small families of the present day may not be due in some degree to the excellent results which modern obstetricians obtain as regards involution, since there is no doubt that superinvolution may lead to sterility.

While on this subject I may add that I think a little knowledge of the process of autolysis is sufficient to elucidate the mystery of the curious pathological process known as red degeneration or necrobiosis which takes place in fibroids and in the centre of other large tumours.

There is at least one very obvious objection which may be urged against this theory of a blood-tight uterus, and that is that for some days after delivery a patient has a blood-stained vaginal discharge. The blood in this discharge oozes from the uterus and from small lacerations in the vagina and cervix. There is no doubt that in the majority of cases the greater part of the blood comes from the uterus, and, of course, in these circumstances the uterus is not blood-tight. But the question whether it is necessary for a patient to have any lochia at all may be asked on the following grounds. First, because in all surgical manipulations it is not in accordance with the best principles to leave any surface oozing. Secondly, because it is possible for a patient to be delivered and to

pass through a puerperium without any further loss of blood; this statement is based upon my own observations on a certain number of cases, and, indeed, is not an uncommon experience. Thirdly, the human female is the only one among the mammalia to be afflicted in this way. No other mammal has lochia in the ordinary sense of the word at all.

Clinical observation has shown me that women sometimes are free from any lochia at all with the exception of a slight muco-serous discharge. In these cases I have more than once noticed about the fifth or sixth day a slight red discharge, which soon ceases. This is due, I think, to the circulation in the uterus being re-established. It ceases as soon as the surface of the uterus is sufficiently healed to check it.

Therefore I think that in the future the day may dawn when it will be generally recognized that it is not necessary for women to have lochia after normal labour. For the conclusion that a thing is right and proper because it is customary, is an argument the fallaciousness of which is at once demonstrated when we remember that forty years ago any wound which healed by first intention was looked upon with suspicion and distrust.

CASE OF LYMPHANGIOPLASTY FOR SOLID OEDEMA.

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A. M., aged 25, had severe erysipelas of the face in June, 1907. This was followed by solid oedema of both eyelids. No improvement had resulted from treatment, including injections of fibrolysin. Fig. 1 shows the condition on

June 29th, 1909, when operation was undertaken. As suggested by Mr. Sampson Handley,¹ artificial lymphatics in the form of sterile silk threads were introduced into the subcutaneous tissue. The operation was carried out as follows: (1) Two short curved incisions, $\frac{1}{2}$ in. long, were made into the oedematous tissue of each eyelid; (2) a similar incision was made at the outer margin of the orbit;

(3) a fourth incision low down on the cheek below the oedematous thickening. The skin below this last incision was freely separated by a blunt director so as to leave a loose pouch into which the lower end of the thread could be dropped. A round needle threaded with sterile silk was then introduced through the incision in the upper lid, and brought out through the incision at the orbital margin, and the thread drawn through till its upper end, which was knotted (to prevent it becoming dislodged by facial movements), lay buried in the swollen orbital tissue. The needle was again introduced, carried along under the

Fig. 1.—Condition at time of operation. Dotted lines indicate the position of the threads. The four lines — indicate the incisions required for introduction.

fascia of the cheek, and brought out at the lower incision. The thread was now cut, leaving enough to drop into the pouch already prepared by separation of skin. A second thread was then introduced in the same way, so as to drain the lower lid. The little incisions were sealed with compound tincture of benzoin and flexile collodion.

The other eye was similarly treated. The dotted lines in Fig. 1 indicate the position of the threads. Fig. 2 shows the condition three weeks after operation.

The thread leading from the right lower lid subsequently gave rise to slight irritation and was removed; the others still remain in position (October 9th, 1909).

The patient was shown to the Surgical Section of the annual meeting of the British Medical Association at Belfast, when I also showed a case of solid oedema of the left side of the face and lips supervening on erysipelas, which attacked a young soldier during recovery after

Fig. 2.—Condition three weeks after lymphangioplasty.

operation for enlarged cervical glands, carried out in one of the military hospitals in England in 1907. On May 11th, 1909, two artificial lymphatics were introduced, the upper ends being secured into the fascia covering the masseter, the threads carried down along the vessels of the neck, their lower ends being dropped into the loose tissue behind the clavicle. The result was entirely satisfactory; the threads never gave the slightest trouble. The face assumed its natural contour.

REFERENCE.

¹ *Lancet*, January 2nd, 1909; *Med. Annual*, 1909, p. 413.