I have only to add that the reason why I did not remove the cervix as well as the body of the uterus was because the patient's condition rendered it desirable that the operation should not be prolonged. In this case it had lasted for twenty minutes, and it then seemed that the further ten minutes or so which would be required to remove the cervix might turn the scale against the patient. On theoretical grounds, however, I should prefer the total operation in a similar case.

"CLEAN MIDWIFERY" IN GENERAL PRACTICE.

By ARTHUR H. GREGSON, M.B., CH.B.,
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FOR five years no doubt had ever entered my mind as to the efficacy of mercury perchloride as a hand and labial disinfectant and a sure preventive of puerperal fever; but in December, 1905, a midwife sent for me to attend one of her septic cases, which proved fatal within a week; and after that, though none were fatal, several of my own had unpleasant rises of temperature; it seemed as though the infection would not be got rid of, so I determined to use rubber gloves.

At first they were carried in a glass bottle containing glyc. ac. carbolic. diluted ten times at one end of my bag; a yard of cotton-wool was also put in, and the midwifery forceps transferred to a sterilizer made by a local tinsmith for 7s. 6d. The nurse was required to find an enamel pan and some soda to boil the gloves, a bowl for lysol to transfer them to, another for perchloride to wash the labia with, as the lysol is too irritant, besides the usual washhand basin, the whole making a somewhat formidable array.

Before long, however, a case occurred in which elaborate preparations were out of the question; even a pint basin for the perchloride had to be borrowed—just such a case where perfectly clean midwifery would be held an impossibility. In these poor houses the gloves are put into the kettle and transferred to the mercury solution instead of to lysol, and this is found to do quite well. Of course the soda is omitted, and then the gloves must be boiled in it at home to remove any trace of blood or fat before being used again; whereas this is usually done at the patient's house, the pan being kept at one side throughout the case and used repeatedly.

The gloves having been boiled, one's own hands are washed with soap and water, all the folds of the patient's genitals and adjacent parts cleansed with perchloride and the vagina swabbed as thoroughly as possible with cotton-wool wet with the same solution and never dipped into it a second time; then one's hands are sterilized in the ordinary way and the gloves put on without filling with water, a pad of cotton being used to work them on, and the examination made without any lubricant except the 1 per cent. lysol when convenient, contamination from the anus being prevented by keeping a pad of dry wool over it. The patient is always instructed to have an enema before she sends for me, but too often she omits it. If during the vaginal examination the rectum is found overloaded and the os not fully dilated, an enema is given.

If instruments are found to be required, boiling water is poured into the tin, the gloves put in, and 2 per cent. lysol added. The whole are then boiled for five minutes with the spirit lamp, half the solution poured into a jug as a reserve, and cold added to the tin.

Such a change in routine had its disadvantages. Tactile sensation required re-educating, but half a dozen cases were sufficient to complete this. The waste of time was at first about an hour, but now it is only fifteen minutes, and is fully compensated for by not having to give intra-uterine douches later. If any rotating or turning is required, lysol makes the gloves too slippery, and perchloride must be used instead.

The greater peace of mind is worth much, although two or three cases of puerperal fever have occurred in my own practice since.

The first was one in which the patient had taken plenty of castor oil, and refused to have an enema, with the result that faeces contaminated my glove during the

rotation of an occipito-posterior into an occipito-anterior presentation, and taught me to leave the pad at the anus.

The second might easily have been a mystery, but that on my arrival a neighbour said, "She won't be long now, doctor." "You have examined her?" I asked. "Yes, but my hands are clean; I am washing," she answered. A washerwoman making a vaginal examination! In this case the mother-in-law remarked, "There should be no blood poisoning here," when she saw my preparations to prevent it.

The third was an occipito-posterior presentation delivered by rotation and instruments; the perineum was torn. There was swelling of the abdomen six hours later, which disappeared after defaecation next day. The temperature never rose above 99.6°, and became normal after removing a painful suture on the fourth day; the pulse fell from 108 immediately after delivery to 80 during the same time. Satisfactory progress reported on the seventeenth day. At noon on the eighteenth day I was called in again. She had vomited; was suffering from pain in the right iliac region; the temperature was 102°, and the abdomen again swollen. On vaginal examination there was tenderness limited to the right fornix; an intrauterine douche brought away nothing and caused no improvement. Involuntary defaecation commenced soon after, and a rigor occurred on the twentieth day. A consultation was held on the twenty-first day; the uterus was normal for the time, and the perineum healed, but the abdomen was more distended. Septic peritonitis was diagnosed, and the appendix mentioned as a possible source; but, owing to the circumstances, it was decided to regard the genital canal as the route of infection. She had always been much troubled with wind—a complaint which I remembered (when too late) that two of my male patients have recently been completely cured of by removal of the appendix.

Patients themselves like the gloves, because they slip in more readily than the bare fingers, and one commented that I had not scratched her.

The greatest enemies were the neighbours, who declared unanimously against the innovation, one admitting that she had not sent for me "because Dr. Gregson is so faddy"; another asking if I was afraid of blood; but the most annoying incident was the setting out of the report that a certain patient must have had syphilis, or gloves would not have been used, after which I put up a notice that an extra charge of 2s. 6d. would be made for rubber gloves.

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

PRIMARY EPIDIDYMITIS IN MUMPS.

On the evening of April 16th, 1909, I saw a youth, aged 18 years, lying in bed and complaining of a pain in the right testicle. This on examination proved to be due to epididymitis, the body of the testicle being quite sound. The temperature was 99.4°, and the history of the onset quite sudden and non-traumatic.

There was no urethral discharge or scalding, nor had there been any; the boy (a country lad) denied any sexual history, nor was there anything about the meatus urinarius to cause me to doubt the truth of his statement. I recommended supporting the testicle on a pillow covered with mackintosh, and hot fomentations, giving at the same time a saline purge. The next day the true nature of the case revealed itself. The left parotid swelled out in the typical way, and also the right submaxillary gland. The temperature rose to 103° and a little over. The body of the testicle began to swell the following day. In about ten days the fever and swelling subsided, and salivary glands and testicle resumed their normal appearance.

The unusual feature of the case is the primary manifestation in the epididymis. The so-called metastatic orchitis frequently precedes mumps, but in no case can I find a record of the epididymis taking the lead. The testicular manifestations are almost invariably unilateral and are frequently followed by atrophy of the gland, which fortunately did not occur in this case.

Whittlesey.

J. J. WADDELOW, F.R.C.S.Eng.