entrance of the vagina, often at the urethral orifice, and extending along the urethral canal; with oedema and hypertrophy of the labia and nymphæ, these parts being often marked with cicatrices, and perforated with old ulcerations, often accompanied by condylomatous excrescences and ulceration about the anus and rectum, and not unfrequently recto-vaginal communications. With the aid of rest, regular diet and habits, and suitable applications, these ulcerations gradually heal; but, when the patient returns to her old occupation, the cicatrices give way, and relapses constantly take place; so that many of these women have been admitted a third, fourth, or fifth time into the hospital. When patients from Woolwich were first sent to the Lock in 1864, I was greatly struck by the number of cases of this kind which presented themselves, as compared with what I had been in the habit of seeing; and it would appear that they are more frequent in women constantly cohabiting with soldiers, than in others—I presume, on account of the more dissipated and vicious habits of this unfortunate class, and the difficulty which they formerly had in procuring proper medical treatment. I believe that these lamentable cases are almost entirely the result of neglect; and that, under a system of inspection properly carried out, they would rarely occur, as they would be arrested by treatment at an early stage. They are certainly becoming much less common in the government wards of the Lock Hospital, and it may be hoped that by degrees the supply of them from the inspected districts will be exhausted. They are met with chiefly in the older women, or in women who, if not older in age, are old in prostitution.

With respect to constitutional syphilis, it will be seen that the proportion was greatest in the ordinary patients. Taking secondary and tertiary disease together, it accounts for 54 per cent. of the syphilitic admissions in them, against 32 per cent. in the others. The secondary cases were also much more severe in the ordinary wards, occupying, on an average, fifty-six days, as compared with thirty-seven days, for their treatment. In fact, the secondary disease in the government patients often consisted only of slight mucous tubercles on the labia, which rapidly disappeared under treatment. The tertiary cases call for no particular remark. They were less frequent in the government patients, in the proportion of 5.8 to 14 per cent.; but in the duration of treatment there was no material difference.

It may be affirmed, then, that a system of compulsory inspection of women known to be prostitutes, associated as it must necessarily be with adequate provision for their seclusion and treatment when found to be diseased, is of the greatest advantage to the unfortunate women themselves; that the early treatment which it necessitates has a most beneficial influence on the character and duration of their disease, that it saves many from local mutilation, and many from permanent loss of health. On the other hand, women of this class, when left to shift for themselves, do not for the most part apply for relief till their disease has assumed serious proportions, or until it interferes with their means of obtaining a livelihood. In the slighter cases of syphilis, both primary and secondary, and in cases of uterine and vaginal discharges, they can follow their profession for an indefinite period without any considerable pain or inconvenience. In fact, many of the government patients professed to be quite ignorant that anything was the matter with them until it was discovered by examination. Is it surprising, then, that venereal disease is rife amongst our population, when it is officially recorded that in London alone there are 6000 women known to the police as prostitutes of the lowest description, and classed by them with thieves and other bad characters (see *Blue Book*, entitled "Judicial Statistics," 1865); when this, on the lowest estimate, does not constitute half the number of those gaining their living on the streets; and when 150 beds represent the utmost hospital accommodation afforded in the whole of London for females afflicted with venereal disease (see Report of the Committee of the Harveian Society, 1867)?

It is satisfactory to know that, as a rule, the women do not regard their compulsory examination and detention with feelings of objection or dislike; I have questioned many of them on this point, and I have found that for the most part they are well contented with the system. They have sense enough to see that it is greatly to their interest to have a refuge at all times open to them when they become diseased; and, though they are often weary of their detention in hospital for what they believe to be trifling causes, they are easily satisfied when they are made to understand that no one is interested in detaining them a day longer than is really necessary.

In the above remarks, I have endeavoured to point out from facts which have come under my own observation, how far the present Contagious Diseases Act is beneficial to the females subjected to its operation, by contrasting their condition with that of patients presenting themselves at the same institution under the voluntary system. I am unable, from my own personal knowledge, to say how far it has been effectual in diminishing disease among the soldiers and sailors, for whose advance-

tage it was mainly intended; but it has been pretty clearly shown by the investigations of Mr. Berkeley Hill, recently published in this JOURNAL, that, if it has not everywhere done as much as was expected of it, the fault has not been in the Act itself, but in the incomplete manner in which it has been carried out, and the too limited area of its operation.

It is, however, an interesting question, whether the Contagious Diseases Act has had any marked effect on the civil population in the districts in which it has been carried out. To ascertain this, I applied to my friend, Dr. Stuart of Woolwich, who is the government medical inspector for that and for the Chatham districts. Dr. Stuart was kind enough to make some inquiries on this point, and I am indebted to him for the following significant facts. He informs me that in Woolwich the very great majority of venereal cases came under the care of druggists, and especially of one or two who make it their especial business by advertisements, etc. When questioned, they all agreed as to the greatly diminished amount and mitigated severity of the cases coming under their notice. One, who carried on a very thriving trade by this practice, told Dr. Stuart that he now meets with very little of it as compared with former years, and that he now cured most of his cases of gonorrhœa by mild injections in a very short time; while another stated that, whereas he always used to keep daily a large bottle of *mistura copaiba* ready prepared, he had lately discontinued it altogether, as he had so little demand for it.

One word, in conclusion, respecting the reformatory results obtained at the Lock Hospital. Associated with this hospital is the Lock Asylum, which all the patients when they leave the hospital have the opportunity of entering if they wish. It contains, at present, 76 inmates, who remain there for periods of from 9 to 18 months. It is to a great extent self-supporting by laundry and needle-work. Out of the 877 patients admitted into the hospital in 1867, 76 entered the asylum; viz., 42 from the ordinary and 34 from the government wards. Of these 16 have left at their own request, 8 have been restored to their friends or have been placed in respectable situations, and 52 still remain in the asylum. During 1867, this asylum has placed 18 of its inmates in good situations, and 13 were satisfactorily restored to their friends. A large proportion of these received sums of money on leaving as a reward for good conduct and industry.

In a succeeding paper, I propose to give a brief account of the treatment adopted at the Lock Hospital in the various forms of venereal disease.

DISLOCATION OF THE SHOULDER-JOINT, WITH INVERSION OF THE HUMERUS.

By JOHN CLELAND, M.D.,

Professor of Anatomy and Physiology, Queen's College, Galway.

TEN days ago, I was summoned to the workhouse in the evening, to see a man who moves on crutches, having lost his left leg, and who had fallen, and was said by the master to have dislocated his shoulder. When I entered the ward, I saw the patient, a robust middle-aged man, lying quietly on his back, with his right hand grasping the left above his head; and I turned to the master laughingly, thinking that he had been imposed on. On going up to the patient, however, it was easily seen that he had no power to move the left arm out of the position in which it rested; and it was found that he was pulling the hand to get relief from a violent pain on the side of the chest, at the lower part of the axilla. I passed my hand over the spot indicated, and found that this pain, which was that from which the patient principally suffered, was caused by the head of the humerus pressing on the thoracic walls, possibly on a lateral cutaneous branch of an intercostal nerve. The humerus, instead of being merely displaced from its socket, had been also turned round, so that the lower extremity was directed upwards and the head pointed downwards. The head rested towards the posterior wall of the axilla, about the level of the fourth rib, in front of the lower part of the scapula; and, the bone being placed with its internal aspect outwards, it was easy to feel the smooth globular form of the articular surface and the neck of the bone lying immediately beneath the skin. The deltoid muscle naturally was very much relaxed, its attachments being greatly approximated; and the fingers could be shoved in easily below the coraco-acromial arch. The patient having been made to sit up, there was no difficulty in depressing the arm to a position nearly at a right angle to the body; the head of the bone rising at the same time up into the axilla. I then placed my knee in the axilla, and pulled the limb towards me, when the dislocation was instantly reduced.

A consideration of the manner in which the accident occurred in this instance will both explain how the particular lesion was produced, and

why that lesion is unlikely to happen frequently. Be it noted, that the displacement observed was primary, taking place at once in the original injury, and of such a kind as could scarcely be produced after lodgment of the head of the humerus in the upper part of the axilla, without injury to the thoracic walls or the shoulder-girdle. While the patient was walking on crutches, his right crutch slipped; he lost his footing; and, the whole weight of his body being thus thrown on the left crutch, the head of that crutch glided outwards from the axilla, and raised his elbow as he fell to the ground. This is the patient's story. The head of the crutch was the fulcrum on which the dislocation took place; and, as it glided outwards, it gave more and more leverage to the forces by which the head of the humerus was depressed—viz., the action of the latissimus dorsi and pectoralis major muscles in the commencement of the process, and the weight of the patient's body throughout. But, in the ordinary dislocation forwards and downwards, the elbow or hand comes into contact with the ground while the head of the humerus is at a higher level, with the weight of the body over it; and the latissimus dorsi and pectoralis major muscles, which are important agents in producing the dislocation, likewise draw the arm and the trunk together, and pull the head of the humerus to the deep part of the armpit. Now, in the present instance, although these muscles doubtless aided in withdrawing the head of the humerus from the glenoid fossa, they were immediately thereafter with great rapidity opposed by the descending weight of the body, which, pressing the acromion against the displaced neck of the humerus, caused the head of the bone to pass between the insertions of the muscles in question, undoing the fold in the tendon of each, and reversing, or more probably destroying, the action of both.

HYPODERMIC INJECTION OF MORPHIA IN A CASE OF FIBROID TUMOUR OF THE UTERUS.*

By SAMUEL MILLS, Esq.,
House-Surgeon to the County Hospital, Lincoln.

It is perhaps worthy of mention that great relief was afforded during life by means of the hypodermic method of injection of morphia to a poor woman (S. G., aged 40) who was lately an in-patient in this hospital, suffering from a very large and irregular fibroid tumour of the uterus. One of the main features of the case, and in fact the one which I am anxious to bring before this meeting, is the pain which she suffered during the last fortnight of her existence; pain of the most dreadful and agonising character during its continuance, and apparently caused by efforts on the part of the uterus to expel the fibroid mass from its interior. The pain was almost of daily occurrence, and, unless speedy relief was afforded her, would continue unabated for six or eight hours at once. In these attacks, she presented more the appearance of a woman in very severe labour than any other state with which I could compare her. She complained of the pain being always either in "her body" over the seat of the uterus, or in her back—most frequently in her back, which latter part, in her agony she often cried out, "must break in two."

Various opiates, amongst others from half a drachm to forty minims of chlorodyne, were given by the mouth; but they all appeared either to disagree with the stomach, or give little or no relief to her suffering, so that I was obliged to resort to the hypodermic administration of morphia, which was first commenced by injecting one-third of a grain of morphia under the skin of the abdomen, over the seat of the uterine tumour. In exactly three minutes (as timed by a watch) from the time of injecting, she was quite free from pain, and certainly presented a sudden contrast to her former state of agony. She was left in a perfectly quiescent state, and breathing tranquilly. She stated that the injection first made her feel very "lightheaded," and then acted like a charm in sending her to sleep. The first injection kept her free from pain for twenty-four hours, after which she had a recurrence in every way as severe as before, but this time the seat of pain was entirely in her back, in the lower dorsal and lumbar regions. The same quantity (one-third of a grain) was injected into the thick cellular tissue of the back, under the skin of the lower dorsal region. The relief was equally significant as in the former instance, and was afforded in four minutes from the time of injection. The pain, principally in the back, recurred almost daily for the space of a fortnight, when she became completely exhausted and worn out by it, and sank, as it were from sheer exhaustion. The quantity of morphia injected was obliged to be increased towards the latter part of her existence, as the system gradually became used to it, but never more than one grain was injected at a time, and this dose had to be repeated occasionally as often as twice in the twenty-four hours. No injurious local effects were ever produced by the injecting process.

* Read before the Lincoln Medical Society, January 1868.

REMOVAL OF FOREIGN BODY FROM THE LEFT BRONCHUS.

By JOHN WALTERS, M.B., Reigate.

T. W., aged 40, tailor, twelve years ago had tracheotomy performed for disease of the larynx and glottis, following fever. He had worn the same tube ever since, not being able to do without it. The voice had been distinct, but husky.

On March 22nd, 1867, at 8.30 A.M., while he was attempting to remove the tube for cleansing, the rim came off, and he could not get hold of the cylinder. When I saw him shortly afterwards, I could see the tube at the bottom of the wound. I went down stairs to get instruments from the carriage, and to ask Dr. Holman to assist me. When I returned, the tube had slipped down the trachea, and could only be felt by a bent probe at a distance of five inches from the external opening, to the right. Respiration was imperfect over the right side of the chest; perfect on the left. Attacks of dyspnoea were at times moderately severe, and cough very troublesome. Inversion was tried, with smart blows on the back and front, without altering the position of the tube. At 3 P.M., having obtained a pair of long curved forceps, we resolved to make further attempts to remove the tube. A stilette, bent at the end, was first introduced, and caught something which seemed like the tube; but, on making traction, smart bright hæmorrhage came rather freely from the tracheal wound, so the hook was disengaged and withdrawn. Chloroform was then administered over the mouth and trachea; it excited him much at first, but he soon went under its influence. The long forceps was then introduced; and the tube was felt, but it could not be caught. Bloody mucus came freely from the mouth and wound, and he retched freely. The respiration became so much impaired, that the chloroform had to be given up, and time given him to eject the accumulation in his air-passages, this condition being somewhat perilous. When he had sufficiently recovered, I made a fresh examination, and found the tube rather more than five inches down and to the left. After one or two failures, the tube was seized with the long forceps, and drawn to the wound, where it stuck; and, while Dr. Holman was enlarging the opening to admit its removal, it slipped back. I managed, however, to catch it again immediately—fortunately, this time in the long axis; and it was readily removed, and found to be filled with mucous membrane. After the removal, he complained merely of being wearied, and of some soreness of the chest.

He did not suffer pain during the attempts at removal—merely distress from obstruction to the breathing. His recovery was very rapid, and in a few days he was able to resume his work.

ON OPERATING FOR STRANGULATED HERNIA.

By G. OLIVER, M.B.LOND., M.R.C.S., etc.

I OPERATED on two cases of strangulated hernia during the past year. The fibrous structures which caused strangulation were dilated by a simple manoeuvre of the tip of the forefinger, after which proceeding the bowel was easily reduced. The hernia-knife was not used. The operation was so simple, and yet so successful, that I am induced to record it.

My patients were both females; and in each case a single reducible femoral hernia had existed for several months before it became strangulated. In one case, symptoms of strangulation existed twenty-four hours, in the other case four days, before the operation was performed. In the latter case, there was persistent and profusely stercoraceous vomiting.

The structures covering the seat of strangulation were incised in the usual way. A wound of about two inches in length was produced, which passed in a direction outwards and slightly upwards across Poupart's ligament. The forefinger exploring the wound felt some firm fibres encircling the neck of the tumour. The knife was dispensed with, and the tip of the forefinger was insinuated under the constricting fibres; and these, as well as firm tendinous bands at the crural ring, were forcibly stretched by firm pressure of the finger in a direction away from the bowel; this, now free from constriction, was easily returned to the abdomen by gentle pressure. The wound, closed by metallic sutures, was healed in a few days. Both patients recovered uninterruptedly.

Since the above cases occurred to me, I have learnt that Baron Seutin successfully dilated the stricture of strangulated hernia by insinuating the tip of the forefinger into it, and by stretching it forcibly.