have yet tried for the subcutaneous nævi, where the ligature is objectionable, is that suggested by Sir B. Brodie, of breaking down the structure with a probe, previously steeped in fused nitrate of silver, and introduced through a small incision made in the skin covering the nævus. The bulb should be removed, and the end of the probe rounded; the instrument must be pushed freely about in the morbid structure, for the cure probably depends rather upon the laceration of the tissue than upon the action of the nitrate of silver. Once I cured a large subcutaneous venous nævus situated on the left side of the occiput by tying the left occipital artery, which was a good deal enlarged. A nævus of the same kind on the ear, was a short time before treated successfully in this hospital by a ligature to the posterior auricular artery. This kind of operation, however, has failed in the greater number of instances in which it has been tried. It is likely to answer only when the nævus is supplied by one chief vessel, that vessel being enlarged. Mr. Wardrop relates in the twelfth volume of the *Lancet*, a case of extensive subcutaneous non-pulsating nævus affecting the nose, eyebrow, and orbit, in a child aged five months, which was quite cured by tying the common carotid artery in the same side; and another case of the same kind of nævus affecting the parts about the angle of the jaw in an infant where sloughing of the mass, which had commenced before the operation, terminated fatally on the thirteenth day after the carotid was tied.

The last form of nævus, the arterial subcutaneous, or the aneurism by anastomosis, is much more rare than the others, and is very seldom congenital; indeed it generally makes its first appearance in the adult. It grows quickly and throbs or pulsates so forcibly as distinctly to raise the finger placed upon it, and to cause much pain and annoyance to the patient. When it shines through the skin it is seen to have a bright red colour. Like the other nævi, it yields under pressure. In almost every instance it has been situated upon the face or head, and in the orbit more frequently than in any other part. The ligature of the common carotid artery is the treatment that has been adopted in most of the recorded cases of this affection, and in three out of four it has proved successful.

CASES OF CRANIOTOMY,

WITH REMARKS.

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Read before the Bath and Bristol Branch of the Association, March 21, 1850.

THE capital operations which devolve upon the accoucheur are far less numerous than those which fall to the lot of the surgeon; but at the same time they may be far more repugnant to his feelings and attended with a much greater responsibility. An amputation, for instance, is a mutilation which involves the sacrifice of a limb only, but craniotomy may require nothing less

than the destruction of a life. To save the life of one fellow creature we are reduced to the dreadful alternative of destroying that of another. Any attempt therefore, to point out more precisely the only circumstances which render such homicide justifiable ought to meet with a hearty response from the profession in all quarters. It is not many months since Dr. Radford, of Manchester, made an appeal, for this purpose, to the profession, through the medium of the *Provincial Journal*, and it is to be hoped that every assistance will be afforded him in arriving at a satisfactory solution of this most important question. It is with this view, and from a conviction that the results even of a limited experience are valuable in such an investigation, that I bring forward the following eight cases of craniotomy.

They occurred to me during rather more than eight years of midwifery practice, (from 1842 to the present time,) amongst a total of 1613 cases. Of these, 1178 were attended under my superintendence by the pupils of the Bristol Medical School. The remaining 435 were chiefly attended by myself and consist of my own private patients, together with the patients of the St. Augustine and St. George's Dorcas Society, during the time that my brother and myself were connected with that institution.

The cases of craniotomy are as follows:—

CASE I.—A. T., 10, Limekiln Lane, a patient of the St. Augustine and St. George's Dorcas Society. Has had two children previously: the first, a female, was very small and born alive; the second, a male, died two or three days after its birth. Both labours were very long and severe. I saw her for the first time at six o'clock P.M. on Friday, December 12th, 1842. I found, on examination, the os uteri dilated to the size of a crown; the pains being not very frequent. The child's head was so high as to be almost out of reach. Soon after this the membranes were ruptured, but still the head made no progress, and the pains did not increase either in force or frequency. I left her and saw her again on the same evening, at about eleven. The labour, however, was in much the same state as to progress, and continued so until the evening of the next day, (Saturday 10th,) by which time the forcing pains had become very violent and frequent, but still the head did not descend. This state of things lasted until Sunday morning, about four o'clock, when the pulse became frequent and feeble, and the patient seemed much exhausted. The pains returned often, but were somewhat diminished in power. After an unsuccessful attempt to deliver, with the vectis behind the pubes, I requested a consultation with my father, who arrived shortly afterwards; and we at once determined to delay no longer, but to deliver by craniotomy. I accordingly opened the head and evacuated a considerable portion of the brain. As the pains were still insufficient of themselves to expel the head, the crotchet was used, and the child, a large boy, extracted without much difficulty. The head was large and firmly ossified. It presented with the forehead behind the pubes. At the time when the head was just at the

outlet of the pelvis, one drachm of ergot was given, because the patient nearly flooded to death at her last labour during the separation of the placenta. This patient recovered without a single bad symptom.

CASE II.—In December, 1848, I was sent for by one of my pupils at the Medical School, to a case of protracted labour he was attending. The patient, a short thick-set woman, had had four children previously, only one of which had been born alive. She stated that she had been delivered of the other three by instruments, and that they were still-born. I saw her at twelve P.M. She had then been in labour about twenty-four hours, and the membranes had been ruptured at six P.M. The pupil in attendance stated that the head had not advanced at all since that time. When I examined I found it high up at the brim of the pelvis, but it could be easily repressed. The sacral promontory projected so as to diminish very considerably the conjugate diameter of the pelvis. As no bad symptom had set in or seemed likely, and the pains were still very strong, we thought it right to leave the case a little longer to nature. I was again called to her, however, at four A.M. the next day. The head was firmly impacted in the pelvis, so that it could not be raised by the finger, the bones overlapping very much, and the scalp very tumid. The patient had become restless, irritable, and feverish. On a consultation with my father, it was deemed prudent to delay interference no longer, but deliver by craniotomy. This was accordingly done without much difficulty. The presenting part (the left parietal bone) was punctured by Smellie's scissors. The delivery was then readily accomplished. The head presented with the occiput towards the right acetabulum. The mother recovered very favourably.

CASE III.—In February, 1844, Mrs. H., a private patient, sent for me to attend her. She had had four very severe labours previously, in which she had been attended by another practitioner. In one of these she had a small female child, which was born alive, but in the other three she had been delivered by the crotchet. When I first examined her the membranes had been ruptured for some hours, but the pains until lately had not been severe. The head was above the brim of the pelvis, but a large loop of cord had descended, and was protruding externally, and pulsating very feebly. There was apparently a very great diminution of the antero-posterior diameter of the brim. Wishing for another opinion, I sent for my father, who arrived very shortly. We determined that it would be inexpedient to turn on account of the deformity of the pelvis, and the slender chance of saving the child; we therefore let the labour go on naturally. We waited two hours, but the head did not make the slightest advance, although it was not impacted. All efforts to pass up the cord above the head were unavailing, and the pulsation of the umbilical arteries soon ceased. We then decided upon delaying craniotomy no longer, as the child must have been dead for

some time. Accordingly, the head was opened, and extracted by means of the craniotomy forceps, with, however, considerable difficulty. A good deal of force had also to be used in bringing the shoulders through the narrow pelvis before the child (a large boy) could be delivered. The mother recovered very favourably.

The same patient was again attended by us in her confinement last year. Premature labour was induced during the eighth month, with complete success, both as regards the mother and the child.

CASE IV.—In August, 1844, one of my pupils requested me to see a woman whom he was attending, in Pile Street. This person had had ten living children, but all her labours had been very severe. The membranes had been ruptured at two the same morning, and the pains had continued forcible, but not frequent, until the time when I first saw her, viz., two P.M. The head was then at the brim of the pelvis. I saw her again at ten P.M. The head had made no advance, but was still at the brim; the pains were not very frequent; pulse 90 between the pains. I saw her the next day, at ten A.M.; the head was still in the same place. The scalp was much swelled, and the cranial bones overlapping considerably. I could readily detect, on examination, a very prominent sacrum. I saw her again at one P.M., and lastly at ten P.M., when the pulse had risen to 110 between the pains, and the patient had become very restless and excited. The pains had much abated in frequency and power. The head was in the same place, and very firmly fixed, although not quite impacted. Deeming it imprudent to wait any longer, I perforated the head, but had some difficulty in doing so on account of the hardness and thickness of the cranium. After some trouble I succeeded in bringing it down to the perineum, the pains being very trifling, and affording no assistance to my efforts. The child, which was unusually large, was then easily delivered. The patient did well.

CASE V.—In December, 1845, I attended Mrs. T.—, a primipara, aged 39, (a private patient) living in Temple Street. The labour progressed very slowly two or three days; she was, at first, much troubled with spurious pains, which it was necessary to check with opium; the first stage of the labour lasted very long, in consequence of rigidity of the os uteri; the membranes were ruptured at six P.M.; the pains were at first light, but after some hours they became much stronger, and continued so for two or three hours; the head, however, could not descend into the pelvic cavity; the sacrum, which was very prominent, could readily be reached by the finger. After the pains had continued very powerful for some hours, but without any effect, they began to decrease both in strength and frequency; the pulse was much accelerated, and the patient becoming exhausted. After consulting with my father, I proceeded to perforate; (twenty-one hours after the rupture of the membranes,) the operation was performed without difficulty, and a full-sized female child extracted; the mother recovered without any untoward symptoms.

CASE VI.—Mary Ann Y—, aged 30, residing in 5, Hampton Court; she had previously borne four children; according to her statement, three of these were footling presentations, and still-born; the fourth was extracted by instruments, and died very soon after its birth; the pains first set in on Monday, Feb. 22nd, 1847, when one of the pupils of the Medical School was first called to attend her. Feeling somewhat puzzled with the presentation, he requested my assistance, and I accordingly went to see her on Tuesday, the 23rd, at about eleven P.M. On making a vaginal examination, I discovered the os uteri dilated to the size of a half-crown; the head of the child could be felt through the membranes in the anterior semi-circle of the os, whilst the posterior segment was occupied by several convolutions of funis. After waiting some time, I examined again, and found the os almost fully dilated, a much larger quantity of cord having descended before the head; a distinct pulsation could be detected in the cord; the membranes were still entire; I therefore proceeded to turn, thinking it a favourable case for so doing, and for this purpose passed my hand into the uterus, but I had hardly reached beyond the head when I felt that the antero-posterior diameter of the pelvis was so much contracted as to offer a serious obstacle to the performance of the operation. I therefore desisted from all attempts to turn, and withdrew my hand a little, in order to keep the cord up above the head, until the latter had descended into the excavation of the pelvis; as the waters escaped, however, a much larger quantity of cord came down, so that I found it impossible to keep it above the head. After waiting two or three hours, during which time, although the pains were violent, the head still remained at the brim, and the cord had been for some time pulseless, I determined to open the head, as there would be nothing gained by further delay. This was done without much difficulty, except from the hardness of the skull, and the head soon extracted by the craniotomy forceps. The child (a boy) was unusually large, and measured 23 inches in length. The placenta soon came away; it was battledore shaped; the cord was very long, measuring 39 inches. When my hand was in the uterus, I distinctly felt that the placenta was attached very low down, in a part of the uterus corresponding to the left iliac fossa. This patient had a favourable convalescence. In 1848 I saw her during a subsequent confinement, in consultation with my friend, Mr. Neild, who was in attendance upon her, and who had induced premature labour in the eighth month. The mother recovered well, but we did not succeed in saving the child, probably in consequence of its being necessary to give ergot two or three times in the course of the second stage, which was very protracted, and also from its being a breech presentation.

CASE VII.—In May, 1847, I attended Mrs. N—, a private patient, in her first labour; I saw her at four A.M., and on examining, found the os uteri pretty well dilated, and the breech of the child presenting; the

membranes had not given way. About half-past eleven A.M., the membranes burst, and on then examining more minutely, I found the breech of a female child presenting, the left ischium being anterior; the back of the child being turned towards the left acetabulum, and the front towards the right sacro-iliac synchondrosis. Notwithstanding that the pains were strong and frequent, the labour proceeded very slowly. The body of the child was very bulky, and seemed completely to fill the cavity of the pelvis, which was by no means roomy. As soon as the breech touched the perineum, I gave some assistance by traction with the finger placed in the angle between the left thigh and ilium. After the breech was born, the body was expelled very slowly, but the head seemed arrested at the brim, apparently owing to its size being out of proportion to the length of the conjugate diameter of the pelvis. After placing the face of the child in the posterior semi-circle of the pelvis, and depressing the chin, I used very considerable extractive force by the neck for some time, but to no purpose. Finding it impossible to bring the head through the pelvis by this means, and as, notwithstanding all efforts, the head had been arrested at the brim for more than one hour and a half, and the pulsation in the cord had ceased for at least an hour, I determined to perform craniotomy, without delay. I opened the head behind the left ear, but with some difficulty, on account of the thickness of the bone in that situation. After evacuating a considerable portion of brain, and making traction by the neck, in conjunction with two or three strong pains, I got the head through the difficulty, and the labour terminated favourably. The child was a large female infant. The mother recovered favourably.

CASE VIII.—In July, 1848, I was requested by one of my pupils to see a woman living in Edward Street Dings. On making an examination, I found the os uteri dilated to the size of a crown piece, and the membranes protruding, but the head was so high above the pubes that it could not be touched. I therefore introduced my hand into the vagina to make a proper examination, and in so doing ruptured the membranes. I immediately distinguished two or three coils of the funis presenting between the head and the sacrum. I found also that the conjugate diameter of the pelvis was very narrow, so much so, that when the point of the little finger of the left hand touched the pubes, and that of the fore finger the sacral promontory, the points of the fingers could scarcely be separated from each other. The conjugate diameter could not have been more than three inches. Thinking it useless to attempt to turn on account of the deformity of the pelvis, I directed all my endeavours to keeping the cord above the head. I fixed the cord to the end of a large elastic male catheter, by means of a loop of twine passed through the eye of the instrument, and then pushed it up beyond the head. This manœuvre succeeded for some time, but as the pains increased a good deal more of the cord came down and could not be put back. Presently an escape of meconium warned

me of the death of the fetus, and all pulsation in the cord ceased. After waiting some hours, during which the head still remained above the brim of the pelvis, I thought further delay useless, and perforated the head. After evacuating the brain I brought the head down into the cavity of the pelvis, and as no urgent symptoms were present, left the case to the natural efforts. The child (a large boy) was born at five the next morning. The mother recovered well.

REMARKS.—The cases of craniotomy just related occurred amongst a total of 1613, making an average of about 1 in 201 cases of labour. This does not differ very much from the usual average in British practice according to Dr. Churchill's statistics, viz., 1 in 219 cases. I have no precise account of the exact duration of labour in each case, as it is difficult to ascertain this from patients who are attended at their own homes, and whose statements as to the time when labour commenced, cannot always be relied on. But in all the cases except the last, I have notes of the duration of the second stage of labour, dating from the full dilatation of the os uteri and the rupture of the membranes, until the time when it was necessary to perform craniotomy. This, after all, is the most important point, as it is the duration of the second stage which chiefly affects the safety of the patient. In case 1 the second stage lasted thirty-four hours; in case 2, twenty-three hours; in case 3, about eight hours; in case 4, forty-four hours; in case 5, twenty-one hours; in case 6, about seven hours; in case 7, nine hours; in case 8, not stated. The second stage was shortest in cases 3 and 6, which were cases of cord presentation. This resulted from the operation not being deferred so long as it would have been otherwise, in consequence of the death of the child being already occasioned from pressure on the cord.* It may appear singular that there should have been so many cord presentations as three in eight cases of deformed pelvis; it has happened, however, that out of four cases of cord presentation which I have met with, the pelvis has been deformed in three instances, so that I am induced to regard an irregularly-shaped pelvis as a frequent cause of this untoward complication.

It is often asserted that craniotomy is unjustifiable in cases where the patient has at any other time given birth to a living child. This assumption, however, is both unfair and incorrect, for it only takes into consideration the size of the mother's pelvis, and takes no account of the other element in the mechanism of parturition, viz., the size of the child's head. It would be correct if all children's heads at full term were the same size; but every one knows, on the contrary, that the diameter of the child's head varies very considerably, as much as one inch, or even more, so that a pelvic brim which would just allow a small head to pass would effectually obstruct the descent of a large one, not to mention the

probability of the latter being much more firmly ossified, and therefore less compressible than the former. However, in such cases as those, where living children have been born at other times, the disproportion between the child's head and the mother's pelvis cannot be very great, and it is to such that the new method of "turning, as an alternative for craniotomy," proposed some time ago, by Dr. Simpson, of Edinburgh, would probably be most applicable. This practice might, perhaps, have been adopted with advantage in Cases 1 and 4, as well as in the cases of cord-presentation; but Dr. Simpson's able and ingenious memoir had not then appeared. There is, nevertheless, one difficulty in the way of the adoption of turning in such cases of slight deformity. No one could be certain in such cases, from the size and position of the child's head before the rupture of the membranes, that it would be unable to pass through the pelvis by the natural efforts. To expose the mother and child to the risk of turning under such circumstances would not be justifiable. The certainty that an operation would be required at all could only be arrived at after the second stage had lasted some hours, the head still remaining at the brim of the pelvis. Turning would then have to be performed under great disadvantages, and these, together with the narrowness of the pelvis, would very much diminish the chance of saving the child.

In cases where the conjugate diameter is under three inches, there would, I fear, be but little chance of saving the child by turning. In case 7, in which the breech of the child presented, the disproportion between the head of the child and the pelvis could not have been very great, but yet it was sufficient to prevent the passage of the head, before its volume was lessened, even when placed in the most favourable position. On the other hand, instances have occurred in which the child has presented by the breech or feet, and has been saved by being forcibly dragged through a deformed pelvis, whilst all the previous children which presented by the vertex have been destroyed by craniotomy.* However, in cases of great deformity, if turning is to be resorted to at all, it can be tried early—before the membranes give way, and if it fails, craniotomy can be adopted at last. The question is—Whether, in such cases the slender chance of saving the child is sufficient to justify exposing the mother to the risk of an additional operation. This can only be determined by a large amount of experience; in the meantime Dr. Simpson's proposal deserves a fair trial, as the experience of some cases has certainly proved that children may be saved by this method, who would otherwise have been sacrificed.

In this paper, I have made no mention of the use of the long forceps in cases of deformity of the pelvis.

* In four cases out of the eight, viz., Nos. 3, 6, 7, and 8, there was undoubted evidence of the death of the child before the operation was performed.

* My father once met with a case of this kind. A woman with deformed pelvis, who had been delivered several times by craniotomy, was attended by him in her confinement. The breech of the child presented. My father succeeded in dragging the head of the child through the pelvis, (although he had to use considerable force,) and in thus saving the child. The parietal bone on one side was deeply indented by the pressure of the prominent sacrum, but this disappeared in a few weeks, and the child has since grown up to be a man. The result to the mother also was favourable.

In the cases narrated above, they were not employed, as in no instance was the head sufficiently low for these instruments to be applied with any degree of precision. The statistics of German midwifery practice, which Dr. West has collected, afford us little encouragement in their use. They are very generally used in Germany instead of the crotchet, and their use has been followed by a very great maternal mortality. The inconveniences attending their employment are such that, according to Drs. Hardy and McClintock, they are now discontinued in the Dublin Hospital. I should anticipate that Dr. Simpson's uterine tractor might form a good substitute for the long forceps, but I have not yet had an opportunity of trying this instrument in such cases.

My chief reason for bringing forward the above cases of craniotomy is, that they show, as far as they go, that women may recover as well after protracted and instrumental labours as after ordinary ones, provided the use of instruments has not been too long deferred; in fact, in some respects they may be said to recover better, as they are usually exempt from the after-pains which frequently produce so much discomfort after ordinary labours. I do not recollect that a single bad symptom occurred after either of the above eight cases. In this respect, they would seem to be exceptions to the general rule, which Dr. Simpson deduces from the statistics of protracted labour, viz., that the danger increases in a direct ratio with the length of the labour. Much stress has been laid on this rule in the arguments which have been used in support both of turning, and the Cæsarean section, as alternatives for craniotomy. I cannot help thinking that the dangers of protracted labour have been over-rated; and that this arises from the nature of the statistical evidence upon which such conclusions are based. A great number of the cases of protracted labour which have been put on record by different practitioners, are cases, many of which have been attended by midwives, and in which all the worst symptoms of powerless labour have been allowed to develop themselves, before the medical practitioner had been called in. I can only account for the favourable results in my own cases by the fact that the operation of craniotomy was performed as soon as symptoms of powerless labour began to set in, such as considerable acceleration of the pulse, heat and tenderness of the passages, restlessness, anxiety, and marked diminution of the pains both in force and frequency. The stethoscope will frequently show that in such cases the child has ceased to live before the operation is undertaken, and thus relieve the mind of the practitioner of all doubt as to the propriety of the step he is about to take; although, even then, he who trusts to *his own* judgment alone for the decision of so momentous a question, incurs a heavy responsibility.

Provincial Medical & Surgical Journal.

WEDNESDAY, APRIL 17, 1850.

WE have received the *Guernsey Star*, of March 12, containing an account of a trial for defamation, "*OZANNE v. DE LISLE*," instituted

by a homœopathic practitioner against one of legitimate medicine. The state of the case is briefly as follows:—Dr. OZANNE (a B.L. and M.D. of Paris) was the occasional attendant of an individual named Wakley. This person being suddenly taken ill, the nearest medical aid was sought, and Dr. DE LISLE, who was passing the door, was the first to attend. While engaged in examining the patient, Dr. OZANNE, who had been previously summoned, made his appearance, and then commenced an unseemly altercation, in the course of which the words "quack" and "impostor" were uttered, and formed the ground of the action.

In the course of the trial, which excited a good deal of interest, several witnesses were called for the defence, all of whom, without exception, tendered their opinion that homœopathy was quackery and imposture, and indeed it was not difficult to see that such was the opinion also of the barrister for the prosecution, as well as of judge and jury; but the point at issue not being the merits or demerits of homœopathy, but the application of libellous epithets to the individual, the legal decision was against the defendant, and £5 was awarded as a plaister to the homœopath's damaged reputation.

No one, we hope, will accuse us of a leaning to homœopathy, if we express our regret that such exhibitions as the above should ever occur, and our belief that they are as discreditable to the professors of legitimate medicine as they are likely to be advantageous to the charlatan. Quackery will not be abolished by abuse: on the contrary, vilification, like artificial manure to a plant, only serves to increase the rankness of its growth. The public, as it were instinctively, side with the abused party, and invest him at once with the sympathy due to a martyr to science, a character which the parties themselves are not slow to take advantage of. The "I loves persecution" of the religious quack in the play, is the characteristic predilection of the whole fraternity, and we may be assured that we never so effectively play their own game, as when, by personal invective or otherwise, we give them an opportunity of coming into court. Notoriety is the life and soul of quackery, whether it appears under the guise of the fashionable metropolitan homœopath, or in some more humble form:—let the regular practitioner leave them to the resources of their own sufficiently fertile geniuses, but avoid furnishing them with cut and dried advertisements, as is too often done, by condescending to come into collision with them.

Although in the present instance we must admit that Dr. DE LISLE was to blame in allowing himself to be betrayed into the expression of personalities towards Dr. OZANNE, by which a gentleman always loses caste, let his cause be