The treatment here described, namely, leeches locally and frequently applied, and methodical compression, are of eminent service in restoring to a healthy condition the mammary gland-tissue when in a state of induration; and I must here confess, that after repeated and long continued trials, I have never yet succeeded in producing absorption of any tumour which exhibited to me unequivocal indications of being a new growth.

The constitutional treatment consists in the administration of such medicines as improve the general health, and by this means restore the generative organs to a healthy performance of their functions. Aperients, tonics, wholesome food, change of air, and bodily exercise, perhaps the use of the shower-bath, or sea-bathing, and the withdrawal from all circumstances tending to excitement of the nervous system, will be found of service. Liquor potassæ given internally is, sometimes, also useful.

The local treatment must be regulated by the condition of the individual. Occasionally, a few leeches afford almost immediate, although temporary, relief from the pain. The application of the extract of belladonna and soap cerate in equal parts spread upon lint, and supporting the gland with strips of plaister and a bandage, is also very useful. I have likewise known the placing a piece of thin gutta percha over the induration to lead to its absorption, as well as the application of the ceratum hydrargyri compositum spread upon lint. In some cases, the pain and sufferings are so intense, and they resist so obstinately all attempts to assuage them, that the patient is induced to submit to the removal of the breast. The operation has been performed under my observation in three or four instances, and success attended it.

I propose in a future communication to illustrate the preceding remarks by the detail of some cases.

Wellington Street, Southwark, June 1853.

CASES IN PRIVATE MIDWIFERY PRACTICE; WITH REMARKS.

By EDWARD L. FALLOON, Esq.

REPORTS of private midwifery practice are rarely submitted to the public. I have been induced to present the following tabular statement, after perusing an interesting paper on this subject from the pen of Dr. G. Hamilton, of Falkirk, in the *ASSOCIATION JOURNAL* for May 27th, p. 467. Up to this time, our statistical results have mainly rested on hospital experience; but, in order to establish a just comparison between public and private midwifery practice, authentic reports of the latter require to be greatly increased.

The following 310 cases are reported exactly as they occurred in uninterrupted succession. I regret to say that I have only been in the habit of keeping notes of my midwifery cases during the last few years, although previously, during dispensary practice in Ireland, as also during some voyages to Australia, in charge of large numbers of emigrants, under the auspices of the Colonial Land and Emigration Commissioners, I had much experience in this department, often under most trying circumstances. The only record that remains—and it is thankfully impressed upon my mind—is this, that I never yet have had a single death in my midwifery practice.

In the published details of hospital and private midwifery practice, I am sorry to find that the old proverb of "doctors differing" comes true. Take the use of the forceps, for instance. Dr. Hamilton, of Falkirk, used them 41 times in 300 cases, occurring, too, "among a generally robust and healthy population", or less than 1 in 7; according to my table, 1 in 53; in Mr. Crosse's practice (of Norwich), 1 in 16; Dr. Merriman, 1 in 98; Dr. J. Clarke, 1 in 295; Ramsbotham, 1 in 729; Collins, 1 in 684: so that Dr. Hamilton enjoys an unenviable notoriety in this respect. Notwithstanding, his mortality-table is not high,

being 1 in 20 among mothers delivered by the forceps, while the children thus delivered were all living. Still, so far as my own experience goes, I think such frequent use of the forceps cannot be defended; nor, on the other hand, can I understand how some men pass a life-time in midwifery practice without ever using them at all. The last case of this kind I had was a woman aged 42. It was her first confinement. The mother and the child are living, and in health.

There are notes in my case-book, appended to some of the cases, which, though conveying nothing novel to men of my own standing, are yet eminently practical to the generation of surgeons arising around us. Medical men in general practice, like myself, are seldom able or inclined to write for publication; and perhaps they do not sufficiently estimate the value of their every-day experience to young beginners. A tersely told practical fact, read in a weekly journal, makes, I am convinced, far more impression than if it had been perused in an elementary work.

CASE I. INCISION OF RIGID OS UTERI. A primipara, aged 33. This was a most tedious labour, occasioned by uterine rigidity, which defied all efforts to overcome it. I remained with the patient for two days and two nights, and administered chloroform freely during most of the time. I resorted to venesection, injections, fomentations, manual dilatation, and nauseating remedies, without obtaining any progress, although the pains were strong throughout this treatment. It occurred to me that, as a breach of continuity was inevitable, it would make very little difference whether it was produced by the natural efforts or by mechanical means. Acting on this view of the case, and without any authority, I took a probe-pointed bistoury, and made it like a hernia knife; and with this I incised the uterus. In an hour, all was safely over.

I was not aware till lately that the practice which I adopted has been recommended by high authority. Two cases are reported, and the practice discussed, by Mr. Houghton, in the *Dublin Quarterly Journal*. Among its advocates are to be found the eminent names of Murphy, Lever, T. Smith, and E. Kennedy. I have since attended the same woman, when her labour was as remarkable for its rapidity as the former was for its tediousness. In a similar difficulty, I should have no hesitation in adopting a similar course.

CASE II. TWINS: NINTH PREGNANCY. The placenta was detached at the commencement of labour. Copious flooding occurred whilst the uterus was dilating. I ruptured the membranes, when the head of the first child descended with the face towards the pubis; it was born dead, and with great difficulty. The membranes of the second descended soon afterwards, in consequence of a dose of ergot previously administered, in anticipation of flooding. Both hands presented. I succeeded in replacing one hand, and bringing the head over the brim of the pelvis (as the uterus was acting too violently to turn). It descended with one arm, face presenting; and, as the fœtus was dead, I evacuated the cranium, and brought it down with the crotchet, without much force. The placenta of the last followed immediately, and the other came away soon after, without inordinate flooding. This woman is again pregnant.

CASE III. TWINS: PLACENTA PRÆVIA: TWELFTH PREGNANCY. This case was somewhat similar to the above; but the practice was different. My notes only state, that the placenta presented, that I turned both children, and that there was hæmorrhage, both before and after delivery, to an alarming extent. This woman is again pregnant.

CASE IV. INTERNAL HÆMORRHAGE. This case answers in all respects to that published by Mr. George King, of Bath, in the *ASSOCIATION JOURNAL* for January 14th, p. 38. Everything is of value that throws light on these most fearful cases. I do not know anything more perplexing than to see a woman fainting and yawning, shivering and sinking, at the commencement of her labour, when you cannot detect any external cause. In this case, there had not been any hæmorrhage previously. She was supported with cordials, and pains encouraged, till the child was born

dead, but evidently only a short time dead; and, after the placenta, came a great clot, as large as itself. The faintness continued some time.

As this case presented some features of interest, I may be allowed to reprint its history, with the remarks which I made upon it, from the *Medical Times* of January 18, 1851.

"I was called, Nov. 20th, at 1 o'clock A.M., to attend Mrs. A., aged 26, with her second child. She had been complaining since 11 P.M.; pains increased; head presenting, and pressing much on the linea of the os pubis, where she referred all her pain. At 2 o'clock, sudden fainting came on, with deadly pallor and cold extremities. On her rallying from this, by brandy, open windows, etc., the pains brisked up, and the uterus kept dilating, but was interrupted frequently by the faintness, which kept recurring without any external hæmorrhage till 3 o'clock, when she had a fearful rigor. She rallied again, and became less faint, but complained loudly, and begged for chloroform, which I was ultimately obliged to give her, with great benefit, till her child was born at 5 o'clock A.M., without any unusual detention in the vulva, but *dead*. Immediately on its exit, the placenta followed, accompanied by an enormous clot, as large as, if not larger than, the placenta; the subsequent hæmorrhage was not excessive, but the faintness was extreme; nevertheless, the uterus contracted well. The shock of her child's death, added to her exhaustion, made her case very critical for some time (she had lost her first child from erysipelas); she looked blanched and anæmic to a high degree, but gradually improved. On the third day, I was not a little alarmed and surprised to find her covered by a scarlatinoid rash, and the more so on being assured by her mother, then present, that she had had both scarlatina and measles. I had not met with this symptom before, and it was the more unaccountable from being unaccompanied by any appreciable fever; pulse 96. I ordered a mild alterative and cooling aperient, and left very uneasy. On returning to my study, I happened to take up the *London Journal of Medicine* for October 1850, and read that highly interesting and scientific article by Dr. Cormack, on 'The Entrance of Air into the Uterine Veins', wherein he alludes to some cases occurring in the practice of Dr. Simpson, in which the same rash appeared three days after delivery, but *all* followed by death; this made the matter more anxious for me by many degrees. Visiting early next morning, I found the patient improved; the rash still out, but *paler*; no febrile symptoms. I ordered a more generous diet, and it continued to disappear daily; and she ultimately did well, and is now able to appear at her dinner-table, little more than a month since her confinement.

"It is evident this was a case of hæmorrhage in utero, prior to the rupture of the membranes, owing to detachment of the placenta, and the rigor I suppose the evidence of the child's death; but I am not in possession of any facts that throw light on the cause of this detachment, except that she had felt debilitated of late from a continuous attack of influenza.

"I am induced to published this case by a remark I find in the ingenious article by Dr. Cormack, above alluded to, where he says, 'he notices his cases, in the hope that others will, when opportunities occur, make and record their observations.' I also refer to this phenomenon (the scarlatinoid rash), more with a view of adding a case to those already on record, than of proposing any theory regarding it. While I say this, I am not disposed to accept any of the theories at present propounded as at all satisfactorily accounting for this appearance; nor do I acknowledge any analogy, so far as I am able to judge, between the 'reddish tinge' of Dr. Warren and the 'scarlatinoid rash' of Dr. Simpson; the former appearing immediately after the evident entrance of air into the circulation, while the latter did not appear until two or three days after the shock of parturition, without any allusion to air having entered the uterine orifices. In my case, I think it is clear that no air entered the fainting commenced long before the mem-

branes were ruptured, and faintness only remained after the birth of child and placenta; besides, I had recourse to such mechanical support as made its entrance almost impossible. Nor do I see any analogy between a continuous, general, and gradually disappearing rash, as above stated, and the 'fitful suffusion of the face with a delicate blush, superseded quickly by extreme pallor.' To this latter, I think Dr. Cormack's theory of 'capillary relaxation' admirably applies; but, with all deference to such high authority, it does not satisfactorily account to my own mind for the former red hue. If I might venture a theory on the subject myself, I would remark, that I believe it to be connected with such a state of body as exists in low adynamic fever, or pure typhus, where there is a general lack of vital tone, depressed organic nervous system, and deteriorated circulating medium; all which were evident in Mrs. A.'s case. The rash disappeared on adopting a generous diet and mildly tonic plan; in a word, it appeared analogous to petechiæ or purpura."

The object of the subjoined tabular statement is to exhibit at a glance my mode of practice, and its success.

RESULTS OF LABOUR IN 310 CASES.

Character of Labour.

Natural	173
Tedious	51
Hard	52
Quick	34
	<hr/>
	310

Complication.

Twin cases (all males)	5
Monsters . { 1 acephalous	2
{ 1 valgus with six toes	
Turning	4
Instrumental { Forceps	6
{ Embryotomy	2
{ Blunt hook	3
	<hr/>
	11

Presentations.

Head	290	Footling	4
Face	2	Placenta prævia	1
Breast	6	Funis with head	3
Arm	2	Hand with head	2

Chloroform used beneficially 41

Hæmorrhage.

Post-partum	20
Ante-partum	8
Internal	2—30

Mortality among mothers 0

" among children:

Ordinary labour	13
Twins	5
Forceps	1
Monster	1
Breech presentation	1
Embryotomy (one a twin)	2
Premature	2
Decomposed at birth	1
Turning	1
Ante-partum hæmorrhage	1
Funis presenting with head	1—29

Sex. Male 176
Female 139—315
(Five cases of twins.)

Retained placenta 19

Funis round neck of child:

Thrice	4
Twice	2
Once	21—27

Hand in utero 1

The mortality amongst children from all causes would be 1 in 10; but deducting the 16 accounted for above, it would be 1 in 75.

The proportion of twins is 1 in 62, rather below the

average, which, according to the hospital returns for England and Ireland, is 1 in 65. All occurred amongst the lower classes. I find the average among the higher classes yields 1 in 120, showing the influence the luxuries and refinements of highly civilized life possess in restraining fecundity.

I trust that my meagre report may soon be followed by others on a larger scale, so that ampler data may be obtained. It is quite evident, from the few published reports of private practice extant, that obstetricians differ widely in their method of practice. Let me give some examples of the differences to which I refer. Dr. Copeman, of Norwich, has used the vectis 108 times in his practice; I never employed it once in my life. Again, in reference to anaesthesia by chloroform, now that it has received the Royal assent, it would be interesting to know the experience of men in large midwifery practice regarding its use. Some, we see, consider it the greatest boon to suffering humanity, and a *sine quâ non* in midwifery; others, again, look upon it as a dangerous innovation, calculated to do infinite physical and moral damage. The ASSOCIATION JOURNAL of June 17th (p. 524) contains a paper by Mr. Beecroft, of Hyde, stating his doubts as to its being beneficial in any case. He commences his communication by the startling acknowledgement and strange fact, that the journals teem with the praises of anaesthesia in midwifery, and contain nothing against it. An exception is said to be needful to form a rule; so Mr. Beecroft wishes to supply one. My experience of this practice is very limited; but, so far as my experience goes, it is in its favour. I never knew it do any harm: I seldom refuse it; and I never press it. How any practitioner can dispute its value, its necessity, in instrumental cases, when wisely administered, I cannot understand. On the other hand, I am no advocate for producing that state of total insensibility which some think necessary, but which appears to me to be an unsafe and uncalled for experiment. If judiciously given, and its effects watched, it is possible to attain insensibility to pain, without the loss of consciousness. This plan I am in the habit of adopting. The first time I became aware that such a state was possible was when attending a lady in the country, some years ago, with her seventh child. The pains were vigorous and effective, and with each she inhaled chloroform; and, when the head was pressing on the perinaeum, she joked me about her pains, as being insufficient for the work. Soon after she had made the remark, the child was born, and the mother would hardly believe that she was delivered. I believe that the advantages as well as the dangers of chloroform consist in its purity, and in the mode of its administration.

Shaw Street, Liverpool, June 22nd, 1853.

BIBLIOGRAPHICAL NOTICES.

THE TREATMENT OF OBSTINATE ULCERS AND CUTANEOUS ERUPTIONS ON THE LEG, WITHOUT CONFINEMENT. By HENRY T. CHAPMAN, F.R.C.S., late Surgeon to the St. George's and St. James's Dispensary. Second edition, pp. 156. London: 1853.

ANY information which enables us to treat with increased success a very troublesome and unsatisfactory class of cases, is at all times acceptable; and, on opening Mr. CHAPMAN'S book, we are led to expect some real help in the treatment of ulcers of the leg, from the following remarks at p. 4:—

"Notwithstanding my conviction of the general superiority of those modes of cure which are founded on the principle of support, it is very far from my intention to advocate an *exclusive* reliance upon them. In obstinate cases of this troublesome complaint, I am too well aware that we require all the artificial aid which can be brought to bear against it. I have accordingly endeavoured to show that, if we would avoid frequent disap-

pointment, instead of attempting to apply any one plan of treatment to all its varieties, our remedial measures must be selected, combined, and adapted, from the varied and ample resources of past and present experience, to meet the special exigencies of each individual case."

The author first examines the Sources of the Intractability of Ulcers on the Leg. These sources of intractability are local and constitutional; these are rarely in operation singly, but are most frequently combined, especially in nearly every case of chronic ulcer; the local causes, if not always preponderating over the constitutional, commonly outlasting them.

"The peculiar intractability of ulcers on the leg is clearly traceable to the dependent position of the lower extremity, which, by impeding the free return of blood in the veins, places the capillaries of the ulcer, and of its immediate neighbourhood, in an unfavourable condition for originating and carrying on the reparative process. If the case is left to nature, . . . to the atonic character naturally impressed upon an ulcer by its locality will be superadded inflammatory, irritable, or callous features; which, being regarded as characteristic of distinct varieties of the complaint, have been laid hold of as grounds of classification." (p. 11.)

The distinctions which Mr. Chapman recognises are those of *Indolence*, *Irritability*, and *Callousness*. He regards, however, the first of these alone as a constant and essential character of ulcers of the leg; the others being merely engrafted on it.

The most simple characteristic, then—but a very troublesome one to the surgeon—is that of indolence, or simple want of activity in the reparative process. The capillaries of an ulcer in a depending part are acted on by the *vis a tergo* of the heart and arteries on one side, and by more or less pressure from the blood in the veins on the other side: hence the circulation through them is impeded; they become dilated; and the balance between vascularity and reparative deposition is disturbed. This condition of redundant vascularity is readily detectable by the naked eye, in the loose semitransparent granulations of indolent ulcers.

There is, however, as Mr. Chapman rightly points out, another cause which influences, though negatively, the formation of indolent ulcers.

"Sufficient importance does not appear to have been accorded, by any writer on this subject, to the circumstances in which the capillaries of a granulating ulcer in a depending part are placed by the loss of an elastic envelope like the skin. The acceleration of the blood's motion during rapidly repeated muscular efforts, when an alternate action and reaction between the muscles and the skin are kept up, speedily emptying the superficial veins, is sufficient to prove that the skin, by its resilience, must afford an essential aid to the circulation in the veins. And since, as long as it remains entire, it thus exercises a constant and uniform control over forces tending from within outwards, it is obvious that the vessels of a granulating surface, deprived of the support of this elastic integument by a breach in its continuity, will have nothing but the feeble resistance of their own walls to oppose to the delicate pressure from within.

"If the distension thus produced be not artificially counteracted, the nearly stagnant blood being quite unfit for any healthy operation, exudation of plastic lymph ceases, the new vessels themselves are gradually absorbed, and the sore at length acquires an indolent or atonic habit." (pp. 17-18.)

Irritability in ulcers is next treated of, and is referred to over-distension of the nerves, which are "not merely incapacitated for the healthy discharge of their share in the reparative function, but are kept by it in a greater or less degree of morbid sensibility". Dr. Billing supposes that morbid sensibility may sometimes be caused by inflammation of nerves; and this, Mr. Chapman says, appears to be a very probable explanation of persistent irritability, as is shown in the tense and fiery look of the surrounding skin, where the pain is mostly felt. But this "tense and fiery look" points to a general inflammatory process in which the nerves are involved along with other tissues, rather than to any special morbid action on their part. In this way we would explain the morbid sensibility of ulcers to arise, in a very great measure, from the passive participation by the nerves in the lesion of nutrition, whether