the right infraclavicular region, the breathing was tubular; over the rest of the right lung, puerile respiration was heard. The respirations, when at rest, numbered eighteen per minute. The slightest movement made the patient feel very short of breath and brought on the cough.

Circulatory System.—There was marked pulsation both to sight and touch in the pit of the epigastrium. Dull heaving pulsation could be felt over the middle and lower sternal and left mammary regions. At the second right costal cartilage, there was well marked pulsation; it was more distinct and apparently not so deep-seated as the pulsation over the sternal region. On auscultation, the heart-sounds were loudly heard all over the front of the chest, most distinctly at the second right costal cartilage and over the lower half of the sternum. The sounds were normal in character. Posteriorly, over the whole of the left side and over the upper third of the right side, the heart-sounds were distinctly heard. Radial pulse 108, soft and weak; the right being very much weaker than the left.