I attribute the success of my practice in this respect mainly to the use of ergot of rye; because it is quite true, as already suggested, that, in nearly every consultation-case of appalling hæmoptysis that I have seen, "everything has been done, and every remedy tried," with the one exception of ergot of rye; and the use of this remedy has generally turned the fate of the patient. It has always struck me as a singular fact, that general practitioners, who are so well acquainted with the effects of ergot in uterine hæmorrhage—who use it more frequently than any other class of practitioners—with whom, in fact, it is almost a "pocket-companion"—never seem to think of using it in pulmonary hæmorrhage. I find, from frequent inquiry of my medical friends, that this is explained by the prevalence of the idea that ergot only acts by inducing contractions of the muscular tissue of the uterus; its remarkable power of inducing contraction of the blood-vessels being lost sight of. This is so generally the case, that I never met with but one general practitioner in the London district (in the country, it seems to be better known) who was at all aware of the power of ergot to control hæmoptysis. This exception was Dr. Betts, formerly of Highgate, now of Ventnor, who has as much confidence in the remedy as I have myself, and dates his confidence from the occurrence that, when a student at Guy's Hospital many years ago, suffering from profuse and intractable pulmonary hæmorrhage, under the care of the late Dr. Addison, his case was on the point of being given up as hopeless, when the bleeding was suddenly brought to a standstill by a large dose of ergot, administered at his own request; the idea having occurred to him, that, as it so often arrested uterine hæmorrhage, it might also answer in hæmoptysis.

But I have said that, in the appalling cases to which I have referred, "everything else had been done, and every remedy tried," before I ordered the ergot; and I desire to attach the greatest importance to this fact. Ergot is only competent to do one of the many things necessary to stop a severe pulmonary hæmorrhage; viz., to contract the vessels. It is necessary to do much more than this.

1. The vital power must be supported by brandy, iced milk, and beef-tea, if indicated by the general symptoms.
2. The heart must be kept steady by digitalis.
3. Congestion must be relieved by saline purging.
4. Clotting of the blood must be promoted by styptics, and by the free admission of cold air.
5. The bleeding part must be kept at rest by position, by enforced silence, and by soothing the cough.

In spite, therefore, of the fashionable outcry against complicated prescriptions, I venture to give the following as the most efficacious, and, as it seems to me, the most rational, combination of remedies for a case of profuse tubercular pulmonary hæmorrhage. It has served me many a good turn, and I hope it may do the same for my professional brethren.

R Ext. ergotæ liq. ʒij (to contract the vessels); tincturæ digitalis ʒij (to steady the heart); acidi gallici ʒj (to clot the blood); magn. sulphatis ʒvj (to relieve congestion); acidi sulphurici diluti ʒj (to assist the rest); infusi rosæ acidi ad ʒviii (to make a mixture). A sixth part every three hours till hæmorrhage is arrested.

In any given case, either of the ingredients may be omitted, if the symptoms indicate that it is not required, or that it has already done its duty.

OBSTETRIC MEMORANDA.

CASE OF SPINA BIFIDA.

By F. W. PARSONS, Esq., Islip.

I WAS sent for by a midwife early on the morning of March 6th to see a poor woman who had been some time in labour. When I got there, I found the child was born, and that labour had been impeded by a large tumour on the back of the child's neck. Upon examining the child, I found it was a case of spina bifida. The tumour extended from the occipital bone to the fifth cervical vertebra, and measured from above downwards six inches and a half, and transversely nearly six inches. About the middle was a bright transparent patch about the size of half-a-crown, where the cuticle was absent. Upon opening the tumour, about half a pint of red-coloured fluid escaped, and the cavity appeared to be nearly equally divided by an imperfect septum, and in the further cavity was a mass of cerebral matter not adherent to the sac. Upon passing my finger behind this, I made out that the spinous processes and part of the laminae of the second and third cervical vertebrae were wanting. The interior of the sac was much ingested, and in parts dark coloured. The child was well formed and healthy, but never breathed.

CONTRIBUTIONS TO THE HISTORY OF MEDICINE.

By AQUILLA SMITH, M.D.,

Professor of Materia Medica and Pharmacy in Trinity College, Dublin.

II.—ON PLACENTA PRÆVIA.

DR. FLEETWOOD CHURCHILL, in his account of the Symptoms of Placenta Prævia, says: "With the first sensible contractions of the uterus, the flooding comes on more profusely, and is observed to increase during each pain. Thus, it would go on until death supervened before delivery in most cases, if no assistance were afforded. I say, in most instances, because there are some cases on record in which the placenta was forced through the os uteri before or along with the child, decidedly the happiest termination. Thus, Smellie and Lee have recorded three; Ramsbotham, five; Hamilton, two; F. Ramsbotham, two; Baude-locque, Perfect, Chapman, Merriman, Barlow, Collins, and Maunsell, one; etc."—*Theory and Practice of Midwifery*, 8vo, 1842, p. 391.

Dr. Churchill's works on Midwifery, etc., are so highly appreciated for the comprehensive research exhibited in them, it is no reflection on his learning to direct the attention of the profession to the record of the following case of placenta prævia by a physician in England published long before any of the works mentioned by Dr. Churchill.

"Observatio XXIV.

Secundina ante foetum exclusa."

"Secundinarum exclusionem, Medici, et inter eos Franciscus Rancinus Medicus, et professor Regius celeberrime Universitatis Mons-peliensis lib. de morb. in partu pro certissimo signo habent foetus mortuus (*mortis*); eò quòd commeatum spiritus materni et caloris vitalis interceptum et interruptum esse indicet. Adui tamen parturienti Heroinæ, Catharinæ, nobilissimi æque ac humanissimi viri Dni Guilielmi Framp-ton Armigeri de Morton, conjugi lectissimæ et secundissimæ, melan-cholicæ admodum et valetudinariæ, quæ in δυστοκία seu partu difficili, tandem secundinam ante partum excluderat, non tantùm foetum, sed et matrem salvâ; nisi quòd ab enixu hystericis aliquot paroxysmis tentata fuit. Nepe homines sæpe à periculis et morbis sævissimis liberantur divinâ virtute, et quòd hæc Heroína servata, solâ Dei bonitate et clementiâ contigit; cui sit laus et gloria in secula seculorum." Vide "Friderici Lossii Heidelbergensis Palatini, Medici Dorchestrensis, Observationum Medicinalium Libri Quatuor. Londini, 8vo, 1672, p. 380."

The name of Frederick Loss does not appear in the Roll of the Royal College of Physicians of London. In his "Epistola Dedicatoria", he says that he practised at Dorchester for forty years, "indefesso labore, sed exiguo et labori impari lucro"—"relictis inani logomachia et futi-libus disputationibus, in quibus multi consenescent, maximi semper feci experientiam."

LABOUR OBSTRUCTED BY A LARGE PELVIC TUMOUR.

By C. G. WHEELHOUSE, F.R.C.S.,

Surgeon to the General Infirmary at Leeds: Lecturer on Surgery in the Leeds School of Medicine.

A FEW years ago, I received a very urgent message from a surgeon practising in this town, requesting my advice and assistance in a case which was causing him extreme embarrassment. He had been engaged to attend a lady in her first confinement, and had not been led to expect that anything unusual would occur at her delivery. He was called to her at about eight o'clock in the morning, and immediately obeyed the summons. He found that labour-pains had been present, more or less, through the whole of the night, and that they, by the time of his arrival, had become both regular and of fair power. On examining his patient, he was surprised and distressed to find the entire pelvis occupied by a globular and elastic swelling, over the whole surface of which he could freely pass the finger, but upon which, after most patient and diligent search, he could nowhere find any trace of os uteri. At each pain the swelling was distinctly advanced towards the perinæum; but, even when this advance was most perfect, he could still find no trace of anything, either resembling the os, or that gave him the impression of any thin point, indicative of the position of an imperforate os. His feeling, at the time he sent for me was, that the uterus had been retroverted, and that he was passing his finger over the fundus of the organ.

My first examination was as fruitless as his had been in discovering the mouth of the womb, but the impression conveyed to my finger was more that of a thick cystic ovarian tumour than of the fundus uteri. I purposely continued my examination during the persistence of two or three pains, and I thus verified his account of the real advance of the swelling during each period of uterine contraction, but I could not feel, as I thought I should do under such circumstances, any part of the foetus, nor any movement, through the walls of the swelling. External examination of the body next convinced me that the uterus was high up in the abdomen, as both the movements of the child could be detected, and the sounds of the foetal heart could be heard in an abnormally high position. This examination led me to make a careful inquiry into the history of the patient's pregnancy, and of her condition before pregnancy had existed.

My inquiries elicited the fact that she had, many months before, sought the advice of an eminent surgeon, for a distinct swelling in the left side of the body, and that, under his care, this swelling had, as she believed, disappeared. The "tumour," as it had been called, was at that time free, moved as she moved, and had given rise to very little pain or even discomfort.

I now felt certain I had an ovarian tumour to deal with, and repeated my examination *per vaginam*. I succeeded in gradually introducing my hand into the vagina, and I then found that I could insinuate my two forefingers between the tumour and the pubic bone, and could, with some difficulty, feel the os uteri, partially dilated, and the head presenting.

The question of the best mode of delivery now presented itself, and formed the subject of a most anxious consultation. Three plans occurred to us:—1. Firm and steady pressure to endeavour, if possible, to lift the obstructing tumour above the brim of the pelvis, and thus allow the uterus to descend. 2. Caesarean section. 3. To endeavour to diminish the bulk of the tumour sufficiently to allow the child to pass it.

The second of the proposed plans seemed to me to be the least feasible of any, as it involved not only Caesarean section, but ovariectomy at the same time; for I feared that, if the child were removed without the extirpation of the tumour also, it would probably be found impossible to prevent such protrusion of the abdominal viscera as might render their return impossible. I determined, therefore, at once to try the first plan, and, if that failed, to fall back upon the third. At this point, the patient's condition was carefully explained to her and to her friends, and they were informed of the necessity which might arise to destroy the life of the child, in order that we might be enabled to extract it. I was fully aware that ovarian tumours are sometimes so pressed down in front of the contracting uterus as entirely to obstruct all progress, but that, by watching for a favourable opportunity, they may often be pressed upwards above the pelvis, sufficiently to permit natural delivery to take place. My friend and late colleague, Mr. Samuel Smith, was in the habit of detailing such instances which had come under his observation. Again, therefore, introducing my hand into the vagina, I endeavoured, in the intervals between the pains, to press back the tumour, bringing, each time, as much force to bear upon it as I felt justified in using, and repeating the effort several times. So firmly, however, was it wedged, and apparently so matted was it to the surrounding organs, that, with all the force that prudence would permit me to use, I could not move it in the least degree. Finally, therefore, after much consideration, I determined to try whether I could so far lessen the tumour as to permit of the extraction of the child either alive or dead.

Before proceeding to this plan, I again satisfied myself that the tumour was adherent to the posterior wall of the vagina on the one hand, and to the rectum on the other, and that no ascitic fluid was interposed. I thus felt assured that the peritoneum was protected, and that the discharge, from any opening I might make into the tumour, would find free exit through the vagina, and that we should run no risk of effusion into the cavity of the body. With the ordinary midwifery perforator I pierced the tumour, and, using the instrument as I should have done in performing the operation of craniotomy, I broke down a considerable mass of its interior. At first, it appeared to be entirely solid, but, after a little time, I pierced the walls of a cyst, and a good deal of grumous fluid escaped. This allowed the tumour to collapse to a considerable extent—to such an extent, indeed, that, in the end, I succeeded in bringing the child away after opening the head and eviscerating the thorax.

For some weeks our patient appeared to be in a very critical condition, and we feared that she would sink; but, after a protracted convalescence, she seemed to recover, in some measure, from the effects of her confinement. What the final result with respect to the remains of the tumour was, I do not know; for, I regret to say, she suddenly left the town, and of her subsequent condition I have heard nothing.

ABNORMAL ORIGIN OF VESSELS FROM THE ARCH OF THE AORTA.*

By J. D. BROWN, M.D., and F. J. BROWN, M.D., Rochester.

S. C., aged 74, died at Rochester on February 22nd, 1867. The case was registered as "pericarditis and disease of the aorta, eighteen months; nephria and dropsy, six months". This man suffered from neuralgia of

Morbid Specimen.

Fig. 6, Pl. 7, from Quain.

Diagram of the Morbid Specimen, and a figure on Plate 7 of Quain and MacLise's Arteries, constituting the nearest approach to the specimen.*

the solar plexus and of the right brachial plexus from October 1866, and the tone of his voice was lowered. He died by syncope. He was a pensioner from the Royal Navy, and had lost a leg. His habits were temperate.

At the *post mortem* examination, there was found to be hydrothorax, with oedema of the lungs and emphysema. The pericardial cavity contained some serum; and there were adhesions to the posterior surface of the heart. There was no disease of the substance or of the valves of the heart. The ascending aorta was large; and atheromatous patches were present in the distal portion of the arch and in the descending aorta. The origin of the vessels from the arch of the aorta was abnormal. The two carotids arose by a common origin from one-eighth of an inch; next the left subclavian; lastly, the right subclavian, arising from the distal end of the arch, then coursing behind the trachea and behind the ascending aorta to gain its usual position on the right side of the thorax. The abdominal aorta was greatly diseased near the origin of the coeliac axis. There were thick ossiform plates and some eroded points. There was atheroma for several inches downwards. The common iliacs and the internal iliacs were greatly diseased, and were eroded. The kidneys were granular; and there was wasting of the left organ, with many cysts. The liver was dark coloured and of nutmeg appearance, and was lacerable. The spleen was gorged and lacerable.

* Read before the West Kent District Meeting.

† It is to be regretted that the parts were not preserved. It was thought at the time that the arch was identical with that figured on Plate 7; but on comparing the diagram with Fig. 6, the difference was observable.

LIGATURE OF THE COMMON CAROTID ARTERY.—The last number of *Langenbeck's Archiv* contains a long article from Dr. C. Pilz of Breslau, on ligature of the common carotid. Included in this are statistical tables of 586 reported cases, which are arranged in the following manner: ligature for hæmorrhage, 220 cases; ligature for aneurism, 86 cases; ligature for tumours, 138 cases; ligature before and during the removal of tumours, 69 cases; ligature for nervous affections, 35 cases; ligature for Brasdor's operation, 38 cases. The total amount of cases is further increased to 600 by others, of which full details are not given. In 29 instances the common carotid was tied on both sides, in 257 on the right side, and in 194 on the left. The sex of the patient is not given in every case, but of 537 patients 403 were males and 134 females. The sympathetic nerve was in one instance included in the ligature. Affections of the nervous system followed the operation in 160 cases; hemiplegia occurred in 8 per cent.; and 76 per cent. of the patients so affected, died. Of the 600 cases, 319 were cured after the operation, and 259 died; the result in the remaining being unreported. The ligature in the majority of cases came away between the thirtieth and fortieth days after the operation. The nervous symptoms following deligation of the common carotid, are attributed by Dr. Pilz to deficiency of arterial supply and to venous congestion, and also to nutritive changes brought about by the establishing of the collateral circulation. In cases of aneurism, Dr. Pilz advocates the application of digital and mechanical compression, and holds the opinion that deligation of the carotid should be performed only as a last resource when all other methods of treatment have failed.—*Archiv für Klinische Chirurgie*, Bd. ix. - 1868.