been proved susceptible but were not injected had to be discharged before it was possible to finish the investigation.

After the first dose only 2 patients of the 38 showed any marked reaction, either local or general. One was a boy, aged 8, who had an inflamed and painful arm for three days, but showed no general symptoms. This boy had no reaction after the two subsequent injections. The second was a girl, aged 7, who also had no general symptoms, but a well marked local reaction; she had both local and general reactions after the second dose.

After the second dose 5 patients had severe local reactions. The girl just mentioned above was kept awake all night with the pain in her arm, and had a temperature of about 100°; it became normal in twelve hours. Another girl also cried for some hours during the night with a painful arm, and six hours after the injection fainted in bed, although she had been kept recumbent all the time. Her temperature then rose to 100.8° (pulse 130, respirations 34), and ten hours after the injection was 102.2° (pulse 130, respirations 36). After this the temperature, pulse, and respirations gradually became normal, and by the next day the child seemed perfectly well. Two of the remaining five patients with local reactions had temperatures just under 100° for a few hours, but no other symptoms.

After the third dose none of the patients had any local or general reaction worth mentioning.

Second Schick Reactions.

The 38 patients who had been immunized with toxin-antitoxin were then tried with the Schick test again. Two of these still gave a definitely positive result, although the reaction was less marked than previously; 8 gave negative and pseudo reactions, 4 of these being in children under 5 years of age. The remaining 28 did not react at all, and were therefore presumably immune.

Summary.

Of 103 persons 32 were apparently susceptible to diphtheria. An endeavour was made to immunize 38 patients, including 10 patients under 5 years of age: 36 of these patients failed to respond to the Schick test, and probably therefore had been rendered immune.

ACUTE PUERPERAL COMPLETE INVERSION OF THE UTERUS: REPLACEMENT: RECOVERY.

BY

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ACUTE complete inversion of the uterus is an accident happily seen only rarely in modern obstetrical practice. According to Beckmann¹ not a single case occurred in the course of 250,000 labours in the St. Petersburg lying-in hospital, only one case was reported among 190,833 deliveries in Dublin, while Thorn² collected only 641 cases from the literature of the entire world. The average incidence, however, of this condition is no doubt underestimated by a study of the statistics collected from large obstetrical clinics in which all possible precautions are taken, and it is probably more common in private practice, in patients cared for in their own homes, and by accoucheurs less skilled in the practice of obstetrics. The following case came under my observation when I was assistant resident medical officer to the Brownlow Hill Infirmary, Liverpool.

A multipara, aged 30 years, was delivered by forceps in her own home at 10.15 a.m. on March 21st. The labour was not remarkable; the placenta was presumably expressed by Credé's method. The midwife in attendance reported that there had been no excessive haemorrhage, although the patient subsequently stated that she had bled profusely and had passed large clots all that afternoon. In the evening there was considerable abdominal pain, which kept the patient awake all night. In her own words, "there was also a sense of something slipping down inside, which felt like the head of another baby coming through." At about 6 o'clock the following evening the patient suddenly collapsed; a doctor was called, and ordered her immediate removal to hospital.

On admission the patient was in an extremely collapsed condition, and obviously suffering from profound shock. She was

quite unconscious, blanched, pulseless at both wrists, not restless, and her respirations very shallow. Completely outside the vulva was a mass about the size of a small coco-nut, in appearance exactly like a placenta with its uterine surface presenting. The usual means of combating shock were immediately taken: the foot of the bed was raised, the lower extremities were bandaged, and hot-water bottles utilized. In addition, strychnine was administered hypodermically, followed by ether intramuscularly. The pulse then became just palpable, and one pint of saline was transfused intravenously through the basilic vein. The pulse gradually improved, and consciousness was restored, but the patient still looked exsanguinated, in spite of the fact that there was no visible bleeding. At 10 p.m. more strychnine was administered hypodermically, and the uterus was then examined. Abdominally the hypogastrium was soft, and instead of the protuberance of the usually hard uterus a depression was noted. The "placental" mass outside the vulva was found to be distinctly pyriform in shape, with its broad end outside the vulva, and its apex firmly embraced by the cervix, whose collar-like circumference was easily palpable. The fundus could not be felt either anteriorly or posteriorly, and the walls of the vagina were normal. Reposition was easily effected manually without an anaesthetic by gently compressing the narrow end and pushing it through the cervical os. Digital dilatation of the os was found necessary before the fundus could be replaced. The fundus was then palpable by the hand on the abdomen; a hot douche was ordered and the vagina packed. At this stage the pulse was 160, temperature 97°, and respirations 28. The patient passed a fairly comfortable night, and appeared much better in the morning, but as the lochia were offensive 30 c.cm. of antistreptococcal serum was given. The temperature remained 101°-99.6° for two days, and on the third day the patient was anaesthetized and a tube was inserted into the uterus by Mr. Leyland Robinson. Eusol douches were given through this tube night and morning. Recovery was now uneventful.

The interesting features of this case are, to my mind: (1) the extreme gravity of shock; (2) the immediate good results of transfusion; (3) the ease with which the uterus could be replaced.

REFERENCES.

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Memoranda: MEDICAL, SURGICAL, OBSTETRICAL.

PERINEAL PROSTATECTOMY.

A METHOD I have used for some time now in removing a prostate by the perineal route, and which I have found very satisfactory, is the following:

The bladder is washed out with warm boracic lotion several times, and an ounce or two left in. The patient is then placed in the lithotomy position and a curved prostatic staff is inserted into the bladder. The scrotum being kept out of the way and the staff held in place, the prostate is reached by the usual perineal dissection—namely, exposure and retraction forward of the transversus perinei muscles, deeper dissection posteriorly bringing into view the lower part of the prostate and the recto-urethralis muscle, which is divided transversely, the necessary care being taken to avoid injury to the anal canal and lower part of the rectum, which is gently separated from the posterior aspect of the prostate. A good light is necessary, and a head-lamp is sometimes useful.

The point of one blade of a pair of scissors is now thrust into the groove in the staff through the membranous urethra at its junction with the prostate, and a cut made directly through the substance of the prostate and the capsular sheath on its postero-inferior aspect for about half an inch, the rectum being kept well out of the way.

A Teale's gouget is now gently but firmly pushed along the staff into the bladder and the staff withdrawn. There is here an escape of the remaining fluid in the bladder. The gouget, which tends to split the prostate, is now withdrawn, and the forefinger inserted in its place. The gland can now in most cases be easily shelled out in two or more pieces through the opening in the posterior and lower part of its capsular sheath which had been previously divided. The more "obstinate" portions may be twisted out with a stout pair of forceps.

The end of a six-inch by half-inch rubber tube with a lateral "eye" is inserted into the bladder, and the other end brought out through the wound, which is now closed interruptedly and the tube anchored by a stitch or two of silk worm gut. This end is clamped and the patient put back to bed, where the clamp is removed and a long rubber drainage tube is connected to it and led over the side of the bed into a basin or bucket.

The bladder is washed out two or three times a day, and the tube withdrawn on the third day and the patient allowed out of bed, the wound and perineum being well supported with