incision was 4 inches in length downwards from the umbilicus; through this the tube, stiffened as described, was passed over the fundus, and then drawn down as low as possible, the wire drawn out, and the tube tightened and knotted. Then the uterus was opened without hæmorrhage, and the left hand introduced to push aside the placenta and find a foot. This was found with some difficulty, and a living infant delivered. Next the uterus with placenta enclosed were drawn out, coils of gauze being introduced to prevent intestines following, and the only assistance that was required by the operator was the "neighbours" to hold up the uterus whilst it was being transfixed with guarded pins and amputated. Four sutures closed the abdominal wound, the "stump" filling quite one-third of its length.

After-History.

On the third day the temperature reached 102°; then, after a dose of Epsom salts, it became normal. The stump came away on August 21st. I exhibit it to show the effect of the elastic ligature. I regret I am unable to show the patient and infant.

The woman was walking about by the fifth week, and they then left the district. I have had the help of the police and the "King of the Gipsies," but the scent was lost at Blackburn.

In conclusion, I would express the hope that two successes so easily obtained may (in the words of Dr. Herman) help "to relegate craniotomy, the induction of premature labour, and symphysiotomy, alike to the past."

NOTES AND REFERENCES.

¹ They were very uncertain about everything. Two "doctors" were said to have attended, but neither of the names given as at Halifax are in the *Medical Directory*. ² Galabin. ³ *Lancet*, 1890. ⁴ In the previous case reported in the *Lancet*, I described the operation as "Tait-Porro's operation." As I find this is not generally understood, I now adopt Galabin's name, "Cæsarean hysterectomy."

A NOTE ON THE TREATMENT OF PUERPERAL ECLAMPSIA.

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IN appreciation of Dr. FitzGerald's article (in the *BRITISH MEDICAL JOURNAL*, November 24th, p. 1496) on the treatment of this condition; but more as a criticism on the article by Dr. Jardine, I would like to point out that Dr. Jardine makes a great mistake in considering "diuretic infusions" the treatment of puerperal eclampsia. It can only be considered a small, and by no means the essential part of the treatment.

There are three great principles in the treatment of this condition:

1. The purifying of the blood.
2. To control the convulsions.
3. The emptying of the uterus.

Diuretic infusion is a valuable addition to the usual treatment adopted for purifying the blood (purgatives, enemata, diaphoretics, vapour bath, diuretics, etc.), but it has no immediate effect in controlling the convulsions, nor has it any effect on the action of the uterine muscle.

In order to control the convulsions in eclampsia, it is necessary to allay the irritability of the cerebro-spinal system; morphine, chloral, veratrum viride, and chloroform have all been used. Chloroform is undoubtedly bad, as its action is very temporary, and very depressing to the patient; the action of chloral and veratrum viride is more lasting, but they are both cardiac depressants; while morphine, judiciously given, is quite free from any disadvantage, and has the following advantages:

1. It controls the convulsions by allaying the irritability of the cerebro-spinal system.
2. It prevents excess of waste products being thrown into the blood.
3. It does not weaken the patient.
4. It does not injure the child.
5. It has no effect on the kidney.
6. When the patient is under its influence labour often commences, and quickly terminates without causing more convulsions.

In my own experience at the Rotunda Hospital, of eight consecutive cases of puerperal eclampsia, all of them treated

by morphine, only one died. In this case only did the morphine appear to have no effect, the convulsions continuing frequent and severe, and the temperature rapidly rising to 106.6° F. The liver was very large and extensively diseased.

Now, with reference to the third great principle in the treatment—the emptying of the uterus. As soon as the patient enters the second stage of labour she should be delivered by the forceps, but any mechanical interference (induction of premature labour, mechanical dilatation of the cervix, version, or *accouchement forcé*) during the first stage of labour is extremely unsuccessful treatment, as is evidenced not only by his own statistics (all the maternal deaths having occurred under this heading), but by the experience of many authorities.

Should labour not supervene under the morphine, the morphine will generally control the convulsions for the time being, and the patient, if carefully treated, will probably go on to full term without any recurrence of the symptoms of eclampsia.

A NOTE ON THE OCCURRENCE OF ABORTION.*

By J. B. HELLIER, M.D.

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IT is a question of some interest to determine what proportion of married women have one or more miscarriages, but never carry the function of utero-gestation to full term. One is not infrequently asked under such circumstances by a woman disappointed of maternity what her chances are of bearing a living child. Some data for answering this question are afforded by the following statistics. I have had the opportunity of collecting records concerning 1,800 women who attended as out-patients at a gynaecological clinic. The observations were made while I was on the honorary staff of the Hospital for Women and Children at Leeds; and by the courtesy of my late colleagues I was enabled to have reference made to their records as well as to my own. The out-patient papers contained a statement of the number of children and abortions in each case. It is quite true that a woman cannot always be relied upon to state accurately the number of abortions she has had. She has probably miscarried as many times as she says, perhaps more. This uncertainty qualifies the value of the figures here given, but does not seriously invalidate the one point on which I draw conclusions from them. The patients being gynaecological, and having, *ipso facto*, in most cases some pelvic disorder, the tendency amongst them to miscarry would be above the average for all married women. They were drawn principally from the poorer working classes in a manufacturing centre, and were almost all engaged in household or other manual labour. The cases of unmarried women were neglected in collecting these statistics.

The 1,800 married women had given birth to 6,974 children, an average of 3.87 each. They had had, according to their own statement, 1,288 abortions. This amounts to about one abortion to every five and a-half children. The number of women in the 1,800 who had had abortion but no children was 58. Deducting from the 1,800 184 women who had never been pregnant, 1,616 remain. So that of 1,616 women who had been pregnant, 58 had had one or more abortions, but had never gone to term. Thus it follows that amongst a group of women where the frequency of abortion might be supposed to approach the maximum, 96.5 per cent. of those who became pregnant did sooner or later bear one or more children at term.

I think this statement of probabilities is likely to afford consolation to many of our patients.

A SUBJECT-PURVEYING SOCIETY.—There appears to be a dearth of dissecting material in Brussels. The scarcity is said to be increasing, and to be so great as to threaten a dearth not only in dissecting rooms but in operative surgery. This state of things has led Drs. Aburnin and G. Daniel to suggest the foundation of a new society, to consist of persons who will undertake to leave their bodies at the disposal of the universities to be used in furthering medical education and the advance of medical science.

* Read before the North of England Obstetrical and Gynaecological Society.