Dr. Matthews Duncan's paper on the "Mechanism of the Expulsion of the Placenta", alludes to Schultze's and Baudelocque's description of the mode in which they conceived this hæmorrhage to occur. In differing from them, he suggests that the mode which they describe as the ordinary one, is in reality very rare, and liable to be attended by flooding. In Schultze's work, *Lehrbuch der Hebammenkunst*, drawings are given, showing the collection of blood behind the placenta, in which it is forced down, inverted, into and through the os uteri, in a manner similar to that described above by myself as occurring to the membranes.

The cases above described confirm Dr. M. Duncan's opinion as to this mode of placental delivery being liable to be accompanied by flooding; yet I expect that the position of the attachment of the placenta to the uterus has considerable influence on the mode of expulsion, especially during varying conditions of uterine tonicity; influenced by the amount of traction made on the fundus either manually or by the natural efforts of expulsion, and also by the amount of separation produced by the latter throes of labour. If complete separation take place upon the last pain, then the mode described by Dr. M. Duncan is probably the usual one; but if it be incomplete, then it is easy to understand that a greater or smaller quantity of blood would be effused, which would produce something of the effect described by Schultze; yet the blood lost would not be sufficient to be alarming, but by no means a rare event even when no traction is made on the funis, at least manually. Still it cannot but be admitted that nothing can facilitate the occurrence of hæmorrhage before the delivery of the placenta more than the slight and imperfect dragging on the funis, so frequently done, in order to find out if the placenta be detached, especially while the uterus is unsupported.

OBSERVATIONS ON A FORM OF DISLOCATION OF THE HIP.

By HENRY ARNOTT, F.R.C.S.,
Assistant-Surgeon to St. Thomas's Hospital.

In the BRITISH MEDICAL JOURNAL for December 23rd, 1871, there appeared an Extract from a Lecture on Dislocation of the Hip-joint by Mr. Jonathan Hutchinson, in which the views of Dr. Bigelow as to the usual nature of the displacement and the means required for its reduction are set forth at some length. In this extract the following sentences occur. "Next, gentlemen, let me say that I regard the researches of Dr. Bigelow in respect to our subject as amongst the most valuable of recent additions to the science of surgery....Amongst the special services which Dr. Bigelow has done is that of explaining the peculiarity of 'the dislocations into the ischiatic notch', and of teaching us how to reduce them. His assertion is, that they differ very little from the majority of so-called dorsal dislocations, for in both the head of the bone lies not so much on the dorsum ilii as just behind, or behind and above, the acetabulum; and in neither does it really pass so far back as the sciatic notch.....Extension horizontally, whether in a straight line or obliquely, he for the most part opposes strongly.....Extension with the thigh bent at right angles to the pelvis he warmly advocates."

I wish to point out, in connexion with this subject, that the special points alluded to by Mr. Hutchinson as constituting "the most valuable of recent additions to the science of surgery", have long been known to English surgeons, and largely practised by them.

In the thirty-first volume of the *Medico-Chirurgical Transactions*, published in 1848, there is a paper by Mr. Quain, in which precisely the same views are put forth, founded on dissections of recent dislocations and on experiments on the dead body made with a view to illustrate the subject, and on the subsequent successful application in practice of the principles deduced therefrom. In the private note-book kept by me when Mr. Quain's house-surgeon in 1865, I find a case recorded which so well illustrates the points under discussion, that I have thought it may interest the readers of Mr. Hutchinson's lecture if I briefly quote some of the notes which I made of the facts of the case and of Mr. Quain's clinical remarks upon it.

"On December 15th, 1865, J. P., a railway-porter, aged 26, was kneeling on the left knee beside a loaded railway-waggon, when a bundle of young trees fell from the waggon on to his back. He fell with his left leg under him; and, being unable to rise or to stand, he was at once sent to University College Hospital. He was admitted under Mr. Quain's care, with all the signs of dislocation of the left hip towards the sciatic notch, the axis of the luxated femur pointing across the junction of the middle and lower thirds of the sound thigh, the ball of the left great toe resting on the dorsum of the right foot, the

distance between the anterior superior iliac spine and the great trochanter being increased, and the left limb being three-fourths of an inch shorter than the right. Moreover, on moving the limb, the head of the bone was easily felt in its new position, nearer to the sacrum than it should be. Chloroform was administered, and a wet bandage was applied for some way above the left knee, a strong jack-towel being fastened over it with a clove-hitch knot. A padded strong leathern perineal band was fixed on, and tied firmly to the rails about the arena. Then a pulley and cord was fixed to the rails nearly on the opposite side, and hooked into the jack-towel on the left thigh. The table was conveniently moved, and the left thigh given into the charge of an assistant, and flexed to a right angle with the abdomen, the knee being also well bent. Then, the man lying on his right side, and Mr. Marshall taking charge of the hip, the pulley-cord was slowly tightened—thus drawing the thigh in a direction at right angles to the trunk. After a few minutes of steady traction, the bone quietly slipped into its place. A long splint was then applied."

In the course of his clinical remarks upon this case, Mr. Quain gave an account of the cases of dislocated hip which had been dissected by himself and by others. "He stated that, in a case of recent dislocation dissected by himself, he found the head of the bone close to the sacrum, just behind the acetabulum, between it and the ischial spine, but not reaching so far as the great sciatic notch; and here he thought it was generally placed. He also found that extension in the usual manner caused a painful stretching of the sciatic nerve; and he was hence led to suggest that the knee should be well bent during reduction. It was best to make the necessary extension at a right angle with the trunk, instead of across the middle of the opposite thigh, as recommended by Sir Astley Cooper. Mr. Quain had tried both methods, and had found his own to succeed better. He tried, in his first case, Cooper's plan for some time without success; and then, on well flexing the thigh on the abdomen, the bone slipped into its place easily and at once. In this reduction, the head of the femur is not pulled forwards straight into the acetabulum, but it is sent downwards over the ischial tuberosity, then forwards towards the obturator foramen, and so up into the acetabulum at the spot where the ligaments have been ruptured."

It will thus be seen that, in the teaching and practice at University College Hospital six years ago, the views now ascribed to Dr. Bigelow were fully set before the students, as they had been for many years previously at the same place. In Sir Astley Cooper's own school, Mr. Cock (to whom I applied, at the suggestion of Mr. Quain) has been good enough to inform me that for many years he has been accustomed to reduce these luxations by flexion and manipulation, instead of by the method of extension with pulleys as recommended by Cooper.

A brief reference to Mr. Quain's original paper will assist in placing the claim of novelty and originality asserted for Dr. Bigelow by Mr. Hutchinson in its true light.

1. The paper contains an account of the dissection of a case of dislocation of the head of the femur backwards. The case is identified by measurement and appearance with the so-called dislocation into the great sciatic notch, but shown to be wholly different from those which such a displacement would produce. 2. The history of experiments on the dead body is given, showing the position of the limb in which the displaced bone is most easily reduced. 3. The deductions drawn from those experiments are: that, in the ordinary form of dislocation backwards, the femur does not reach the sciatic notch, but lies on the base of the ischial spine, just behind the acetabulum; that, during the extension made to restore the bone to its place, the thigh is most advantageously directed across the pelvis, so that it shall form a right angle, or nearly a right angle, with the abdomen; that at the same time the limb is to be in a state of abduction; and that the knee is to be bent, the extending force being fixed above this joint. 4. Reference is made to cases illustrating the difficulty of replacement when the usual position is adopted, and the immediate facility of reduction when the limb is placed in the position now recommended.

It further appears from the perusal of this paper, that so little traction is needed with the thigh flexed on the abdomen, that the position alone, with very little force, is sufficient to guide the bone back into its place.

I am, of course, aware that reduction of this form of dislocation by flexion has been advocated by very many writers both before and since the publication of Mr. Quain's paper in 1848. But the merit which I venture to claim for my former teacher's views is that, being founded, not on supposition of what might be the case, but on accurate observation of what actually occurs, and on experiments undertaken to throw yet further light upon the subject, they were confidently announced to the profession more than twenty years ago, and constantly taught and acted on by him, in opposition to views which had been published by Sir Astley Cooper, and which had received such universal sanction as

to supersede all other teaching, and to remain even to this day as the doctrine of the ordinary text-books.

I am sure that Mr. Hutchinson will not be displeased with my endeavour to show that English rather than American surgery is to be credited with observations and precepts which he justly regards as amongst the most valuable of recent additions to the science.

I should wish to suggest, in conclusion, that the somewhat formidable tripod apparatus devised by Dr. Bigelow for angular extension is wholly unnecessary. All that is needed, beyond the ordinary pulley-cords and perineal band, is that the patient be laid on his side, and the mattress turned to a suitable position, as described in the case reported above.

OBSTETRIC MEMORANDA.

PARTIAL PLACENTA PRÆVIA: PROFUSE HÆMORRHAGE: PLUGGING AND ERGOT.

ON the evening of January 26th, I was hastily summoned to see Mrs. L., aged 31, the mother of four children. She was between seven and eight months advanced in pregnancy, and had been for ten days losing blood, but not to any great extent. For the last nine months she had been in delicate health, consequent upon a miscarriage. On my arrival, I found her faint, almost pulseless, and the surface cold. The pains, which had been very strong, were now much weaker. I was shown the chamber-utensil, which was nearly filled with large blood-clots. On examination, I found the os uteri about two inches in diameter, and could distinctly feel the placenta overlapping about three-fourths of its circumference. My patient being alarmingly prostrated, I deemed it unsafe to turn, fearing that the shock might prove fatal. I therefore plugged the vagina, and gave ergot, in half-drachm doses of the liquid extract every half-hour. Here I had another difficulty. My patient for some hours had had most urgent vomiting; nothing could be kept down. Fortunately, however, only the first dose of ergot was rejected; after the fourth dose had been given, stronger labour-pains set in; and in a short time the placenta and a dead fetus were expelled entire, without further loss of blood. The patient is now making a steady recovery.

WM. STAMFORD, L.R.C.P.Lond., M.R.C.S.Eng., Tunbridge.

EARLY RUPTURE OF THE MEMBRANES.

MR. BASSETT has added to our knowledge upon this matter, by stating that the fluid may escape from a sac situated between the chorion and amnion, and therefore consist of neither liquor chorii nor liquor amnii. Perhaps it may be useful to briefly recapitulate the causes which have been assigned for the production of the phenomenon in question during the recent debate. They are three in number.

1. *Rupture of the Amnial Membrane itself, and consequent Escape of true Liquor Amnii.*—When this is the source of the discharge, the rupture must be situated high up, nearer the fundus than the cervix of the uterus, and therefore beyond detection by exploration. That this is an essential element in the case is clear, both from the fact that the discharge is periodical, and because gestation continues undisturbed to the completion of the full term. Dr. Savage, in rather complicated language, states the obvious truth, that the lowest part of the membranes have to sustain the greatest pressure, and hence infers that it is there the sac gives way; but if it were really the most dependent portion which was ruptured, labour would undoubtedly quickly ensue, as the amnial bag would of course be emptied in the erect position, and the uterine walls must then tightly embrace and shortly expel the contained fetus.

2. *Rupture of the Chorion Sac, and consequent Escape of the Liquor Chorii.*—Dr. Whitehead pointed this out as a source of the discharge in a letter to myself, from which I quoted in a former communication. In his opinion, this is the most frequent cause of the accident.

3. *The existence, and subsequent Rupture, of a Sac situated between the Amnion and the Chorion (probably an outgrowth from the latter?).*—This condition was first recorded, according to Mr. Bassett, by Mr. Elkington of Edgbaston, and is quoted by the former gentleman in his letter on the subject to the BRITISH MEDICAL JOURNAL.

Perhaps some little practical value is attached to this subject, inasmuch as it inspires caution in prognosing approaching labour when we are informed that there has been some escape of fluid from the uterus during the seventh, eighth, or ninth months of pregnancy. If it do serve this purpose, the discussion is not to be regretted.

S. MESSENGER BRADLEY, Manchester.

CASE OF QUADRUPLETS.

ON January 5th, I was summoned by a midwife of the Lying-in Hospital to a woman who had just been delivered of four children. She was 25 years of age, a widow, having lost her husband a few months since. This was her third labour, the other two having been normal in all respects. When first called, the midwife found the os dilated and the head presenting. She ruptured the membranes, and a small but fully matured living female child was speedily expelled. Finding, from the state of the abdomen, indications of a second child, she examined *per vaginam*, and found another bag of membranes and a breech presenting. The membranes having been ruptured, a small male child was quickly delivered, in a state of incipient decomposition; in half an hour a third fetus in a similar condition was expelled by the breech, and was followed rapidly by a fourth, in a putrid state. A large single placenta came away after a short interval, followed by considerable hæmorrhage; and on my arrival I found the patient much collapsed, with sighing and jactitation, and the pulse almost imperceptible. As hæmorrhage was still going on, I introduced my hand and removed a small portion of adherent placenta and an immense mass of clots. The uterus then contracted well, and by the free use of stimulants the patient soon rallied and made a fair recovery. The first born girl is living, and likely to thrive.

FRED. W. LOWNDES, Ex-Assistant-Surgeon to the Liverpool Ladies' Charity and Lying-in Hospital.

THERAPEUTIC MEMORANDA.

PERCHLORIDE OF IRON AS A STYPTIC.

A GENTLEMAN, aged 68, has recently been under my care suffering from melæna and hæmatemesis from ulceration of the stomach, which gallic acid and ordinary astringents failed to check. He was rapidly sinking from exhaustion; and, as a last resource, I gave fifteen minims of the strong liquor ferri perchloridi in a tablespoonful of water every half-hour. The third dose stopped the hæmorrhage, and he slowly recovered. He was sustained by enemata of egg, beef-tea, and brandy. Six weeks afterwards, a further attack of melæna was at once stopped by the same plan. Oxide of silver pills and a careful diet relieved the distressing stomach symptoms. He has now gone to the south of France. I find that a spray of the strong liquor ferri perchloridi (one part to four of water) invariably stops the hæmorrhage in hæmoptysis. This was especially successful in a case of cancer of the lung where all other remedies were useless. The styptic property of this preparation in uterine hæmorrhages and external cancers is well known.

F.R.C.S. and L.A.S.

CLINICAL MEMORANDA.

SPONTANEOUS DISLOCATION OF HIP DURING SCARLATINAL DROPSY.

H. T., aged 6 years, had an acute attack of scarlatina, followed by most severe renal affection. The dropsy was very general; the legs, scrotum, abdomen, and face, being much swollen. The urine was highly albuminous, becoming solidified by heat and nitric acid. During this stage, he complained of great pain night and day in the region of the left hip. Shortening of the limb became evident, and at first it was thought that hip-disease had occurred. It, however, proved to be spontaneous dislocation of the femur, the head of the bone resting on the dorsum ilii. The dislocation could be easily reduced, but very shortly returned. Convalescence went on very gradually, and a stout leather case, to lace up the thigh, with a band round the abdomen, was made by Best of Birmingham, and carefully applied. The little patient improved, the bone remains in its proper position, and he very soon was able to walk well. At the time when I left Birmingham, he appeared to have regained perfect health.

Jersey, February 1872. JOSEPH SMITH, M.R.C.S.Eng.

REVACCINATION BY VESICATION.

THE plan of revaccination which I would bring under notice appears to have the advantages of simplicity in operating, and limitation of the vesication. This latter I have found difficult when using plaster or applying the fluid with a brush. It is my custom to introduce the liquor epispasticus under the cuticle by means of an exploring needle, dipped into the fluid and passed down. This is done in the evening; and on the following morning as many vesicles as punctures, about the size of