The appearance presented is not unlike a single projection of the surface of a raspberry.

Another most important modification of the results of the application of syphilitic matter depends upon the structure to which it is applied. Hunter showed that the mucous membrane was capable of the adhesive form of inflammation. Lymph may be secreted on its surface as the result of great or prolonged irritation, or effused into its structure, and into that of the submucous tissue. As a rule, however, irritation of a mucous membrane produces suppuration, and the pus-cells are thrown off from the surface, together with any irritating matter that may be mixed with it. The mucous membrane does not then become permanently thickened, nor does it ulcerate. The newly formed bioplasts carry their life up with them, and cease to be a part of the living being which produced them.

There are three ways, Hunter says, in which chancre may be produced: first, by the poison being inserted into a wound; secondly, by being applied to a non-secreting surface; and, thirdly, by being applied to a common sore. But infection of a patient's system, Hunter held, might be and often was produced by a gonorrhœa, independent of a chancre. He says the matter of a gonorrhœa will produce either a gonorrhœa, a chancre, or the lues venerea. Now there can be no doubt that Hunter in his descriptions has confounded together several different affections of the urethra, and has classed them together under the common name of gonorrhœa. That the very large majority of cases of urethral discharge do not depend either upon syphilis or upon gonorrhœa, may be concluded from the simple consideration of the great variety of causes which will produce such affections. These will be more fully considered hereafter. But if it be conceded that some forms of urethral discharge are really syphilitic, it is no easy matter always to distinguish them from those that are not. Inoculation has been supposed to furnish the means of diagnosis. How far this is the case, will be considered in the next lecture.

ON OBSTINATE SICKNESS DURING PREGNANCY.

By J. HENRY BENNET, M.D.,

Formerly Obstetric Physician to the Royal Free Hospital.

IN the various communications that have recently appeared in the *BRITISH MEDICAL JOURNAL* on obstinate sickness during pregnancy, I have looked in vain for the mention of one very important and very frequent cause of such sickness; viz., chronic inflammation of the body or of the neck of the pregnant uterus. I was the first to draw attention in Anglo-Saxon literature to this frequent cause of obstinate sickness, as far back as the year 1849, in the second edition of my work on *Uterine Inflammation*. I had become acquainted with the fact in the Paris hospitals ten or twelve years before that date, and had during all that period paid much attention to the subject in varied fields of observation. So frequently, indeed, have I found actual uterine disease, often removable by treatment, to be the cause of severe pregnancy sickness, throughout my entire active obstetric career, that I have no hesitation in saying that it may always be suspected when sickness proves unusually severe and intractable. Such being the case, no practitioner is justified in continuing to treat by medicine alone such a case of pregnancy sickness, without making a most minute and careful ocular and digital examination of the uterine organs.

Chronic inflammatory disease of the body of the uterus, or extensive inflammatory disease of the cervix, even when ulcerative, does not necessarily preclude pregnancy. Some women conceive so easily, that no morbid condition of the uterus prevents conception, although the sequelæ of such conception are often lamentable. It is a diseased organ, a piece of machinery out of gear, that has to do nine months' work, to undergo all the wonderful modifications of tissue which accompany pregnancy: is it surprising that the entire process should be one of intense suffering, and that various and numerous morbid manifestations should accompany every stage of the process? Indeed, I published twenty-six years ago, in the work alluded to, my firm conviction, a conviction which subsequent experience has only confirmed, that a considerable proportion of the morbid manifestations of the pregnant and puerperal states may be traced to the unrecognised existence in the pregnant woman of chronic inflammation of the body or of the neck of the uterus. The latter is the most frequent, because lesions of the mucous membrane are always more frequently met with in any part of the body where there is one, than parenchymatous lesions. Ulceration generally accompanies inflammation, and is of a peculiar fungoid-looking character. The granulations are large, and bleed easily on being touched: a characteristic which becomes more

and more marked as the pregnancy advances. The diseased state may spread over the enlarged cervix, or be limited to the inner region of its cavity, and be partly or entirely concealed. Thence the necessity of a very careful and accurate examination, not only digital, but ocular. The patient should be out of bed and dressed, and be examined lying in the lithotomy or dorsal position, on a couch or sofa; the pelvis elevated by one or two hard pillows; in a good light, that is, near a low window. The speculum used should be a conical bivalve, such as Coxeter's large one, which sustains the vagina, relaxed by pregnancy, and admits of expanding or opening the lips so as to see into the outlet of the cervical canal. The examination ought to be such that a grain of dust should be seen anywhere on the cervix. I am still constantly examining women who have been previously examined in bed by others in the usual English obstetric position, and have been pronounced free from disease, whereas I find well marked morbid conditions; the difference being, no doubt, the imperfect examination of my predecessors.

Chronic disease of the body of the uterus, generally localised to a limited region, is more difficult to diagnose in the gravid uterus. The diagnosis must rest on the antecedents of the patient, on the presence of dull aching constant pain in some uterine region, and on the sickness. In my own obstetric practice in former days, my patients were principally, in private life, women whom I had previously attended for uterine disease. This previous attendance was the link between us, and I was thus able to follow the sequence of events. I may incidentally mention that I found adhesion of the placenta after confinement very frequent in these cases.

When there is disease of the cervix, the discovery once made, all difficulty and danger usually cease. As soon as, under the influence of local surgical treatment, emollients, astringents, caustics, etc., the simply inflamed or inflamed and ulcerated surfaces assume a healthy hue, the intense sickness ceases; and, when they become healthy, it disappears, or assumes its usual mild form. I am sure that I have saved scores of pregnancies and children's lives by the above treatment. I have often succeeded in women who had had half a dozen abortions previously to my appearance in the field.

In chronic inflammation of the body of the uterus, it is more difficult to arrest the sickness or to prevent abortion. Still I have succeeded with the assistance of the usual antiphlogistic means, hip-baths, emollient injections, and external applications, leeches externally and even internally to the cervix in the early period of pregnancy. I learnt accidentally long ago that leeches might be applied without risk—indeed, with positive advantage in some cases—to the uterine neck in early pregnancy. I overlooked the existence of pregnancy in several instances where it “ought not” to have existed, and only found out the mistake later, after seeing urgent symptoms of uterine irritation subside under the influence of leeching.

It is now more than a quarter of a century since I opened out this wide and important field of observation in the diseases of pregnancy and of the puerperal state, and I have often wondered that so little has been done in it since I did so.

Grosvenor Street, June 1875.

TREATMENT OF OBSTINATE VOMITING IN PREGNANCY.

By E. COPEMAN, M.D., F.R.C.P.,

Senior Physician to the Norfolk and Norwich Hospital; President of the British Medical Association.

I WAS much pleased with the remarks made upon my late communication by Dr. Graily Hewitt, whose opinions on matters connected with obstetrics, I feel sure, all will consider worthy of special attention. Since I read his paper in the last number of our *JOURNAL*, a case has been brought to my recollection which adds some confirmation to his views as to the obstinate sickness occurring in pregnancy being due to displacements or flexions of the uterus; and, although I do not yet believe that such flexions are the *only conditions* of the uterus which give rise to the vomiting, yet I quote a few remarks from my case-book to show how probable it is that they are, at all events, *amongst* the causes of this troublesome and sometimes dangerous complication of pregnancy.

In March 1865, I was called to visit a lady in the country in consultation, on account of severe and most distressing vomiting during early pregnancy. About two years before, this lady consulted me on account of an almost constant loss from the uterus, which had gone on for about a year. She did not look much out of health, and had had several children; but the continued loss made her feel very languid and good for nothing. Some months before, she had consulted Mr.