life. Many foetal diseases were hereditary—for example, ichthyosis, general dropsy, foetal rickets, etc. Direct heredity could seldom be proved, but family prevalence was very common. He had reported two, and even three, anencephalic foetuses in the same family, and polydactyly was often seen in several generations and in several individuals of the same generation. It was evident that in addition to morbid causes coming from without, we had to deal constantly with hereditary tendencies for or against pathological developments existing already in the organism. This was true of the pathology of all periods of life, antenatal as well as postnatal, and the net result was the health or disease, deformity or malformation of the individual.

REMARKS

ON

A FROZEN SECTION OF THE FIRST STAGE OF LABOUR.*

[WITH SPECIAL PLATES]

By WILLIAM C. LUSK, M.D.,

Assistant Demonstrator of Anatomy in Bellevue Hospital Medical College, Visiting Surgeon to Workhouse, Almshouse, and Incurable Hospitals, New York.

THE frozen section here presented is one of a 7-para, aged 37, who died suddenly during the first stage of labour. The case was first seen by a physician two or three hours after death. He found the fundus about 2 or 3 inches above the umbilicus, and the os internum dilated sufficiently to admit about one half-finger. He then expanded the calibre of the cervical canal by manual dilatation to the extent of admitting three fingers. An old cerebral abscess was found *post mortem*. The body was injected with red starch injection through the right carotid artery, and was frozen in the nearly vertical position.

I and II. (See description of Plates.)

III. Vertical mesial section, the outlines from an original tracing.

Pelvic Measurements.—Obstetrical conjugate 11.2 cm. (4.42 in.) Transverse diameter of brim about 12.4 cm. (4.9 in.) Oblique diameters about 12.7 cm. (5 in.) each. Pelvic floor projection (coccyx partly lacking) about 7 cm. (2.75 in.) The obstetrical conjugate is narrowed by the compressed soft parts 1.27 cm. (0.5 in.) anteriorly, and 1.22 cm. (0.48 in.) posteriorly. The aperture of the inlet was found on subsequent dissection to be padded within its entire circumference by a thick layer of fat, the latter not only narrowing but also deepening the inlet. Estimated narrowing of transverse diameter of brim by soft parts, about 2.28 cm. (0.9 in.) on each side; of oblique diameters, each about 2.54 cm. (1 in.) behind, and 1.5 cm. (0.6 in.) in front.

Uterus.—The shape of the uterus is globular. The longest antero-posterior diameter of the uterine cavity in the plane of the section, including the placental thickness, is 13.7 cm. (5.4 in.). The walls of the uterus posteriorly exhibit above a thickened portion (1 cm. or 0.4 in.) and below a thinned lower segment (0.5 cm. or 0.2 in.), the limit between which is marked by a bulging of the uterine muscle (1.5 cm. or 0.6 in.). Anteriorly the walls show no marked variations in thickness. The fundus is in contact with the breech. The height of the fundus above the brim is 18.4 cm. (7.25 in.) The length of the line of placental implantation measured in the plane of the section is 20.3 cm. (8 in.). The membranes are unruptured.

The Fœtus.—The presentation is an L. O. A. The head is well engaged in the inlet. A scalp tumour has formed, the limits of which are not restricted at the cranial sutures. The angle formed by the intersection of two lines drawn in the respective long axes of the head and trunk measures about 135° and opens posteriorly. The spinal column looks to the left and forwards.

The peritoneum descends anteriorly 1.2 in. below the brim, and posteriorly as far as to a line passing from the lower border of the symphysis to the junction of the fourth and fifth pieces of the sacrum. Laterally it is reflected directly into the middle of each iliac fossa.

*Read in the Section of Obstetrics at the annual meeting held at Montreal.

The bladder is collapsed and flattened between the child's head and the pubic bones. The upper portion is embedded in a mass of fat. The apex reaches just above the brim. The cavity of the bladder was found on subsequent dissection to be Y-shaped, the shorter arm of the Y extending downwards and backwards from the neck of the viscus.

The rectum is distended with feces.

The coccyx below its first piece is tilted backwards.

IV. Vertical mesial section with foetal parts of opposite side superimposed, showing child in relief. Shows attitude of foetus. The head is strongly flexed. The right extremities of the foetus are more prominent than the left. The bladder is slightly opened up (Cf. II, Fig. 1).

V. Interior of the left half of the uterine cavity, placenta, and membranes *in situ*. (Cf. VII, Fig. 4). With the exception of a short depth posteriorly, and a small margin anteriorly, this half of the uterine cavity is an almost perfect mould of the segment of the foetus therein contained. The bulging in the posterior uterine wall is here seen to preserve its form as a thickened ridge as far as the left (about 3.2 c.cm. or 1.25 in.), as accommodation for its unrestricted development is provided by displacement of liquid contents of the ovum, that is, as far laterally as to the area of close embrace of the foetus by the uterine wall. (See VIII, Fig. 4.) From the termination of the thickened ridge, and forming an obtuse angle with the same, a much smaller ridge passes downwards and forwards through this area of foetal compression, fitting closely a groove between the upper part of the child's trunk and the umbilical cord, and becomes lost anteriorly.

The membranes are separated posteriorly from below upwards to a point a little more than an inch below the site of greatest thickening of the bulging area, anteriorly to just below the brim. Laterally the line of separation runs a little way below the impression of the umbilical cord.

VI. Interior of the right half of the uterine cavity, placenta and membranes *in situ* (Cf. VII, Fig. 3). Laterally, impressions of the foetal irregularities are distinctly outlined in the uterine wall as well as in the placental mass in this situation. The bulging of the uterine muscle passes on this side from behind forwards, finally merging into the area of placental implantation. As it passes forwards it fits the foetal interspaces.

DESCRIPTION OF PLATES.

I.—Photograph quarter life size of vertical mesial section. Original by the three-plate colour process. Negative by Dr. Edward Leaming.

II.—A.—Photograph quarter life size of vertical mesial section with frozen foetal parts of opposite side placed in exact superposition; the cavity of the bladder is slightly opened up. Negative by Dr. Edward Leaming.

II.—B.—Photograph quarter life size showing interior of left half of uterine cavity with placenta and membranes *in situ*. Negative by Dr. Edward Leaming.

III.—(Quarter life size). 1, Third lumbar vertebra; 2, liquor amnii; 3, left thigh; 4, left forearm; 5, promontory; 6, retraction ring; 7, coronary vein (injected); 8, Presacral pad of fat; 9, left parietal bone; 10, rectum (distended with feces); 11, fifth sacral vertebra; 12, sagittal suture; 13, right parietal bone; 14, cul-de-sac of Douglas; 15, caput succedaneum; 16, membranes; 17, posterior fornix; 18, mucus; 19, fibres of levator ani; 20, vagina; 21, (not yet identified); 22, bladder; 23, symphysis pubis; 24, (not yet identified); 25, uterovesical peritoneum; 26, right ear; 27, umbilical cord; 28, right arm; 29, placenta (injected); 30, cord; 31, right thigh.

IV.—(Quarter life size). 1, Third lumbar vertebra; 2, amniotic fluid; 3, retraction ring; 4, promontory of sacrum; 5, coronary vein (injected); 6, presacral pad of fat; 7, amniotic fluid; 8, fifth sacral vertebra; 9, cul-de-sac of Douglas; 10, membranes; 11, rectum distended with feces; 12, symphysis pubis; 13, uterovesical peritoneum; 14, bladder (slightly opened up); 15, umbilical cord; 16, outer canthus of right eye; 17, placenta.

V.—(Quarter life size). 1, Retraction ring; 2, promontory of sacrum; 3, coronary vein (injected); 4, height to which membranes detached posteriorly; 5, impression of left ear; 6, impression of umbilical cord; 7, approximate location of three collapsed coronary sinuses; 8, height to which membranes detached anteriorly; 9, left limit of bulging; 10, situation of left Fallopian tube.

VI.—(Quarter life size). 1, Situation of right Fallopian tube; 2, situation of right thigh; 3, situation of right knee; 4, umbilical cord; 5, situation of right forearm; 6, impression of prominent right frontal region; 7, approximate location of three collapsed coronary veins; 8, impression of right foot; 9, impression of right hand; 10, coronary vein (injected); 11, promontory of sacrum; 12, retraction ring; 13, impression of left leg; 14, impression of left foot.

Fig. I.

Fig. II.-A.

Fig. II.-B.

TO ILLUSTRATE DR. WILLIAM C. LUSK'S PAPER.

Fig. III.

Fig. IV.

Fig. V.

Fig. VI.

TO ILLUSTRATE DR. WILLIAM C. LUSK'S PAPER.

VII. Lateral aspects of cast of foetus in comparison with corresponding aspects of a mould of the interior of the uterine cavity.

VII, Fig. 1.—Cast of foetus viewed from right side (quarter life size). 1, Anterior fontanelle; 2, umbilical cord; 3, prominent right frontal region.

VII, Fig. 3.—Cast of uterine cavity, right aspect (quarter life size). 1, Impression of left knee; 2, impression of right foot; 3, impression of right hand; 4, groove due to bulging; 5, right limit of bulging; 6, placental outline; 7, impression of prominent right frontal region; 8, region of right knee; 9, impression of left foot; 10, placental outline.

VII, Fig. 2.—Cast of foetus viewed from left side (quarter life size). 1, Posterior fontanelle.

VII, Fig. 4.—Cast of uterine cavity, left aspect (quarter life size). 1, Placental outline; 2, situation of left Fallopian tube; 3, placental outline; 4, left limit of bulging; 5, groove due to bulging; 6, impression of right ear.

Fig. 1. Cast of foetus viewed from right side.

Fig. 2. Cast of foetus viewed from left side. The spinal column is rotated more or less anteriorly on the vertical axis of the trunk, so that a mid-point in the back is turned more anteriorly than is the occiput of the foetal head. This is most marked in the thoracic region. The right shoulder rests above the horizontal ramus of the left pubic bone. A portion of the umbilical cord lying between the right shoulder and ramus is flattened like a ribbon. The spinal column is bent laterally toward the child's left, as evidenced by the closer approximation of the shoulder and buttock on this side than on the right. The wrinkles in the left flank would seem a natural consequence of this flexion.

Figs. 3 and 4. Casts of interior of uterine cavity, right and left aspects respectively. The foetal impressions are deeply outlined on both lateral aspects. That part of the mould of the uterine cavity corresponding to the portion that contained

the foetal head is seen to resemble the latter in both shape and size.

Cubic Measurements.—Cubic contents of cast of interior of uterine cavity, 1,600 c.cm. (97.6 c.in.); cubic contents of cast of foetus and umbilical cord, 1,510 c.cm. (92.1 c.in.); cubic contents of amniotic fluid, 90 c.cm. (5.5 c.in.).

VIII. Anterior and posterior aspects of casts of foetus in comparison with corresponding aspects of a mould of the interior of the uterine cavity.

VIII, Fig. 1.—Cast of foetus, anterior aspect (quarter life size). 1, Groove due to brim; 2, umbilical cord; 3, line of section.

VIII, Fig. 3.—Cast of uterine cavity, anterior aspect (quarter life size). 1, Placental outline; 2, depression due to stump of cord; 3, line of section; 4, placental outline; 5, groove due to brim; 6, impression of right side of foetus.

VIII, Fig. 2.—Cast of foetus, posterior aspect (quarter life size). 1, Line of section.

VIII, Fig. 4.—Cast of uterine cavity, posterior aspect (quarter life size). 1, Situation of left Fallopian tube; 2, groove due to bulging; 3, placental outline; 4, impression of left knee; 5, line of section; 6, placental outline; 7, impression of left foot.

Fig. 1. Cast of foetus, anterior aspect.—The right extremities of the foetus lie almost entirely to the (mother's) right of the line of sagittal section. The soft parts bulge in right frontal and temporal regions above groove due to brim.

Fig. 2. Cast of foetus, posterior aspect. The left extremities of the foetus are sunk considerably into the left half of the uterine cavity.

Figs. 3 and 4. Casts of uterine cavity, anterior and posterior aspects respectively. In contrast to the sharp foetal impressions laterally, areas of comparative indefiniteness of outline or complete absence of impressions are observed in front and rear, which bespeak the presence of more or less amniotic

fluid in these situations. Owing to the inclination forward of the fetal trunk against the anterior uterine wall, a larger space for amniotic fluid is provided behind them in front.

Displacements of the Cranial Bones.—There is overlapping at both the coronal and lambdoid sutures, which is far greater on the right side of the fetal head which is directed toward the pubic bones than on the left. At the coronal suture both parietal bones overlap the frontals. At the lambdoid suture, on the other hand, the left parietal overlaps, while the right parietal is depressed beneath the occipital bone. There is no overlapping at the sagittal suture.

IX. Microscopic section of posterior uterine wall just to left of median line, from os externum to about 1 inch above bulging area. The hardened section of this region as mounted for microscopic examination preserves a contour similar to that of the gross specimen. The bulging in the former is, however, less prominent than in the latter.

Microscopic Examination.—The epithelial and decidua structures have suffered more or less destruction. The membranes have been torn away. The appearance at the site of the bulging and above it is one characteristic of tissue belonging to the body proper of the pregnant uterus. A broad muscular layer, its outer fibres longitudinally and its inner fibres transversely or obliquely disposed, adheres firmly to the peritoneal covering. Within this layer the appearance is as one of intersecting muscle bundles. Thus, here are found certain lamellæ unevenly thickened and of irregular outline, their individual fibres exhibiting, where distinguishable, rounded or ovoid contours, and presenting an abundance of well-stained nuclei likewise of rounded or oval shapes, which could well be regarded as having suffered cross section; while other bundles less numerous discovered in this area, having more or less clearly-defined and parallel margins, their individual muscle fibres as well as nuclei presenting themselves in their long axes, would appear to have been cut longitudinally.

The structure of the tissue below the bulging area downward until cervical tissue is reached is, in general, characteristic of lower uterine segment. It consists of clearly outlined anastomosing muscular plates loosely associated together, the individual muscle fibres generally presenting themselves in their long axes, though sometimes they give evidence of oblique section. The muscle nuclei, though taking the stain badly, where apparent are usually spindle-shaped. A small area of this lower segment, however, situated anteriorly in the tissues immediately below the bulging, extending downwards from the latter for the distance of about one inch, and occupying about three-fourths the breadth of the section, contains patches of muscle bundles similar to those of the body, suggesting an area of transition from body to lower segment structure. The lower limit of this area would seem, by comparison with the gross specimen, to correspond approximately to the lowest limit of attachment of the membranes in the plane of this section.

The change from muscular into more fibrous tissue determines the boundary between lower segment and cervix, at which situation the region of the os internum can readily be located. This region can be designated in the illustrations as a little above a horizontal line passing through the site of reflection of the utero-rectal peritoneum. The cervix presents many dilated venous spaces indicating an oedematous condition. The glandular structures cannot be distinctly defined.

GENERAL CONSIDERATIONS.

In the study of this section it is to be regretted that the exact duration of pregnancy is unknown, that the cervical canal suffered *post-mortem* manual dilatation, and that the body could not have been frozen until some days after death. Gestation can be approximately fixed as being at the end of the seventh month.

Two conditions here found are of particular interest—one the presence of but a small amount of amniotic fluid (90 c.cm. or 5.5 c.in.) within the ovum, and the other the considerable encroachment by the soft parts upon the size of the inlet. As a result of the former, the contained foetus is subjected to unusual influences of pressure and counterpressure from the surrounding structures. That the latter condition has here in effect converted this sizable pelvis into a moderate justo-

minor seems unquestionable in the presence of certain supporting evidences.

The uterus presents features characteristic of the contracted state. Its shape is globular, and the greatest transverse (13 cm.) and antero-posterior (13.7 cm., including placental thickness) diameters approximate equality. That the former diameter is narrowed to a minimum is evidenced by the close embrace of the foetus laterally by the uterine walls. The compensatory lengthening in the antero-posterior direction affords accommodation centrally for the fluids displaced by the lateral pressure.

Though still early in the first stage, the uterine wall on section presents posteriorly an appearance suggestive of a certain amount of permanent change characteristic of advancing labour having already taken place in it. In this connection are noted the thickening of the wall above, the thinning below, and the bulging between. That the latter is an area in which permanent thickening has taken place, and not a mere moulding of the contracted uterine muscle on the foetus, is supported by the fact of the preservation of its contour in the hardened specimen. The bulging might, therefore, not improperly be termed a retraction ring, although still in its incipency. The microscopic examination of the specimen shows this ring of retraction to have taken origin at the lowest limit of body tissue proper—that is, down to, but not including, the area described above as that of apparent transition between body and lower segment. The extent of the ring laterally has not yet been definitely determined.

Regarding the absence of any gross appearance in the anterior uterine wall suggestive of retraction, it would seem likely, from indications on the child's head of the receipt of a considerable pressure at the situation where it encounters the resistance of the pubic bones, that any such change here had been prevented by an effectual catching of the lower uterine segment between the head and the brim. (The microscopic section of this portion is still unfinished.)

The detachment of the membranes to the height indicated cannot with positiveness be regarded as the result solely of physiological procedure in the presence of the fact that the cervical canal suffered *post-mortem* manual dilatation.

The forces of pressure and counterpressure here concerned in the progress of labour are best studied together with a consideration of their effects upon the foetus. In this connection of especial interest are the influence of the obstetrical canal upon the conformation of the head, the mechanism of descent of the head, and the position of the foetus.

Regarding the first consideration, one observes at once that the head, already well engaged, presents features distinctly characteristic of transverse narrowing of the inlet—namely, its extreme flexed condition, the tendency of the small fontanelle to occupy the middle point of the pelvic space, the neck resting upon the linea terminalis, the anterior portion of the head pressed against the opposite pelvic walls, the long diameter of the head (from chin to vertex) lying in the axis of the pelvis, and the face looking upward toward the fundus uteri. Also characteristic of justo-minor pelves as observed in this case, is the formation of a scalp tumour during the first stage of labour while the membranes are still intact. Turning now to look for the condition of which these effects are the apparent result, it is found that, though the bony pelvis is one of good size, the opening of the superior strait has actually been so encroached upon by the thick layer of fat within its circumference that its diameters, after deducting the soft parts, are reduced to those of a moderate justo-minor (obstetrical conjugate 8.7 cm., or 3.44 in., transverse diameter about 7.87 cm., or 3.1 in.; oblique diameters about 8.6 cm., or 3.4 in.). Adding to this the observation gained from a comparative study of corresponding elevations and depressions in the casts of the foetus and uterine cavity, that a circumference of the head accurately fits this opening, as well as the fact of the overlapping at the cranial sutures within this site of encirclement, there would seem to be lacking no link in the chain of evidence that, consequent upon a moderate disproportion in size between the inlet and the child's head, the latter was here undergoing the characteristic moulding process in accommodating itself to transit through the narrowed canal.

Inferences regarding the probable mechanism of descent of

the head here taking place can be made, based upon a study of the forces of resistance met at the narrowed inlet, the most reliable information regarding the action of which can be gained through an investigation of the effects produced at the yielding cranial sutures. At each of these several sutures the extent to which the bones overlap might reasonably be taken as an index of the relative degrees of pressure exerted upon the bones themselves, while that bone which is depressed beneath its over-riding fellow might be regarded as the one having received the greater pressure of the two. Reasoning from such premisses, the actual findings here would seem to indicate the action of forces of counterpressure of varying intensity upon different portions of the foetal head. Thus the greater over-lapping at the coronal and lambdoid sutures on the right side (anterior aspect) of the foetal head than on the left, at about the plane of the superior strait, would indicate a stronger resistance encountered anteriorly and antero-laterally at this level than behind. Also the absence of over-lapping at the sagittal suture, here situated well below the brim, would indicate an absence of any particular antero-posterior compression within the pelvis acting upon the parietal bones. The depression of the right parietal beneath the occipital bone, instead of its over-riding the latter, suggests its having met a resistance of especial intensity against the left horizontal pubic ramus to have thus influenced it in this particular situation. Hence it would appear that the circle of cephalic embrace at the inlet is one of unevenly distributed pressure, the greatest resistance being met anteriorly against the brim, and the least behind; while within the pelvis there seems to exist a space devoid at least of antero-posterior compressing influences.

In the presence of which observations the mechanism would plainly not be one of direct downward descent of the head into the inlet, but rather can it be imagined that, the site of greatest resistance anteriorly exercising a pivotal influence on the head, descent is taking place by rotation over this pivotal site around a transverse axis. In perfect conformity with this idea of mechanism, it can be seen how the head, sweeping over the soft tissues of the inlet posteriorly, its vertical circumferences touching the latter at each point of contact in the relation more or less of a circle to its tangent, would meet a lesser resistance in this situation than in those at which opposition is more directly encountered. Similarly as well could the non-overlapping at the sagittal suture be accounted for on the supposition that, in the rotation of the head over the brim, the long axis of the former is not tilted far enough toward the vertical position for the right parietal bone to here encounter marked resistance against the posterior surface of the symphysis. The evidence suggestive of the head's having met a resistance of especial intensity against the left horizontal pubic ramus might be interpreted as indicative of a tendency to forward rotation of the occiput, possibly here the result of a twisting action imparted by the trunk of the fetus, which is as well rotated in the same direction on its vertical axis, but to a greater degree than is the head.

In view of the foregoing, the cause of the bulging of the soft parts in the right frontal and temporal regions could as well be attributed to a pushing upward of the loose scalp tissues by the force of the friction encountered at the site of pivotal action of the brim upon the head as to a *post-mortem* change. Owing to this bulging the bitemporal diameter of the foetal head is relatively increased.

The more or less close embrace of the foetal trunk by the contracted uterine muscle suggests the probable importance of the latter as a causative factor in having determined the position of the child as here found. The position presents certain features of similarity with that existing in a frozen section of a case of generally contracted pelvis (diagonal conjugate 11 cm.), described by Professor Leopold in his recent work, *Uterus und Kind*. In his case, however, the foetus was at term, and labour was less advanced than here, the head not having become firmly fixed at the brim. The features in common are the marked forward rotation of the spinal column on the vertical axis of the trunk, the bowing forward of the back, and the opening posteriorly of the angle formed by the intersection of the long axes of the head and trunk. In Leopold's case this angle is much more marked

(95° to 97°) than here (about 135°). In the case here presented one is inclined to associate the contact of the fundus with the breech of the child on the one hand and the lateral bending of the back on the other in the relation of cause and effect.

TWO LECTURES

ON

THE TEMPLES AND RITUAL OF ASKLEPIOS AT EPIDAUROS AND ATHENS.

Delivered at the Royal Institution of Great Britain

By RICHARD CATON, M.D., F.R.C.P.

LECTURE I.

LADIES AND GENTLEMEN,—You are aware that during the last twenty-five years the energy and enthusiasm in archaeological research of such men as Dr. Schliemann have not merely thrown a considerable amount of light on historic and prehistoric Greece, but have also awakened a keener enthusiasm among classical scholars and in archaeological societies, and have even influenced Governments for the further advancement of these studies. We have seen the German Government spending large sums in the excavation of Olympia and Pergamos; the French Government has also spent much in the excavation of Delphi and on other works, each nation thus making the whole world its debtor. The American school has explored the Heræon and other classical sites, and lastly our own British school in Athens has done much, considering its difficulties and the lack of the sufficient pecuniary support with which other countries have endowed their representatives.

Although considerable interest is felt by the English public in regard to the work just referred to, one important field of investigation has remained almost unknown in this country, I mean the exploration of the shrines of Asklepios, the God of Healing, at Epidaurus and Athens, about which I am to have the honour of speaking to you. As the time allotted to us is brief, it is needful to avoid all prefatory remarks, and to restrict this paper almost entirely to a consideration of the new discoveries and to inferences from them. As a matter of fact there is but scant information as to the sanitary and medical aspects of Greek life in ancient literature. Homer and Pindar have brief references to Epidaurus and other sanctuaries; so also Plato, Hippys of Regium, Strabo, and some of the dramatists, as Aristophanes, also certain of the late Greek writers, especially Pausanias. Under these circumstances most precious are the researches made by the spade. The pioneer in this inquiry was M. Cavvadias, the eminent archaeologist, now Minister of Education in the Greek Government. He was aided efficiently by the Greek Archaeological Society. M. Stais has deciphered the hundreds of inscriptions which were found. MM. Defrasse and Lechat, and M. Girard, associated with the French school; Dr. Doerpfeld, Dr. Furtwaengler, Herr Baunack, Professor Reinach, Dr. Koechler, connected with the German school, and others, have had a share in the work; but little has been done by the English, and still less has been published in our language. An interesting paper by Professor Percy Gardner in his *New Chapters in Greek History*, some valuable references by Miss Jane Harrison, the admirable notes in Mr. Fraser's new edition of *Pausanias*, and one or two articles in American journals are among the chief. I have to express my acknowledgment to the authorities I have named, but chiefly to M. Cavvadias for his kindness in giving me special facilities in Greece, and for allowing me the use of some of his plates; also to MM. Defrasse and Lechat, who permit me to show you some of their beautiful restorations. Apart from these, most of the lantern slides I shall show you were taken by myself on the spot.¹

According to tradition Asklepios, the son of Apollo and Koroni, was born in the Hieron valley, in the Argolic peninsula; the place names still preserve the legend; the hamlet of Koroni commemorates his mother, the hill Titthion owes

¹ Of course only three or four of these can be reproduced in the *BRITISH MEDICAL JOURNAL*.