vertical length of the abdominal cavity. The amount of blood lost was much less than might have been expected, and the real cause of death appeared to be the shock of commencing peritonitis.

THE TREATMENT OF INERTIA OF THE UTERUS.

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A SENTENCE in Dr. Playfair's introductory lecture leads me to believe that a note on a very simple method of assisting labours which are tedious in the second stage, that I have recently adopted, may not be unacceptable. The method is far too simple for any expectations of mine to be fulfilled that I have been the first to use it, though I am perfectly certain that it is original in my own practice. As it was, however, actually based on Dr. Braxton Hicks's method of external version, and suggested itself to me when I was performing that operation in a case of placental presentation, it may possibly prove to be, like Dr. Hicks's device, from its very simplicity, something new in obstetrics.

Dr. Playfair writes: "We have learnt, also, some valuable lessons from a careful examination of the abdomen externally, such as the possibility of aiding the force of feeble and ineffective pains by judiciously applied pressure to the uterus. In this plan, indeed, which is as yet little known in this country, I feel convinced we have a means of assisting the progress of a labour in which the delay is simply due to the want of sufficient uterine contraction, far safer both to the mother and the child, and far more effective than the administration of oxytocic drugs, such as the ergot of rye, in which many place much confidence."

The fact that this is the only reference I have yet seen to the employment of external pressure in cases of inertia of the uterus, must be my apology for describing the method in which I employ it, and, first of all, the case in which it was suggested to me.

In August last, I was summoned hurriedly one morning to see a woman in labour and attended by a midwife. I found her cold, pulseless, and the bed and floor swimming with blood. It scarce needed an examination to know that the placenta was presenting. The os readily admitting my hand, and the uterus being perfectly flaccid, I at once removed the placenta, and, by the combined version, easily brought down both feet. I could get no amount of manipulation to induce contraction of the uterus; and to wait for the action of ergot was to waste time. I therefore passed my left arm under the patient and my right arm over her, embraced the uterus between them in a direction parallel with the axis of the brim, interlocking my fingers and spreading them over as large a part of the fundus as possible. In this position, and by the external pressure, I imitated normal contractions, as one does with the forceps, and soon had the satisfaction of finding the child extruded as far as the shoulders; then, with the left hand on the fundus, and the right guiding the child, birth was soon completed. The child was almost dead, of course; but the mother made a good recovery.

Since this case, I have had on three occasions to adopt the method of external pressure in cases of inertia.

Mrs. K., confined on December 20th of her seventh child, had a large roomy pelvis; but though the passages were relaxed to the fullest and ergot administered twice, the uterus was absolutely passive. I placed her at once under chloroform, and commenced the intermittent pressure described above. In about ten minutes delivery was completed, and there was no *post partum* hæmorrhage.

In September, I was retained to attend Mrs. E., the mother of seven children. Her attendant informed me that nearly all her labours had to be assisted by the forceps on account of an inert state of the uterus, and that in the last two she had nearly lost her life from *post partum* hæmorrhage. A few days before her confinement, the house was entered during the night by burglars, and she awoke to see one of them removing her husband's watch from the toilet-table. She was, of course, much excited, and in the morning I was asked to see her. We feared very much that the fright would exercise an unfortunate influence, and so, indeed, it proved, for symptoms of labour came on immediately. We tried by opium and rest to delay it, and succeeded for a time. At last, however, it came on, and, as before, the second stage was characterised by inertia. The pains were sufficiently severe to require anæsthesia, but whether it was continued or not, they did nothing. Instead of resorting to the forceps, as I originally intended, I employed the external pressure, and very soon had the head on the perinæum. I then used the forceps to guide the head through the passages, still having the external pressure kept up. She recovered more rapidly and more completely than she had ever done, according

to her own account, though she attributed this to the chloroform. It is certain that she had no after-hæmorrhage.

The third case was in the person of a strongly built woman, in whose second labour the pains suddenly ceased without apparent cause. The head was nearly on the perinæum when I arrived to assist the midwife. I advised the external pressure instead of ergot, and we found it perfectly successful in re-establishing the pains, and by its help labour was completed.

I feel convinced from even this short experience, like Dr. Playfair, that the method of external pressure will soon and in most cases supersede all uterine stimulants, and that the use of these will now be confined to the *post partum* state. External pressure is of great help when, from accident or necessity, anæsthesia has been pushed so as to interfere with the intensity of uterine action. I have little doubt that this communication will bring many others from obstetricians who have practised the same or some similar method of external pressure. My plea is that, so far as I know, it is not used in this country as it ought to be, and that ergot is far too largely consumed by parturient women, especially when under the care of the so-called "trained midwives".

[Since correcting the proof of this note, I have seen a reference to a method of assisting the inert uterus by external pressure in Dr. Meadows' *Manual*, with allusions to the writings of Ritzen, Kristeller, and Playfair, but I have as yet had no opportunity of going further into the history of this method of treatment. It would seem to be not of older date than 1856.]

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

TREATMENT OF ULCERS.*

CHARING CROSS HOSPITAL.

Mr. BELLAMY says that the treatment of old standing ulcers of the leg in the out-patient department of a hospital is in general very unsatisfactory, from the fact that the essential adjuncts to therapeutical measures—rest, cleanliness, good food, abstinence from excesses in drink—are impossibilities with the class of patients afflicted. The most frequent form, that complicated with a varicose state of the veins, appears to be best relieved by a carefully applied bandage commencing at the web of the toes, or by a neatly adjusted method of strapping, maintaining equable pressure. If the patient can lay himself up for a while, the obliteration of the veins usually effects a cure. The internal administration of iron, and if the ulcers be chronic, of opium, is of great use. Lotions of nitrate of silver, sulphate of zinc or copper, on pieces of lint of the size of the ulcer, are useful dressings. In the irritable form, rest, elevation of the limb, at all such times as the patient is not absolutely obliged to use it, water-dressing and poultices, and the administration of iron, seem as good remedies as any. The chronic callous ulcer, which is frequently met with in old people associated with an œdematous condition of the feet or ankles, is greatly benefited by neatly applied strapping, blisters, and by the administration of opium. The local application of the aqueous solution of opium affords great relief. Opium is sometimes given night and morning. Of ointments or lotions, the ointment of nitric oxide of mercury, and zinc or copper lotions, are the best. A rather strong solution of carbolic acid has often been found of great service. Mr. Bellamy has, in many instances, transplanted cuticle, in old standing ulcers among out-patients, with considerable success. The great obstacle is, he thinks, the absolute necessity of the patients moving about to earn their bread, and their want of ordinary attention and of the means of existence in many instances. But the little pieces of transplanted cuticle can be pretty securely held on by being strapped down by the strong waterproof isinglass plaister, and the whole surface covered with lint, also securely strapped on. With the better class of patients, those who help the surgeon, in fact, the plan is often highly successful.

ST. MARY'S HOSPITAL.

Mr. ARTHUR TREHERN NORTON says that the majority of ulcers which occur in the out-patient department of a hospital are the result either of insufficient food, or of too long standing, or of varicose veins; and none of these are likely to be relieved by internal remedies. He

* Continued from page 642 of number for June 15th.