principle determined the remuneration of the medical man. If such were the case, there could be no objection to an exclusive standard. But we know this is not so, either in public appointments or in private practice; and the necessary consequence of such a standard would be to starve the public service, and to deny to our teeming population a sufficient supply of qualified medical men.

(To be concluded.)

OBSTETRIC MEMORANDA.

[UNDER this head, we shall, from time to time, as materials come to hand from correspondents, publish records of cases remarkable in themselves, or illustrating points of interest in obstetric practice, therapeutic or manipulative. We shall probably in this way preserve from oblivion the notes of very many useful and instructive occurrences in private practice; for the great obstetric experience is that—for the most part hitherto unwritten—of the great body of general practitioners throughout Great Britain. We will only ask those who may forward cases for record, to relate them with the utmost brevity, and equally to condense any appended remarks.]

HEAD AND HAND PRESENTATION.

By E. T. R. TENISON, M.D., Keith Terrace, Shepherd's Bush, W.

MRS. F., aged 21, was in her first labour at the full period. The membranes ruptured five hours from the commencement of the pains. On examination two hours afterwards, I discovered the presentation to be head and right hand, the fingers of which reached to the border of the posterior fontanelle. I made several attempts to push the hand and arm upwards, but all my efforts were fruitless. As the uterine action was not immoderate, and the pelvis roomy and well developed, I determined to leave the case to nature. The labour progressed favourably, and a healthy male child was expelled twenty-two hours after the membranes ruptured. The suffering was not more than usual in first cases, with the exception of the last half hour. The patient made a good and rapid recovery.

Head and hand presentations are excessively rare. Churchill states that no example is mentioned by Drs. J. Clarke, Collins, or Jansen; and only three (in 75,903 cases) by Mesdames Lachapelle and Boivin.

CELLULAR INFLAMMATION OF MAMMA.

By JOSHUA PARSONS, Esq., Frome.

MRS. J., aged 43, was confined on December 17th, 1862. The labour was tedious, owing to malposition of the child, the vertex presenting; but the case did well for twelve days, when rigor and great general debility, with much pain of the right breast, were complained of. Poulitices and a supporting, but not stimulating regimen, were resorted to, and as soon as a red point was perceived an incision was made. Nothing but sanious watery fluid was discharged; and on enlarging the opening the interior of the swelling was seen to be filled with a dark coloured, brawny slough. In spite of energetic treatment, the patient sank rapidly, and died on the twenty-first day after delivery. The whole organ was found converted into an undistinguishable gangrenous mass.

On the 5th of March in the present year I attended in the same house Mrs. K., aged 23, who was delivered of her first child after an easy labour. On the seventh day she complained of rigors with pain and swelling of the left breast. Poulitices were applied for several days, but the general symptoms becoming serious, a deep puncture of the breast was made in the most painful part, and some pus discharged with temporary relief. The pain and febrile symptoms repeatedly returned for more than two months, attended by a succession of small abscesses in all parts of the organ, which, after discharging streaky pus for a few days, closed up, leaving a deep sulcus where each occurred. During the whole of the time healthy milk exuded from the nipple, and the glandular tissue appears to be left untouched, though the organ is reduced to a singularly shrunken and distorted condition.

The above cases appear to me to record a rare form of disease, as well as a curious coincidence. The structure attacked seems to have been the cellular, rather than the glandular, textures of the part, and the inflammation to have been of a furuncular type, as characterised by the great pain and constitutional disturbance, in contrast with the small amount of swelling and discharge, and the nature of that discharge in the latter case.

NOTES ON THE OPERATIVE SURGERY OF THE FACE.

By FURNEAUX JORDAN, F.R.C.S.,

Surgeon to the Queen's Hospital, Birmingham; Professor of Surgery at the Queen's College; etc.

I.—THE RESTORATION OF THE LIP, LOWER OR UPPER, AFTER COMPLETE REMOVAL.

CIRCUMSTANCES may arise which require the complete removal of either the upper or the lower lip. Not long ago, I was required to remove the whole of the upper lip, an operation which I performed in the manner indicated in the third and fourth diagrams. I have several times removed the whole of the lower lip as seen in figs. 1 and 2. I am, therefore, able to say, unhesitatingly, that a mouth may be made from one lip. The lower can be made into lower and upper lips; the upper can be made into upper and lower. The cut margins (of cheek) can be brought together with certainty of union. Any one may bring the angles of his mouth together over the closed jaws. The cut parts are to be brought together (this is very important) with thick silver wire. Wire as thick as an ordinary brass pin causes no irritation; it does not cut, and very powerful traction can be made with it. The simple suture should be used, and should include a great amount of tissue. The cheek should be separated freely from the jaw, so that the deep parts may come together easily as well as the skin.

With intentional brevity, all other details are left to be told by the

diagrams. Fig. 1 shows the removal of the lower lip; and fig. 2, the appearance a few days afterwards. Fig. 3 shows the removal of the upper lip; and fig. 4 the appearance after a few days. The latter two diagrams

also show the best method of operating on severe hare-lip—forgetting the thick wire.

Advantages.—The incisions are the simplest and the least extensive

that can be made for the removal of the disease; yet they are sufficient for the restoration of the lip. The natural margin of the lip is retained. The only cicatrix left is the single one in the middle line. The resulting mouth shortly becomes an excellent one, perfectly useful, and not inartistic.

A CASE OF VAGINAL ATRESIA AND ABSENCE OF MENSTRUATION CURED BY THE USE OF TANGLE-TENTS.

By W. MURRAY, M.D., M.R.C.P. Lond.,
Physician to the Newcastle-upon-Tyne Dispensary, etc.,

MISS A. B. C., a young lady, aged 27, slightly marked with the pits of small-pox, consulted me fifteen months ago. She complained of a severe pain in the hypogastric region, and radiating pains in the back, loins, and lower extremities. She had suffered in this way for some years, and she said her pains were periodically increased at intervals of five or six weeks. On further investigation, it appeared she had menstruated only once or twice in her life, and that the show scarcely amounted to a teaspoonful on each occasion. On proceeding to examine the uterine organs, I was surprised to discover that the vagina was a mere *cul-de-sac*, an inch deep, terminating in a conical depression. The walls of the *cul-de-sac* were made up of cicatricial tissue; and at the fundus of the depression in which the *cul-de-sac* terminated, I detected a minute opening* through which a No. 1 elastic bougie would scarcely pass. In order to make a further diagnosis of the case, I determined to introduce a tangle-tent into the minute orifice I had discovered, and then to pass the uterine sound through it. This was done; and on passing the sound, I introduced my finger into the rectum and felt the point of the instrument projecting through the solid barrier in the vagina into a cavity above. Beyond this upper part of the vagina I could feel a round body very like the uterus in size and shape. As the dilatation had caused some pain, and as no immediate result followed it, the patient and her friends declined further interference at this time, and I did not see her again until August last. I then found her suffering as before, and very much altered in appearance; her countenance was haggard, her manner hysterical, and her nutrition impaired by constant vomiting. She was now prepared to go through any kind of treatment to obtain relief.

Having obtained the assistance of Mr. J. B. Fife, whose advice and surgical skill proved invaluable throughout the whole procedure, I dilated the small opening running through the closed portion of the vagina, until it admitted the tip of the little finger. At this point an accident occurred, from the string attached to the tent having given way, leaving the tent firmly impacted in the newly formed canal, where it remained for about thirty hours, when Mr. Fife removed it by making a slight notch in the canal on each side of it. When the tent was removed, the finger could be freely passed through the opening it had formed into the upper part of the vagina, and there we found a somewhat contracted but perfectly formed cervix uteri. The dilatation was now continued freely by sponge-tents until a large speculum could be passed into the vagina. The uterine sound was then passed, and a very minute os uteri was discovered by it. The sound, when twisted a little to the right, could be introduced an inch deep into the cervix uteri. This enabled us to secure the introduction of a small softened tangle-tent in the direction indicated by the sound, and by a little careful manipulation, the tent slipped almost overhead into the uterus. When this tent was withdrawn the next day, a very free passage into the uterus remained. Both the vagina and the uterus now showed an obstinate disposition to contract and assume their former condition, so that we were compelled to incise the cervix uteri freely with Greenhalgh's hysterotomy, and to keep both the canal of the cervix and the vagina constantly dilated for some days.

Exactly one month from the time the hysterotomy was used, the menstrual flow appeared and continued for three days. In every respect the period and the flow were normal. From this time the patient improved rapidly in general health. At the end of another month, finding the os uteri slightly contracted, I introduced a tent for a few hours, and gave the patient two doses of aloes. After this, the menstruation again took place, but it was unfortunately stopped by a severe fright received by the young lady during the following night. From this time all went on well till another month elapsed; then she began to suffer pain, to vomit, and to assume a hysterical manner, but after waiting patiently for a few days, relief of all these symptoms was obtained by the reappearance of menstruation for the third time. On this occasion, it was full,

* I must mention the existence of several large pits near the vulva. These, the patient's mother remembers, were the result of small-pox, from which her daughter suffered when she was two years old.

free, painless, lasted five days, and left the patient quite well, without ache or pain. Six or eight menstrual periods have now occurred; for the most part they have been very satisfactory, and on each occasion they have been followed by great improvement of the patient's health.

The chief point of interest in this case is the entire abeyance of the menstrual functions of the uterus during a period of at least fourteen years from the age of puberty. The entire want of action previous to the dilatation of the parts was proved by the total absence of retained menstrual fluid. I might add, that it is quite clear the closure of the vagina was produced by the extension of small-pox into the vulva, and subsequent ulceration of the walls of the vagina. The case strongly commends the use of dilatation instead of cutting in cases of closure of mucous canals of all kinds; and where no opening exists to permit of this, I should introduce a fine trocar, and then leave a tangle-tent in its place as a commencement of the dilating process.

In a subsequent communication, I hope to draw attention to the cure of false anus by the use of tents, and to show that by stretching such fistulous openings, we can rely upon such an amount of contractile inflammatory action being set up as to close them.

THE PATHOLOGY OF RIGORS:

ILLUSTRATED BY A CASE OF HEMIPLEGIA, FROM DISLOCATION OF THE ATLAS, PRECEDED AND ACCOMPANIED BY CONSTANT SHIVERING AND SENSE OF COLDNESS.

By J. BURNEY YEO,

Resident Medical Tutor in King's College.

THE following case, extracted from the second volume of Cruveilhier's *Pathological Anatomy*, fell under my observation after reading Dr. G. Johnson's lecture in the BRITISH MEDICAL JOURNAL on the Pathology of Rigors. As it appeared to me to afford very remarkable, and, of course, entirely undesigned, support to the explanations therein given of their phenomena, I called Dr. Johnson's attention to the case; and he agreed with me that it was of so singular a nature as to deserve translation.

Femme La Croix, aged 68, came under notice on October 13th, 1832, with hemiplegia of the right side; paralysis both of sensation and motion. The hemiplegia came on suddenly, while she was in the hospital of La Charité, into which she had been admitted six months before for *severe shivering, which never left her* (un grand frisson qui ne la quittait jamais). Warm baths were prescribed for her; and it was after one of these baths that she became paralysed. One curious point is, that at first she was uniformly paralysed, or rather enfeebled, on both sides (*affaiblie des deux côtés*), and it was only later that the hemiplegia came on. She stated that ever since the commencement of her illness she had *felt frozen* (*glacée*). The hottest applications could not make her warm. The cold "penetrated even to the marrow of her bones". The surface of the body was cold to the touch, like "touching a cold-blooded animal." She complained of severe pain behind the right ear, and suffered much from painful cramps of the lower limbs. She remained in this condition till Jan. 30th, 1833, when she died.

During all this time, the coldness was constant. Cruveilhier observes, "La constance de l'algidité était toujours pour moi un nouveau sujet d'admiration."

The *post mortem* examination shewed that the *raison anatomique* of the hemiplegia and other symptoms was a displacement of the atlas, producing compression of the cord immediately below the medulla oblongata. This compression had borne more on the right than the left half of the cord, and had led ultimately to its disorganisation. In the right half, the *débris* of the cord was grey, without a vestige of white substance. In the left, the *débris* contained still a little white substance. The annular ligament of the odontoid process was large and yellowish, with little chalky plates in its substance, much like the alterations undergone by the coats of arteries. The odontoid, or check ligaments, were much weakened, and their fibrous bundles separated by a reddish substance. They permitted the odontoid process to play backwards and forwards so as to produce an incomplete luxation.

Cruveilhier observes that the displacement was due to disease of the ligaments uniting the odontoid process to the occipital bone and the atlas, probably of rheumatic origin.

There is no evidence whether in this case, at the onset of the shiverings, the sense of cold was simply subjective, as we know it to be in ague and in many other cases. It may have been so; although at the time when this patient came under Cruveilhier's observations, six months after the first appearance of these symptoms, and when she had become hemiplegic, the surface was unusually cold.