and this is, as a rule, so complete that the whole body feels unsupported, as if floating in air. Pain, even at this stage, frequently persists, showing how little influence this drug evidently has on the sensory nerves. In some cases, spasmodic contractions of the voluntary muscles result, and this is more especially to be noted in the muscles of the jaw. Dimness of vision in many cases quickly follows, the pupils in some remaining unaltered, in others being apparently contracted. The pupil responds to light, but accommodation is interfered with, objects at a distance being very indistinct. The pulse is invariably rapid, but quite regular. Sensibility to touch is unaltered. Numbness and tingling have been constant symptoms in all the cases.

OCCIPITO-POSTERIOR PRESENTATIONS.

By A. D. LEITH NAPIER, M.D., Dunbar, N.B.

APPROPOS of recent memoranda relating to occipito-posterior presentations, three cases have recently fallen to my lot within one week.

CASE I.—A secundipara, aged 34, had been delivered, by forceps, two and a half years before, and then sustained perineal laceration, which was sutured and healed. On March 26th, 1883, I was sent for about 11.30 P.M. On examination, found the membranes ruptured, the os well dilated, the anterior lip swollen, posterior freely movable. The head was lying in the third position (right oblique, occiput posterior), and fixed in the middle third of the pelvis; transverse diameter was somewhat contracted. The anterior lip was supported, and slipped over the head; there was no natural attempt at rotation. Manual efforts to bring the occiput forwards failed. Equal parts of ether and chloroform having been given, the straight forceps was applied about 1.50 A.M. Rotation was attempted cautiously, but as more force seemed necessary than was thought justifiable, it was not continued. It was impossible to raise the head, as mentioned by Smellie and others. Traction being directed backwards, as the head neared the outlet, the forceps, pressing on the cicatrised part of the perineum (the cicatrix being easily distinguished by its hardness and non-elasticity), caused a right lateral laceration of about an inch; the tear was foreseen and calculated on. The head came without further rupture, and a large female child was born about 2.10 A.M. On the removal of the placenta, a violent gush of blood occurred, and the uterus did not contract. More ergotine was injected, and with extra-uterine and intra-uterine manipulation, the uterus contracted. A silver suture was inserted for the perineal rent, and the patient washed with carbolic water. No single unfavourable symptom during the puerperium.

CASE II.—A secundipara, aged 26, had been delivered two years ago instrumentally, and sustained considerable perineal laceration, for which she consulted me several months later. Labour came on on March 30th, 1883. On visiting about 4 P.M., I found the membranes had been ruptured for some hours; the os was almost of the size of a crown; the head on the upper third and in the fourth position, left oblique occiput-posterior. The patient was highly nervous, and the pains most feeble and unsatisfactory. I revisited about 5 P.M., and found very little alteration, except that the parts were hot and tense, and the anterior lip swollen; the caput succedaneum was prominently felt on the right parietal bone. Dr. Steele's modification, and, afterwards, one of Barnes's largest sized bags was introduced within the uterus anteriorly; the former became displaced; and, partly owing to accidental tension from the connecting syringe, the larger bag also was dislodged; it was reintroduced, but not, as formerly, wholly within the os, and fully distended. Pressure on the bag, and digital posterior expansion during the pains, shortly relaxed the os; the bag was withdrawn, and the os slipped over the head. The pains increased in severity; the head advanced, and, aided by digital manipulations, the occiput rotated forwards as it neared the pelvic floor, and, before seven o'clock, a large male child was born with the occiput anterior, the face turned to the right thigh of the mother. The umbilical cord entangled the shoulder. Recovery excellent.

CASE III.—This was a quartipara, aged 29; youngest child eighteen months old; her deliveries had been usually easy. The patient was taken ill on the afternoon of April 1st, 1883. I was summoned on April 2nd about 4 A.M. On examination, the os was found easily dilatable, the membranes unruptured; the head occupied the right oblique position, the occiput posterior. After waiting nearly an hour, and finding no alteration, and noting the inefficiency of the pains, I supported the anterior lip, which slipped

over the forehead, ruptured the membranes, and shortly after the pains increased. Upward pressure was maintained on the head anteriorly, and the natural rotation aided during the pains. As the head reached the pelvic floor, the perineal and vaginal tension was relaxed by stretching the posterior vaginal wall by the fingers; the occiput moved to the front, and, about 6.30 or so, a fine male child was delivered: the face rotated downwards to the left thigh. Recovery was excellent.

The occurrence of these consecutive occipito-posterior presentations is uncommon. Two clear examples of third presentations, within so short a time, is a proof of the assertion advanced by modern writers, that these are less unusual than was credited by bygone authorities.

The character of the labour was alike in all three, inasmuch as the pains were feeble, and of brief duration; artificial aid was given in all. The anterior lip was pressed upwards, as it delayed delivery, and far more effectual support to the anterior portion of this can be made digitally.

In Case I, the narrowed transverse diameter and the unyielding perineum probably explained the non-possibility of forward occipital rotation. Despite assertions to the contrary, I venture to think some perineal laceration in instrumental occipito-posterior deliveries is almost inevitable, unless either the fetal head is smaller, or the maternal parts more roomy than the average. I also think that more scientific and accurate instrumentation can be carried out in these cases by means of straight forceps, unless the head is at the brim, when curved instruments are preferable. To reverse curved forceps, for rotation purposes, would generally be more risky than the circumstances warranted. I esteem artificial rotation, by curved instruments, attempted in the cavity, far more hazardous than the chance of moderate perineal laceration, which is rendered probable by effecting delivery with the occiput backwards.

In Case II, pressure on the anterior part of the head was continuously maintained by the India-rubber bag; certainly this manoeuvre was serviceable, and merits further trial. Had it not been for its adoption, I am convinced the case would have required forceps.

Case III illustrates the value of precise diagnosis, and how, by means of safe and ready aid, nature may be assisted.

ON THE DELIGATION OF LARGE ARTERIES BY THE APPLICATION OF TWO LIGATURES AND THE DIVISION OF THE VESSEL BETWEEN THEM.

By W. J. WALSHAM, F.R.C.S.

IN the BRITISH MEDICAL JOURNAL of April 21st, Mr. James Black, referring to an article of mine on the above subject in the JOURNAL of April 7th, suggests, as a possible objection to the method therein advocated, that, in the case of an artery such as the femoral, the branches of which are apt to arise abnormally, a large branch might occur between the two ligatures, and, not being discovered until the moment of dividing the vessel, would cause at least some embarrassment. The presence of a large branch either close above the upper ligature or below the lower would, no doubt, tend to endanger the success of the operation, as it would were it to occur near a ligature applied in the usual way. Given, however, an abnormal branch at the situation where the artery is usually tied, should it happen to arise between the two ligatures, it would, I take it, be a fortunate occurrence for the patient, as a ligature could then be applied to it also before dividing the vessel, and all chances of secondary hæmorrhage from this source be prevented. As to the discovery of such an abnormal branch, Mr. Black says that, when an artery is neatly tied, such a very small opening is made in its sheath, that it would be quite impossible to tell whether a branch is given off from the posterior aspect of the trunk. This, of course, holds good in applying a ligature in the usual way, but not in the method advocated by me. In my cases, the sheath having been freely opened, the ligatures were applied a little less than half an inch apart (*not* a little less than an inch)—*i.e.*, as close together as possible, consistent with the division of the vessel and the prevention of the slipping of the ligatures. The small portion of the artery, therefore, between the two ligatures, was fully exposed, and a director passed under it before the division was made. Any branch, consequently, arising from its posterior or other aspect, would have been readily discovered.