On the other hand, statements most definitely denying any such connections are not wanting. Dr. Wood, in his large American work on the practice of medicine, states—"It is generally admitted that ordinary unhealthy hygienic influences, such as confined and vitiated air, and all the accompaniments of poverty and privation, have no effect in favouring the development or propagation of the disease, which seems to be as prevalent and destructive in healthy situations as in the most unhealthy." Sir William Jenner, in his recent monograph on the subject, is most definite: he states "that the infection element in diphtheria does not require for its development any of the ordinary considered antihygienic conditions," and "that it is very doubtful if any of those antihygienic conditions favour its development or give it a more untoward course when it occurs."

For my own part, I must say that, in several outbreaks of diphtheria which I have investigated, I do not think that the presence of that disease in conjunction with prominent sanitary deficiencies could be fairly explained as a coincidence.

To aid in settling this important question, I venture to propose to the members of this society two questions.

1. Does diphtheria ever arise in consequence of sanitary deficiencies?
2. Are sporadic cases of diphtheria often met with?

In the discussion which followed the reading of this paper—

Mr. GILL (Wem) was decidedly of opinion that bad hygienic conditions could produce diphtheria, and stated that a few weeks ago he had investigated an outbreak of true diphtheria in his district, in which there was evident connection with various nuisances; and, from inquiry and personal knowledge, he was in a position to state positively that there had not been for a length of time any other cases in the neighbourhood.

Mr. S. WOOD (Shrewsbury) said that some years ago a remarkable series of cases came under his notice. The epidemic extended to several hamlets in one district, and in each locality he ascertained that the disease had first attacked the children attending one national school, and commenced immediately after the holidays. On investigation, he found that, during the holidays, the contents of a ditch receiving the overflow from some privies had been mixed with ashes and spread over the playground; on the reassembling of the school, this formed a ready material for making ovens and dirt-pies, and, as a matter of fact, the children had so amused themselves. It was impossible not to connect this circumstance with the outbreak of diphtheria.

Mr. MATHEWS (Nantwich) referred to an epidemic in which the cases were almost entirely confined to farm-houses, to which a quantity of night-soil had recently been removed from a neighbouring town.

The opinion of the meeting seemed decidedly to favour the theory of a definite connection between diphtheria and bad hygienic local conditions.

THE OBSTETRIC BINDER IN *POST PARTUM* HÆMORRHAGE.

By A. B. STEELE, L.K.Q.C.P.

Lecturer on Midwifery in the Liverpool Royal Infirmary School of Medicine.

My views as to the true value of the obstetric binder differ so materially from those of Dr. Boulton, that I feel bound to state them during the present discussion on the important question of the means of anticipating flooding.

I find it difficult to believe that the use of the binder in the way suggested, or, indeed, under any circumstances, can have much to do with the prevention of flooding, because I have never used it with that object myself; and my experience includes the observation of a very large number of cases of unassisted labour, and those attended by other practitioners and also by midwives, in all or nearly all of which the practice has been not to apply the binder until *after the uterus has contracted*. Its proper use is, in my opinion, to give moderate support to the relaxed condition of the abdominal parietes following labour. As a means of compressing the uterus, in anticipation of and during the presence of flooding, it is vastly inferior to the hand, and less trustworthy. In natural labour, if the last stage be either uninterfered with by "meddlesome midwifery", or judiciously managed, the uterus contracts and no flooding occurs, even although the patient may be subjected to reasonable movement. Such, at least, is my experience; and I regard flooding as an extremely rare accident, and, when it does occur, as due to a constitutional cause—to inertia from protracted labour; to errors in the management of labour, a common one being too great haste in emptying the uterus and removing the placenta; and in no case that I have met with could it be attributed to the want of

attention to the binder. If it were otherwise, surely those who, like myself, do not trust to it, and especially those, and they are not a few, who never use it, must have discovered their mistake long ago. Nothing, I imagined, had been more generally understood and agreed upon by experienced obstetricians, than that the essential point in the management of the third stage, where interference of any kind was called for (and this, I suspect, is more seldom than is often supposed), was to compress and follow down with the hand the uterus during the expulsion of the child, and to maintain such pressure until the uterus has firmly contracted. This manœuvre, I conceive, would be in no way assisted, but, on the contrary, somewhat embarrassed, by the application of a binder. I am aware that, in the Dublin school of obstetrics, great importance is attached to the value of the binder and compress as a means of sustaining contraction; but I have always preferred sustained hand-pressure until firm contraction is secured; and then, so far as my experience goes, the danger is over. In those extreme exceptional cases which I have ventured to call recurring hæmorrhage, in which, in spite of due compression, the uterus, after having once contracted, melts away under the hand again and again, I know no more effectual remedy than the intrauterine injection of perchloride of iron, as recommended by Dr. Barnes.

ELECTROLYSIS OF EXOSTOSIS OF THE EAR.

By THOMAS E. CLARK, M.D., C.M., Surgeon to the Bristol Royal Infirmary.

THE following case of exostosis, blocking up the meatus of the right ear, causing total deafness of that side, and its removal and cure by the continuous current, may be of interest. The patient was M. D., a girl aged 15. In the early part of 1869, a discharge from the right ear was noticed; some simple remedies were used, but without any good effect. In April, I saw her; and, upon examination, there appeared a mucous polypus filling up the meatus, and bathed in a thin purulent discharge. Tannic acid was ordered; and, under this treatment, the mucous polypus disappeared, leaving a hard substance, which proved to be an exostosis.

January 1871. I examined the ear, and found a bony growth nearly filling up the cavity of the meatus, allowing only the end of a director to be passed with difficulty and pain between it and the anterior wall. An application of tincture of iodine and liquor belladonnæ was locally used, and iodide of potassium and citrate of iron internally; and this was continued for some weeks without any beneficial result. I again examined the ear in July, when a director could not be introduced, and only a very small fissure existed between the exostosis and the anterior wall, the largest parts of the fissure being above and below the centre. The hearing was very indistinct and uncertain, the slightest moisture causing entire deafness.

I suggested the application of the continuous current to the exostosis, to promote its absorption and arrest its growth by blocking up the vessels of the periosteum. This was found too painful, and was given up, except under the influence of chloroform.

August 29th. The whole meatus was entirely blocked up by the exostosis; its surface was pinkish, and it felt of stony hardness. No probe could be passed in any direction by the side of the growth. She was totally deaf in this ear. She was placed under chloroform. I introduced three needles, two at the base, close to its attachment to the posterior wall, and one at its anterior edge. The former were attached to the negative pole, and the latter to the positive; and the application was continued for three minutes. This produced a large coagulum at the point of entrance of the needles, and rendered the whole tumour white. There was no subsequent irritation or pain produced. The battery used was Dr. E. Stöhrer's (six pairs of plates).

September 12th. Two needles were introduced while she was under chloroform; and in introducing them the resistance was very slight, whereas at the first application one of the needle-points broke on account of the great hardness of the growth. The connections were similar to the last, but were continued for five minutes. No ill effect followed.

September 26th. There appeared some diminution in the size of the growth.

October 4th. She was again placed under chloroform; and, upon examining the exostosis, it gave the idea of being loose; and with a closed scissors I pressed against its base, and it came away entire. Only a few drops of blood followed. There was no subsequent pain.

On examination of the growth, the front, or part facing the anterior wall of the meatus, was seen to be convex, with slight depressions above and below, covered with periosteum. The posterior part, or its