In the *London and Edinburgh Medical Journal*, May, 1845, (see also *Medical Gazette* and Editors remarks, Oct. 17th, of the same year,) we find Syme, from two successful cases, giving his reasons for recommending amputation at the ankle-joint in preference to the leg, to avoid unnecessary mutilation, and sawing through the condyles of the femur to prevent the frequent deaths from the effects of separation of the thigh at its centre.

Fergusson, ("Practical Surgery," 1842,) says, "In selecting amputation over excision of the knee-joint, I have been influenced chiefly by the consideration whether the object to be gained by the patient would be worth the risk incurred, and have invariably come to the conclusion, that by removing the limb above the seat of the disease I have done what was best for present safety and future comfort;" and, moreover, writes upon the subject of excision of the head of the femur, undertaken for disease of the hip-joint,—that although he has meditated the performance of the operation for ten years, he had never met with a single instance where the practice could have been deemed justifiable. In the *Medical Gazette*, No. 12, 1845, we read of his excising successfully the head of the femur of a boy in the last stage of hectic exhaustion.

Liston, ("Practical Surgery,") pronounces "resection" to be "scarcely applicable to the hip and knee." After Fergusson's success, this able surgeon may alter his opinion; he will scarcely be surprised to hear again of provincial daring; the love of but little beyond what he himself originates or practices is hardly excusable, even in one who has done so much for operative surgery.

S. Cooper, ("Dictionary," 1838,) inquires, "whether a patient, greatly reduced by hectic symptoms, will be able to recover from so bold and bloody (!) an operation as the dissection of the whole of the knee-joint out of the limb? &c., &c. The proverbial caution of this eminent authority, seems to have been lost upon Dr. Gordon Buck, of the New York Hospital. In the second number of the *Medical Times* for the present year, we read of his having performed so successfully the formidable operation of excision of the head of the tibia and the condyles of the femur, to remedy the inconvenience arising from an ankylosed knee, that the patient in little more than six months was enabled to walk about the hospital grounds with a cane.

M. Blandin's amputations in the regions of contiguity of bones, the joints being sound, or the section through the condyles, as suggested by Professor Syme, may not be advisable modes of operative procedure; nevertheless, the reported results of such practice, and the limited observations I have been enabled to make upon open joints, do not, in my humble opinion, justify the extreme fear of interference when the larger joint-ends of bones, and even their articular surfaces, have become slowly diseased. In such cases I venture to express my belief that a more frequent resort to the trephine, or to excision, may possibly save life and limb, and render amputation unnecessary.

Lynn, Jan. 28, 1846.

ON PLACENTA PRÆVIA.

(A paper read before the Medical Society of University College, London, on Friday, January 30th, 1846.)

By JOHN ELLIOT WOOD.

(Continued from page 76.)

We now come to speak of the treatment when hæmorrhage occurs at the commencement of labour, arising from the abnormal situation of the placenta over the os uteri. Time would not allow me here to enter fully into the management of those cases in which flooding takes place before the accession of labour.

Guillemeau advocated the practice of delivering immediately, by passing the hand into the uterus, and extracting the child. This was his practice also where the placenta did not present, but had become detached by some accidental cause from the fundus. In cases where the placenta had not entirely escaped, and the membranes were not ruptured, Mauriceau advised the part of the placenta which presented to be put aside with the hand, the membranes to be ruptured, and the delivery completed by turning. When the placenta was entirely detached, he brought it away before the child. Portal separated the placenta from the os uteri, ruptured the membranes, and turned the child. If the patient were plethoric, he recommended the use of the lancet. Giffard was of opinion that the only thing to save the patient was a speedy delivery. Røederer recommends the dilatation of the os uteri to be slowly and cautiously effected by the hand, which is to be passed between the placenta and uterus, and turning is to be immediately accomplished. Levret advocated immediate delivery by turning. He remarked that uterine contractions invariably increased the hæmorrhage where the placenta was implanted over the cervix, and that the contrary effect was produced where the placenta adhered to the fundus, and had been detached by an accidental cause. He considered it prudent, therefore, to rupture the membranes in the former case, but not in the latter. He recommended passing the hand through the placenta.

The practice of rupturing the membranes, by which alone in many cases the hæmorrhage is stopped, is generally attributed to Puzos, and was claimed by him as a recommendation of his own, but the merit of introducing it is undoubtedly due to Mauriceau. Smellie recommended rupture of the membranes, so that the uterus might contract and squeeze down the fœtus; and if this were not sufficient, turning was to be had recourse to as soon as was practicable. He alludes favourably to bleeding in some instances. Plenck, in 1781, says—"Hæc menorrhagiæ species est periculosissima, nulli remedio, sed solâ fœtus extractione, curanda." Dr. Rigby recommended passing the hand through the placenta, on the ground that not more than was actually necessary for the introduction of the hand would thus be separated. He delivered by turning. It is probable that he was in the habit of using the plug, though it is not actually so stated in his work. Merriman and Denman advised turning as soon as possible; the former passing through, or by the side of, the placenta indiscriminately. He says the operation should be slowly performed, and the patient's strength recruited from time to time by the administration of nourishment.

Davis insists strongly on the necessity and expediency of plugging the vagina, and recommends it, not merely to rescue the patient from profuse uterine hæmorrhage,

but also as a powerful means of exciting the uterus to contraction by its mechanical irritation of the vagina and os uteri. He says the hand should not be passed through the centre of the placenta, because it would only separate still more of this organ from the uterus, and diminish greatly what little chance remains of the probability of saving the child. Thus we see practitioners, so distinguished as Dr. Rigby and Dr. Davis, each recommending an opposite practice, and using the same arguments to give weight to their adverse opinions.

Dewees recommends that the hand should be passed between the placenta and membranes, and the uterus, to the fundus; that the membranes be ruptured there, the child's feet seized, and the delivery completed. The advantages of this method are:—1. Much less violence is done to the connection of the placenta with the uterus, and thereby the risk of increased hæmorrhage is prevented.—2. Much time is saved.—3. We arrive at the feet, and can command their descent with much more certainty.—4. We prevent an atony of the uterus by allowing the waters to escape gradually and at will.—5. It prevents the fœtus from being entangled with the placenta, and thus does away the inconvenience that would arise from the increase of bulk, as in the method formerly practised the size of the placenta is added to that of the child.—6. It prevents the rude and sudden separation of the placenta from the uterus.

These reasons are amply sufficient to justify the practice advocated by Dr. Dewees, independently of many arguments which might be adduced against the opposite plan of treatment. For:—1. While an attempt to penetrate the placenta is being made, the flooding continues or increases.—2. The further violent separation of the placenta from the cervix uteri is inevitable.—3. The hole made by the hand is too small to admit of the passage of the child, and in the act of delivery the whole placental mass must become entangled with the fœtus, and thus be separated.—4. By lacerating the placenta we increase the risk of hæmorrhage, in spite of some apparent exceptions to this rule.—5. It is an extremely difficult operation to force the hand through the placenta, even when placed on an unyielding surface; but this difficulty is much increased when the organ is attached to the cervix uteri.

The most approved plan of practice in the present day, in ordinary cases of placental presentation, unaccompanied by any peculiar complication, is as follows:—

1. In the commencement of labour, after making an examination, and satisfying oneself of the nature of the case, the vagina should be filled completely with three or four plugs, in order to control the hæmorrhage, and give time for the dilatation of the os uteri without exhaustion to the mother. The external plugs can be removed from time to time, in order to allow of an examination of the state of the case, and to facilitate the introduction of the catheter, which will probably be required. This first stage of the labour may last forty-eight hours, or even more.

2. When the os uteri is moderately dilated, (if the hæmorrhage be great, we need not wait till complete dilatation takes place,) the hand should be passed, in the manner advocated by Dewees, but first recommended by Portal, in 1685, and Peau, in 1694. The arm of the operator takes the place of the plug, and restrains the hæmorrhage. It is important to bring the

feet through the os uteri quickly, in order that the breech of the child may make pressure on the bleeding placenta; with this exception the operation should be slowly performed.

3. After the delivery of the child, the placenta is generally found lying detached in the vagina or uterus, and is to be removed. The usual precautions, as to giving nourishment and stimulants, are to be taken as in other important obstetric operations. These need not be detailed here.

This practice is recommended and adopted by every practitioner of note at the present day, in these, the most favourable cases of placenta prævia, as offering a reasonable chance of safety both to the mother and child; but instances were so numerous in which, owing to common and frequently recurring complications, or from neglect of the appropriate treatment in an early stage of the labour, or both, this treatment was unavailable to save either mother or child, that it became a desideratum to discover some modification which should promise more successful results.

Cases occurred from time to time, in which, after profuse and long-continued hæmorrhage, the unassisted efforts of the uterus sufficed to throw off the placenta, which was thus expelled, and the bleeding having ceased, time was allowed to the mother for recovery from the consequent state of exhaustion, before the fœtus was naturally or artificially delivered. In the great majority of these cases, violent hæmorrhage ceased immediately that the placenta was entirely detached, and in very many of them even all oozing of blood was put a stop to by this last but successful effort of nature.

Dr. Rigby says, that "in a few rare cases the placenta has been entirely separated and expelled before the child, but these have usually been attended with a most alarming loss of blood."* We can easily conceive this to have been the case, if the task of separating an adherent placenta from the uterine neck were left to the uterus itself. It would have been well if Dr. Rigby had stated when this alarming hæmorrhage, of which he speaks, had taken place, whether before or after the expulsion of the placenta. Dr. Lee records a number of cases of this description. "On the 8th of February, 1830," he says, "I was called to a woman residing in Falconberg Court, who had been attacked with profuse uterine hæmorrhage at the end of the seventh month of pregnancy. The placenta was protruding through the orifice of the vagina; I immediately extracted it, and a dead child followed. A great hæmorrhage succeeded, and she remained for a considerable time insensible, but gradually recovered.† Dr. Ramsbotham, sen., gives three cases of the same kind.‡ Merriman mentions one:—"I was once consulted by a very careful and judicious practitioner respecting a woman, who, when I first saw her, was rapidly sinking under puerperal fever. In this case the placenta was expelled many hours before the child was born, and no extraordinary means were used to expedite the delivery of the child."§ Various other practitioners, as Baudeloque, Perfect, Barlow, Collins, and Dr. F. H. Ramsbotham, record cases of a like character.

* *Rigby's Midwifery*, p. 256. + *Med. Gazette*, July 13, 1839.

‡ *Practical Observations*, case 151, et seq.

§ p. 126. Note.

(To be continued.)