Operation.—On consultation with Dr. Rendell of this city we discussed the advisability of hysterectomy and other measures, and decided to try the operation recommended by Dr. Pryor, of New York—namely, of opening the posterior cul de sac and the application of antiseptic dressings.¹ At 4 P.M., under chloroform, with Dr. Rendell's assistance, I curetted the uterus, irrigated with salt solution, and then made a broad incision into Douglas's pouch, applied enough 20 per cent. iodoform gauze to completely fill all parts posterior to the uterus, and packed the uterus with the same. On putting the patient back to bed we applied the icebag over the lower abdomen, injected a pint of normal saline solution into the cellular tissue of the back, and kept up the saline injections into the colon every eight hours, using about a quart or more at each injection.

After-Progress.—By midnight the temperature was 104.4°; the pulse was still 128, but fuller; the urine was very plentiful, and gave the reaction for iodine by the chloroform-nitric-acid test. On January 2nd the temperature had fallen to 101° F. (the pulse to 108), but rose again by the evening. The patient was feeling and looking better; the headache, however, was still severe, and only relieved by the application of ice to the head. She was given gr. $\frac{1}{4}$ of strychnine every three hours, and 3j of brandy every hour. The dressing was changed each day until the third day, when it was left off. From the accompanying chart it will be seen that while an evening rise occurred each day, there was a gradual fall to the normal, which was reached on the seventh day after operation. Further convalescence was uninterrupted nor has any evil effect followed. All through the summer she worked hard and enjoyed good health.

The happy termination of the case, which at one time looked so hopeless, causes me to put it on record. In the treatment of such cases Dr. Pryor lays great stress upon the preparation of the patient by colon injections of salt solution—beforehand, if possible—and in grave cases by intravenous infusion. This is necessary to secure the rapid elimination of the iodine. "Curettage is performed as much for the purpose of creating a raw surface, which can rapidly absorb iodine, as to remove infected tissue." What effect iodine in the blood has upon septicaemia he does not attempt to explain, but regards its action as something more than the mere sterilisation of the pelvis.

REFERENCE.

¹ American Journal of Obstetrics, vol. xl.

A NOTE ON THE SEPARATION OF THE PLACENTA IN THE THIRD STAGE OF LABOUR.

By J. D. SLIGHT, M.A., M.D., CH.B. EDIN.,
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In a recent paper read before the Edinburgh Obstetrical Society,¹ Dr. Berry Hart drew attention to the fact that the wall of the third stage uterus, examined *in situ*, is thinner at the placental site than it is elsewhere above the retraction ring. If I remember correctly, the wall where the placenta is attached is about $\frac{1}{4}$ inch in thickness, while the rest of the wall is four times thicker. This fact was used by Dr. Hart to cast doubt upon the view that separation of the placenta is effected by retraction. I venture to suggest that in it there is to be found the key to the mechanism of the third stage.

The hypothesis which I put forward is that in a "pain" the thin part of the wall (that is, the placental site) is stretched by the thicker part, and the connection between placenta and uterus is so torn through.

Suppose a contraction in the third stage to come on gradually and to increase in force by degrees, so that more and more of the uterine energy comes into action. At first the contents (which completely fill the cavity) are squeezed into smaller bulk. Soon, however, further compression of them demands from the thin part of the uterus greater energy than it is able to supply. But contraction is not yet ineffective; compression of the uterine contents can still be accomplished by the power of the thick part, provided that the thin part does not yield. If, as I submit, this yielding must, and does, take place, then, instead of forcing the contents to occupy still less space, the additional energy of the thick muscular tissue merely stretches the thin.

If the placental site is stretched, the separation of the placenta from it is unavoidable. The placenta is firmly grasped by the encircling uterus, and it is quite unable to move or rearrange its parts in the densely packed cavity, for the stretching brings no relief of pressure, and the periphery of the placenta cannot move with the corresponding part of the uterine wall, since the space into which it would seek to pass is already occupied.

According to this theory, separation will in most cases occur first at the lower pole because of the proximity of the placental site to the thin lower uterine segment. I would suggest that, in the cases in which separation does not begin here, there intervenes a considerable area of thick wall between the lower segment and the placental site.

The placenta having been thus freed is next expelled, and in this process of expulsion the membranes are stripped from the wall of the uterus.

Much might be adduced in support of my contention, but I have thought it best to be satisfied in the first instance with a brief exposition of the theory.

REFERENCES.

¹ BRITISH MEDICAL JOURNAL, January 19th, 1901, p. 152. ² Barbour, Edinburgh Medical Journal, September, 1884.

CASE OF ECTOPIC GESTATION: OPERATION: RECOVERY.

By H. H. LLOYD PATCH, L.R.C.P., M.R.C.S., L.S.A.,
Hertford.

THE following case shows what can be done in the cottage of a labouring man, provided cleanliness and nursing can be obtained.

History.

E. S., aged 26, who had always been strong, was married in 1893; her first child was born in May, 1894. She had three children subsequently, and had never had any miscarriage. About the middle of September, 1900, I treated her for an attack of pelvic peritonitis, and at that time there was an offensive bloodstained vaginal discharge.

Condition on Examination.

On November 26th, 1900, she was taken ill with acute pain in the stomach, more severe over the pubic region; this was accompanied by sickness and profuse menstruation. On December 4th I saw her, and found the following condition: Face pale and acutely drawn, as though the patient was in much pain; eyes sunken; pulse rapid and small, 136 to the minute; respirations quickened; temperature 102.8° F.; abdominal muscles contracted and rigid, much pain caused by palpation; percussion note was dull over the abdomen below the umbilicus, and absolute dullness over a portion extending from pubes below to within an inch and a half below the umbilicus, above, and about 3½ inches in breadth; below this dull area a tumour could be felt. The vomit had a stercoraceous odour and was most offensive; and there was retention of urine necessitating the use of the catheter. On vaginal examination the uterus was found lower than normal and somewhat fixed; the cervix was not enlarged to any extent and there was a bulging inwards of the posterior and left lateral walls of the vagina above, and obliteration of the left fornix. The vaginal discharge was very offensive and blood-stained. Having in view ectopic gestation I decided to operate.

Operation.

On December 6th under chloroform I made an incision in the median line of the abdomen 3 inches in length, the lower extremity ending one inch above the pubes. On the general peritoneal cavity being opened a tumour the size of a foetal head at full term presented itself, extending from the pelvis to within an inch of the umbilicus. The abdominal opening I extended upwards 1 inch. The tumour was covered in patches with recent lymph; its wall was composed of peritoneum, a quarter of an inch thick, and the tumour was found to be fluctuating. Its upper two-thirds was fairly free, but the lower portion was matted by adhesions, so that it was impossible to form a pedicle. The uterus was felt on the right side adherent to the lower portion of the tumour, its body being slightly enlarged. I then opened the tumour, and found inside the thickened wall a thin membrane which bulged into the wound when pressure was made on the tumour. I incised the membrane, being careful to protect the general peritoneal cavity. The contents were composed of fluid resembling liquor amnii, and when the tumour was relaxed I could feel a small body floating in the remaining portion of fluid. I then tried to separate