and two of tincture of iodine into the womb in cases of chronic internal metritis. It has occasionally caused severe uterine tormina, which subsided in a day or two. My friend Dr. Emmet of New York, after operating on the interior of the womb, injects it or soaks it with tincture of iodine; and, since he has adopted this plan, he has not had a case of septicæmia. Dr. Fordyce Barker, to check severe hæmorrhage following abortion, lately injected an ounce of the undiluted tincture of iodine (and the American tincture has double the strength of ours) with perfect success and no ill-effects; so it is not likely that any would follow the injection of a very strong solution of iodine into the womb soon after labour. I have then injected four drachms of the tincture in half a pint of tepid water, Dr. Wynn Williams has been in the habit of using three drachms to the same quantity of water; but Dr. Dupierri's practice has been to inject into the womb, immediately after the removal of the placenta, four drachms of tincture of iodine (double the strength ordered in the *British Pharmacopœia*), ten grains of iodide of potassium, and one ounce of distilled water.

It remains to be seen which is the best plan, either to inject the tincture of iodine little diluted, so as to act strongly on the womb, or to largely dilute the tincture, so that it may wash away fragments of putrid tissue.

Had I been aware that Dr. Braxton Hicks had already treated this subject, I should have contented myself by referring to his trustworthy teaching,* which shows that he has been long aware that puerperal fever is likely to arise from the retention of foetid uterine fluids. These remarks of mine may not be, however, altogether useless; and most acceptable were those made by Dr. Wynn Williams, in the JOURNAL for August 7th, on the washing out of the puerperal womb.

CASE OF INVERSION OF THE UTERUS, OF THREE MONTHS' STANDING.†

By J. H. EWART, L.R.C.P.,
Surgeon to St. Mary's Hospital, Manchester.

ELIZABETH V., aged 22, married, was attended by a midwife in her first confinement on March 27th, 1874. She was at full term, and the labour went on well to the end of the second stage; there was then, according to her account, some difficulty with the afterbirth, which the midwife endeavoured to overcome by pulling at the cord. Eventually a surgeon was called in, and he and his assistant attended the patient up to the time of her admission to St. Mary's Hospital, Manchester on the 6th July, 1874, *i.e.*, for upwards of three months. She stated that she lost an alarming quantity of blood at the time of her confinement, and that she had had more or less hæmorrhage ever since. Sometimes she had lost a very considerable amount of blood; the last occasion on which this occurred was about a fortnight before her admission. Various injections had been given to her for the purpose of controlling the loss; no vaginal examination, however, was made after the confinement.

On admission to the hospital, the patient presented a most blanched appearance. She complained of no pain; the appetite was pretty good; the pulse 100, feeble. A small pear-shaped tumour, bleeding readily when touched, was found in the vagina.

On the following day (8th July), the patient was placed under the influence of chloroform, for the purpose of further examination. The tumour was smaller than I should have expected an inverted uterus to be; it bled very readily; on passing a finger into the rectum and pressing the fingers of the other hand at the same time deeply above the pubes, no intervening substance could be felt. The absence of the uterus from its normal position was further demonstrated by passing a sound into the bladder, and again by the impossibility of introducing the uterine sound by the side of the tumour, the neck of which was tightly constricted. Being now satisfied that the case was one of inversion of the uterus, I tried digital pressure, and persisted in it for some length of time. (I regret I did not notice the time accurately.) Considerable force was used; as much, indeed, as I deemed justifiable. I therefore desisted, with the intention of employing the elastic stem-pessary described by Dr. Barnes in the first volume of the *Obstetrical Transactions*, and in the event of that failing, of incising the neck, as recommended in the same communication. Some of those present, however, thought that further efforts should be made with the hand, and I reluctantly gave my consent. Pressure was accordingly resumed; and

after some time the operator announced that he had succeeded in reducing the inversion. It was obvious to the onlookers that the success was due to the exertion of extreme force; and, on examination, two fingers could be passed into a rent in the anterior vaginal wall just where it formed the cervix uteri. There was also some laceration of the perinæum, but at what stage of the proceedings this happened is uncertain. After the operation, the patient's pulse was pretty good, and her general condition was not alarming.

July 9th. She complained of soreness, and a little abdominal pain. Temperature normal; pulse 110.

July 10th. She felt chilly; had no pain. Temperature 98; pulse 104.

July 11th. She felt better. Temperature normal; pulse 100.

July 12th. There was a good deal of whitish discharge. Temperature normal; pulse 100.

August 8th. Since the last note, the patient had not had a single bad symptom; the vaginal rent had healed, a very slight thickening marking its site; the uterine sound passed two inches in the normal direction. The woman then became an out-patient, and preparations of iron were prescribed for her on account of her extreme anæmia. She subsequently went to Southport for six weeks; and on October 21st, she again presented herself at the out-patient room, looking much improved in colour and general appearance. She had menstruated twice since leaving the hospital. The uterus was normal in position; the sound passed rather more than two inches; the os was somewhat flabby, and presented the appearance of a little superficial ulceration, which soon yielded to the application of nitrate of silver; the situation of the vaginal rent could not be discovered.

I saw my patient after some time, when there were signs of commencing phthisis; after this, I lost sight of her, and am now unable to obtain any trace of her.

Inversion of the uterus is not a very common occurrence, only fifteen cases having been reported in the English journals since the year 1871. It does not seem necessary to enter into the details of these cases; suffice it to say, that nearly all of them are said to have been due to traction on the cord.

In the BRITISH MEDICAL JOURNAL for January 28th, 1871, Dr. Tylecote reports a case of spontaneous inversion twenty-four hours after labour. Dr. Braxton Hicks relates a similar case in the JOURNAL for August 31st, 1872; and also another where the inversion followed delivery by forceps; and in the first volume of the *Obstetrical Journal* (page 319) Mr. J. Prankerd narrates a case where inversion occurred during the effort of straining at stool seven days after labour. With regard to the possibility of spontaneous inversion, and for an explanation of this phenomenon, I beg to refer my hearers to Dr. Hicks' paper in the BRITISH MEDICAL JOURNAL for 1872.

The treatment of these fifteen cases varied; most of them were reduced by pressure of one kind or another; two died before medical aid could be procured; in two, the uterus was removed as a last resource in order to save life; and in two others Dr. Barnes succeeded in reducing the inversion by the method to which I have already alluded, and the value of which cannot be overestimated.

Dr. Barnes has clearly pointed out how an inverted uterus *ought* to be treated; it has fallen to my lot to bring before the profession a case which teaches how it *ought not* to be treated; for the satisfactory termination of the case does not prove that the treatment was one to be recommended.

How many women would have recovered after such severe injuries? and what would have been the result if the rent had occurred posteriorly instead of anteriorly? Now, how are such accidents to be avoided? We are directed to use as much force as is justifiable: what is the measure of justifiable force? What amount of strain will the vaginal walls bear? Speaking from my experience in the case here recorded, I would urge that the utmost care, care even approaching timidity, be used in the application of manual pressure to chronic cases, and that, in the event of failure by this method, recourse be had to the air-pessary, or even incision of the neck, inasmuch as such an operation must be far less serious than rupture of the vaginal wall.

INVERSION OF THE UTERUS.

By WILLIAM KELLY, M.D., Physician to the Taunton and Somerset Hospital.

In the abstract of Mr. Ewart's case of successful reduction of an inverted uterus of three months' standing, as given at page 231 of the JOURNAL of August 21st, the author is stated to have said "that, in any future case, he would firmly discountenance the treatment adopted in the case here recorded".

* On *Post Partum* Douching of the Womb (BRITISH MEDICAL JOURNAL, November 13th, 1869).

† Read before the Obstetric Medicine Section at the Annual Meeting of the British Medical Association in Edinburgh, August 1875.

I have recently had under my care a case very parallel to that related by Dr. Ewart, with one important exception; viz., that the inversion was *not* reduced. I append a brief account of the case.

The patient, aged 24, had been delivered of her first child by a midwife in December last. She was admitted into the Taunton and Somerset Hospital on March 22nd, suffering from extreme exhaustion and uterine hæmorrhage, the latter having continued more or less from the time of her confinement. She had received medical treatment before coming to the hospital, but no vaginal examination had been made. The state of inversion being ascertained, she was put under chloroform, and for more than an hour efforts were made with considerable force to effect reduction; but they were ineffectual. Some amount of constitutional disturbance followed, and a second attempt was not made for a month (after the next catamenial period had passed over); this proved equally unavailing with the first. The patient having soon recovered from the effects of this second operation, and the uterine hæmorrhage with its attendant exhaustion having also disappeared, she was anxious to leave the hospital, as the displaced uterus caused her little inconvenience. She was, however, prevailed upon to submit to a third attempt at reduction; but, this being followed by no better results than those which had gone before, her husband removed her from the hospital, and the case has now been lost sight of.

In employing taxis, I followed, or rather I endeavoured to follow, the directions given by Marion Sims in his *Clinical Notes on Uterine Surgery*; i. e., after pushing the body of the uterus up within the cervix, he says the reduction should be completed "by compressing the fundus laterally, and deeply imbedding the thumb in the cornu uteri, by which means we slide one-half of the organ at a time through the os internum, instead of the whole fundus, which presents a greater diameter". The first stage was easily got over; but all the sustained pressure I could employ failed to open the internal ring (for that was the form the part assumed) for the passage of the fundus. I varied the position of the patient, and I also used alternately both my right and my left hand.

CLINICAL MEMORANDA.

THE TREATMENT OF CHLOROFORM-POISONING.

As I have always taken a deep interest in all that pertains to the induction of anæsthesia by means of chloroform, I have perused the remarks of Mr. Messenger Bradley of Manchester with interest. The state in which he has described his patient to have been is an unusual one; it is a state of collapse preceding chloroform-sickness, complicated with a fit; and, although the phenomena are sufficiently alarming, they invariably pass off with the advent of the sickness, if not before. I would call attention to the rigidity of the jaws: "his teeth were closed". The patient is never fully under the influence of chloroform—complete paralysis of the sensorium—so long as a single muscle of the body is capable of contraction, either spasmodically or otherwise; and I have long observed that the last muscle to lose the power of contracting is the orbicularis palpebrarum. As soon as this muscle ceases to resist the finger in raising the right upper eyelid, *cæteris paribus*, one may consider the patient fully anæsthetised, and ready for the severest operation in surgery.

Although I have frequently seen similar phenomena to those of Mr. Bradley, I am not prepared to say they have been the same. I have never observed closure of the jaws. Clenching of the teeth or closure of the jaws is not a symptom of deep anæsthesia under chloroform, and is only possible in the first stage, or when the patient is returning from complete anæsthesia; therefore, in itself it is not a dangerous, but rather a favourable symptom. In chloroform-poisoning, as a rule, whenever there is muscular contraction or rigidity, I should consider my patient's life safe. I was once asked in a Medical Society, "Are you not afraid when the patient kicks violently?" to which I replied, "No; I am more afraid when he ceases kicking." In any dangerous case which I have seen, the lower jaw has always fallen or become relaxed. This I believe most certainly to be the rule; therefore, taking into consideration the frothing at the angles of the mouth, the lividity of the lips, and the temporary arrest of the respiratory and circulatory organs, I conclude that the lad had taken an epileptic seizure, or something very like one, whilst under the influence of the anæsthetic, and most likely when he was beginning to come to himself, as it occurred towards the "completion of the operation".

The treatment I do not object to; only I should have been inclined to trust most to encouraging vomiting, if there were any threatening of the same, by turning the patient on his side, with his face looking somewhat downwards, which at once protrudes the tongue and saves

the laceration from the use of a vulsellum; tickling the fauces with the fingers, the jaws being forced open if necessary; and giving him plenty of air in the horizontal, and not in an inverted, position. Time and quiet will do the rest, as in an ordinary attack of epilepsy. It is worthy of note, that the lad had had chloroform on a previous occasion "without any bad symptom". As to artificial respiration in such a case, is it of any use? I doubt it, simply because of the fit, if it fit it were. No amount of artificial respiration will ever overcome an epileptic seizure; it simply comes right of itself. It is just possible that in this case, as in many others, the *post hoc* may be mistaken for the *propter hoc*. The indication to my mind would be to induce or precipitate the sickness, which has relieved, if not saved the life of, many an epileptic. The sickness failing, artificial respiration was the sheet-anchor.

I only offer these remarks as suggestions from the study of Mr. Bradley's interesting case. I think it would be well that every such case were so probed and digested: good is sure to come out of it. It is said that prevention is better than cure; and I beg to suggest, for the future guidance of those who have the responsibility of administering chloroform, never to give it on any account except on an empty stomach. No food should be taken for at least four hours beforehand. Although this rule is well known and generally appreciated, there is no rule of practice so universally neglected or so constantly broken. Surgeons will give brandy and water beforehand, and chloral, and laudanum, and mixed anæsthetics; they will do anything and everything but the right thing in order to obviate sickness and other consequences of the administration of chloroform. For the future, if they will only make sure that no kind of food, solid or liquid (water or a mild cup of black tea excepted), be taken by the patient for at least four hours before taking any anæsthetic, I will guarantee less sickness and a decided fall in the number of accidents from anæsthetics in general, and chloroform in particular.

I trust that Mr. Bradley will kindly take these remarks in the purely suggestive spirit in which they are meant, and that humanity may profit by them.

THOMAS SKINNER, M.D., Liverpool.

RHEUMATISM WITH HIGH TEMPERATURE AND FATAL CEREBRAL COMPLICATION.

W. H. S., a hosier, aged 35, of arthritic diathesis, regular habits, and healthy appearance, usually excitable, had lately been subject to additional excitement, consequent on his having opened a new business and being about to be married. He had lost two sisters and one maternal aunt from rheumatic fever and its complications. On August 5th, he felt pains in his knees; and on the 7th he put himself under my care, labouring under acute rheumatism. He was put in bed between the blankets; the affected joints were wrapped in cotton-wool; and bicarbonate of potash was administered every four hours. Slight pericarditis showed itself on the fourth day of the attack, but it yielded to small blisters. A draught containing half a drachm of solution of muriate of morphia procured comfortable rest at night. On the tenth day, although his pains were better, his tongue cleaning, and his appetite slightly improving, he was restless and languid. On the eleventh day, when seen at 6 P.M., he complained of feeling very weak, and had been a little delirious once or twice during the day. He had also had frequent micturition, passing more urine than previously. The pain and swelling of the joints were very much better; the perspiration was not quite so profuse. A careful examination of the heart showed no fresh complication. His temperature, which throughout the illness had varied from 101 to 103 deg., was not taken at this visit. His pulse was about 100, and his tongue cleaning. Later in the evening, feeling very restless, he asked his mother, who was nursing him, to send for his draught, which he took at 10 P.M.; and shortly afterwards both he and his mother dropped asleep. Three hours afterwards, at 1 A.M. on the twelfth day, Mrs. S. was roused by the noisy breathing of her son; and, finding she could not awaken him, she sent for me. I found my patient quite unconscious; the pupils were moderately contracted, as in natural sleep; respiration was catching and irregular; pulse weak, about 120; skin intensely hot; temperature in the axilla, 110½ deg.; in the palm of the hand, 109 deg. By applying towels wrung out of cold water, and fanning, the temperature of the surface was lowered; but the intense heat in the axilla and the palms of the hands continued; and, as the respirations became worse and the pulse flagged, it rose to 111½ deg. in the axilla. The patient died at 3 A.M., only two hours from the first observation of the serious symptoms. The decomposition of the body after death was extraordinarily rapid. The symptoms in this case correspond in every point with those observed in the other cases, now tolerably numerous, in which, during the last five or six years, the coincidence of fatal cerebral rheumatism