A doctor, or a nurse who is familiar with the treatment, should stay with the patient all the time. External stimuli should be excluded as far as possible. If there is a light it should be kept shaded except when urgently required. The attendants must be absolutely quiet, and refrain from disturbing the patient beyond what is necessary. I have not used the memory test on this account. The effect of the injections usually becomes obvious after the second. The patient begins to sleep between pains; she usually lies quiet. When a pain comes she shows that she feels it, and tosses about. She mutters like a delirious person, but as soon as the pain goes she stops, maybe in the middle of a sentence, and falls asleep at once. Some patients become very restless, or attempt to get out of bed. A few lie comatose even during the pains. Coma, great violence, or a slowing down of the pains are indications for prolonging the interval between injections. Undue wakefulness calls for a shortening of the interval. The pupils soon become dilated. In most of our cases the pulse rate rose, in some to over 120. Often it fell again as labour proceeded, and always within a few hours of the birth. The rise may be explained by the restlessness or by the effect on the vagus. The bladder should be carefully watched. The patient soon becomes thirsty, and asks for a drink, especially in the first few hours; this should be given. Some patients cannot see well owing to paralysis of accommodation for

twenty-four hours or so after the birth. It is important not to omit the last injection, even if the child is about to be born; otherwise the worst pains may be remembered, and the whole labour reconstructed by the patient from them. Additional help, as Jennings says, may be required at the time of delivery. The "obstetric helper" is a useful appliance for keeping the patient in position in the later stages. Our experience did not bear out Jennings's observations on the expulsive pains. These were as a rule remarkably strong, and the abdominal muscles certainly played their part.

With practice it should be possible to obtain a much higher percentage of complete successes than has been obtained in this series, and I have no doubt I shall do so. I have dwelt on the less satisfactory cases because, as experience, they are more valuable than those that are perfect. I hope that others will be encouraged to use the treatment; the success, demonstrated by the patient's gratitude, is a great reward for the trouble involved.

I offer my thanks to the other members of the honorary staff of the Leeds Maternity Hospital for permission to use the treatment on their patients; to Mr. A. J. C. Latchmore, who performed most of the forceps deliveries, and was of great assistance in the management of the cases; and to those students of the Leeds School of Medicine who gave their help in compiling the records on which this paper is based.

REFERENCE

¹ Greenwood: *Scopolamine-Morphine Semi-narcosis during Labour*.

PHIMOSIS AND CIRCUMCISION

BY

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Circumcision is an operation performed with great frequency. It is obviously bad surgery to perform any operation without definite indications, and probably no operation, with the possible exception of tonsillectomy, is frequently advised upon more slender grounds than that of circumcision.

The term phimosis implies such a narrowing of the preputial orifice that the foreskin cannot be retracted over the glans. A foreskin which can be easily and completely retracted without effort is very rare indeed. Phimosis may be of several degrees:

1. A pin-hole preputial orifice smaller than the urethral orifice. This is the only degree in which obstruction to the urinary stream is possible. Apart from cicatricial contraction resulting from inflammation (*vide infra*) it is very doubtful whether phimosis ever produces urinary obstruction. It is reasonable to suppose that healthy and distensible skin will allow the rapid dilatation of the orifice by the ordinary stream to the required size.

2. A match-head orifice.

3. A wide preputial orifice with adherent prepuce (crowned glans).

4. Coronal adhesions.

Any of the above conditions may be associated with a long, lax prepuce.

Popular indications for circumcision include restlessness, straining during micturition, and enuresis. Congenital stenosis of the terminal urethra is a condition which should be borne in mind, for in such a case it is of course futile to attend to the phimosis and overlook the urethra. If circumcision has any effect on enuresis it is probably a psychical effect, which would equally result from any operation.

DILATATION AND RETRACTION OF THE PREPUCE

This procedure is safely carried out and is eminently satisfactory in infants. In older children it may be unsatisfactory owing to the undesirability of carrying out manipulations over any period of time.

Technique.—The only instruments required are a fine probe and a pair of Spencer Wells artery forceps (not too blunt). The first step is the complete separation of the prepuce from the glans. The prepuce is grasped between the thumb and fingers of the left hand and retracted as far as possible. The probe is then inserted (care being taken not to enter the urethra) and swept right round the glans. This manipulation also serves to stretch the preputial orifice slightly. If the prepuce cannot now be retracted, the point of the artery forceps is inserted into the orifice and pushed up as far as it will go between the prepuce and the glans. The blades are then gently separated for a few seconds. It will now be possible to retract the prepuce, exposing the urethra and part of the glans. If complete retraction is not possible the artery forceps are inserted again, care being taken not to split the prepuce. In very resistant cases it is well not to attempt complete retraction at one sitting, but to leave it for a week. When the foreskin has been completely retracted the smegma in the trough round the corona is wiped out, the glans smeared with sterile olive oil and the prepuce drawn down. The preliminary separation of the prepuce from the glans is important, as otherwise the point of the forceps will be found merely to carry the orifice inwards without penetrating it. The mother is instructed to retract the foreskin daily as far as possible, *but not to leave it back*. Nevertheless in a few cases paraphimosis will occur. This, as a matter of fact, may serve a very useful purpose if it is not neglected too long. One often finds after paraphimosis that the foreskin is quite lax and retracts easily. The child is seen every week for a few weeks. The foreskin is retracted, and the glans, having been smeared with olive oil, is brought down again. In two or three weeks' time it will be found to retract very easily. As soon as there is no danger of a paraphimosis it can be left back altogether.

INDICATIONS FOR CIRCUMCISION

The indications for performing circumcision may be grouped as follows:

1. Cases that come from a distance and cannot attend regularly, unless the prepuce can be very easily retracted and is unlikely to cause further trouble.

2. Some boys over 12 months old.

3. Most patients over 3 years—always excepting those cases of "crowned glans" or cases with only marginal adhesions round the corona.

4. Recurrent dermatitis and fibrous thickening round the preputial orifice.

5. Balanitis if persistent. One sometimes sees cases of purulent balanitis put down for circumcision and when the child is sent for some months later the condition has completely cleared up.

6. Repeated paraphimosis.

7. A few cases of unsuccessful stretching. These cases are very rare in infancy, and are almost invariably due to lack of interest on the part of the mother.

Hypospadias is an absolute contraindication. All the available skin may be required for an operation of the Mayo or Russell-Duplay type.

The question naturally arises, "Why, in the absence of actual obstruction to the urinary flow, should the infant's prepuce be interfered with at all?" The adhesions between foreskin and glans which are so common in infancy do certainly tend to disappear as the child gets older, and the foreskin may retract perfectly easily. This is the ideal to which nature does not always attain. A permanently retracted foreskin or a foreskinless organ is more hygienic than an organ in which the glans is more or less covered up and in a moist condition.

The physiologists state that the function of the prepuce is to cover the glans and protect it from vicarious irritation. It does not appear, however, that contact with the outer world does it any harm or that the circumcised races are any less fertile than the uncircumcised. In the event of subsequent urethral infection the absence of the glans covering is certainly an advantage from the point of view of both diagnosis and treatment.

Circumcision without an anaesthetic is a somewhat barbarous procedure, and any anaesthetic is a potential danger and entirely undesirable in an infant unless it is absolutely unavoidable. The enormous number of entirely unnecessary circumcisions that are done in infancy is nothing less than deplorable. It is thoroughly bad surgery to remove anything, whether it be a foreskin or a tonsil, unless one has definite reasons for doing so.

CONCLUSIONS

1. Circumcision is never necessary in the newly born as a primary procedure—and very rarely necessary at all.

2. Dilatation and retraction of the foreskin in these cases is easily and rapidly carried out; it requires no anaesthetic, and is extremely satisfactory.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

HAEMORRHAGE AND DEATH FROM A GASTRIC MYOMA

Innocent tumours of the stomach are not common, and death as the result of one of them must be a rare phenomenon. Eusterman and Senty¹ estimate that malignant tumours of the stomach are seventy-eight times as common as innocent tumours. Of the latter they find that myomata are the commonest. Haemorrhage is stated to be a rare complication; pyloric obstruction (due to the ball-valve action of a polypoid growth), intussusception of the stomach into the duodenum, strangulation, and malignant hyperplasia being more frequently met with. These writers record haemorrhage in ten cases out of twenty-seven described, but not to the extent of causing death in any one. Miodowski in 1901 recorded a case

of a woman, aged 51 years, who had been ill with marked abdominal pain and melaena for six weeks, when she died from a recurrent haemorrhage from the ulcerating surface of a polypoid gastric myoma. This case bears some resemblance to that about to be described.

Clinical Notes of Case

A woman, aged 54, was admitted to hospital on July 22nd, 1930. She stated that she had enjoyed normal health until six months prior to admission, when she suddenly vomited about a pint of bright red blood. This did not recur; but for ten weeks after her stools were dark and tarry. During this period she became progressively paler. She remained in this condition until four days before admission, when she became very faint, and the dark stools reappeared. Apart from one attack of haematemesis she had never vomited. There had never been any abdominal pain or discomfort or nausea at any time, and her appetite had remained good throughout her illness.

On physical examination she was found to be very pale but well nourished. Her pulse rate was 120, and her temperature subnormal. There was slight rigidity of the upper half of the left rectus muscle, and the stomach was made out to be dilated. A haemic murmur was heard over the precordium, otherwise there were no physical signs of note. The melaena persisted and became more marked until her death five days after admission. Blood count: red blood corpuscles, 2,600,000 per c.mm.; white blood corpuscles, 5,600 per c.mm.; haemoglobin, 25 per cent.

Post-mortem Findings

At the post-mortem examination a soft spherical tumour, about the size of a tangerine orange, was felt in the lumen of

the stomach, projecting from its lesser curvature by a sessile base. There was a large quantity of altered blood in the stomach and in the whole of the intestinal tract. All other organs were normal.

Pathological Report

I am indebted to Dr. J. B. Duguid, acting professor of pathology in the University of Wales, for the following pathological report: "On the anterior wall of the stomach, about midway between the greater and the lesser curvatures (see photograph), and about one and a half inches from the pylorus, there is a spherical tumour projecting into the lumen of the stomach. This tumour is about one and a half to two inches in diameter, and attached by a base about one inch in diameter. It is covered by mucous membrane except at two points: one at the summit of the outgrowth, and the other near the base on the cardiac side. At these two points there are punched-out ulcers with slightly overhanging margins. Each one is about a third of an inch in diameter, and about a quarter of an inch in depth. Their internal surfaces are ragged and necrotic, and at the base of the former there are two patches of haemorrhagic discoloration representing the points of origin of the haematemesis. The ruptured vessels cannot be seen by the naked eye. Histologically the tumour is a leiomyoma of entirely typical structure."

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¹ Eusterman and Senty: *Surgery, Gynecology and Obstetrics*, 1922.