beginning (so long as haemoptysis has ceased)—will get their best chance at Davos, or at some other Alpine station with the climatic conditions of Davos—namely, pure, still, dry, cold, diaphanous, and diathermic air.

Unsuitable early cases for the high Alps are: acute cases, nervous, irritable people, elderly people, chilly people, most laryngeal cases, and those with much emphysema, with heart disease, or with albuminuria.

In choosing other foreign climates than Switzerland we must not forget that Australia, New Zealand, the Cape, Canada, and the United States no longer admit cases of active tuberculosis.

This leaves us a rather narrow choice. Sea voyages are by no means a safe prescription, particularly if they cross the tropics. The Riviera does not appear to give better results than can be obtained in England. Egypt at the present moment does not suggest itself as desirable. Las Palmas in Grand Canary has given good results; its climate should not be confused with the quite different climates of Orotava in Teneriffe and of Madeira. South-eastern Spain and the desert behind Algiers are still advised. In sending phthisical patients long distances their travelling powers must be considered, as well as the luxuries of travel and accommodation which they are prepared to allow themselves; also, and very important, the medical skill available in the health resort decided on. In the light of home sanatorium results all these localities will require consideration.

CONCLUSION.

To conclude, I would like to leave it clear that, from the foregoing comparison of open-air results, I claim to draw no final inference. They are too few, the definitions of "early" are too various, and the absence of uniform finding of tubercle bacilli renders the diagnoses too uncertain. *What I do claim, and claim strongly, is that they constitute a case for immediate investigation.*

ACUTE PUERPERAL INVERSION OF THE UTERUS.

BY

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THE two cases of puerperal inversion here recorded were recently met with in hospital practice, and are published by Dr. Croft's permission.

CASE I.

A. L., aged 21, 2-para (the first being a miscarriage), a healthy woman with strong abdominal muscles, had a normal first and second stage, the latter lasting two hours; twenty-five minutes later the uterus was grasped to see if the placenta had separated, and as it was uncertain whether separation was complete control and pressure were maintained on a well contracted fundus, and the patient of her own accord bearing down, part of the placenta appeared at the vulva. During this time there had been no excess of haemorrhage: the sister in charge then said the hand on the abdomen seemed to lose the uterus, and the emerging placenta was gradually followed by the completely inverted uterus, the whole appearing slightly larger than a foetal head, with part of the placenta separated but quite two-thirds remaining attached to the uterus, which accounted for the uncertainty of separation and the slight haemorrhage only. At once the parts were surrounded with hot sterile towels and the best available antishock treatment instituted.

Thirty minutes later (that is, fifty-five from delivery) I saw the case, finding the degree of shock markedly progressive, the patient looking extremely ill, with deep sighing respiration and almost imperceptible pulse. The inverted structures were not examined, but the abdomen gave no uterine swelling whatever, so that the condition was evidently one of complete uterine inversion. It was decided to leave the uterus *in situ*, with the placenta attached to avoid superimposing any haemorrhage on the prevailing shock. The antishock treatment was continued, though no morphine, no pituitrin, and no intravenous medication were administered, subcutaneous saline, hypodermic camphor, and ether being given.

Fifteen minutes later (that is, seventy from delivery) the patient appeared moribund, the pulse being quite imperceptible; so, as (1) her condition seemed hopeless, (2) she had not reacted to antishock treatment given for forty-five minutes, but had become steadily worse, (3) the husband had been sent for, (4) the apparatus was ready for an instant blood transfusion, it was decided to risk replacing the uterus. Accordingly the placenta was peeled off the uterus, very little haemorrhage occurring; the uterus was quite easily replaced through the relaxed cervix, and a hot intrauterine douche given; no pituitrin was administered as there was no bleeding of any account, and infec-

tion of this drug has been followed by reinversion. It was difficult to decide on the immediate effect of the replacement, as the general condition seemed so bad, but it appeared still further to deepen the shock, so that the case became quite hopeless.

Ten minutes later (that is, eighty from delivery) the husband arrived, so that transfusion was immediately performed of 22 ounces; the patient's colour slowly returned, and her condition improved.

The puerperium was apyrexial, and the lochia normal; on the fourteenth day vaginal examination showed the uterus a little bulky, but otherwise normal in shape, consistence, mobility, and position, so that the patient was discharged the same day.

CASE II.

A. H., aged 22, one previous child, had a difficult labour (forceps delivery) and severe *post-partum* haemorrhage. She got up on the tenth day and seemed quite well till the sixteenth day, when during the act of defaecation she felt her "womb drop"; the doctor sent for made a diagnosis of uterine inversion. The patient was admitted to hospital on the seventeenth day under Dr. Croft. Under an anaesthetic the vagina was found to contain a sloughy-looking mass, corresponding in shape and size to the inverted fundus of the uterus; the body of the uterus was not felt on bimanual examination. Manual replacement was found difficult owing to the rigidity of the cervix—the operation took close on forty minutes; it was followed by an intrauterine douche and iodoform pack; the chief difficulty, Dr. Croft said, was to start a dimpling of the uterine wall.

The puerperium was not eventful, and vaginal examination on the fourteenth day disclosed the body of the uterus normal and the cervix closed.

In the first case the result would certainly have been fatal had it not been possible to do blood transfusion. Owing to the lack of response to the antishock treatment, it seemed that there was nothing to be lost by risking replacement of the uterus, but the effect was apparently to deepen the shock as far as could be discerned with the patient in so precarious a way.

The ideal treatment would appear to be immediate blood transfusion with later replacement of the uterus. If blood is not available it would be worth while to try gum acacia solution, but saline seems useless if not harmful in certain cases.

Reference might be made to a case reported by Dr. Barris¹ of blood transfusion in a case of uterine inversion in which, two hours after delivery, the midwife tried forcibly to express the placenta and made traction on the cord, with the result that the patient felt something come down, and was admitted to hospital eleven hours later with the fundus inverted inside the vagina; the immediate treatment with pituitrin and a vaginal douche was directed to the prevention of shock. Two days later the first blood transfusion of 100 c.cm. was performed, and twenty-three days after that a second of 600 c.cm. Reposition of the uterus was done in the seventh week with an Aveling repositr, as there had been local sepsis and Carrel treatment had been called for.

The second case falls more into line with the series published in 1920 by Dr. Spencer, of which the first three cases were admitted with the inversion on the fifth, nineteenth, and twenty-second days, reduction taking place on the sixteenth, fortieth, and twenty-second days respectively, though in each it was uncertain when the actual inversion occurred; the next two cases occurred nine months, and two years and eight months, after labour; the last four being associated with tumours, and appearing seven, twelve, thirteen, and twenty-five years after labour, reduction in each case being effected by Aveling's repositr.

REFERENCE.

¹ *Transactions of the Royal Society of Medicine*, January, 1921.

DR. HUBBARD, director of public health education of the New York Department of Health, has recently published statistics which appear to show that since the last year before the prohibition law took effect there has been a constant increase in New York in the number of arrests for drunkenness, the number of deaths due to wood alcohol poisoning, and the number of persons admitted to hospital suffering from acute alcoholism. During last year 5,624 persons suffering from acute alcoholism were admitted to Bellevue and King's County hospitals, as compared with 3,345 in the preceding year. In 1922 the number of deaths from alcoholism was 295, as against 141 in 1921. The number of deaths, however, is smaller than it was in the years preceding prohibition; in 1916, for example, 690 persons died in New York from alcoholism; the low-water mark was reached in 1920, when there were 127 deaths, but since that time there has been a rapid increase. The number of arrests for drunkenness in New York in 1922 was 7,866, as against 6,233 in 1921.