brim, the effective force being far less than half the amount which is used. In the axis A B there is no loss of power, and risk of any injury to the structures over the pubic bones is reduced to a minimum. Although in its ordinary use this attachment is a tractor, it is possible with ease to lift a head over the pubic brim in pendulous abdomen (F S) and adjust it to the brim, or to the diameters of a deformed pelvis. In brief, by combined use of handle and tractor, the head can be moved into any position, and traction made in any direction with the greatest ease and precision. And whilst the lock is allowed considerable play, so that continuous pressure of the head is avoided, the force requisite for delivery is, in practice, found to be little, for it may be entirely used in the line of least resistance.

If instrumental delivery is conducted with precise knowledge of the mechanism of natural labour and of the direction of natural force—which is not downwards, but backwards into the hollow of the sacrum—and the instrument used is capable of accurately supplementing that force, and is, in its slightest movement, absolutely under the control of the operator, all difficulty disappears and with it the excuse for an undue and dangerous expenditure of force on parts which were never by Nature intended to suffer such abuse.

REFERENCE.

By Messrs. R. Sumner and Co., of Liverpool, by whom I am informed that many hundreds are now in use in this country.

DYSTOCIA DUE TO ANTE-PARTUM HOURGLASS CONTRACTION OF UTERUS: CÆSAREAN SECTION.

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HISTORY.

On July 29th, 1897, I was called to Mrs. B., aged 25 years, who was in labour with her second child. The pains occurred on and off for two days, and the "waters had broken" shortly before my arrival. On making an abdominal examination one was at once struck by the peculiar contour of the abdomen. It seemed to be occupied by two distinct tumours, one in its upper and the other in its lower part. The lower seemed to be about the size and shape of a child's head; the upper, larger, had its long axis transversely, and protruded very much forward. Between these two swellings a distinct groove could be made out; foetal limbs could not be palpated. The two swellings seemed (as the patient lay on her back) to occupy different planes, and suggested the possibility of twins.

Vaginal examination revealed the vertex presenting with occiput posterior. The os was well dilated, and the head just above the promontory of the sacrum, which was somewhat though not excessively prominent. An attempt was at once made to rectify the malposition, but quite failed. It was then noted that although the pains were strong and regular, and the uterus could be felt to contract, that absolutely no descent of the head took place. It seemed to be "strung up" over the promontory of the sacrum. Four hours after seeing the patient I gave chloroform, and made a further examination of the uterus preparatory to application of the forceps. The vagina and os seemed normal; the latter was well dilated. On passing the hand up by the side of the foetal head—(this was done with difficulty owing to the firm contraction of the lower segment of the uterus)—I found that the neck was firmly grasped by the uterus, which was powerfully contracted at this point. At first it was absolutely impossible to pass beyond this contraction. Bimanually the lower segment of the uterus was felt to be thinned, but not markedly so. It was also demonstrated that the sulcus, felt abdominally, corresponded with the contraction felt internally.

Forceps were applied, but absolutely no descent was produced. After a further interval I sent for Mr. S. H. Perry, and later for Dr. M. Perry, and from first to last we endeavoured either to rectify the malposition or deliver by forceps or version. All our efforts failed, even under deep chloroform anaesthesia and chloral hydrate. The pains throughout these manipulations kept very strong, and somewhat rapidly the

patient's condition became so serious that we decided that the uterus must be emptied.

OPERATION.

Craniotomy was resorted to but without any success. Cæsarean section was then decided upon sixteen hours after I first found the os fully dilated, and not until we fully agreed that it was the only chance for the patient. Chloroform was administered by Dr. Perry. The skin was rapidly prepared, and a very thorough mercurial vaginal douche given after one final attempt at forceps delivery. The abdomen was opened by a median incision, and the uterus exposed. Sponges wrung out of warm boracic lotion were then placed all round the uterus, and it was incised, whilst Mr. S. H. Perry placed his hands well down on each side of the uterus in the pelvis, and so most effectually and thoroughly controlled the hæmorrhage. The child was quickly delivered, and was rapidly followed by placenta and membrane; a large sponge was then placed for a few seconds in the uterine cavity, and firm pressure was kept up whilst the uterus contracted, which it did very well. No cause could be ascertained for the contraction; the uterus was a dark, slaty, blue colour. A double row of sutures—one taking up the whole of the thickness of the uterine wall as far as the submucosa, and the other taking up only the peritoneal cover so as to cause infolding of the edges, were used. The abdominal wound was closed by one set of sutures only.

AFTER-HISTORY.

Immediately after the operation strychnine and ergotine were given hypodermically, and soon after 15 c.cm. of anti-streptococcus serum, the operation being done in a not over-clean cottage. There was a good deal of collapse, but the patient rallied well, and her temperature at night was 100° F., and was normal the following morning.

For fifty-two hours the patient did very well in every way, the highest temperature being 101.4° at the end of forty-eight hours. There was practically no pain, no vomiting, no distension, flatus passed *per anum*, the tongue was clean and moist, respiration was abdominal, and the facial aspect good. She slept and felt and looked very comfortable. On the third day she had a little cough, and after one coughing attack (lungs appeared normal) she complained of severe abdominal pain, became very collapsed, and vomited a little bile-stained fluid. The pulse was very rapid, feet and hands were cold. There had been no chills or rigor, and now the patient complained simply of pain, and asked for a "good dose of salts." Stimulants caused a slight rally, but only for a while; a few hours after this initial attack of pain the abdomen was slightly distended. The abdominal wound was then examined; a few stitches had given way in two places, allowing knuckles of omentum to protrude. These were reduced and a couple more stitches removed, so that the uterus might be examined for any hæmorrhage. This was fifty-nine hours after the operation, and we found the wound beginning to heal and an entire absence of any sign of hæmorrhage or inflammation.

We attributed the collapse to the nipped omentum. Various stimulants, rectal and axillary injections of saline solution, were tried, but the patient gradually sank thirty-two hours after the attack of pain, and eighty-four after the operation. The respiration towards the end was of a peculiar sighing character, and resembled that seen in collapse due to loss of blood. The lochia were established, and never had any bad odour. Vaginal douches were used from the first. There was no vomiting until the "acute attack of pain," and only twice very slightly afterwards. There were no rigors, diarrhoea, nor tenderness of abdomen. Hearts, lungs, and great blood vessels normal. The clinical picture was one of good progress for fifty-two hours, and then sudden and eventually fatal collapse.

POST-MORTEM EXAMINATION.

There were no signs of any peritonitis; the uterus was well contracted, and of a light bluish colour. In the right iliac fossa was an ileo-cæcal intussusception, reduced fairly easily; only slight extravasation of lymph. The adjacent coils of intestine were slightly injected and finely granular on the surface.

REMARKS.

The interest of this case naturally centres in the cause of the dystocia. That we had a very definite "contraction of a

number of uterine fibres around the child's neck" I am quite satisfied. The contraction was, moreover, not due simply to a "rigid internal os," but to a strong unyielding tetanus of one portion of the uterine wall.

The diagnosis in our case was made by :

1. The definite palpation of the constriction around the neck of the child, corresponding with a sulcus felt abdominally.

2. The insuperable difficulty experienced in attempting delivery.

3. The absence of signs of tonic contraction of uterus until long after the constriction was felt.

The literature of the subject seems to be somewhat scanty. Playfair mentions the condition, and refers to Hosmer's cases in the *Boston Medical and Surgical Journal*, 1878. Blundell also is referred to by Dr. Playfair. In Hosmer's article four mothers are referred to and seven labours. In each of the cases mentioned the constriction was felt abdominally; Case No. iv especially resembles my own.

Brunings¹ refers to a case where marked tetanus followed premature rupture of membranes. Demelin,² referring to this subject, mentions the various times at which "retraction," or, as I have termed it, "contraction" occurs. Probably my own case would come under the third head, namely, "Contraction before rupture of membranes," in so far as I found the condition immediately on my arrival very soon after the membranes had broken.

Herman,³ writing of Partial Contraction of the Uterus, says, "The so-called strictures are produced not by partial contraction, but by imperfect dilatation." But in the above case dilatation must have been so far advanced as to allow the head to pass, since the contraction was around the neck. I believe the cause of the condition is found in sudden rupture of the membranes when a strongly acting uterus is associated with some mechanical obstruction.

I take this opportunity of thanking Dr. Perry, Mr. S. H. Perry, and Nurse Ridley for much help and kindness at the operation and subsequently, and Dr. Rivers Pollock for help in looking up the literature of the subject.

REFERENCES.

¹ EPIHOME, BRITISH MEDICAL JOURNAL, May 14th, 1898. ² *Ibid.*, August 27th, 1898. ³ *Difficult Labour*, 1895.

ABSTRACT OF THE HARVEIAN LECTURES.

ON

DISEASE AND ITS TREATMENT, AND THE PROFESSION OF MEDICINE IN THE YEAR 1899.

Delivered before the Harveian Society of London, December 1898.

By WM. EWART, M.D., F.R.C.P.,

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LECTURE III.

EDUCATION AND MEDICAL PRACTICE.

THE PROVIDENT SYSTEM AND ITS PROBLEMS.

In its ideal form the provident system seeks to secure the greatest good to the greatest number, benefiting alike the deserving poor and the profession. Its principle is the insurance of the healthy against the expenses of future illness. That principle has been accepted by the profession as belonging to our scheme of usefulness, and as tending to professional advantage if only it were fairly worked. Our services are for many a necessity, and it is right that they should be within the reach of those for whom they are intended.

The poorer patients have five courses open to them: (1) Some of them are sufficiently near the margin of pauperism to enable them to obtain Poor-law relief. (2) Many of them

apply to the chemist for advice and medicine, and this largely keeps up the practice of counter prescribing. (3) Others are anxious for treatment by hospital physicians and surgeons, and endeavour to obtain it at the hospital for which they have a predilection, though this may not be the nearest one to their own home. (4) A large number enrol themselves in the lists of the provident dispensaries and of the clubs. (5) Others prefer to get their advice independently, and at the time when they think they need it.

It is the patient who chooses between these courses. The medical man has no choice, except that of refusal when he is appealed to. If his charges should be prohibitive he would drive this humble practice into the other channels which have been indicated. In order to meet the necessities of the case there must be for his advice a sliding scale within the reach of the humblest means. This unavoidable smallness of remuneration is a reason for his preferring a system where it is to a certain extent disguised.

Unfortunately the slender compensation so well deserved has been only partially reaped by the profession. Benevolent in its intent, co-operation has opened the door to novel dangers and abuses of which the practitioner is ultimately the victim.

The Provident Association.—The beneficent institutions known as dispensaries seek to be self-supporting; but a charitable interest is taken in their management by members of a richer class, and this is a saving clause, for much depends upon the spirit of those who administer as well as of those who receive the relief. The collateral advantages which are opened up to those who serve a well-conducted dispensary render it a matter for regret that it has not been found practicable to extend them to all the local practitioners or at least to as many as may wish to participate. The remuneration itself is small, but it is fairly divided according to the work done.

The difference between these institutions and the friendly societies is fundamental; in the latter the softening element of charity is less prominent, and that of sentiment is not included. In early days the medical man's willingness to help them may have been considered a favour. This is now changed, and they have not always refrained from turning his difficulties to account. Other associations, built purely upon the principle of commercial insurance, although business-like in some directions, are free from any scruples connected with medical etiquette, and in other directions there is less regard than in the friendly societies for the individual interests and for the professional dignity of the medical officer.

THE PREVALENT ABUSES.

The defects which have arisen are clearly unintentional, and the outcome of ordinary economical principles. They include: (1) The obviously inadequate remuneration for excessive work and responsibility; and (2) the unjust appropriation of advantages intended for the poor by those able to pay.

Were the charitable ministrations bestowed only on the deserving poor, their cost would be a lighter burden. But it is well known that, owing to imperfect checks, and to the failure to realise the fault of which they are guilty, many thoughtless individuals receive relief who are really able to pay a fair honorarium for private attendance, and this is contrary to the intentions of those who manage these institutions.

This abuse is not sufficiently guarded against in the organisation of clubs. Some men of substance are admitted as members, or retain a membership assumed in less prosperous days, and do not refrain from getting their medical advice at an almost gratuitous rate. The practice of others is made to suffer besides that of the medical officer, for should he fail to meet cheerfully the behests of his employers, or refuse to submit to a reduction, the club may find a stranger to fill his place, and this will mean additional competition in an already restricted field of practice.

The worse troubles arise in connection with the medical aid societies. They actively canvass the public. Their medical officer is advertised—not always fairly, it is said—but he may have to suffer for the advertisement. And the climax is reached when he is victimised not only by the societies but by intermediate agents. Instances have often occurred when