sterility is probably due to the structural and developmental abnormalities in the uterus induced by the abnormal diet. It has been shown² that the consumption of meat per head in this country is to-day almost seventeen times as great as it was in 1850. During the same period the fall in the birth-rate has been most marked.

While it would be unwarrantable to attempt to found any theories in regard to the falling birth-rate on the results of this limited experiment, yet, when we add to the above facts the further consideration that the diminished birth-rate is most marked in the better-off classes of society—that is, among the very classes whose means permit of an unrestricted use of the more expensive meat diet—it is evident that the food factor is one which is at least worthy of consideration in dealing with the great question of the falling birth-rate.

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A CASE OF SUDDEN DEATH AT THE CLIMACTERIC.*

By ELDON PRATT, M.D.LOND., M.R.C.S.,
HENFIELD, SUSSEX.

On August 3rd, 1906, I was hastily summoned to see a woman who was said to be in a fit. I was on the spot within a few minutes, reaching the house at 9.10 a.m. I found her lying supine on a sofa dead.

She was a highly-respectable woman, aged 45 years. The history of this fatal attack was as follows: She rose as usual at 5.30 a.m. on the morning of her death, and attended to the requirements of the house, taking only a cup of tea with her husband, who left for work at 6 a.m. She was quite cheerful and complained of nothing. Her next door neighbour saw her at 7.20 a.m., and remarked that she looked "faint and rather bad"—lately a not unusual thing with her, as she knew the "change of life" was about her. She said she began to "feel queer" about 7 a.m. Her neighbour gave her some hot tea at 7.30 a.m., which was quickly vomited. Smelling salts were administered as she continued to feel faint, and eventually her husband was sent for. Although so faint she was cheerful, and quite thought she would soon be feeling better; she retched two or three times but brought nothing up after the first vomit. At 8.45 a.m. she seemed to change suddenly; the hands became clenched, the face somewhat dusky, and the nails discoloured; she said she felt very cold and she looked as if a "fit" were impending. A few minutes later, and quite suddenly she changed again for the worse, became unconscious, gave three blowing expirations, and then seemed as dead. When questioned as to why I was not sent for sooner, the neighbour said she had seen her in many previous attacks quite as bad as, or even worse than, this one, except for the sudden and unlooked-for change at the end.

The recent history of this woman was thus: For the last year she had suffered from occasional severe headache; for the last six months she had been subject to "fainting turns," with frequent retching, such attacks lasting half an hour to an hour, when she would be all right again; the attacks always occurred early in the morning. The frequent flushes and cold sweats of the climacteric were experienced, and irregular catamenia, of late every two weeks or so, not much loss, but extending over a longer period than normally. The last menstrual period was a week previous to the fatal attack. She was a healthy, cheerful, bright, and happy woman. She had borne seven children, five now living. Her father died suddenly at the age of 60.

The autopsy revealed nothing, all organs and structures being normal, with no signs of internal haemorrhage or of poisoning.

The following points are especially worthy of note: (1) The fatal attack occurred during the climacteric; (2) attacks of a similar nature (except for the fatal termination) had occurred before; (3) the attacks were always in the morning; and (4) absence of any signs of disease *post mortem*.

It is a well-known fact that the nervous organization of most women is put to a considerable strain during the climacteric, and attacks similar to the one recounted above are common enough, being reflex in origin, and always occurring early in the morning, in which respect the attacks are analogous to the vomiting of pregnancy. Whereas the symptoms associated with the climacteric are not usually of a serious character, I take it as quite within the bounds of possibility for an attack such as I have described, and originating in the genital organs, to so act

reflexly that the balance would turn towards death instead of towards recovery. For have we not in this case the evidence of the neighbour who said that she had seen the deceased in attacks worse than this last fatal one, except for the immediate change at the end? Yet from these sufficiently serious attacks she had always previously recovered. Be it noted that this change at the end of the attack was a matter of a few seconds—it was truly a case of *sudden death*. The negative result of the autopsy also supports me in this solution of the cause of death. In my evidence at the inquest I gave as the cause of death "asthenic syncope immediately dependent upon the climacteric." Such a cause of death, although rare, seemed to me to be so obvious that subsequently I was indeed surprised to find no record whatever of any similar case; after searching numerous authorities, I have failed entirely to discover that the climacteric has been held to account for sudden death; hence my paper with a view to ascertaining the opinion of others.

A NOTE ON THE USE OF THE BLUNT HOOK.

By J. EDWARD GODSON, M.B., B.Ch.BIRM.

THE point I desire chiefly to emphasize in the following report is the comparative ease with which delivery was effected with the blunt hook in a case which presented elements of great difficulty. As a matter of fact, I doubt if any other means could have been successfully employed without recourse to anaesthesia, and this, too, where the use of chloroform was practically inhibited.

Mrs. G., an 8-para, with advanced mitral disease, commenced labour on April 4th, 1907, and after several pains the membranes ruptured and the waters escaped in one gush. The pains then abated, but continued at intervals of about an hour. Her last two confinements had been prolonged and severe; the sixth a shoulder presentation, the seventh a vertex terminated by high forceps extraction. In her case there were several causes inevitably tending to produce difficult labour: constitutional debility, uterine inertia, swelling and oedema of the soft parts, and above all marked contraction of the A.P. diameter at the brim produced by projection of the sacral promontory.

I was called to see her on April 5th, and found the os uteri the size of a sixpence, the soft parts very oedematous, and a breech presentation (abdomino-anterior position) with the legs fully extended on the trunk. As labour was progressing naturally, I judged it unwise to interfere at this stage, and contented myself with watching her closely during the next forty-eight hours. The general condition continued good, the uterine pains were hesitating, long-delayed, and inadequate, the dilatation of the os was progressive but tardy, and there was a free escape of meconium. On April 7th the patient was in much the same condition, but suffering from want of sleep and inability to take nourishment, while the uterine contractions still came at half-hourly to hourly intervals, and the oedematous os would now admit the tips of four fingers. After some hesitation I determined to leave her yet awhile, being chiefly influenced by the long-interval character of the pains, the desirability of further modelling and descent of the breech, the danger of chloroform with the heart so faulty, and the difficulty of working without it in so confined a space, and with the presentation so high up. The rectum was emptied by enema, the vagina washed out with antiseptic douches, four 5-grain doses of quinine were given every four hours to whip the uterus into quicker action, and liquid food was administered regularly. Under this treatment the pains became more frequent, and the os was fully dilated by 10 p.m., but to counteract these advantages the patient had an alarming attack of syncope, and the breech became impacted. I tried to break up the presentation and bring down a leg, but found this even more impossible now than it had been at an earlier stage. An attempt to get a fillet over the thigh was equally unsuccessful; while the forceps were easy to apply and equally easy to withdraw, as they failed to obtain an efficient grip.

The blunt hook remained as a final resource, the instrument to hand being of an obsolete pattern with an internal diameter of 1½ in. A small hook is easier to use than a large one, but possesses certain dangers and disadvantages of its own; the device by which I have attempted to overcome these will be mentioned later on. I applied the instrument without difficulty, and extraction of the breech followed with greater readiness than might have been anticipated. The shoulders—the most massive I have ever seen in a newborn child—caused considerable delay, but this did not matter much as the child had evidently been dead for several days. The final stage of delivery was concluded without trouble.

The child was a male, at full term. It had an offensive odour, and large surfaces were denuded of epidermis. It was 12 lb. in weight and 23 in. long. The bones of the skull were strong and normally ossified; the occipito-frontal circumference was 15 in., the occipito-mental diameter was 6 in. while the biparietal was 4.50 in. The circumference of the

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