perature was 101° F., and the pulse 110. A fortnight before this she noticed a lump on her left side, which she declared moved about and changed its position from time to time. The lump, about the size of the fist, was hard, smooth, very tender on handling, dull on percussion, and tympanitic all round, with a well-marked sulcus between it and the pregnant uterus, which it had pushed to the right. Nothing distinctive was made out on vaginal examination.

To summarize, we have a patient in a pregnant condition with a movable lump in the side seized suddenly with severe pain, vomiting, rise of temperature, and acceleration of pulse. I came to the conclusion that I should have to alter my diagnosis of the previous night, and diagnosed an ovarian cyst—probably a dermoid—which had undergone axial rotation. Mistake No. 2. Baldy says if you get sudden and violent pain in the abdomen, vomiting, and acute swelling, suspect axial rotation, which is still more probable if the patient is pregnant. Bland-Sutton says:

The symptoms are very characteristic. A woman known to have an ovarian tumour complains of sudden and violent pain with vomiting, or, if seen for the first time, has these symptoms associated with an abdominal swelling, suspect axial rotation. If there is also a gravid uterus more probable still.

Mr. Moynihan, who saw the case with me, agreed in the diagnosis. It will be admitted, then, if I made a mistake I made it backed up by the best authorities. I think the error was pardonable. Here was a small tumour with presumably a long stalk, seeing that the tumour was a couple of inches higher than the umbilicus; and acute torsion is generally seen in small tumours with long stalks, pregnancy being the most commonly associated condition.

There were a few symptoms, however, not quite characteristic; although the tumour was very tender the pain was not in the abdomen but in the lower part of the back, which should have made one suspect the body of the uterus, not an ovarian cyst; there was no acute swelling of the abdomen, and the patient instead of gradually getting worse was, if anything, a little better on the third day, especially after a dose of morphine. It is always easy to be wise after the event.

I operated the next day, and on opening the abdomen was rather astonished to find a sessile mass attached to the left of the fundus uteri. There were no adhesions and no discoloration of the peritoneum covering the tumour, showing that there was no inflammatory condition present in it. On section of the tumour after hardening there was neither haemorrhage into its substance nor beneath its capsule. The pain, I believe, was due to the malignant influence all fibroids have upon the pregnant state—a tendency to produce abortion or miscarriage.

The uterus was gently rotated so that the tumour appeared in the abdominal incision. The growth was sessile, with a broad base, and although truly subperitoneal it was deeply imbedded in the wall of the uterus, more than one-third of the tumour lying in a saucer-shaped cavity. The amount of tissue separating it from the interior of the uterus must have been small indeed. It was almost spherical in shape and measured 9½ in. in circumference. The way recommended to remove a subperitoneal fibroid is to transfix the base and cut off the tumour. By rough dragging one could have succeeded in making a sort of pedicle and so followed the above line of treatment, but I am sure with fatal results as far as the pregnancy was concerned, even if no other evils had followed. The way to remove an interstitial growth is to cut down into its capsule and enucleate. I adopted a middle course by making a circular incision through the peritoneal covering near the base of the tumour, which latter readily shelled out of its bed. The bleeding from the tissue in which it was embedded was profuse, as none of the bleeding points would hold a ligature, the uterine tissue being so soft and friable, and the blood vessels so fragile. I applied pressure for a time, and then gently drew the sides of the cavity together with Pagenstecher's thread. This was irksome, as the peritoneum and the uterine wall beneath tore through readily, and did not hold well, but by overlapping stitches the bleeding was controlled. Greig Smith mentions the stoppage of haemorrhage as one of the difficulties in enucleating fibroids from the unimpregnated uterus; how much more so must it be in the pregnant state!

It is interesting that this patient had no uterine contractions, nor pain of any moment, although there was a considerable injury to the wall of the uterus, neither were the fetal movements interfered with. I attribute this to the fact that no antiseptics were used.

The patient was delivered of a boy at full term.

OCCIPITO-POSTERIOR PRESENTATION.

By GEORGE GEDDES, M.D. ABERD.,
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A CLEAR knowledge of this condition is of the utmost importance to the general practitioner, because of its frequent occurrence and the difficulty often experienced in recognizing it in practice.

Many members of the profession consider the necessity of distinguishing between cases where the occiput presents in front, and those presenting posteriorly of little importance. At least one of large experience considered life too short for any one to trouble about such a trifling matter. Personal experience teaches us that unless one can diagnose occipito-posterior positions upon the threshold of professional life, there is little hope of being able to do so in later years, when the exigencies of general practice allow little time for the acquirement of fresh knowledge. It is useless to consult textbooks upon the subject, because most of them only devote a few paragraphs to the subject.

Theoretically there would appear to be no difficulty in the diagnosis of occipito-posterior positions, but in practice, unless great care is exercised, it will be found most difficult, if not impossible. Moreover, a correct diagnosis is essential to correct prognosis and treatment, for if the condition is recognized much unnecessary loss of time might be avoided, for such cases are invariably tedious and could therefore be left to themselves while the accoucheur attended to other work. Again, unless endowed with great patience it is difficult for the accoucheur to resist the temptation to use the forceps, and if he does so he is almost certain to rupture the perineum because of the abnormal position of the head.

For five years after graduating I attended a large number of primiparae, and was much impressed by the large proportion of occipito-posterior presentations occurring among them.

The following figures are based upon 300 cases:

In multiparae:

10.5 per cent. of the total vertex cases were occipito-posterior presentations.

In primiparae:

20.8 per cent. (of the total vertex cases) were occipito-posterior presentations.

(a) In England:

25 per cent. were occipito-posterior presentations.

(b) In Scotland:

15 per cent. were occipito-posterior presentations.

The question naturally presents itself, Why should occipito-posterior presentation be more frequent in primiparae? And, again, Why should occipito-posterior presentation be more frequently met with in primiparae in England?

To suggest an answer, let us consider what differences, anatomical or physical, exist between a primipara and a multipara, and it will be admitted that the condition of the anterior abdominal wall seems most likely to furnish a feasible explanation. It will be admitted that in primiparae the abdominal wall is capable of greater muscular power than in multiparae, because in the latter the abdominal distension is bound to have a weakening effect upon it. How, then, does this factor explain the frequency of occipito-posterior presentation in primiparae?

There seems no reason why the head should enter the pelvis with occiput anterior rather than posterior. Let us assume, therefore, that the chances of occipito-anterior and occipito-posterior are equal, and that the head enters the pelvis occiput posterior with equal frequency in multiparae and primiparae. Then one can easily show why on this theory the occiput should tend to remain in the posterior position more frequently in primiparae than in multiparae.

Suppose the head engages the pelvis occiput posterior: In primiparae the tense abdominal wall tends to push the top end of the lever (the lever is the uterine axis)

backwards, and therefore the lower end of the lever by acting more on the anterior part of the head fixes the head in this abnormal position because flexion is retarded, whereas in multiparae the abdominal wall being more relaxed the top of the lever being forward produces pure flexion and thus rotates the occiput forward.

This theory would also explain why there is a larger proportion of occipito-posterior presentations in England (Lancashire) than in Scotland, because in Lancashire many mothers follow their occupations until within a few weeks of confinement, this necessarily involves increased muscular exertion, in which the anterior abdominal muscles would certainly participate.

This theory is advanced with diffidence. It certainly appears tenable, and accords with the facts. Consider now symptoms, etc., frequently associated with occipito-posterior presentations.

1. *False Pains.*

A history of genuine false pains should always suggest the probability of the presentation being one of occipito-posterior. The qualifying adjective genuine, as applied to the false pains, is used advisedly to distinguish them from the false pains often present without dilatation of the os. In the genuine false pains we have for a longer or shorter period before birth pains occurring at irregular intervals and associated with more or less slight dilatation of the os.

It appears reasonable to suppose that those pains are due to uterine contractions induced by abortive attempts of the womb to rotate the head.

2. *Position of Fontanelles.*

Were those always easily recognized diagnosis would be simplified; but generally it is difficult to recognize them at all, to say nothing of distinguishing the anterior from the posterior, because they become obliterated by the bones overlapping at the sutures, and this obliteration is more marked the lower the head descends in the pelvis.

Although baffled here, there are other signs, however, whose presence suggests occipito-posterior presentation. They are not peculiar to occipito-posterior presentation, but their presence is suggestive, and careful examination prevents mistake.

3. *Premature Rupture of Membranes.*

This occurring in a vertex presentation should always suggest occipito-posterior presentation. A probable explanation of this symptom is the position of the head. The head being fixed in front and behind does not fit the pelvic cavity so accurately as in the case of occipito-anterior presentation. All the intrauterine pressure, therefore, is exerted upon the membranes on each side of the head—hence early rupture is inevitable. Again, a leakage of liquor amnii during each pain is suggestive of occipito-posterior presentation, and is capable of a similar explanation—that is, the head does not act as an efficient plug, as in the case of occipito-anterior presentation.

4. *Parchment Os.*

The name is sufficiently descriptive, and, once recognized, the condition is never forgotten. The cervix feels like a sheet of notepaper, especially posteriorly. The anterior lip is pendulous. This condition is produced by the head pressing upon the posterior lip more than upon the anterior, but at no part of the circumference does the head approach near enough to the margin of the os to produce dilatation, although it causes thinning of the cervix. The cervix also seems to hang free in the pelvis, suspended, as it were, between the head and the outlet.

5. *A Sensation of Emptiness in the Hollow of the Sacrum.*

This is evidently due to the arrest of the head at or near the promontory of the sacrum, and, if present, is not so pronounced in occipito-anterior presentation.

6. *Position of Ear.*

If the ear can be reached—and in occipito-posterior presentations it is generally easy to reach it—and its position recognized, it aids the diagnosis.

There are other conditions in which one or more of the foregoing signs might occur, only they are associated with other characteristic signs which render their discussion superfluous.

A complication of occipito-posterior presentation not

infrequent is prolapse of the cord, a misfortune which upon two occasions in my experience caused the death of the child.

Treatment.

The best advice seems to be, allow Nature a long time in which to rotate the head. Attempts at rotation by forceps usually fail. Pressing upon the front of the head during a pain is a safe procedure, and sometimes accelerates rotation. Best of all—go away and attend to other work, and upon your return you will generally find the child born. In any case, think twice before using forceps.

OPHTHALMOLOGY: PAST AND PRESENT.*

BY SIMEON SNELL, F.R.C.S. EDIN.,

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THE subject on which I now wish to address you is a comparison of ophthalmology as it existed in my student and early professional days and as it is at the present time. Time only permits of a reference to a few topics.

The ophthalmoscope—the discovery which brought to Helmholtz undying fame—had, of course, been invented for many years, and it had completely revolutionized our knowledge of diseases of the interior and background of the eye. The main features of disease, as observed by this instrument, had been studied and differentiated and their appearances depicted in the well-known atlases of Jaeger and Liebreich. The value of the ophthalmoscope was in a measure understood by the physician. Whilst I was acting as house-physician to Dr. Clifford Allbutt he was engaged on his book on *The Use of the Ophthalmoscope in Diseases of the Nervous System and of the Kidneys, etc.*, and I remember some, at all events, of the cases from which he drew his material for that work. It was about this time, too, that Hughlings Jackson was impressing the need for the routine use of the ophthalmoscope in medical cases, and was pointing out that optic neuritis could be present without diminution of vision. Before this time, also, Graefe had shown the value of iridectomy in glaucoma, an operation which combated a disease hitherto regarded as hopeless, and in succeeding years must have been the means of preserving sight in count-

* Part of an address to the Leeds University Medical Society on November 28th, 1905. Portions dealing with the Leeds Infirmary and its medical staff of the past, as well as with that of Moorfields Ophthalmic Hospital in those days, are omitted.