four months, enclosed in its membranes. The liquor amnii was muddy, but not fetid; and the foetus was of the same dark muddy colour. It had to all appearance been retained in the uterus many months, but had been preserved from decomposition by the liquor amnii. There was very little loss of blood; and the patient made a good recovery.

REMARKS.—Were the symptoms caused by the pregnancy? Ollivier has written a work on this particular form of paralysis. He had seen only one case, and that had no connection with pregnancy. He attributes it, like Dr. Radcliffe, to “congestion of the grey matter of the spinal cord.” Might it not, however, be possible for pregnancy to produce this identical congestion and consequent paralysis? Whatever may have been the cause in my case, I feel indebted to Dr. Radcliffe for having pointed out to me its true pathology. It is evident that there was something more than mere hysterical or functional disturbance. Dr. Churchill is disposed to attribute all cases of paralysis during pregnancy to the presence of albuminuria; but that had certainly nothing to do with the case I have related. With regard to treatment, if it had been possible to prove the existence of pregnancy—assuming that condition to be the cause of the paralysis—it seems plausible enough, that it would only be necessary to remove the cause. In several of the cases, however, collected by Dr. Churchill, the paralysis disappeared during pregnancy without interfering with gestation; therefore, in such cases, I do not know that the induction of labour should be too readily adopted; though, in some special cases, no doubt it would become necessary. The ergot was given on account of its supposed contractile effects on the smaller vessels, thus lessening congestion; but it might also have had some effect on the uterus and its contents. Did the case take a favourable turn because of the death of the child? I hardly think so; because, in several of the cases, the patient recovered from the paralysis before delivery, and afterwards gave birth to a living child. Did electricity cure the patient? This question I am unable to answer; but, in a similar case, I should certainly use it again, for, besides its possible therapeutic effects, it serves to occupy the patient's time and attention, and to introduce a gleam of hopefulness when there is much to cause depression and despair.

INVERSION OF THE UTERUS.

By JOHN THOMPSON, M.D., Bideford.

LATE in the autumn of 1848 I was summoned to the wife of a respectable farmer residing some miles from Bideford, who had been for more than forty-eight hours in labour under the management of a midwife. The presentation was, at first, believed by the nurse to be footling; but at length the hand protruded, and then her error was evident. Finding delivery impracticable, she sent for me; and, on my arrival, I found the foetal arm protruded up to the armpit, and discoloured throughout. The uterine action being very powerful, it was clear that there would be much difficulty in turning the child and completing delivery. After explaining the danger to the husband, and sending for a professional friend in case I should need assistance, I bled the patient to about twenty ounces, and gave her a drachm of tincture of opium. Then, lubricating the back of my left arm and hand, I slid them little by little up the vagina and uterus to the feet of the child. Notwithstanding the bleeding and the large dose of opium, the uterus made such resistance that my hand had to sustain pressure, causing cramp and great pain, before I could effect my object. After about an hour delivery was effected, the child being dead; but the mother was uninjured. The placenta came away without difficulty, and, though there was rather free bleeding, neither exhaustion nor other evil consequence ensued. The arm and hand with which I operated were so much injured that several weeks elapsed before full power and normal feeling were restored. Had I known the full value of chloroform at that time, its administration would perhaps have been substituted for bleeding and opium, and have prevented the punishment I personally sustained.

My patient made a good recovery, and in the next year retained me to again attend her. The presentation in this case was natural; but the placenta was retained, and I had to introduce my hand into the womb to remove it. She was subsequently confined in the years 1850, 1852, and 1853, which shows that fecundity had not been impaired by the severity of her confinements. There was some difficulty in each labour, either a faulty presentation or retained placenta, or the birth was premature; but there is no object in giving details of these cases.

Her last labour was in December, 1853. The presentation was natural; she had arrived at her full time, and delivery took place in a few hours. After handing the infant to the nurse, who then retired from the room, I applied my hand to the abdomen of the mother, but, instead of the usual

uterine tumour, there was a vacuity such as I had never before met with. As I had not attempted to withdraw the after-birth, this seemed strange; nevertheless, believing that inversion of the uterus only occurred where traction had been exercised on the funis, it did not strike me that it could have happened here. On examining the vagina, I found the placenta, and at once attempted its removal. In a few seconds it came away with an unusual sort of plunge as if a coagulum had emerged with it, and I tried to remove the mass from under the bedclothes to the ordinary receptacle, but found myself hindered by a band which appeared stouter than the ordinary membrane, and which was, in fact, the inverted vagina. Lifting the bedclothes, I was astonished to observe the after-birth and womb both escaped together, the latter completely inverted, and having the placenta partially attached. There was no bleeding, nor had much blood come away by the vagina. Promptly taking off my coat, and baring my arm, I first peeled off the placenta—this was done with great facility. No blood flowed from the uterine surface. Then, taking the uterus in my right hand, I passed it up the vagina, and, bending my fist, pressed nimbly against the fundus (my left hand meanwhile supporting the abdomen) and in an instant restored its position. My right hand passed into the uterine cavity, where I allowed it to remain till contraction came on, and it was only withdrawn when uterine action became decidedly expulsive. The patient, during this time, experienced no shock in her system; she lost but little blood, and subsequently made as good a recovery as she had done in any former confinement. Since that time she has not been pregnant, though she has had good general health, and looks ruddy, vigorous, and cheerful.

Two practical views derive support from the facts of this case; the first, that inversion may, and sometimes does, take place without interference on the part of the attendant; the second, that reversion may be readily effected, if the manipulation be prompt and well-directed. Formerly, it seemed to be the opinion of the profession that inversion of the uterus always indicated a faulty interference on the part of the practitioner—perhaps the view now generally held is that this is only the most frequent cause. On this point I may refer to the section on Inversion of the Uterus in Dr. Tyler Smith's *Manual of Obstetrics*, where it is pretty fully discussed. His views are concluded with the remark, that, “Owing to the prevalence of the mechanical idea respecting its origin, obstetricians have often been blamed most unjustly in cases of *post partum* inversion.” The ease with which I restored the displacement was the most remarkable feature in the case; it contrasts strikingly with the distressing failures related in the columns of the different medical journals. The reason for this difference seems to me clearly attributable to the fact of my having acted at once. It is noticeable that in nearly every unsuccessful case the accident has occurred for some time before attempts have been made at reduction—in the majority it could not then be remedied. A reason for delay to procure professional assistance is afforded when, as in the instance I have described, the mouth of the uterus contracted over the course of the uterine vessels and prevents hæmorrhage, but it is to be remembered that this is the very case likely to give the most resistance to reduction if delay be allowed. Dr. S. Merriman, writing in the *Medical Times* of July 12th, 1851, says: “It cannot be too urgently impressed upon the mind that one of two consequences must follow, unless the complete reversion of the uterus is soon effected—either the profuse hæmorrhage will destroy, or the hæmorrhage will be stayed by the contraction of the uterus in its misplaced condition, and this contraction which prevents the further loss of blood, will also render impossible the reversion of the womb.” In the operation for reversion, time seems to be the essence of success. As in my patient procidentia uteri was combined with inversion, the diagnosis was very easy; but had the placenta separated from the womb in the vagina, and left it there inverted, there was nothing about the patient's symptoms that would have indicated so grave an accident. The diagnosis must have rested on the perception of the vacuity in the abdomen, where the uterus is commonly felt. This was so striking that I should, in any future case, instantly have my suspicion on pressing my hand well down on the abdomen. This point derives additional importance from the remembrance that many cases of inversion have escaped detection, and that the question of a vaginal tumour being a polypus or an inverted uterus has, in the chronic condition, puzzled some of our most experienced practitioners. A careful examination through the parietes of the abdomen soon after delivery would probably have decided the matter. It has been stated by Cruveilhier, in opposition to the views of Dr. W. Hunter, that the internal surface of the uterus after delivery is completely denuded of mucous membrane, and left very much in the condition of an amputation-stump. Though this view, coming from so great an anatomist, long obtained credence among a large number of the profession, its truth has of late been questioned; and a paper was read before the Obstetrical Society of London in May 1862, by Dr. Matthews Duncan, in which he contro-

verted the views of Cruveilhier. In the case that I have just detailed, I took notice that the internal surface of the uterus was covered generally by a fine mucous membrane, very smooth, thin, and much resembling in colour an inflamed facial lip. There were sundry spots, in size like finger-points, where mucous membrane was entirely wanting, and the muscular substance looked like the raw muscle of the amputation stump. The edges of these spots were irregular and ragged, and by them I was enabled to see that the mucous tissue was thin and delicate. Looking at the surface generally, it was clean and free from bloody points. Probably the constriction which restrained hæmorrhage also prevented grumous exudation.

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

GUY'S HOSPITAL.

OPERATIONS, DECEMBER 8TH, 1871.

Necrosis of the Lower End of the Humerus.—Mr. COOPER FORSTER operated on a girl fourteen years of age, for necrosis of the lower end of the right humerus. About four years ago, she was hit by her brother on the right elbow, and the arm became painful and swollen. A year after the injury, some fistulous openings appeared about the joint, which became stiff; and she was under the necessity of wearing a splint with a cap which allowed the openings to be dressed. There was at the time of operation some slight rotation of the radius; but the arm could not be bent or straightened. Mr. Forster removed two pieces of necrosed bone, each about an inch in diameter; but did not attempt to render the joint movable or of any further service to the girl.

False Ankylosis of the Hip-joint.—Mr. BRYANT made an opening in the neighbourhood of a boy's left hip-joint, and took out a small piece of necrosed bone from behind the head of the femur. The joint appeared perfectly stiff and ankylosed before the administration of chloroform; but the fibrous adhesions were to some extent broken down, and the joint rendered more moveable, under the influence of the anæsthetic. Mr. Bryant quite expected that he would have to take out the head of the femur; but, finding the joint so moveable under chloroform, he thought it only necessary to relieve it by manipulation.

Stricture with Fistulous Urethra.—An interesting case of strictured and fistulous urethra was operated on by perinæal section. J. H., a labourer, aged 37, had suffered fourteen years ago from gonorrhœa, which lasted several months, and for which injections were used. He had congenital scrotal hernia. Three years ago, a lump formed in the under part of the penis, which increased in size and hardness until it reached the size of a hen's egg; and sinuses then formed, from which the most part of his urine flowed on micturition. This lump was removed at Maidstone Hospital, and a part of the urethra was taken away. Mr. BRYANT was unable to pass any sound or probe into the bladder. He could not, therefore, perform Syme's operation for stricture. He was able to pass a grooved probe through the fistula; and, hitting upon the anterior portion of the prostate gland, he cut down upon it through the perinæum, and then cut forward, dividing all the tissues down to the probe (Mr. Cock's operation). He thought that, if this proved successful, a plastic operation might close up the fistula in the urethra.

He next proceeded to examine a case of skin-grafting in an extensively ulcerated leg; but the grafts were all dead, and no good results had been obtained.

KING'S COLLEGE HOSPITAL.

OPERATIONS, DECEMBER 9TH, 1871.

Cancer of the Breast.—Sir W. FERGUSSON amputated the scirrhus part of a woman's left breast. She had been operated on for scirrhus of the same side nine months before; but the disease had returned, although not to any great extent. Sir William Fergusson thought another operation might give further immunity to the patient, and answer the purpose better than caustic or any other application. Up to the present day it is, he said, a vexed question among surgeons whether the whole breast or only the diseased part should be removed. He believed it was always best to take away *only the disease*, and leave as much of the breast as possible to the patient—especially the nipple. In this case he left the nipple.

Amputation of the Middle Finger.—Mr. HENRY SMITH amputated the middle finger, supposed by the patient to have been poisoned with

copper. The three joints being diseased, the whole finger was removed, with the head of the metacarpal bone. He recommended the removal of the head of the metacarpal bone, even though undiseased, whenever the middle finger had to be amputated, but not when any of the other fingers were taken away. The reason he assigned was, that, the other fingers being closely approximated, the hand was rendered more useful.

Varicocele and Hernia.—Mr. WOOD applied his spring tractor for varicocele to one case, and operated for the radical cure of hernia in another—explaining in detail the steps to be taken in such operations. In reference to the latter operation, he mentioned that the patient received the hernia as an inheritance from his mother, and that this was frequently the case. In many cases where hernia itself is not inherited, there is a tendency to it from the inherited patulous and weak state of the rings. He had now operated on two hundred patients, with a bad result in only three—an unprecedented success in the treatment of disease of this kind; but he attributed his success in no small measure to his never attempting the operation on those suffering from any serious organic disease, or in a debilitated state of health.

NATIONAL HOSPITAL FOR THE EPILEPTIC AND PARALYSED.

A CASE OF PARALYSIS AGITANS.

(Under the care of Dr. H. CHARLTON BASTIAN.)

THOMAS S., a tall, thin man, aged 51, a draughtsman, again came under observation on November 28th, having previously been an out-patient under Dr. Bastian's care from April 1868 to March 1869. On first presenting himself, he said that four years ago, whilst on a surveying tour, he was much exposed to cold and wet, and remained in damp clothes for several days. A week afterwards he felt slight twitchings of the left fingers, which gradually increased, and extended to the whole of the left upper extremity, though the parts above the elbow had been only implicated during the last eighteen months. For the last four months he felt twitchings of the left toes, more especially when the weather was damp. He never felt an ache or pain in either limb, in the head, or in the back; and there was no tenderness in the latter situation. The left arm had gradually become weaker. His general health and appetite were good. There was no cardiac bruit; no history of syphilis. The patient exhibited constant twitching movements of the fingers and hands, and occasional movements of the same kind in the fore-arm and arm. When the two arms were compared, there seemed to be no wasting of the left, though the circumference of the largest part of the fore-arm was half an inch less than that of the opposite side. His grasping power, measured by Duchenne's dynamometer, was 11 deg. on the left and 42 deg. on the right. The patient stated, however, that he had always been notable for a great difference in the strength of the two arms; and, as it was found that the left foot and the left arm (more especially the former) were slightly smaller than the right, it seemed most likely that the patient's own notion was correct, as to the existence of a congenital weakness of this side. The smaller size of the fore-arm might, therefore, have been in part due to a deficient development. The electro-sensibility was found to be slightly impaired in the fore-arm, though the electro-mobility seemed to be unaffected. Sensibility was not otherwise impaired. He was ordered eight-grain doses of iodide of potassium in infusion of calumba three times a day, and drachm doses of cod-liver oil night and morning. Two months and a half afterwards he had decidedly improved—sometimes passed a whole day without any shaking (this being in the month of June); whilst the twitching of the toes had ceased. His attendance became irregular soon after this; but when seen in the following December, his grasp, measured by the dynamometer, was 15 deg. on the left and 60 deg. on the right.

On again making his appearance at the hospital, on November 28th, he stated that he had ceased to attend about two years ago, thinking his malady incurable; although he had felt better whilst taking the medicine. He had not followed any occupation since, and had lived very plainly, getting only a very small quantity of animal food at intervals. He came to this hospital again because he had been feeling much worse during the late cold and the wet weather. A similar exaggeration of symptoms had been frequently noticed—cold dry weather not affecting him so much. Eighteen months ago, the right arm began to be affected, and continued to get worse (in the same order as the right). The right arm and hand were now rather worse than the left. The legs shook much less than the arms, and the right leg only when in certain positions. He walked fairly well and steadily; but directly he began to walk the twitchings of both hands and fingers became much more marked. The twitchings were also increased by mental acti-