lead from ignorance to perfect knowledge, minds that might have continued to be busied and puzzled with the unsettled problem of the circulation, would be set free to engage in other and more profitable inquiries; that no one could henceforth devote himself to the study of any matter relating to the physiology of the human frame, but must own himself in some degree his debtor; that every physician every time he felt a pulse, would have a more intelligent appreciation of its indications, every surgeon who should staunch a hæmorrhage, or tie an artery, or perform an operation, would do it with a firmer hand, in consequence of his discovery of the circulation.

And these annual orations!—may we not venture to hope that in as far as, year by year, they faithfully portray Harvey, in his studious youth, busy manhood, and serene old age, they promote the objects he had in view, supplying with motive, example and encouragement, all who are now striving to render the life that now is longer, healthier, pleasanter, happier, by manifold methods of cure, palliation and prevention; in full assurance that true knowledge is real power; and that, if we make the discovery of truth our motive, and use intelligent industry as our means, we shall not miss some portion of that rich reward which fell in unwonted measure to the lot of him whose “immortal memory” we honour this day, for this among other reasons, that he conferred upon us, in the full practical sense of the words, the *Discovery of the Circulation of the Blood*.

POSTSCRIPT.—It will be seen that, throughout my Harveian Oration, as now published, I have abstained from the use of notes; for I was anxious to present to the reader a continuous unbroken text. But it is the more necessary that I should acknowledge the obligations I have incurred to the elegant and scholarly translation of the works of Harvey made for the Sydenham Society by Dr. Robert Willis. It is his English version that I quote throughout.

For facts and dates relating to the life of Harvey, I am indebted partly to the same source, and partly to the *Roll of the Royal College of Physicians*, compiled by our learned librarian Dr. Munk.

What I have said on the subject of Harvey's belief in the efficacy of the hand of a corpse, and on the origin of the inquiries which led to his discovery of the circulation of the blood, will be found borne out by reference to *The Works of the Honourable Robert Boyle*, published in six volumes quarto in 1772. The passages to which I have referred occur in vol. ii, p. 167 and vol. v, p. 427.

This handsome and complete edition of the Works of the Christian Philosopher will be found in the Library of the College.

CASE OF STERILITY FROM ANTEFLEXION OF THE UTERUS, AND CONSTRICTION OF THE INTERNAL OS UTERI, CURED.

By HEYWOOD SMITH, M.A., M.D.,

Physician to the Hospital for Women and the British Lying-in Hospital.

OF all the causes of sterility depending on malposition of the uterus, that of anteflexion is the most frequent. Other malpositions of the uterus, except marked retroversion, leave the cervix uteri depending into the posterior original *cul-de-sac* in the dorsal decubitus; but in acute (I here use the word acute with regard to the angle, not time) anteflexion, the os uteri is lifted out of the posterior *cul-de-sac*, and placed in a position unfavourable for the imbibition of the semen. Anteflexion, dysmenorrhœa, and sterility, are three conditions so frequently associated, that, when a patient comes complaining of dysmenorrhœa, and is also barren, a vaginal examination more often reveals anteflexion than any other condition. And here it may be noticed that it is the dysmenorrhœa that causes the patient to seek for advice. Among the applicants for relief at hospitals, pain is that for which medical advice is generally sought, seldom barrenness. The latter is either considered a blessing, or women give themselves up to their fate, never for a moment supposing that such a condition is remediable; whereas among the upper classes, when property or name are at stake, medical men are more frequently consulted for relief from barrenness; and in such cases, pain not necessarily being an element of complaint, the sterility may be found to depend on many causes other than flexion. It is therefore, perhaps, more among the poorer classes that favourable results, as far as sterility is concerned, may be looked for from operation and treatment for the cure of anteflexion, and for the relief of obstructive dysmenorrhœa.

E. S., aged 29, married six years, became an out-patient at the Hospital for Women, February 20th, 1871. The catamenia commenced at the age of 18; they were regular, with some pain generally before the flow. The passage of a thick sound before the period lessened the

pain. She was admitted into the hospital on July 3rd, 1871. The uterus was normal in size; a thick sound could be passed after some gradual pressure, and the constriction held the sound rather firmly. On July 13th, Dr. Protheroe Smith's uterine dilator was used to half an inch. On the 17th, the dilator was used to three-fourths of an inch, and the constriction at the internal os divided bilaterally with a straight knife, as well as the external os slightly, and a spring metallic (Greenhalgh's) stem introduced. On the 19th, the stem was extended half its length, with some forcing pains, and was replaced. On the 23rd, the patient was free from pain. A slight blood-stained discharge continued. On the 26th, the stem was removed; and on July 31st, the patient was discharged.

In April of the following year (1872), she was seen again. The external os was divided a little more freely, and the spring stem again introduced. It remained in altogether nearly three weeks. The patient continued under observation from that time, the thick sound being occasionally passed until conception took place, after the catamenia of November 13th, 1873; and she was delivered of a living female child on August 31st, 1874.

The above case is given in order to encourage practitioners not to lose sight of a case after operation for dilatation of stricture of the internal os, because pregnancy does not immediately follow, but to persevere, by the occasional passage of the thick sound, to maintain the cervical canal in a state of sufficient patency.

Moreover, it often happens that, for some time after forcible dilatation, there may exist some chronic irritation of the cervical mucous membrane with or without granular inflammation of the labia uteri, which, giving rise to leucorrhœa of some form or other, may hinder impregnation. And here it may be well to insist on the necessity of not trusting to dilatation alone, whether by tents or by the introduction of graduated sounds, to enlarge the cervical canal. For if dilatation alone be had recourse to, its action is only temporary, for the uterine fibres are thereby merely stretched, as India-rubber might be, and, on the stretching force being intermitted, the cervix returns to its usual condition.

The dilatation must be associated with, and made subsequent to, incision of the canal. After incision of the cervical canal from within, which need not be extensive, dilatation then continues the incision with a slight rupture, and, this being kept from closing, the dilatation remains permanent. Many failures of this treatment are due to the external os being too freely divided, and being thereby rendered too patent; the act of imbibition is greatly interfered with, if not altogether prevented. The object to be gained is slightly to enlarge the cervical canal, and, at the same time, not to destroy the orifice of the uterus.

TREATMENT OF HABITUAL DRUNKARDS.*

By J. W. EASTWOOD, M.D. Ed., M.R.C.P. Lond., Darlington.

THE subject of Intemperance, and the diseases specially produced by the free use of alcohol in its various forms, has occupied my attention, more or less, during the last twenty years. The different forms of insanity, or some morbid conditions of the brain, which have been produced by drinking habits, have especially come under my care. At the annual meeting of the British Medical Association, held at Newcastle in 1870, I read a paper before the Public Medicine Section, on “Intemperance in its Medical and Social Aspects”, when I strongly urged the appointment of a committee to examine the whole question. The difficulty which was found in obtaining men from different parts of the country to meet together sufficiently often to go into this subject seemed a serious objection, although there were not wanting those who by their special knowledge and devotion to the profession, were quite willing to form members of such a committee. I may here particularly mention Dr. Rumsey of Cheltenham, and Dr. Morgan of Manchester. Again, at the Birmingham meeting in 1872, I read another paper on “The Use of Alcohol in Health and Disease”. To those who have paid any attention to this subject, it will be obvious that during the last three or four years the great question of intemperance, and the proper use of alcohol, as well as the treatment proper for some of the individuals who suffer from its excessive use, have made rapid strides both with the public and the profession. It is not, however, this large question which I wish to bring before you now, but a portion of it which has recently been taken up by a committee of the Birmingham and Midland Counties Branch. This has reference to the treatment of habitual drunkards, and the committee recommend the different Branches to consider the subject for themselves. Before I saw this report, I intended to bring this matter before this meeting.

* Read before the North of England Branch.

Those gentlemen who are in any way engaged in the special treatment of insanity, and many others in general practice, will readily bear me out when I state how difficult it is to know what to do with certain cases which come before us, where it is manifest that a morbid desire for intoxicants exists. The essential disease itself, whatever may be its exact pathological cause, is dipsomania. This may produce different results: acute mania, delirium tremens, and chronic alcoholism. The treatment of the first is clear enough; for if the patient cannot be kept at home, as the mania is generally of a noisy and destructive kind, he is sent to a public asylum or private retreat. The second form is likewise very clearly understood; and if the patient cannot be managed at home, he is also sent away for treatment. So far there is suitable provision already existing for the treatment of these cases; for it is of no consequence what the cause is, if the patient have mental symptoms which warrant medical certificates being signed, he can be placed under suitable care and treatment, as an insane person. The cases of chronic alcoholism are the production of the long continued habits of the dipsomaniac. It is most difficult to know what to do with those persons who appear not fit to be placed under care as lunatics. I am frequently appealed to by medical men, who write me letters containing a heart-rending account of some amiable young man, or gifted lady, who would sometimes do anything or submit to anything in order to be cured of their malady. It is with great reluctance that I admit such patients into my house, for they are more trouble than they are worth, and one cannot help feeling that they are not in their proper place amongst lunatics. If I admitted them, I should have more than I could accommodate. Sometimes the good effects of confinement continue for a considerable time, but it is always too brief to be of permanent good to them. The patients can only be kept during the period when they are mentally unsound, and obviously so. Two cases have recently been under my care, but only for a month each. One of them has learned a lesson, and at present keeps sober, but the other relapsed in a very short time. In the case of females, the result of any treatment is very unpromising.

There is another class of drunkards which do not come under my care and notice: the drunken criminals. These are to be found chiefly in a lower stratum of society than the patients to which I have referred, who are often educated and refined, at least at the commencement of their malady. They are more frequently dealt with by the magistrate than the physician, and they belong to that border-land between crime and insanity which it is so difficult to deal with.

What then is to be done with these unfortunate people, who are undoubtedly the victims of either mental or moral deficiency, or actual disease? The cases being properly selected, I think there can be no doubt about their being treated in suitable places or establishments for the purpose, under legal control. They are not fit for asylums generally—at least in the early stages, and they *will not*, as a rule, go voluntarily to an establishment for dipsomaniacs.

At the time that Mr. Dalrymple's Bill for Habitual Drunkards was brought forward, I advocated its adoption, with some amendments, and I was in correspondence with the late author of the Bill at the time that it came before the House of Commons. I think, however, that the Bill may now be taken as the basis on which to act, and that we should be justified in recommending it to the members of the British Medical Association to support by petitions to Parliament. The chief clause to which I have objections to make is the fifteenth, as the one most likely to be abused, and I should therefore desire some modification of this clause, so that its strictness shall be lessened.

I beg, therefore, to propose that the Bill for the Management of Habitual Drunkards, brought before the House of Commons by the late Mr. Dalrymple, be the basis for any future action on this subject, with a modification of the fifteenth clause, and that the members of this Branch be requested to sign a petition in favour of this Bill, to be presented to the Houses of Parliament.

That a copy of this resolution be forwarded to the Birmingham and Midland Counties Branch.

OBSTETRIC MEMORANDA.

A CASE OF FOOT AND HEAD PRESENTATION.

THE presentation of a foot along with the head is, I believe, of sufficiently rare occurrence in obstetrical practice as to call for a short notice from me of the following case. On June 12th, 1875, at 6.40 P.M., I was asked to attend Mrs. S. in her sixth confinement, six weeks earlier than she expected it. On examination, I found the right foot presenting, and the membranes entire. About an inch above the foot, and entering the brim, a large substance was to be felt, which I was

unable to reach sufficiently easily to decide what it was. Because of this doubt, and as the patient required to change her position, I was anxious not to rupture the membranes immediately. With the change of position and the advent of the next pain, the membranes ruptured just before I again made an examination; but, even after the rupture of the membranes, I could not determine with certainty what was presenting above the foot; I, therefore, immediately introduced my hand into the vagina, when I found that a small head was entering the pelvis with the foot. The presenting foot was immediately returned well above the head; this caused another pain, which sent the head much lower, and converted the labour into a natural one. A small premature child was born at 8.15 P.M., which only survived its birth seven hours. The right foot had evidently occupied the position in which I found it for some time; for, when the child was born, that foot was still very dark in colour, from pressure above the ankle. JAMES SEDGWICK, M.D.

CASE OF PLACENTA PRÆVIA: TURNING: SUDDEN DEATH ON THE EIGHTH DAY AFTER DELIVERY.

A. B., AGED 35, a somewhat stout but well built woman, at the eighth month of gestation with her sixth child, commenced flooding at 8 P.M. on May 6th. Her husband applied to me the same evening, about 11 o'clock, for some medicine for her. He stated that his wife had suddenly commenced to lose blood *per vaginam* without any apparent cause, and that up to this time she had always enjoyed good health. I accordingly sent her a mixture containing ten grains of gallic acid and five minims of tincture of opium, a dose to be given every three hours; and gave the husband instructions to send for me at once should she be any worse. At 4.30 the following morning, I was summoned to the patient, who, it was stated, had been taken much worse about an hour previously. I went at once, and found the woman somewhat blanched. I ascertained that she had lost a considerable amount of blood, and that it was still coming away in "large clots". Her pulse was small and rapid, 120 in the minute. She complained of slight pains in the lumbar region, coming on about every quarter of an hour, and at each recurrence of pain the loss of blood was increased. On examination, I found the os considerably dilated, the membranes still intact, through which could be felt the head and a hand presenting; but posteriorly a portion of the placenta was protruding. Whilst I was making this preliminary examination, a slight pain came on, which caused a considerable gush of blood. I now felt convinced that, unless I used prompt measures, my patient would soon sink from loss of blood. I therefore determined to rupture the membranes and turn the child, which I did with little difficulty; and, having got the breech of the child, filling up the cavity of the pelvis, I waited for more decided uterine action, which up to the present had been both slow and feeble. I therefore gave thirty minims of tincture of ergot in half an ounce of brandy, with some water. The pains soon became stronger and more frequent, and a living child was born about twenty minutes after administering the ergot and brandy. I removed the placenta immediately, and applied pressure over the uterus, which contracted firmly; consequently there was very little more loss of blood. The patient fainted about a quarter of an hour after the birth of the child, but soon revived. Still the pulse was extremely small, and also rapid (120). I now gave her another half-ounce of brandy, and also fifteen minims of tincture of opium. On the following day, I found my patient much better, she having had a good night's rest. Each day now she gained strength up to the seventh day after delivery, when I found her very cheerful, and to all appearance doing well. I gave special directions that she must not sit up at all until I saw her again; which, however, unfortunately, I had not the opportunity of doing, for on the following day (the eighth after delivery), about 4.30 A.M., I was summoned again to see her, as she had been taken suddenly worse. I accordingly went immediately, but before my arrival she had expired. Her husband informed me that she had a light supper the previous evening, and went to sleep apparently well about 11 P.M., but that about 2.30 the next morning she awoke suddenly with a feeling of constriction at her chest and great difficulty of breathing, which became rapidly worse until she died at 4.30 A.M., two hours after the commencement of the attack. Such was the sad end of a case which appeared to be progressing favourably. There had been no *post partum* hæmorrhage. I could not obtain a *post mortem* examination; but I think, in all probability, this was a case of embolism of a branch of a pulmonary artery, due to a clot being carried from the uterus, and so giving rise to the asphyxia. The child, I should have stated, was very weak at birth, and gradually sank; it died the third day after delivery.

J. ASPINALL HUNT, M.R.C.S.Eng., Ockbrook.