In breech cases I always use the blunt hook. Once I had a fractured thigh, but that was through carelessness.

I had a footling case that gave me a surprise. It was a seven months case, and the leg was protruding well into the vagina. I broke the membranes, when the rush of waters caused the child to perform a somersault, and converted it into a head presentation. The os closed, and left me absolutely dumfounded. The case came off naturally in a couple of days.

As regards some of the curiosities in this series:

Once I heard a child cry before the head was born.

One case was hydrocephalic, and not so easy to diagnose as one would think.

One patient gives birth to enormous dead children with a deep layer of solid oedema. One placenta, after squeezing out the blood, weighed 3 lb. 10 oz.

Another patient had a very projecting promontory, and the head slipped over it with a bump that was audible over the room.

One patient developed peripheral neuritis in both feet; what caused it I never could find out.

I think the most extraordinary experience I ever had was a case of some species of catalepsy—or, more accurately, perhaps, prolonged fainting. She was a primipara whom I delivered with forceps. There was some hæmorrhage, but nothing alarming. She then passed into a state of unconsciousness. Her pulse became slower, weaker, and finally could not be detected at the wrist. Her breathing became almost imperceptible; her cheeks became of a dead-white colour. She lay motionless as if carved out of marble. I stayed some time, but had to leave her, and on passing by the house in the early morning I called and found her perfectly well, and as lively as if nothing had happened.

I have another patient who behaves in somewhat similar manner. Twice I have been called after labour was over and found her unconscious, and had considerable difficulty in restoring life. She has sharp hæmorrhage in each labour.

One primipara kept me busy all day running to and fro endeavouring to keep the heart going, and when she recovered she calmly informed me that similar trouble arose in a London hospital after chloroform for a trivial operation.

Once I was called in to see a case of proptosis of the eyeball in the newborn, and I thanked my stars that there had been no necessity for my services. I lost sight of the people, and cannot say what was the result upon the eyesight. The eye certainly settled back in the place and seemed to be all right.

Four of my cases suffered from pronounced fibroids. There was no hæmorrhage.

I had two cases of vesicular mole. One called for curetting on account of the hæmorrhage.

Once I was called up in the middle of the night to attend a patient, confined seven days. I found her on the verge of departing this life. She had been flooding with secondary *post-partum* hæmorrhage for three or four days. She was in such a critical state that I dare not give chloroform. Fortunately there was no trouble in exploring the uterus. I found a small hard growth in its interior which I curetted away. She made an excellent recovery. This case is stamped upon my memory because I used chloroform instead of lysoform in douching. In the dim light I mistook the bottles, and the result was that she nearly blistered round the buttocks. However, it must have acted as a good antiseptic.

One of my cases swallowed a tablet of mercury perchloride instead of pil. opii. The nurse had stupidly left the tablet upon the dressing table. Luckily the burning sensation in the mouth and throat aroused suspicion. I was summoned and happened to be handy, when an apomorphine injection and plenty of mustard and water saved the situation.

I had a case of hyperemesis in which I was compelled to induce labour in the seventh month. A live child was born, but my patient unfortunately contracted septic endometritis. This is the only case of the sort I ever saw. The stench in the room was unbearable. After repeated use of the curette, douching, and swabbing, she recovered. I am afraid she was infected by the nurse, who happened to be attending a septic case at the time. The chief

peculiarities of the case were: no great rise of temperature, a state of sleepless excitement almost amounting to mania, and the fetid, dark-coloured discharge.

I have consulted all the nurses, and looked over whatever records I possess, and I can find mention of only 7 cases of puerperal infection. I am confident that there were no more. In these 7 cases I had one death, the others recovered; in fact, only two gave rise to any anxiety.

The plan of action that I follow is that laid down by Dr. McCann. For the first couple of days I give a saline mixture, get the bowels well opened, and employ the vaginal douche. I then proceed to uterine douches, and, if there is not a speedy improvement, I give chloroform, press down the uterus, and explore. I use the blunt curette, sometimes the sharp, swab out with perchloride or iodine, and follow up with copious injections of some weak antiseptic solution.

I had one case of puerperal ulcer. This developed on the left labium and destroyed part of the perineum. Of puerperal eclampsia my experience has been fortunate. In this series there were two cases, not severe. I must confess I believe in emptying the uterus as soon as possible. Twice have I been summoned hurriedly to deliver and found the patient dead. One had severe cardiac disease, and the other was badly waterlogged.

One woman, the mother of thirteen children, never knew the meaning of after-pains, and one daughter has inherited the happy peculiarity.

One patient never menstruated before marriage, and another menstruates only when she is pregnant. She enjoys fairly good health.

The ages of the primiparae varied from 17 to 44. Once I was engaged to attend a married woman of the mature age of 14 years and 9 months, and when I arrived the baby was born.

One of the trained nurses was followed for a whole summer by an epidemic of pemphigus neonatorum. She changed her clothes and took antiseptic precautions, but it still clung to her, gradually dying out.

It has happened to me at least once to be summoned to a case after confinement and to find the patient dying and nothing to account for it.

There are two curious opinions current amongst the older midwives:

The first is, that if you have to attend a patient who by reason of her occupation has been chained to a chair, you always get a badly ruptured perineum. I believe there is some truth in that.

The second is, that undoubtedly instruments are called for more often now than formerly. They consider the babies are larger, the parents earn more money, get better food, and altogether take life more easily. Perhaps a simpler explanation is that people are more impatient of bearing pain.

That last *obiter dictum* leads up to the question, Did all these cases really require instruments? I must say that I consider the vast majority did; doubtless there was a small minority that only required a little more time and patience.

Perhaps the confession may lead to censure, but that I can only accept from those cognizant of all the peculiarities of this kind of practice; and these only judges are my fellow-workers, often harassed, often ill-paid and often overworked—the body of colliery surgeons.

LARGE SIMPLE OVARIAN TUMOUR REMOVED FROM A GIRL.

By GEORGE McMULLAN, M.B.,
WALLINGFORD, BERKS.

THE following case is of some interest on account of the age of the patient, the large size of the tumour, which probably had been present in some degree since the onset of symptoms—that is, some eighteen months previous to operation—and lastly, on account of the character of the cyst; for, while the occurrence of malignant tumours of the ovary is not uncommon at this or even at an earlier age, simple multilocular cysts are comparatively rarely met with.

Edith L., aged 16, single, a domestic servant, had first menstruated at the age of 14½ years. She continued to do so regularly every four weeks until July, 1908, when she was 15.

Menstruation then commenced to be irregular and accompanied by pain, and some months later intramenstrual pain was experienced. This state of things continued for some twelve months, the menstrual periods becoming more irregular and occurring at longer intervals, while the pain became more constant in character. About September, 1909, she noticed her clothing becoming tight, and thought her abdomen was becoming larger. It was not, however, until January, 1910, that she sought medical advice, and was then treated for some weeks apparently on the assumption that she was the subject of tuberculous peritonitis. She had had no previous illnesses of importance, and the family history did not appear noteworthy.

Condition on Examination.

The patient was somewhat emaciated, but did not show any symptoms of respiratory embarrassment, in spite of the enormous enlargement of the abdomen, neither were the functions of the bladder or alimentary canal interfered with to any extent. Inspection of the abdomen showed marked symmetrical enlargement; abdominal respiratory movements were normal. The whole abdomen was very tense, and a well-marked thrill could be elicited. Palpation produced no pain, even on considerable pressure. The whole swelling yielded a dull note, extending as high as the costal margin. Above this there was a resonant area, completely replacing the liver dullness. There was resonance in either flank, and, furthermore, the latter resonant areas could be slightly increased by turning the patient on to the opposite side. Rectal examination showed a normal uterus, freely movable, but an ill-defined mass could be felt lying to the right of this organ.

Operation.

The patient having been prepared overnight, an incision, 5 in. in length, was made through the right rectus muscle near the middle line, extending from the umbilicus to a point about an inch above the pubis. The character of the cyst was at once apparent. Having been found to be free from adhesions, it was tapped, 14 pints of clear, glairy fluid being evacuated; it was withdrawn from the abdomen, its pedicle transfixed and ligatured by interlocking sutures of silk, and removed. The left ovary having been examined and found normal, the abdominal wound was closed by three tiers of sutures.

The anaesthetic used was gas and ether. Recovery was uneventful. The tumour, on examination, was found to consist of one very large and several smaller cysts. No ovarian tissue could be recognized in it by the naked eye.

SPINAL ANALGESIA AND PITUITARY EXTRACT FOR FORCEPS DELIVERY DURING ACUTE PNEUMONIA.

By J. A. HENTON WHITE, M.D., F.R.C.S. EDIN.,
BIRMINGHAM.

I CAN find no record of forceps delivery under spinal analgesia, and venture to think the following case is of interest.

On April 4th I first saw Mrs. M., aged 28. She expected to have been confined of her fifth child on March 30th, and had engaged a midwife to attend her. All went well until April 3rd, when a bad shivering fit, accompanied by stabbing pain in the right chest, set in.

I found her sitting up in bed breathing very rapidly (40), cyanosis was marked, the pulse 140, and the temperature 102°. There were signs of consolidation and pleuritic friction over the lower and middle lobes of the right lung. There was no sign of labour. Next day the patient was weaker and did not recognize people, and showed signs of puerperal insanity.

At 1 a.m. on April 7th I was sent for, and found labour had set in; the os was about the size of a crown, and the waters were broken; the head was above the brim. The patient was desperately ill, the pulse was thready, and the cyanosis was of a livid hue. In spite of strychnine hypodermically, no efficient pains could be induced, and to prevent the patient dying undelivered I decided to try spinal analgesia; 1 c.cm. of a 5 per cent. solution of tropacocaine was injected in the middle line of the back below the twelfth dorsal spine with the patient leaning forwards sitting up in bed. Analgesia supervened rapidly, and I applied forceps with the patient sitting on the side of the bed, with the legs as far apart as possible, and supported on two chairs. I found it impossible to exert enough traction in this position, and put the patient on the left side, with the shoulders well raised on pillows, with the double object of easing the breathing and preventing the fluid running too high up the spine. I then rapidly effected a difficult delivery. The child was a large one, and there was a depressed fracture of the frontal bone owing to the severe traction required and the angle at which I was obliged to pull; it survived only two days. As soon as the child was delivered serious flooding set in, due to atony of the uterus from the spinal analgesia, and also to the engorged state of the venous system. I had anticipated this, and at once injected 12 minims of pituitary extract (Duncan, Flockhart and Co.) into the buttock, and introduced my hand into the uterus; as soon as I had well grasped the placenta a violent contraction of the organ took place, so violent that it

would have been impossible to introduce the hand. The placenta was removed and the bleeding stopped. The pulse greatly improved; instead of being thready and uncountable it became of full volume and good tension, and the general condition was very good.

The pneumonia ran a severe course, the upper lobe of the right lung becoming involved on April 10th, and puerperal insanity set in severely. The patient died from exhaustion on April 19th.

This case, although unfortunate in its termination, is instructive in that it shows the possibilities of spinal analgesia under conditions which precluded the use of a general anaesthetic. The woman felt nothing of the severe traction which I had to use. I could not safely have injected ergot to cause uterine contraction owing to its depressing action on the heart. Pituitary extract acted splendidly in this emergency, and is, I feel sure, a drug to be kept in the midwifery bag for use with a weak heart. Normal sensation returned in the legs about two hours and a half after the injection. The urine had to be drawn off on April 10th.

This case was conducted single handed with the help of an untrained woman, in a badly-lighted room.

SOME OPHTHALMIC CONDITIONS CAUSED OR INFLUENCED BY DISEASES OF THE UPPER RESPIRATORY TRACT.

By A. S. COBBLEDICK, M.D., B.S. LOND.,

LATE RESIDENT MEDICAL OFFICER, GOLDEN SQUARE THROAT HOSPITAL AND SOUTH LONDON EYE HOSPITAL.

THE consideration of abnormal nasal conditions and the possibility of their presence coincident with eye disease is of much importance to the ophthalmic surgeon in forming his diagnosis and carrying out his treatment; the rhinologist, on the other hand, does not obtain so much assistance from ophthalmology, for nasal conditions are not much affected by ocular disease.

The ophthalmic surgeon may not be able to complete his treatment of a case without the assistance of a rhinologist, but he should be so equipped as to be able to complete his diagnosis without additional advice.

EYE CONDITIONS IN CHILDREN.

Corneal Ulcer.

One of the most common eye diseases of childhood, especially in hospital practice, is ulceration of the cornea. The condition is troublesome to treat, usually very painful, and cure is frequently delayed for years on account of the great tendency to recurrence. As the ulcers may be deep and centrally situated, leaving permanent and dense nebulae, they are the cause of a considerable amount of defective vision.

The chief causative factors are bad hygiene, insufficient and unsuitable food, and the presence of post-nasal growths.

The first and last of these may be said to be always present in hospital patients, but the food factor may not be so prominent, owing partly to the fact that the painful nature of the affection and the general depressed condition of the child makes him refuse the best of food. Bad hygiene, which includes lack of cleanliness, of nursing, of warmth, and of good surroundings, has much to do both with the general ill health and tardy recovery. This is shown in patients admitted into hospital when nearing perforation; the child is cleaned, kept warm, and well nursed, generally as well as locally, he soon begins to eat, and recovery is much more rapid. This, however, is not cure, and recurrence is the rule within six or twelve months; the chief cause of this recurrence is the presence of post-nasal adenoid growth. If the adenoids are removed when the eye condition is quiescent recurrence is the exception. I am so convinced of this that I do not consider any case of severe or even slight corneal ulceration has been adequately treated without resort to this operation, for a slight initial attack may be followed by a severe second one with great disturbance of vision. The following is a typical case:

A boy, aged 6 years, with deep central corneal ulcers of both eyes, much pain and photophobia, was treated for three years at the South London Eye Hospital; on an average he had three recurrences yearly; consequently he was practically in continuous attendance. On three occasions his condition was so