A VALEDICTORY LECTURE

ON THE

PROGRESS OF OBSTETRICS AND GYNÆCOLOGY.

Delivered at King's College Hospital,

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GENTLEMEN,—I have been asked to devote this lecture—the last which I shall have the privilege of delivering in connection with King's College—to a consideration of the advances which have taken place in the subjects which I profess, since I assumed this Chair, now more than five and twenty years ago. I had hoped that the fact of this being my last lecture might have passed unnoticed; but, since it is not so, I feel that the subject proposed to me is an appropriate one, and the more so as my inaugural address was devoted to *The Progress of Obstetrics and Gynæcology*. As time goes on it is well to take stock of our movement with it. But that I should undertake to give anything in the least like a comprehensive account of our gains in obstetrics and gynæcology in less than an hour would be an absurd and useless endeavour. I shall not attempt so impossible a task, but shall content myself with a brief allusion to one or two matters that I hope may prove of interest to you.

It is, I think, certain that there is no department of medicine or surgery the progress of which in recent years can in the least compare with that of which we can boast. That is because our subject is to a great extent a new one. When I came to this hospital, now five and thirty years ago, gynæcology was practically in its infancy. If you look at any book on the diseases of women of those days—I think Churchill or West were the ones most used—you will be astonished to find that the subjects which now chiefly occupy the attention of gynæcologists were altogether unknown. There is in them practically no allusion to most of the work with which we are now daily occupied. Even such everyday matters as ovariectomy were only beginning to be considered, and were damned with faint praise. Morbid states of the Fallopian tubes, such as pyosalpinx, salpingitis, and the like, now known to play so large a part in the causation of pelvic diseases, were unknown, and operative and curative procedures now employed every day were undreamt of.

It was in the year 1854 that I became a pupil of that wonderful man, Sir James Simpson, to whose initiative we may fairly ascribe much of the progress made within the last half century in the departments of medicine I have mentioned.

He was a man, take him for all in all,
We shall not look upon his like again.

Many have depreciated his work, have called him ill-balanced and impulsive, lacking in judgment, and unreliable; and in a certain sense all this is true. But his boundless and contagious enthusiasm, his commanding personality, that indefinite something about him which men call "genius," his sweet and lovable disposition, which made him never see anything but good in others who would admit no good in him, combined to make of him a leader and a teacher such as I have never seen equalled in the past and never expect to see in the future. His enthusiastic study of all advances in his favourite pursuits, and the energy and zeal with which he advocated new methods and treatments, many of which have passed into the limbo of things that are justly forgotten, founded a school of disciples who have since worked hard at subjects which before his time were almost completely neglected. I crave your pardon for this brief allusion to my honoured master, since I am talking of ancient history unknown to most of you.

It is to my mind no objection to a man's work that all of it will not bear the test of time and experience. If that were always essential, who is there amongst us whose work would stand? Take, for example, Henry Bennet's book on *Inflammation of the Uterus*, which attracted a great deal of attention in its day. If ever there was a book which was thoroughly unsound, the views in which were completely untenable, and the practice based on them most pernicious, it is surely this. Yet who shall say that Henry Bennet's work did no good? It did at least this, it directed attention to diseases of the reproductive organs in women, it caused them to be recognised,

studied, and diagnosed, and in due course of time its errors were realised and its mistakes avoided. And so it is with many things which for a time received undue attention, as, for example, Graily Hewitt's extravagant views on uterine displacements, which yet had an element of good in them, and other examples which I might give, but which, perhaps, I had better not dilate on.

The lesson from all this is one sadly needed, but rarely acted on, and that is a little less dogmatism, and a little more charitable consideration for views which do not commend themselves to us.

I might fill up the whole of the time allotted to me, and it would not be unprofitably spent, if I were to address you solely on the confident, absolute, and unhesitating condemnation passed by men who have no practical knowledge at all on the matters they condemn, on such mooted points in modern gynæcology, for example, as trachelorrhaphy, the use of electricity in gynæcology, laparotomy in pelvic inflammations, total extirpation and *morcellement* of the uterus, and many similar topics I could mention.

The well-known definition, "orthodoxy is my doxy, and heterodoxy is other people's doxy," surely applies with remarkable force to all matters gynæcological. What I have said reminds one forcibly, and the remembrance should teach us a valuable lesson, of the days, not so very long ago, when the benches of the Royal Medical and Chirurgical Society rang with excited cries of "Down with these belly rippers," when Spencer Wells had the temerity to bring before it a paper advocating the performance of ovariectomy. Even after I came to this hospital I well remember urging ovariectomy in the case of a near connection of my own who had a perfectly simple ovarian tumour. She was taken to several of the most eminent surgeons of the day, all of whom discouraged it, one of them telling her husband that I was recommending what was "mere butchery."

If there is one lesson more than another I should like to leave behind me here, it is that of charitable consideration for the views of others and deferred judgment.

If I were asked what is it more than anything else which has enabled obstetrics and gynæcology to take their present position, of course I should unhesitatingly say the principles of antiseptics. In directing attention to the changes which these have produced I am, of course, mentioning an obvious truism. In this hospital at least, which may make the proud boast of being, so far as London is concerned, the *fons et origo* of antisepticism, since Lister came to us from Scotland, no word need, perhaps, be said of it. You are so imbued with the knowledge of it that it is to you, I hope and believe, a second nature. To you the things I have seen before it became known would be absolutely incredible. If I were to tell you what I have seen from septic surgery in my early days in India, where I passed two or three years after I qualified, nay, even if I were to tell of things I have seen within these very walls in the way of abdominal surgery,

I could a tale unfold.....
Would.....freeze thy young blood,
And make each particular hair to stand an-end
Like quills upon the fretful porcupine.

I am not going to occupy your time by repeating the twice-told tale of what antiseptics have done for obstetric practice. That the very hospitals and wards which were, when I came here, hotbeds of puerperal septic disease are at this moment the safest place in the world for women to be delivered in is a very fairy tale of medical science which will always be remembered in connection with the time I am talking of.

It is worth while recalling in this connection a curious experiment made here just after I came, when a lying-in ward was established in what is now the Pantia Ralli. The mortality was so terrible that we had soon to close it, and the experiment of having a labour ward in a general hospital will, I hope, never be tried again; but such is the safety of antiseptic midwifery that if it were the results would, I fully believe, be very different.

It is a matter of deep regret that the mortality of ordinary domiciliary practice has not lessened with that of lying-in hospitals. This was conclusively shown only the other day in an interesting address by Dr. Cullingworth to the Obstetrical Society. It is certainly a preventable thing, and it should not be. But I am convinced that the blame does not

rest with the medical profession. Those members of it who neglect antiseptics will certainly become fewer day by day as younger men, trained of late years, get into practice. If ever some proper and effective control can be established over the midwives or obstetric nurses, or whatever you choose to call them, who practise so largely among the poor—attending, it is startling to hear, more than half the confinements in the country—then, and only then, will the mortality of domiciliary practice approximate to the vanishing mortality of our lying-in hospitals.

But the gain from the extended use of antiseptics in midwifery is very far from being limited to natural labours. Several of the more serious conditions which were practically hopeless when I joined the hospital are now treated with a fair prospect of success.

Cæsarean section was formerly considered an operation which was almost certainly fatal. Therefore it was never resorted to except under the direst necessity and under conditions which practically precluded the hope of recovery. Now, once more from the extension to it of the principles of antiseptics, as well as from our experience in abdominal surgery, it is no longer the dreaded thing it used to be, but can be resorted to as an operation which affords a fair chance of recovery, the mortality in the hands of experienced operators being little more than that of some other abdominal operations constantly performed.

There is another operative procedure which had practically fallen into disuse, that of symphysiotomy, which has again been brought into prominence, and is now safely performed, but more in other countries than in ours, which enables us sometimes to avoid the horrid alternative of destroying the living foetus. This, again, is the direct result of the safety arising from antiseptics.

One of the chief improvements in modern midwifery, however, is the enormous strides we have made in the treatment of that far from uncommon and most dangerous condition—extrauterine foetation. Five-and-twenty years ago if an accoucheur was called to a patient in early pregnancy who was collapsed and moribund, he might, and probably would, have diagnosed the existence of a ruptured tubular foetation with intraperitoneal hæmorrhage, but he would have had to stand helplessly by and see his patient die. Now he would without hesitation operate, with a fair chance of snatching his patient from the jaws of death, and of adding one more to the many cases which have thus been successfully treated.

Another not very dissimilar condition as to its effects, before practically hopeless—rupture of the uterus during labour—is now well within the hope of successful treatment.

These are some of the gains which have accrued from antiseptics—surely a remarkable record.

I have no intention of going over all that has been done within the last quarter of a century in midwifery; these are only some illustrations of our progress.

There is one subject, however, on which I feel called to say a few words, and that is the modern practice in protracted labour from uterine inertia, and that because it has been strongly attacked by my friend, Professor W. Japp Sinclair, of Manchester, in his recent address to the British Medical Association at Montreal.

When I joined this hospital, the old—and I venture to think the bad—practice was common of leaving women to drag on very many hours in powerless labour from an unfounded dread of assisting them by forceps. No doubt many of the more advanced practitioners were gradually shaking themselves free of it, but the textbooks all adhered to the old dicta. If you want to see what this practice led to, I would ask you to read the account of the labour and consequent death of the Princess Charlotte of Wales, which I have introduced into the more recent editions of my book on midwifery. You will there see how that gifted Princess's life was sacrificed to thoroughly bad midwifery. Had it not been for this, our present gracious Sovereign would in all human probability never have come to the throne. The extent to which the dread of instrumental interference was carried may be judged of from the fact that in the Rotunda Hospital at Dublin between the years 1786 to 1793, Dr. Clarke, the master, used the forceps only 14 times out of 10,387 deliveries, and during the mastership of Dr.

Labbatt (1815-1822) out of 21,867 births there is no record of the forceps having been used in a single instance.

The first edition of my book on midwifery was published in 1876, and I believe it to be the first systematic treatise in which the more rational, and I think now generally adopted, practice was openly advocated. This I did in fear and trembling, and deemed it necessary to offer a sort of apology in the preface. Happily my fears in this respect were not justified, the views I enunciated were generally approved, and the practice inculcated, with all proper reserve and safeguards as I maintain, was generally adopted.

It is very likely indeed that the pendulum has swung too far in the opposite direction. Injudicious practitioners abound everywhere, but apparently far more abundantly in and about Manchester than in London, for certainly here I do not come across the enormous numbers of lesions which Dr. Sinclair attributes to the use of the forceps, forgetful of the fact that the cervix used to tear, and the perineum to lacerate, long before the forceps were heard of. He forgets also, or at any rate minimises the fact, that in the good old times he so much laments lesions were abundant from not using the forceps, which are hardly ever seen now, such as vesico-vaginal fistula, which are not made nowadays because the forceps are more frequently used. So much is this the case that it is probable that most of the gentlemen I am addressing have never even seen the operation for their repair. Dr. Sinclair, however, rather lets the cat out of the bag when he tells us that in the quarter of a century before the introduction of antiseptics, which is practically the quarter of a century before I assumed this chair, Dr. Matthews Duncan, whom he very properly takes as a type of the obstetricians of that time, and his contemporaries "were long busy in repairing the characteristic ancient injury of vesico-vaginal fistula, for they had the accumulated misery of a whole generation of women to cure and ameliorate." The "accumulated misery" of generation after generation of women living before Marion Sims's great discovery was left uncured and unameliorated.

Nor does Professor Sinclair even mention one of the great glories of modern midwifery resulting from the practice he condemns—that is, the practical abolition of the operation of craniotomy, formerly so common. It would be a curious study to inquire what happened with regard to that in the *tempora acta* in the hands of injudicious practitioners, who I suppose existed then as now. I have heard of one distinguished obstetrician at least, celebrated for his hostility to "progressive" practice, who, when called in to a bad midwifery case, exclaimed in emphatic Doric, "Man, what's the deeficulty—dang out the brains!" I wonder how many lacerated cervixes or torn perineæ should be taken as the fair equivalent of even one human life saved from the deadly perforator?

Professor Sinclair sets himself to prove a most extraordinary thesis, let me quote his own words: "A thesis which I shall endeavour to maintain to-day is that gynæcology has become so largely surgical as the direct results of surgical interference in midwifery practice; the accoucheurs are the providers of material for the gynæcologist"; and, again, "for the material of his ordinary daily labour the gynæcologist has to look to the accoucheur." Surely these extravagant statements cannot be seriously meant? I was under the impression that the surgical expansion of gynæcology was due to such operations as ovariectomy, the removal of diseased appendages, vaginal and abdominal hysterectomy, colpotomy, and the like, which the wildest imagination cannot say are the production of the accoucheurs. If Dr. Sinclair had been content to preach against injudicious excess in operative midwifery, I should have heartily agreed with him, and welcomed his address as sure to do good. But he does far more than that, he advocates in effect, if not in so many words, return to the old bad times and disastrous practice against which, as one of the teachers and writers of the textbooks he so much blames, I feel bound to raise my voice. I do not, however, intend this as an answer to his criticisms; that I have attempted more at length in the forthcoming edition of my book on midwifery, but as a passing allusion to a topic of current interest.

That gynæcology is becoming year by year more and more surgical is a fact that cannot be denied. Indeed, nowadays a

gynæcologist who cannot operate or handle a knife, or is not allowed to do so by the rules of his hospital, if such fossil institutions still exist, is very like a modern soldier prohibited from using gunpowder.

If a gynæcologist must be either a surgeon or a physician, then in future he must certainly elect to be a surgeon. But on this I should like to say a few words, and to make them intelligible it is necessary to be a little retrospective.

Many of our London hospitals are very ancient institutions, and the more modern ones are modelled upon them. When they were founded midwifery was only practised by women, and gynæcology did not exist; so that the staff was naturally formed of members of the old corporations of physicians and surgeons only.

As time elapsed it became necessary to appoint obstetric physicians, who came in as interlopers, who were "neither flesh, fowl, nor good red herring." As they taught midwifery only they generally belonged to the College of Physicians. As gynæcology developed, the necessity arose for these gentlemen to operate. The first Fellow of the College of Physicians who had the boldness to shake off the shackles of precedent was the late Dr. Tyler Smith of St. Mary's, who performed ovariectomy, and has left a lasting name for himself in connection with the operation, since he introduced into this country the intraperitoneal treatment of the pedicle. I believe, although it was before my time, that he gave great umbrage by doing so.

Everyone who has the honour to belong to the College of Physicians is proud of it, and fond of it, but it is a very ancient institution, and like other ancient institutions it is not free from traditions and prejudices that are not altogether wise. Moreover it has a good many Fellows who are by nature fine old crusted Tories, whom everyone loves and respects, who would like to keep the College very much as it was in the time of Henry VIII. Possibly some of these may still object to obstetric physicians operating when they have an aptitude for doing so, and have such work to do. But if such views are still held, as is not unnatural, they have never done any practical harm. Under the judicious guidance of its successive presidents, the College of Physicians has been as progressive as such an institution can be expected to be, or, indeed, in my opinion, ought to be. From it, at least nowadays, no difficulties arise. Of the views on this subject of one of the wisest and most liberal-minded of its Presidents, the late Sir Andrew Clark, there can be no doubt, for I have often heard him say that a man should do exactly what he thought himself most capable of doing; and I have had practical proof of it by having on several occasions operated on gynæcological cases he sent to me for the purpose.

But I am told, for I have not myself seen it, that there is a cloud, at present no bigger than a man's hand, rising in another quarter. I am given to understand that our friends the hospital surgeons—or some of them—dismayed, let us hope, by the operative successes of their obstetrical colleagues, are beginning to clamour for protection, and are agitating for the enactment of a rule that no obstetrician is to operate unless he is a Fellow of the Royal College of Surgeons.

Now see for a moment what a grievance this would be. Take the case of a comparatively young obstetrician who has qualified by taking the very high diplomas of M.D. and M.R.C.P. Is such a man to be suddenly debarred from following the career for which he has prepared himself by being called upon, without previous warning, to pass the difficult examination necessary for admission to that very limited body, the Fellows of the College of Surgeons?

A man's skill as an operator depends on his brains and on his fingers, not on the letters he writes behind his name. I know Fellows of the College of Surgeons whom I would not trust to vaccinate a baby, and I know Fellows of the College of Physicians to whom I would unhesitatingly confide any operation they chose to undertake; and, *per contra*, if I were called to choose as obstetric physician to a hospital between a man who was an M.D. and F.R.C.P. Lond. whom I knew to be an inferior man, and a man who was a simple M.R.C.S. whom I knew to be a superior man, I would certainly select the better man of the two, irrespective of his qualifications.

If such a rule were to be enforced it would at once lead to a divorce between obstetrics and gynæcology. These subjects

are each so large that I think it likely that such a separation will eventually take place, to the advantage of both, by mutual agreement; but we are not prepared for it as yet, and to force it on by such an enactment would completely dislocate the teaching machinery of our schools.

We boast of belonging to a country which has been wise enough to adopt free trade in commerce, yet we talk of adopting a protective measure which could not find a parallel in any other country of the world, in none of which do such mediæval distinctions between different branches of the profession exist.

Some of our more conservative friends tell us that we may with propriety interfere surgically in anything occurring in the course of our midwifery practice, but that the moment any surgical interference is required in gynæcology the case must be handed over to the surgeons. I do not envy the sensations and position of the accoucheur, nor, for the matter of that, of his patient and her friends, who, in deference to this opinion, has acquired no surgical experience, when suddenly called upon to cope with such an obstetric emergency as a Cesarean section, or a symphysiotomy, or a ruptured tubular foetation, or a ruptured uterus.

The plain fact is, and it is one which cannot be got over, that the evolution of medicine has produced a class of practitioners who are and must be "physicians and surgeons" in a higher sense, and the sooner sensible and unprejudiced men reconcile themselves to their existence the better.

I have been tempted to this somewhat polemical discussion because it is one of great moment, and it is well that a senior member of the obstetric branch should have his say on behalf of his junior colleagues, although he has himself no longer any personal interest in the matter. And I may speak all the more plainly because I have never myself experienced any difficulty of the sort, and have always received the most kindly, generous, and ungrudging assistance from all my surgical colleagues in anything of an operative nature which I have thought it right to attempt.

Do not suppose for a moment, however, that in arguing in this way I am advocating overmuch operative interference in gynæcology. None of you, I feel sure, to whom I and my work are well known, will accuse me of want of caution in that respect. There is, I am constrained to admit, a good deal of unwise excess amongst us which is much to be deprecated. As we have to acknowledge that injudicious practitioners have erred in carrying out what is, on the whole, a right principle in the management of protracted labour, so also we have to acknowledge that injudicious practitioners have interfered surgically far more than most of us think justifiable, and in a way that brings discredit to themselves and needless risk to their patients. *In medio tutissimus ibis* is the wise and safe principle which should guide you in shaping your course.

In the opposite direction we have to deprecate the tinkering practice adopted by the ultra-conservative gynæcologists who would shun surgical interference altogether, which was caustically described, not without some reason, by my friend Professor Clifford Allbutt, in an often quoted passage in which he talks of the patient as "being entangled in the net of the gynæcologist, who finds her uterus, like her nose, is a little on one side; or again, like that organ, is running a little, or it is as flabby as her biceps, so that the unhappy viscus is impaled upon a stem, or perched upon a prop, or is painted with carbolic acid every week in the year, except during the long vacation, when the gynæcologist is grouse shooting, or salmon catching, or leading the fashion in the Upper Engadine."

It is difficult to say which sort of error is eventually worse for the patient. It is to be feared that one or other of them will be met with until the halcyon days arrive when the possession of a diploma provides its owner with judgment that never errs, and enthusiasm so well regulated that it never leads him astray.

I have left myself no time, I regret to say, to direct your attention to our gains in gynæcology during the years we have under review. I can only make a mere passing allusion to some of them, but they are no less remarkable than in obstetrics, and they have practically all arisen also from the great principle of antisepsis which has done so much for midwifery.

One note of modern gynaecology which is remarkable is the increasing favour which the treatment of pelvic disease by the vaginal route is finding. Things are possible now, and with comparative safety, previously undreamt of. Thus malignant disease of the uterus, formerly practically left to run its course unchecked, can now be dealt with, if detected sufficiently early, which is unhappily often not the case, by the partial or total extirpation of the diseased organ and with a reasonable hope of success. Then, again, certain diseased conditions of the appendages may also be treated by this route with less danger than by abdominal section. So also some of the most troublesome cases of pelvic inflammation following on childbirth, or on morbid conditions of the tubes, are being thus dealt with with increasing frequency and success; and so likewise are certain diseases of the uterus, such as small fibromyomata, old-standing displacements producing serious symptoms, and other conditions which I merely mention without any expression of opinion.

Many other topics suggest themselves, some of them involving most vexed questions, such as the treatment of fibromyomata by hysterectomy; the removal of the appendages by laparotomy for various diseased conditions, or, unhappily, sometimes, for no diseased conditions at all; the treatment of pelvic inflammations by abdominal section, and many others which cannot even be mentioned.

One subject, however, I cannot pass over, as it has always interested me much, that is, the possibility of treating systematically and successfully the strange and manifold neurotic symptoms which so often shipwreck the lives of women, and reduce them to a state of chronic invalidism previously quite hopeless. That cases of this sort, unhappily so common, can so often, when properly managed, be restored to health, is, in my judgment, one of the greatest gains to practical medicine in the last quarter of a century. This is, perhaps, not strictly a gynaecological matter, but it is often so closely connected with it that this passing allusion to it may be pardoned.

I hope that even these few words may prove to you that gynaecology has not been at a standstill. It is my firm conviction that the more scientific basis on which it is being placed by pathological, histological, and bacteriological research will ere long give it a position which it has hitherto lacked, as is not unnatural in a subject of comparatively recent development.

And, now, gentlemen, I cannot conclude without a word personal to myself. It is just thirty-five years since I came to London to seek a livelihood, as so many of my countrymen have done since the time of that "high and mighty Prince" James I of England and VI of Scotland. It is not an exhilarating thing to put up your brass plate in a city such as this, in which you could count your acquaintances on the fingers of one hand. I was greatly encouraged when, in the same year, the Council of King's College elected me to be assistant obstetric physician to this hospital. I may say of it, and I say it with the deepest gratitude, that I was a stranger and it took me in. In retiring from the active work in connection with it, which for so many years has been the chief occupation, and interest, and pleasure of my life, it would be a comfort to me if I could carry with me the conviction that the generous confidence thus shown to an unknown young man has not been entirely misplaced. It is a painful thing to say farewell. I cannot do it better than in the words of a prayer often offered up within these walls: "God bless King's College, and King's College Hospital, and all connected with them."

THE French Society of Otology and Laryngology will hold its annual meeting on May 2nd and following days. The subjects to be discussed are (1) The Unification of Acoustic Notations (to be introduced by MM. Gellé, sen. and jun.; (2) The Pathology of the Lingual Tonsil (to be introduced by M. Escat).

SPANISH CONGRESS OF OTO-RHINO-LARYNGOLOGY. — The Second Spanish Congress of Oto-rhino-laryngology will be held in Barcelona on September 20th and following days. The President of the Organising Committee is Dr. Roquer y Casadesús.

REMARKS ON THE ETIOLOGY OF SUNSTROKE (SIRIASIS):

NOT HEAT FEVER, BUT AN INFECTIOUS DISEASE.

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VERY different conditions have been described by authors under the designation of "sunstroke," and at one time apoplexy was frequently accounted as such. In recent works we find two distinct conditions—heat exhaustion and thermic fever—classified together under the common title of "heat stroke," and most writers describe heat exhaustion as an initial stage of thermic fever. I believe heat exhaustion to be nothing more than syncope and thermic fever, a specific infectious disease which I shall mention in this paper by its oldest name, "siriasis."

SYNCOPE.

When syncope occurs in an overheated atmosphere, it is commonly called heat exhaustion; but this appellation is misleading, because heat is by no means its primary cause. Syncope is really a symptom, not a disease. It occurs in persons of unsound constitution, and especially in those suffering from organic diseases of the heart. The original disease may have been latent, and the sudden prostration, under the stimulus of fatigue, excitement, alcohol, or heat, may be its first manifestation. Numerous necropsies prove this statement.² Syncope is common among old stokers—"stokers' collapse"—who are greatly liable to cardiac affections on account of their laborious occupation and of their free indulgence in strong drink. It is very frequent among soldiers, who likewise suffer exceedingly from circulatory disorders, as is well known.³ Soldiers fall unconscious from syncope at parades or even in barracks, but far more frequently on the line of march, especially when oppressed by tight-fitting clothes and heavy accoutrements, and when obliged to march in "close order" and breathe the foul air which surrounds a close column. Striking examples are on record to show the effects of excessive exertion under unfavourable conditions. On July 4th, 1859, among the French army at the passage of the Mincio, 2,000 out of a force of 12,500 men were prostrated by syncope, and 26 died (Guyon).⁴

In syncope the skin is moist, pale, and cool; the breathing is easy though hurried; the pulse is small and soft; the temperature is at or below normal; the pupils are dilated; the loss of consciousness is incomplete, and though death may occur, an immediate recovery is the rule.

SIRIASIS.

The symptoms and conditions of siriasis are widely different from those of syncope. Siriasis is an acute disease characterised by hyperpyrexia, profound coma, and intense pulmonary congestion. Its mortality is exceedingly high. It has a peculiar geographical distribution; it prevails in the hot season, and occasionally in an epidemic form.

It seems surprising that syncope should have been confounded with siriasis, but it is so and it is all-important to remember this in studying siriasis, because it is the reason of the great confusion which exists in the description of its symptoms and of its *post-mortem* appearances, in the theories advanced to explain its pathology, and in the remedies suggested for its cure.

ETIOLOGY.

Siriasis is universally considered as the most obvious effect of exposure to excessive heat, but opinion varies greatly as to the way in which elevated temperature acts in producing the peculiar symptoms of the disease.

Some authors attribute siriasis to a gradual heating of the blood to a degree incompatible with the maintenance of nervous function. Others believe that heat paralyses the centre or centres which are supposed to regulate the disposition of the bodily heat, and thus causes the hyperpyrexia