the relaxed state of the levatores ani? and, if constantly supported during the evacuation of the rectum, what more reasonable than to suppose that the hæmorrhoids will yield to some mild treatment? or, if requiring removal, that their re-formation will be prevented?

Such was the train of reasoning that occurred to me in the after-treatment of the following case.

CASE. A. B., aged 25, had suffered from prolapsus for sixteen years. During that time, the bowel had descended invariably with each act of defæcation. On examination, I found external piles, large and numerous, and a loose fold of integument completely encircling the anus, and projecting about three-eighths of an inch. I found also internal piles, two in number, about half the size of a filbert, and a general abnormal rugosity of the mucous membrane, the nidus of future hæmorrhoids in the present state of parts. She suffered great pain at stool, and the faeces were generally more or less marked with blood. Her general health was very delicate: she had a pale, exsanguined appearance. I removed the external piles by incision, and the loose fold of (skin?) projecting from and encircling the anus. This was, no doubt, originally mucous membrane, which had been protruded, and had taken the form of skin from atmospheric exposure. The wound soon healed, but the prolapsus was as bad as ever, and, if not remedied (the parts being protruded and strangulated for a time daily), would soon have brought on fresh piles, and my patient would soon have receded into her former state.

What was to be done? Here the records of surgery give us no information. I adopted the following plan, with the utmost possible success. My patient has now used it for upwards of two years, and has not during that time had the bowel down, except when accidentally requiring an evacuation when from home. This occasional exception, so certain when the board was not used, distinctly proves that the non-prolapsus, at other times, was due to the contrivance, as truly as the non-descent of the bowel is due to a truss. It is probable that the analogy may go further, and that the *absolute constancy* of this support during defæcation will cure prolapsus, just as a truss cures hernia, when used for years without the permission of one descent of the bowel. I may also add, that, since the use of the board, I have heard no more in this case of piles, either internal or external.

The plan may be described thus:—Cover a chamber utensil with a strong flat board, taking a circular form, and projecting one inch; let into the edge of the wood three or four pieces of wood, to keep it fixed on the chamber-pot; make an opening on the surface of the board, a little behind its centre, just large enough for the anus to act; and surround this opening with an elevated ridge, to support the entire perinæum and sides of the anus during evacuation. The anal foramen which I have used, has been oval, its long diameter being antero-posterior, and four inches in length, and its transverse diameter being two inches and a half. It has been abrupt, not bevelled; the sharpness of the edge being removed. The ridge has been half an inch high, and has extended all round the anal foramen, and has been less than half an inch from it. The great object is to keep it within the ischia. Some of my patients have felt more secure and more comfortable *with*, and some *without* this ridge. For females, I have had a large anterior urinary fissure, half an inch wide towards the middle of the board, and opening into the foramen, and gradually enlarging forwards to the size of three inches in front. With males, I have recommended another utensil in front.

As "there is nothing new under the sun", some such apparatus may possibly have been already used without my knowledge; and I have no doubt that, if the attention of the profession be directed to the subject of this paper, some better plan may be discovered than that which I have suggested.

Chatteris, Cambridgeshire, Dec. 10th, 1852.

AMPUTATION OF THE ARM IMMEDIATELY BELOW THE SHOULDER JOINT, FOLLOWED BY RECOVERY, IN A CHILD AGED FIFTEEN MONTHS.

By ROBERT EDWARDS JONES, M.R.C.S.

On the sixth of September, in consequence of the absence of Mr. Mason, of Sudbury, I was hastily summoned to visit Eliza Harrington, aged 15 months, the child of poor parents, residing at Wickham St. Paul's, Essex, who had been knocked down by a waggon, the wheel of which had passed over her left arm. On examination, I found a fracture of the humerus at its lower third, the bone protruding denuded of its integuments, and the soft parts lacerated nearly to the shoulder joint: the little patient was much exhausted from loss of blood. I administered small quantities of brandy and water, which had the effect of producing reaction; and feeling there was no time to be lost, I at once amputated just below the shoulder-joint, being just able to save sufficient integument to form a good stump. I was ably assisted by Mr. Mason, jun., and very little blood was lost during the operation, and but one artery required a ligature. The child had severe convulsions the following day, which were relieved by small doses of tinctura opii; after which it progressed most favourably, and at the end of a month had perfectly recovered.

I am induced to send this case for publication, because I believe that it is rare for a child of such a tender age to recover from so severe a proceeding.

Long Melford, Suffolk, Nov. 1852.

FATAL DISEASES OF THE STOMACH.

By JOHN CHARLES HALL, M.D., Fellow of the Royal College of Physicians of Edinburgh, etc.

THE most important truths may be derived from a faithful record of those cases in which, notwithstanding all our efforts, the disease we are called upon to treat proves fatal. However pleasing and flattering to our vanity it may be, to publish those cases only in which we have been successful,—fatal cases, at least, as much as those which have had a favourable termination, convey important lessons.

CASE 1. On November 1st, 1852, I was requested to see, in consultation with my friend, Mr. Henry Julian Hunter, surgeon, Mr. F——, of Sheffield, aged 46, a brass-turner. From Mr. Hunter I learnt that he became his patient on the 20th of May, 1852, with symptoms of dyspepsia, under which he had then laboured for some time. He prescribed mild laxatives, with infusion of calumba, and prussic acid, and, on the 25th of May, the nitrate of bismuth and rhubarb. Under this plan of treatment, and a mild diet, the patient became much better. Mr. Hunter did not see him again until the 27th of August, when he called upon him, having, meantime, been under the care of Dr. ———, who had ordered him to be rubbed with the linimentum hydrargyri, etc. He had also been to Dr. M——, a physician, residing some distance from Sheffield, who prescribed calomel and the compound powder of antimony, and a simple saline mixture. He had now the same symptoms as when last attended by Mr. Hunter, and the same plan of treatment was again adopted.

Sept. 19th. He was much worse; had obstinate constipation; almost constant vomiting; and severe pain in the region of the stomach. Small doses of castor oil, and clysters of warm water, were given. An ointment of tartarised antimony was applied over the region of the stomach, which gave some little relief. He continued much the same until Oct. 7th, when all the symptoms were aggravated; the pain and sickness were constant, and the food rejected almost as soon as taken. Sometimes, however, it remained some hours, and was then vomited. The bowels were kept open with clysters; leeches, and a plaster of belladonna, were applied to the epigastrium.

Oct. 8th to 10th. First, prussic acid and water, then creasote and water, were prescribed; but the pain still continued, and even a little milk was vomited a few minutes after it was swallowed.

Oct. 10th. Mr. Hunter tried the nitrate of silver with opium, with some little advantage; but the symptoms again returned with increased severity, and so continued to the day when we met in consultation.

Nov. 1st. The first thing that struck me was the shrunk appearance of Mr. F—. I had not seen him for nearly two years, when attending another member of his family. He was then very fat, and appeared to be in good health. This wasted appearance at once impressed my mind unfavourably; for I have found, in the cases of this kind I have seen, that emaciation is a very ugly circumstance, and affords strong presumption that the long-continued pain and sickness are caused by organic disease of the stomach.

He told us, that for more than a year he had felt a constant uneasiness over his stomach, and that now and then during that period he had had severe pain; that on these occasions he was sick; after which the stomach did not feel so full, and he was better, often for days together. This appeared to have been the case, from Mr. Hunter's prescribing for him, on the 25th of May, to the end of August, when Mr. F— again consulted him. He had for many years past partaken freely of spirits and ale, but more ale than anything else.

When we entered the room, he was in violent pain, having just thrown up some milk, which was shown to us. He said that the pain was constant, that he was sick every two or three hours, and could get no rest. His face had a yellowish green aspect, and looked more like *wax* than *flesh*. The pulse was 80; the tongue clean and moist; the urine natural. The organs within the chest appeared healthy. The liver was evidently much enlarged. The abdomen was generally flat, and had the appearance of being drawn inwards; *pressure over the stomach gave no pain*; and the most careful examination did not enable either Mr. Hunter or myself to detect any hardness of or tumour near the pylorus.

Mr. Hunter had noted the case as one of disease of the pylorus, an opinion of the correctness of which there could be no doubt.

It was agreed in consultation to give a teaspoonful of water, with one drop of prussic acid (*Scheele's*), every two or three hours; and to confine the diet to a teaspoonful of milk, thickened with arrow-root. The bowels, which had been confined for a day or two, were relieved with a clyster, and the strength of the patient was ordered to be supported with injections of strong beef-tea. A blister was applied over the stomach.

Nov. 7th and 8th. He appeared better; was only sick twice in twenty-four hours; but at times had been in great agony.

Nov. 10th. He had been again very sick, and complained of *almost constant* pain. The countenance had a pinched and anxious appearance, and the peculiar yellowish-green hue, so characteristic of organic disease of the viscera, was more marked. We were shown some dark, grumous, offensive fluid, which he had vomited, evidently containing a considerable portion of blood.

The pulse was quick, and very feeble. Everything was now ejected, even a little cold water. In a case I had seen some time ago, in Nottinghamshire, with Mr. Nelson, chloroform had, for several weeks, given the greatest relief; the vomiting appearing to be checked by it, and the pain to be relieved, although only for a time; the patient, a female, in the end, dying from cancer of the stomach. At my suggestion, therefore, three drops of chloroform were given in a little water; but the patient disliked the smell, and refused to take it.

He was ordered to take nothing but a little ice, and to let it melt in his mouth. Beef-tea injections, etc., to sustain life; morphia, opiate injections, a plaster of belladonna, and opium, etc., were suggested, in order to give what temporary relief from suffering we could, but, I fear, with

little success; the pain and sickness continued, and he died from exhaustion on the 16th of November.

Post-mortem examination, 36 hours after death. The body was much emaciated; the organs within the chest were healthy. The omentum was not thicker than a piece of paper. The liver was much enlarged from hypertrophy of the white substance (*nutmeg liver*); the gall-bladder contained a small quantity of bile; the pancreas, spleen, and kidneys, were healthy; as was also the alimentary canal below the stomach. The stomach* was enlarged, and behind the lesser curvature there was a mass of scirrhous glands. On opening the stomach, below the cardiac orifice, we observed a *large and very bright vermillion patch* on the mucous membrane, several inches in extent, and shaded into a grey colour, as it passed towards the pylorus. Below the sphincter of the pylorus, was a large cancerous ulcer. To borrow the words of a gentleman present at the examination, as highly characteristic, the edges had a "punched appearance". The ulcer had destroyed all the coats of the stomach, the contents of which were only retained by the adjacent peritoneum, which had evidently become united during the progress of the disease; and even this was so softened, that it gave way in removing the stomach from the body. The pylorus was surrounded by and involved in a mass of disease of the same nature, by which the natural outlet was reduced to a very small size. The mucous membrane, *softened throughout*, could easily be separated. The stomach was empty.

REMARKS. It will, perhaps, be better to direct the few observations I have to make on this very interesting case, 1stly, to the symptoms present during life; 2ndly, to the post-mortem appearances; 3rdly, to the treatment of similar cases.

1. SYMPTOMS DURING LIFE. This case well illustrates the fact, first, I believe, pointed out by M. Andral, in his work on Clinical Medicine, that, in the early stages of disease of the pylorus, causing this opening to be narrowed, there is generally copious vomiting every eight or ten days, or even more frequently, by which the sufferings of the patient are much relieved; the distended stomach disgorge its contents. The late Dr. Hope† has remarked, that when the contraction has proceeded from carcinomatous tumours, "*the vomiting ceases when the ulceration of the tumour leaves the orifice free*"; but the symptom "*recurs in proportion as the tumour is regenerated*"; still, it occasionally happens, that similar dilatation of the stomach takes place when the pyloric orifice is enlarged—an anomaly which arises from the thickened walls of the viscus having lost their tonic contractile power, whence accumulations arise as in an inert bag.‡ M. Andral,§ Dr. Seymour,|| Dr. Watson,¶ and others, have directed attention to the peculiarity of the symptoms characteristic of cancer of the stomach; but sometimes there is not one symptom by which it can be detected by the most experienced and skilful practitioner. Some patients have much pain—others have none at all; one patient vomits continually—another patient, from the commencement to the termination

* The body was examined by Mr. Hunter, in my presence; the stomach was removed to the Sheffield Medical Institution, and examined by Messrs. Allanson and Atkin (lecturers on anatomy), Mr. Parker, and Dr. Elam. The preparation (with remarks on the case) was shown by me to the members of the Sheffield Medical Society, Dec. 2nd, 1852.

† Morbid Anatomy, p. 214.

‡ Those cases in which the food is vomited, when the pylorus remains open, are very interesting. Dr. Watson has shewn that the "pylorus is a sphincter muscle, the natural and habitual state of which is contraction": it yields, in health, to the pressure of the digested aliment which is driven forwards by the muscular fibres, which compress and surround the pyloric end of the stomach. Of course, when the natural outlet is closed, the food will be thrown up again; but even when open, from the ulcer involving the pylorus, the propelling force cannot be exercised. Should the pylorus be closed, the disposition to hypertrophy in the muscular coat is conservative but in very thin and delicate people (more particularly, according to our experience, in females), the muscles are never sufficiently strong to conquer the impediment; the consequence is, that meal after meal is retained; the distended coats become thinner and thinner: so long as, by vomiting every now and then, the organ can relieve itself, the patient lives, or rather lingers, through a miserable existence, until the power to reject the contents of the stomach ceases, and death takes place.

§ Clinique Médicale.

|| Medico-Chirurgical Transactions.

¶ Practice of Physic, vol. ii, p. 415.

of the disease, has little or no vomiting. These are all points of great practical importance, and direct us, in some degree, to the *situation* and nature of the disease. It has long ago been pointed out, that when the ulcer is situated, as in the case of Mr. F—, near the pylorus, the pain is much greater than when it is placed in the middle of the stomach; and we can readily conceive why an ulcer placed at or near either opening of the stomach, should give more pain than when attacking the intermediate parts, in either curvature.

When the ulcer is situated at the entrance to the stomach, the disease has symptoms very similar to those of stricture of the œsophagus; but the food, generally, gradually passes in the right direction, and then for a time the sufferings of the patient are over. This I have observed in a case in St. George's Hospital, under the care of Dr. Seymour.

Mr. Kiernan examined the body of a gentleman after death, in whom the pain had been unusually severe, and found, on a careful dissection, that the *scirrhous mass* had surrounded the trunk of the gastric branch of the *par vagum*, which in fact ran directly into it.

The emaciation has already been alluded to: not but that we have seen patients more reduced than this man; still, as his wife said, he was a mere shell when compared with what he had been two years before. Although not always a symptom of malignant disease of the stomach, wasting of the body has been observed in every patient dying of this disease that I have seen. Napoleon Bonaparte is said to have been very fat when he died; his omentum remarkably so. The fat is said to have been "upwards of an inch thick on his sternum, and one inch and a half upon his abdomen."

It will have been remarked, that, a few days before death, the pain, sickness, and vomiting, were urgent, even when the stomach was kept without food, and the thirst mitigated by permitting a bit of ice to dissolve slowly in the mouth. The vomiting on the 10th also began to resemble coffee-grounds, and was very offensive, affording almost certain evidence of organic disease of the stomach. From this time, the powers of life, too, rapidly declined. This was also the case in another patient under the care of Mr. S. Parker, a few months ago, whom I saw two or three days before he died, and whose stomach was found diseased, on examination after death, from the cardia to the pylorus. Here, as in the case of Mr. F—, the matter ejected resembled coffee or chocolate grounds, or lees of wine; and the patient rapidly sank after this symptom was present. The dark matter was evidently blood extravasated from the disorganized surfaces, and changed by exposure for a sufficient time to the action of the gastric juice. So far as we know, this kind of vomit generally ushers in a rapidly fatal termination. It is also interesting, as teaching that a mechanical obstacle is not the only cause of vomiting in cancer; for we see that, independently of any mechanical obstruction, and where no food of any kind has been taken, there may be repeated and copious vomiting, from the morbid irritability of the stomach in the advanced stages of the disease, and more particularly when the surface of the organ is denuded by ulceration.

Cruveilhier relates a case the symptoms of which, during life, were somewhat similar to Mr. F—'s; that of Madame A—, aged 42 years. The symptoms were, perpetual vomiting of mucus and food for three months; then hæmatemesis came on, and the lady died in three weeks. All treatment was ineffective, even to palliate. On examination after death, *encephaloid vegetations* were found in the stomach, chiefly about the pyloric half. One obstructed the pylorus.

2. POST-MORTEM APPEARANCES. Cancer was not observed in any other organ of the body; and I believe, notwithstanding the fact that cancer is a constitutional affection, or, at any rate, if local and solitary at first, is apt to disseminate itself, that, when it attacks the stomach, it is accompanied less frequently than some other modes of carcinomatous disease by cancer in other parts of the body.

The peculiar bright redness observed at the cardiac portion of the stomach was a feature of much interest, not

mentioned by any author I have met with, in connexion with a fatal disease of the pylorus, such as was present in this man. The researches of Dr. Yelloly, M. Billard, and Morgagni, are very interesting. The first-named physician conceived that these patches are not to be regarded as unequivocal marks of disease of the stomach, inasmuch as they "occur in every variety of degree and character, under every circumstance of previous indisposition, and in situations where the most healthy aspect of the organ may be expected": an opinion fully confirmed by Dr. John Abercrombie.

Cruveilhier describes the anatomical characters of the simple ulcer of the stomach to be spontaneous loss of substance; ordinarily circular, with well-defined edges; the bottom of it greyish and dense; of variable dimensions; almost always in the lesser curvature or posterior wall of the stomach; sometimes as a zone in the pyloric orifice. He remarks, also, that the simple ulcer is almost ever solitary.

The simple ulcer differs from the cancerous ulcer in the character of its base, and the absence of circumscribed hypertrophy, which always attends the latter.

The symptoms are described by this eminent writer to be emaciation, constipation, nausea, vomiting, hæmatemesis. The cases he gives, as illustrative of this disease, are such as have died from perforation without preliminary adhesion and consequent peritonitis. This adhesion is mentioned by Cruveilhier as one of the ordinary attendants on ulceration.

The distinction between simple ulcer and cancerous ulcer of the stomach is still further illustrated by the curability of the former. Two cases are quoted by Cruveilhier, of death from perforation, as a sequel of simple ulcer; the opening being found at the border of a cicatrix of an old ulcer, the relic of a previous disease. The progress of one of these cases extended over a period of more than twenty years.* There is no case illustrative of the vermilion injection of the mucous membrane observed in the stomach of Mr. F—.

3. TREATMENT OF SIMILAR CASES. The treatment of the advanced stages of a disease, which may be fatal by gradual exhaustion after long-continued suffering, by fatal hæmorrhage from the ulcer, or by perforating the stomach and permitting the contents to escape into the cavity of the peritoneum, giving rise to extensive peritonitis, can at the best only be palliative. Prussic acid, opium by the mouth, or anodyne enemata, and nutritive injections, when food cannot be retained, may afford some little comfort; but of one thing we are certain, *that the less we put into the stomach, in the way of medicine or food, under these painful circumstances, the better.*

But can anything be done in the first stages of these diseases of the stomach? We have already pointed out the important diagnostic mark of Cruveilhier, that *simple ulcers* of the stomach may be distinguished from *malignant*, by the former admitting of cure; and our treatment must be directed in the hope that the disease is not malignant; and even when we have every reason for supposing that chronic inflammation has ended in ulceration, we must not altogether live without hope. The possibility of the cicatrization of ulcers, once doubted, is now fully ascertained. The process certainly takes place with difficulty, having many obstacles to contend with; but there are now few pathological anatomists who have not met with instances in which some intestinal ulcers were in full activity, while others were healing, and a third set completely cicatrized.†

In a case in which we had reason for suspecting ulceration of the stomach, the treatment we should reply upon, in the first instance, would be, leeches, counter-irritation, prussic acid, and, in some patients, small doses of nitrate of silver. The treatment will of course demand great perseverance and patience; but we know that, if the patient have not the scrofulous diathesis, he may recover from a condition apparently the most desperate. Of course, each case

* Cruveilhier, *Livraison* xx.

† Vide Dr. Hope's *Morbid Anatomy*, fig. 167 to 170.

will require modifications of treatment, which must be left to the tact of the medical attendant to regulate; but, in reference to the disease itself, I would remark, that the smallest possible quantity of food, and of the least irritating nature, is absolutely to be insisted on: wine, spirits, ale, should be avoided, and even the mildest kind of food, such as milk, arrow-root, etc., must not be given in sufficient quantity to distend the organ. As the emaciation, during the progress of the disease, often becomes very great, some food must be given to support life. The difficulty in the treatment consists in steering between the two extremes; but, so far as my experience teaches, the danger is *greater* of giving *too much* and too stimulating food, than *too little*. If we have a choice as to the kind of food, it is for a diet consisting, as proposed by the late Dr. Barlow, wholly of fresh-made curds; and even of this a small quantity only is to be taken at a time. Aperients always do harm, and are therefore, if possible, to be avoided. The bowels can be kept open by clysters of warm water, and the powers of life may also be sustained by injections of beef-tea, by which the necessity for food taken by the mouth is lessened, and the diseased stomach longer permitted to enjoy that perfect rest, which is so very important.

Sheffield, Jan. 1st, 1853.

CASE OF INTERNAL UTERINE HÆMORRHAGE.

By GEORGE KING, Esq., Surgeon.

In the *Provincial Medical and Surgical Journal* for 31st March, 1852, I published a case of internal uterine hæmorrhage. The subjoined is another case of the same class, which recently occurred in my practice.

CASE. On Sunday, Sep. 5, 1852, I was sent for to see Mrs. T., a patient whom I had attended three times before in her confinements, and who had always had a quick and natural labour. She was now, as she supposed, in her last month with her fourth child. Not expecting for a month or five weeks, she had taken lodgings for a week or two on a hill about a mile from the city, for the benefit of the children's health, as well as her own. On the morning of the day when I was called in, she was preparing to go to church with her husband and family, when a wasp stung one of the servants. This trifling incident caused great commotion in the house, and so upset Mrs. T. that she did not go to church, but lay down on the bed. The account the woman of the house gave me was—that, soon after the husband and family were gone to church, Mrs. T. complained to her of a slight pain in the back, with a little discharge, and she felt altogether very unwell; and soon after she had a very copious motion, which she (the old woman) thought *smelt very deathly*. Here the old woman's olfactory organ was at fault. She had fainted twice in about an hour. They both became alarmed; and at half-past twelve o'clock the husband was called out of church. Immediately on his return to the house, a servant was sent off for me.

It was about two o'clock when I saw her. I found her then on the bed. She appeared much depressed, and complained of tingling pains in the back, and she thought that labour would very soon come on. On examination *per vaginam*, there seemed to have been no discharge, and I found nothing more than the usual premonitory symptoms of approaching labour. In the parturient passage the mucous secretion was very abundant, and the parts most amply lubricated. The os uteri was thin, and sufficiently dilated for me to introduce my finger with ease. Having fully satisfied myself that there was no external hæmorrhage, or any other alarming symptom, I did not interfere. I was with her about two hours. During that time there were no labour-pains, but she still continued to complain of great sinking, and fainted once, and was also sick; still this did

not improve her condition, (sickness often excites labour-pains). As she seemed much exhausted, I gave her a table-spoonful of brandy twice, but she kept yawning, and did not rally. The pains were slight, and less frequent, and not so strong as when she was first taken. Yawning and fainting occurring during labour, are unmistakable symptoms of mischief going on: they must always be looked upon with suspicion, and must create in the mind of an observant obstetric practitioner some degree of alarm, and will require his most prompt and active assistance. As there was no advancement at half-past four o'clock, I then gave a dose of ergot, but it did not increase the pains much. On making another examination, I found the os uteri a little more dilated, and a pouch of the membrane presenting, about the size of a filbert; this I ruptured, but only a very little liquor amnii escaped. I then discovered that it was a natural presentation, and was satisfied that if the pains followed I had nothing to apprehend. Shortly after the membrane was ruptured, the pains became stronger and quicker, and in about two hours a dead child was born, without any unpleasant symptoms succeeding. Before the placenta was expelled, and in a few minutes after the child, a large clot came away with a very slight pain. Although it was not very large, this fully explained the fainting and the other unpleasant symptoms which had been observed during the day. The clot had no doubt been accumulating ever since the first fainting-fit in the morning; and would have gone on until checked by fatal syncope or labour. The vessels had no doubt ceased to bleed the moment the membranes were ruptured, and the formation of the clot was stopped by the expulsive action and contraction of the uterus. That took place in the afternoon, without producing the slightest appearance of anything like internal or external hæmorrhage. It was very evident, from the appearance of the child, that it had not been dead long, and it was very clear that the mother had not gone her full time. She had herself expected to go three weeks or a month longer. I examined the placenta immediately after it was expelled, and there was a rent in its membranous covering, at the root of the umbilical cord; and on the surface of the placenta itself there was a large thick coagulum extending over it, an inch and half in circumference, which was very easily removed. This coagulum was no doubt nature's plug, which had put a stop to the hæmorrhage, and all the other unpleasant symptoms.

I need not here enter on the pathology of the utero-placental circulation, nor on the intricate subject of uterine susceptibility; but we all know, and those of us who have had much midwifery practice must have noticed that, at the placental end of the cord, the umbilical vessels are very large, particularly the umbilical veins. From this point they ramify, and are distributed over the whole membranous covering of the placenta, till lost in the substance itself; and from this point, also, springs, and is conveyed, the nourishment to the fœtus in utero. Thus, a rupture, or hæmorrhage, or any disorganisation taking place at this important and connecting link and vital union between the mother and the fœtus in utero, must be attended with very serious, if not fatal consequences, both to the mother and child; and would be calculated to produce the symptoms and all the great constitutional derangement, of which my patient complained, and from which she was suffering before the child was born, when I was first called in; and is another strong proof of the powerful influence and the great effect of passion and mental impression on the mother's system, and on the fœtus in utero. There is not here the slightest doubt that the agitation and commotion of the mother's mind, caused by the sting of the wasp, must have produced a shock to the whole system, the effect of which was so powerful, as to produce the copious evacuation from the bowels, and consequent great exhaustion; and no doubt it was a sudden and violent movement of the fœtus that tore the membranous lining of the placenta, and lacerated the umbilical vein; and here was the cause of the internal hæmorrhage which caused so much uneasiness during the day, and would soon have caused the death of the