at the end of six weeks a plaster-of-paris jacket was applied, and the boy allowed to move about by the aid of crutches.

I showed the case before the Hull Medical Society on November 16th, 1894, and then he was quite recovered, and able to walk about without the help of crutches or any aid whatever, and indeed a few days ago I saw him running and flying a kite.

ON DELIVERY IN CERTAIN CASES OF IMPACTION OF THE TRUNK OF THE FŒTUS.¹

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In the present paper I purpose speaking briefly of some practical points in connection with the method of delivery in a class of obstructed labour which has received very inadequate treatment in the ordinary textbooks of midwifery, namely, those in which the obstruction caused by the trunk of the fœtus is an indication for embryotomy. I shall omit the consideration of cases in which with a large child or a small pelvis craniotomy alone is sufficient to remove the obstruction, and also those in which obstruction occurs in breech presentation, as embryotomy is rarely required and easily performed in such cases. My remarks will be limited to those cases of head presentation in which, after delivery of the head, it is found that the child's body will not pass through the pelvis without reducing its size and to those cases of presentation of the trunk in which embryotomy is called for on account of the impossibility of performing version or decapitation. Of the first class of cases I have met with several instances, of the second class only two.

In cases of head presentation it is sometimes found that it is impossible to deliver the child's body unutilated after the head has been born, especially through a contracted pelvis. Apart from the rare cases of double monster and of tumours external to the child's trunk, the difficulty may be due to the large size of the child. The largest fœtus I have ever seen weighed 13½ lbs., and required mutilation on account of its great size. But through a small pelvis a child of half this weight may be unable to pass.

With a normal pelvis the obstruction formed by the child's trunk may be due to pathological conditions either in the serous cavities or the viscera. Disease enlarging the thorax to any considerable extent is very rare. A slight serous or bloody effusion in the pleura is very common, and I have once met with acute pericarditis in a newborn child; but these effusions very rarely enlarge the thorax sufficiently to cause obstruction in labour. The trouble will almost always be found in the abdomen.

One of the most common causes of obstruction is distension of the child's belly with the gases of putrefaction—a somewhat rare occurrence even in fetuses which have been dead some time. It is, however, a good rule in all cases of obstructed labour to percuss the uterine tumour; a tympanitic note will indicate the cause of the obstruction. Another not infrequent source of distension is ascites or peritonitis, by which sometimes the belly is distended to an enormous size. I have seen the vagina distended sufficiently to form an abdominal tumour, and great distension of the bladder and uterus has been met with by other observers; but the only other causes of obstruction which I have personally met with have been distension of the colon by meconium in cases of imperforate anus, cystic kidneys, hydronephrosis, and distended ureters, and enlargement of the liver and spleen in syphilitic children. The diagnosis of the cause of the obstruction can usually only be made by careful exploration under anaesthesia. The question of treatment then arises. Traction upon the child's head in order to deliver the trunk should be made with caution and judgment; the employment of great force has caused rupture of the uterus.

If judicious traction fails to bring down the trunk it may be necessary to reduce the width of the child's shoulders.

With this object I have found it a useful plan to snip through the clavicles with scissors, then, if necessary, to pass a blunt hook into the axilla and thus to bring down the arms. If delivery is still impossible it may be necessary to remove the head in order to gain room for further manipulations; but before decapitating it is advisable to seize the neck with a strong volsella furnished with interlocking teeth which will prevent the trunk from receding out of reach. Usually not much advantage is gained by opening the thorax, and the broken ribs are troublesome. The hand should be passed up to the abdomen, which should be opened with the scissors or the perforator, if the obstruction is due to gas or liquid effusion, the obstruction is immediately relieved and delivery effected; in other cases it may be necessary to remove the abdominal viscera.

And now to speak of the second class of cases. In transverse presentations it is rarely that version cannot be performed, and in impacted transverse presentation it is very rarely that decapitation is impossible. It has twice happened to me to meet with cases in which neither operation was possible. In both instances the pelvis was contracted and the soft parts oedematous, and in one there was the complication of placenta prævia. The uterus was retracted and as hard as a board; the back of the child presented; it was impossible to introduce the hand far enough to perform version or decapitation. I have never in midwifery met with such an *impasse* as these two cases presented, and the fact that Caesarean section has more than once been performed for this state of affairs² is an indication of the difficulty that has been experienced by others. It is in the belief that the method which I successfully adopted in these two cases meets the difficulty that I place before you the following method of treatment:

Make an incision through the skin of the child's back, and cut through its spine with scissors, then apply Braxton-Hicks's cephalotribe (the points of which meet when the instrument is closed) to the sides of the trunk of the child and screw up the instrument. By making traction with the cephalotribe the soft parts are brought down, and may be cut through with scissors. The delivery of the two halves of the child's body then presents no special difficulty.

A CASE OF BILATERAL HERPES ZOSTER OF THE FIFTH PAIR.

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On January 5th I was asked to see N. M., aged 18, a Highland ploughman, supposed to have an infectious disorder. Three days before, he had been attacked by headache and vomiting, and on the morning of my visit a rash had developed on the head and face. I found him in bed, still complaining of pain in the head, but as he did not speak English fluently, it was impossible to determine the exact seat and nature of the pain. The pulse and temperature were normal. I found the alleged "rash" to consist of patches having an inflamed well-circumscribed base, upon which numerous clear vesicles were implanted. They were most marked on the left side of the face, picking out very neatly the sensory distribution of the fifth pair. There was a patch near the root of the nose on the supraorbital ridge, another just below the orbit, another on the left side of the nose, and one or two spots in the moustache of the left upper lip. On the upper part of the helix of the left ear there was a small patch, and, curiously enough, upon the lower and back part of the neck, between the contours of sterno-mastoid and trapezius, was an oval patch of the same nature. On the right side of the face there were patches in the supraorbital region, on the chin, a large one on the cheek just beneath the outer end of the zygomatic arch, and one on the right temple. The development of the eruption had a good effect upon the pain, which, except for a little in the supraorbital region, very soon left for good, and by January 12th the dried-up crusts were separating.

¹ Read before the West Sussex District of the South-Eastern Branch of the British Medical Association.

² As by Professor Hubert, of Louvain, *Rev. Méd.*, Louvain, 1892-1893, xi, 385-388.