to stem the bleeding, and delivery may take place naturally. Should the bleeding continue, version must be undertaken, and it is a much more difficult operation after the waters have been drained away.

One may almost say that the treatment of placenta praevia resolves itself into version and allowing the uterus to expel the foetus, with two exceptions: First, in a primipara at term with a central placenta praevia, Caesarean section must be insisted on for the sake of both mother and child. Secondly, in a multipara in the same case Caesarean section may be suggested if a living child is especially desired. If not, version is the treatment. However great the temptation to terminate the case either by version with extraction or by forceps extraction, this temptation must be resisted.

Post-partum haemorrhage is a subject closely associated with the two foregoing conditions.

Severe uncontrollable post-partum haemorrhage is only met with in cases where a uterus which is not contracting has been suddenly emptied. In placenta praevia this extra loss is sufficient to kill the patient before the uterus has time to recover. In accidental haemorrhage the same occurs, only the uterus would probably not recover its tone anyhow. I have already indicated how with due care these misfortunes may be avoided.

The average case of post-partum haemorrhage following unduly prolonged labour or overdistension of the uterus by twins or by hydramnios as a rule readily responds to massage of the fundus and pituitrin, or careful control by a hand on the fundus for a judicious period of time. Failing this, bimanual compression of the uterus, taking the opportunity to ascertain that the uterine cavity is quite empty of secundines, possibly combined with a hot douche, generally meets the case. Compression of the abdominal aorta often gives the uterus time to contract successfully and retract, and so stop the bleeding. The question of the treatment of post-partum haemorrhage is so well worn that I will not dwell on it. A great percentage of the cases respond to any of the accepted forms of treatment. Those that do not generally die unless it is feasible to perform hysterectomy, and this, hoping against hope, is generally postponed until it is too late.

III. HAEMORRHAGE DURING THE THIRD STAGE OF LABOUR.

Some of the most alarming cases with which we have to deal in midwifery are those of severe bleeding while the placenta is still *in utero*. This is due to a partial separation of the placenta, and this separation itself is generally due to efforts to expel the placenta by pressure on the fundus before it is naturally separated from the uterine wall and has passed into the vagina. The signs of this having happened—rising up of the fundus, uterus smaller and flatter from front to back, escape of more cord, and slight gush of blood—are well known. In a partial separation thus brought about, the bleeding is often extremely severe. Attempts at expression will have failed, and the only treatment is to pass the sterilized hand into the uterus, complete the separation with the fingers, give 5 c.cm. of pituitrin, and maintain a firm grasp of the fundus till the uterus is and remains firmly contracted. This is what the midwives are now taught to do in extreme cases where they find it quite impossible to get a medical man in time to save the patient's life.

IV. SECONDARY POST-PARTUM HAEMORRHAGE.

Haemorrhage occurring after the first twenty-four hours may be due, first, to retained products of conception, often a small piece of placenta or placenta succenturiata, or, more rarely, membrane; secondly, to getting up too soon, or overexertion, and not infrequently as a sequela of puerperal sepsis.

The treatment is to clear out the uterus, and swab it out afterwards with tincture of iodine, and pack with gauze for twenty-four hours.

REFERENCES.

¹ Blacker, G. F.: *Practitioner's Encyclopaedia of Midwifery and Diseases of Women* (Fairbairn), p. 261. ² Shaw, W. Fletcher: *Trans. Roy. Soc. Med.*, October, 1916. ³ Tweedy, Hastings: *Ibid.*, October, 1920.

CYESOEDEMA: A PECULIAR BLOATING OF PREGNANCY.

BY

A. A. LENDON, M.D.LOND.,

HONORARY LECTURER IN OBSTETRICS, UNIVERSITY OF ADELAIDE.

THE object of this somewhat bizarre heading* is to attract attention to an accompaniment of pregnancy which I have seen very pronounced in 6 out of 363 consecutive cases of midwifery since I first observed the condition in 1901.

It is a peculiar bloating or swelling, which is quite distinct, on the one hand, from anasarca or ordinary pitting dropsy, and, on the other hand, from the solid swellings, such as myxoedema, which it certainly more nearly resembles.

It affects the whole body, but naturally it attracts more attention in the face, as it so greatly alters the features of a young woman as almost to make her unrecognizable towards the end of pregnancy. In my experience it has occurred only in primiparae; it disappears with considerable rapidity after the labour is over; it has not recurred in my cases in subsequent labours; though not specially associated with post-maturity according to the maternal reckoning, the babies have been large—in three instances they weighed on the average just under 8 lb., and in two other cases were described as very large. In two cases there was some albuminuria, but no other recognized indication of the so-called toxæmia of pregnancy.

To describe cyesodema is a matter of some difficulty, and I must confess rather beyond my powers. I was never able to induce a victim of it to sit for her photograph. There is no accompaniment such as the slow speech of myxoedema, nor the supraclavicular fatty masses; there is no sense of general ill health complained of. There is not the pallor of renal oedema, nor the porcelain china tint to be seen in the cheek. There is rather some lividity, but happily it does not suggest alcoholic indulgence; it has not been associated with high blood pressure, though the cases mostly were observed before the sphygmomanometer came into general use.

Of one of these cases I have lost sight; of the remainder four agree in this respect—that they have all become stout in middle age, and three have undergone treatment for obesity.

What is its nature? It is certainly not due to nephritis, and I think that hypothyroidism may be ruled out of the question. I have failed to find any description of cyesodema in any textbook in our university library, but Whitridge Williams refers to "the non-oedematous" (presumably non-pitting) "thickening of the features observed in so many pregnant women," and suggests that it may be related to hypertrophy of the anterior lobe of the pituitary body, which, he says, has been "shown to undergo regularly great hypertrophy during pregnancy and to atrophy after the termination of the pregnancy."

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

THE NON-LUETIC ARGYLL ROBERTSON PUPIL.

IN my experience the phenomenon of this form of Argyll Robertson pupil reported by Mr. Foster Moore (November 7th, p. 843) is not uncommon, and to the features described by him I would add certain others which appear to me no less important—namely, that the condition occurs more often in women than in men, and that when uniocular it is (or has been in all my cases) the left eye which is affected. In a paper entitled "Emotion and eye symptoms," read in 1921 before the Medical Section of the British Psychological Society, I referred to several of these cases, whose history strongly suggested that the unequal pupils were the result of emotional stress, and in each of these it was associated with the death of the father. This led me to regard the phenomenon as a disorder of the sympathetic nervous system, and

* *Κύσσις*, pregnancy; *οίδημα*, swelling.