shifting of powerlessness from one side to the other which he says rarely occurs in hysteria. He also regards loss of the plantar reflex as a sign in favour of hysteria. This is undoubtedly true, but this reflex could not be obtained in my case till towards the termination of the disease. In disseminated sclerosis, pallor or atrophy of the optic disc is not uncommon, but in hysteria the characteristic affection of vision is blindness on one side, the optic discs being perfectly normal.

It may be thought that I have been too anxious to point out the possibilities of mistaking organic disease for hysteria, and have ignored the converse error of diagnosing organic disease when hysteria only is present. I should be sorry to convey such an impression because one mistake is as bad as the other, and it is certainly pleasanter for all parties concerned to have the case diagnosed as one of hysteria than as one due to the presence of organic disease. But I particularly wish to lay stress on one point, and that is that, having decided that a patient is suffering from hysteria, do not let us close our minds to the possibility of future developments. An hysterical person is just as liable as, perhaps more liable than, other persons to become the subject of organic disease; also we must admit the possibility of having misinterpreted some of the symptoms; and further, the manifestations, although purely hysterical, may have been started by minute yet definite structural changes, which ere long will lead to symptoms of serious augury. Hence let subsequent examination be as thorough as the first examination, and quite unbiassed by our first diagnosis of hysteria. Only in this way can we avoid the danger of omitting to recognise signs of serious disease.

I shall never forget the case of a lady whom I attended about twelve years ago. She was a stout, robust-looking woman, of about 50 years of age. She complained of an aching pain in the back and of creeping sensations in the lower limbs and of being easily tired by short walks. Her manner was distinctly hysterical and she was very loquacious, giving graphic details of all her symptoms. A careful examination revealed nothing abnormal. There was no paralysis and no alteration in cutaneous sensibility, and the knee-jerks, though irritable, could scarcely be said to be pathologically exaggerated. I looked on the case as hysterical, and prescribed massage and tonic treatment. As there was not much improvement after a fortnight's treatment, I asked an eminent physician to see her with me. He also made a thorough examination of her case, and agreed with me that there were no signs of organic disease, and that in all probability the symptoms were purely hysterical. After the consultation I visited her from time to time, but, having now a strong bias in favour of hysteria, I did not again make a thorough examination. About ten days later I received a message to come at once, for the patient was paralysed. I found that she was suffering from complete paraplegia, and from other symptoms indicating an acute myelitis in the upper dorsal portion of the spinal cord, and she died within the week. Such an experience as that is not easily forgotten.

There is the same necessity for caution in regard to the diagnosis of what we call neurasthenia; for example, it is by no means always easy to distinguish between neurasthenia and the early stage of general paralysis, and I could well illustrate this by notes of cases from my own practice.

Again, some of the chief symptoms met with in neurasthenia—headache, vertigo, mental incapacity, and feelings of exhaustion—may constitute the premonitory symptoms of a brain tumour. Hence once more we must recognise the necessity of admitting the possibility of commencing organic disease every time we examine a patient whose case at the first investigation was diagnosed neurasthenia. Between the years 1880 and 1884 my judgment was much exercised with regard to a boy who suffered from attacks of severe headache and dizziness. He was a pale delicate-looking lad, highly sensitive, who had always shown a marked tendency to make the most of his ailment. There was a history of tubercle in the family. The headache at times was so constant and the boy looked so very ill that the question of brain tumour was often discussed. Again and again his optic discs were examined, and the condition of his nervous system was carefully investigated and by more than one physician, but always

with negative results, and the diagnosis of neurasthenia seemed to be the only possible one under the circumstances. He is now 22 years of age, and nearly blind from atrophy of his optic nerves, the result of neuritis which first declared itself about two years ago by the presence of bilateral temporal hemianopsia. The case is still obscure, inasmuch as there are no definite paralytic symptoms, but there are reasons for believing that a tumour of exceptionally slow growth exists at the base of the brain, and that it is pressing on the middle of the optic chiasma. If there is a tumour, has it existed for sixteen years, and was it responsible for the early symptoms, or did its development commence only two or three years ago, its presence and the symptoms of neurasthenia which still exist having no relation to one another?

ON THE IMPORTANCE OF THE EXAMINATION OF THE ABDOMEN DURING THE PUERPERIUM,

WITH SPECIAL REFERENCE TO THE INVOLUTION OF THE PUERPERAL UTERUS.

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THE process of involution in the human uterus is of great interest to the physiologist, owing to the amount of material absorbed in a short space of time. The exact causation has not yet been definitely ascertained, although microscopists have offered many theories. It is not, however, the purpose of this paper to deal with the intimate changes occurring in the uterine tissue, but to determine the period when the uterus has returned to such a size that the puerperal woman may without risk, *ceteris paribus*, assume the erect posture. For this purpose two methods of investigation have been used, namely, external and internal measurement:

(a) *External Measurement*—where the distance between the fundus uteri and the symphysis pubis is measured, together with the breadth from side to side at the widest part.

(b) *Internal Measurement*—by means of the uterine sound to determine the length of the cavum uteri.

To the first method few objections can be raised, but to the second the dangers of infection must always retard such a procedure, more especially where a series of observations can be made, for example, in maternity hospitals. The observations recorded in this paper were carried out by me six years ago. At that time I was unaware of the work of Serdukoff,¹ and it was not until the termination of my work that I discovered the existence of his paper. Serdukoff employed external measurement, giving his reasons against the internal method as follows:

1. From the curvature of the sound being always the same, and from the fact that we have a varying axis of the uterus corresponding to the curvature of the sound, it follows that we do not by this method ascertain the natural length of the uterus as it lies anteflexed or anteverted, but only an artificial length as it is straightened out.

2. The sound is not always easily introduced, its point is frequently to be felt with difficulty or not at all through the anterior abdominal wall and thick uterine wall, and you can never be certain that at each observation the point touches the same part of the fundus; accordingly we may have an apparent length which is less than the real one.

3. This method is not unaccompanied with danger, however carefully it may be employed.

To these I would add a fourth:

4. The diminution of the uterine cavity is not proportionate to the diminution of the uterine tissue, being much more rapid. This I have proved by examination of puerperal uteri *post mortem*.

It is clear then that the most accurate results would be obtained by combining the two methods. However, for all practical purposes the external measurement is sufficient, and on this account my observations will be confined to it.

Method.—In a series of patients the measurement of the distance between the upper border of the symphysis pubis and the centre of the fundus uteri was taken by a tape measure drawn tight. These measurements were obtained daily at the same hour, due attention being paid to the condition of the bowels and bladder. Cases in which there was evidence of septic trouble were excluded.

Reference to works on obstetrics shows that the date when

¹ *Obstetrical Journal*, vol. iii. p. 477. The paper was communicated to the Obstetrical Society of Edinburgh by the late Dr. Matthews Duncan, February 10th, 1875.

the uterus becomes a pelvic organ is variously stated. To the practitioner this date is of great importance, for until the uterus has become a pelvic organ no patient should, after her confinement, be allowed to assume the erect position. This seems to me a scientific method of teaching, and stands in strong contrast to the teaching that a woman should get out of bed on a certain day, and should be permitted to walk on another fixed day. I would therefore insist on an abdominal examination being made in every case before a patient is allowed to assume the erect posture.

The evils attendant on the assumption of the erect posture too soon after labour or abortion must be impressed upon the mind of obstetric practitioners. How often do we meet with cases where constant bearing-down pains, discharge, and a train of symptoms which are associated with uterine disease can be traced to a confinement or miscarriage, after which sufficient rest in bed had not been enjoined? Although the importance of rest has been urged by many writers, yet the frequent recurrence of cases of subinvolution shows that this advice has not been followed.

It is only from a study of cases in which the septic element has, as far as possible, been excluded, that we can arrive at a fairly accurate estimate of the normal rate of involution in the puerperal uterus. On this account one would expect that the results of investigations made since the introduction of the antiseptic system would show a more rapid rate. The occurrence of septic inflammation in and around the uterus is a most important cause of delayed involution.

The causes which govern what we may conveniently term "normal involution" have not as yet been ascertained. As is well known, for a few hours after labour the uterus is contracted, expanding later, and followed from day to day by a gradual diminution in size. In this process there are two factors at work, namely, contraction and retraction, with the result that the uterus returns nearly to its pre-gestation size in six weeks. At the same time, the uterus of a woman who has borne a child is usually larger than the nulliparous uterus.

Out of 37 primiparous cases, the uterus was found in the true pelvis—

In 7 cases on the 10th day	
" 6 " 11th "	
" 5 " 9th "	
" 3 " 8th "	
" 4 " 12th "	
" 4 " 13th "	

In the remainder (8) the uterus had not returned into the true pelvis on the 12th day.

Out of 21 multiparous cases, the uterus was found in the true pelvis—

In 4 cases on the 11th day	
" 3 " 10th "	
" 3 " 12th "	
" 1 case " 9th "	
" 2 cases " 8th "	

In the remainder (8), the uterus had not returned into the true pelvis on the 13th day.

In addition to the condition of the bowels and bladder certain fallacies must be kept in mind. In some patients there is prominent anteversion of the uterus, so that this organ, having passed through a split in the recti, hangs forwards above the symphysis pubis—in short, a hernia of the puerperal uterus is produced. In such a case the uterus should be replaced before a measurement is taken. Lateral deviation should also be corrected. Where the uterus sinks down into the pelvis the external measurement could not be relied upon.

Although we do not yet understand the laws which govern the rate of involution in the puerperal uterus, there is abundant evidence of individual variation—for example, where women under the same conditions are observed. It is known that certain factors do influence the rate of involution. Amongst these we have:

1. The effect of prematurity of the labour: Here in all probability the uterus is not prepared for the work which it is suddenly called upon to undertake, and therefore we expect to find a diminution in the rate of involution. After abortions the rate of involution is less rapid, although we are only justified in making this statement when sepsis has been excluded. It may yet be shown that the contrary is true.

2. The length of the labour affects the rate of involution during the earlier days of the puerperium.

3. The cause of the abortion may be the cause of the delayed involution.

3. The rate of involution is greater during the first week of the puerperium.

4. The influence of lactation: It is universally accepted that the suckling of the child hastens the involution of the uterus by promoting uterine contractions.

In my observations I have paid special attention to the supposed influence of lactation, but the small number of cases prevents me formulating definite conclusions. I may say at once that involution has been most rapid and complete where the milk secretion was entirely absent. Is it possible that the relief to the maternal system where no milk is manufactured favours the increased rapidity of the uterine involution?

In women who suckled their children increased rapidity of involution was not observed. Prolonged lactation is probably a cause of a distinct pathological condition—superinvolution—and here the effect is produced by the constant drain on the suckling woman, together with the anæmia and weakness accompanying or following the superlactation.

We have few definitely ascertained facts to support the widespread belief in the intimate relationship between the breast and the uterus. Physiologists tell us that stimulation of the nipple causes uterine contractions; beyond this nothing is known. I believe many of the associated phenomena explained by this relationship will be shown to have a separate and distinct causation.

5. Parity: The influence exerted by parity has not been definitely determined. In all probability involution is more rapid in primiparæ. Many causes of delayed involution have to be excluded before the results can be compared in primiparæ and multiparæ.

6. "After-pains": these are not necessary for a favourable involution of the uterus. It must be remembered that after-pains may be divided into two classes:

(1) Where the uterus is contracting in order to expel blood clots, placental remains, etc.

(2) Where painful uterine contractions exist without a known cause.

This latter class has been compared to spasmodic dysmenorrhœa. It follows that where anything is contained within the uterine cavity, involution will be delayed, and in proportion to the degree of care exercised in emptying the uterus at labour, will be the number of patients who complain of the variety of "after-pains" in Class 1.

It should be added that observations were made on cases where no evident disease of uterus existed, as inflammatory affections, new growths, etc., are prominent causes of subinvolution.

In conclusion, let me again insist on the careful examination of the abdomen during the puerperium, to determine:

1. The position of the uterus.
2. The presence or absence of a uterine new growth, for example, a fibroid.
3. The condition of the Fallopian tubes, which are easily palpated during the first week of the puerperium.
4. The presence or absence of ovarian new growths.
5. The position and degree of distension of the bladder.
6. The condition of the intestines.
7. The presence or absence of any peritonitic or cellutic inflammation.

I have to thank Dr. Grigg for permission to make use of cases under his charge.

A series of observations on the Involution of the Puerperal Uterus have been published in the *Transactions* of the Obstetrical Society of London for 1895, p. 246, by Drs. Stevens and W. S. A. Griffith.

SOCIETY FOR THE STUDY OF INEBRIETY.—A meeting was held on July 9th, the President, Dr. Norman Kerr, in the chair. A paper by Dr. Stephen Lett, Medical Superintendent of the Homewood Retreat, Guelph, Canada, entitled "Why do Men Drink?" was read. The author laid the chief stress on pain, in its most comprehensive sense, liquor being taken for the relief of physical and mental unrest. In the consequent discussion Drs. Poole, Hazell, and Gray took part.

3 How often practitioners are informed that the patient is passing water freely, when on examination the bladder is distended almost up to the umbilicus; in short, the bladder is overflowing.