ation commences as a dark spot at the root of the nail), it is best to scrape the nail as thin as possible, and repeatedly apply the solid nitrate of silver, as well as a lotion of the same salt, to the parts, by which the death of the nail is procured, and, as it rises from its bed, it can be separated. In some it will be necessary to enucleate the nail, and then to treat the ulcerated surface.

Syphilitic Iritis. In the treatment of this affection, mercury and the application of atropine are the ordinary means used.

The mercury need not be given in large doses; and there is no reason against employing such other remedies as the state of the patient may indicate. It is well to drop the solution of atropine into the eye every six hours, or sufficiently frequently to maintain a dilated condition of the iris.

In some cases, neither mercurials, iodide of potassium, nor turpentine, appear to exert any effect. The iritis, instead of yielding, appears to advance. Some cases are, probably, of complicated nature—a mixture of the rheumatic with the syphilitic form of the disease.

I have seen an iritis commence in one eye of a patient who was affected with mercury for an iritis of the other eye.

In these cases there is not only a good deal of circumorbital pain, with photophobia and lacrymation, but the anterior chamber becomes clouded; the iris with the periphery of the cornea yield, so that the latter appears to rise abruptly out of the sclerotic, although the cornea, as a whole, is less convex than normal; and the eyeball feels a trifle more tense and firm than that of the healthy organ.

In addition to the synechia, and recurrence of iritis from this very cause, there is a well grounded fear that the eyesight may remain impaired. In such cases nothing answers better than a division of the ciliary muscle and evacuation of the aqueous, by Mr. Hancock's operation.

In two cases in which I pursued this course, great and rapid improvement ensued.

The operation is so slight, and so easily performed, that there is little or nothing to fear from it in these respects. When it is considered that the ciliary muscle is the point at which the sclerotic, cornea and iris meet, and that any effusion behind the iris must tell directly upon this, the most unyielding part of the eye, we cannot be surprised at the beneficial results ensuing from its division, and the establishment of an opening between the anterior and posterior chambers.

Now that I am upon the subject of iritis, I may remark that there is a variety of ophthalmia occasionally following gonorrhœa, allied, in its symptoms and appearances, to rheumatic iritis; indeed, it is a form of gonorrhœal rheumatic inflammation. This disease is very easily mistaken for syphilitic iritis; but it differs from it in not having the minute beads or nodules of lymph deposited upon the iris, which are so common in the syphilitic disease. The sclerotic is always affected; the conjunctiva generally so; and the margin of the cornea looks dull, preventing the perfect view of the iris. The pupil is contracted, as in syphilitic disease, and yields difficultly to the action of atropine, but synechia is not a common result. The disease is more chronic, painful, and difficult of cure than the syphilitic form; photophobia and lacrymation are also more marked phenomena.

Rollet has well described this sequela of gonorrhœa. I have given the symptoms as I have observed them; and the subject has been introduced here upon account of this form of disease being very commonly, but erroneously, referred to a syphilitic origin.

In conclusion, I must reiterate, what I have already implied, that any treatment of syphilis, particularly in its constitutional phases, will be materially assisted by a strict attention to hygiene. The patient cannot take too much air, nor live too plainly, nor can we endeavour too much to invigorate his system. In military hospitals this cannot be done, unfortunately, to anything like the required extent. Air and exercise cannot be obtained; and the patient, after a monotonous confinement within the wards of an hospital, but too frequently plunges into dissipation as soon as he leaves it.

ON UTERINE FLUXES, THEIR CAUSE AND CONSEQUENCES.

By W. E. C. Nourse, F.R.C.S., Brighton.

Uterine and vaginal fluxes mainly originate in conditions of local vascular fulness and activity, dependent on the anatomy of the uterine blood-vessels, or on the vascular determinations consequent on the various physiological conditions of the womb. In this, they differ from the bowel-flux and lung-flux, the two other great classes of disorder in which discharge from the body is an essential feature, and which are more under epidemic influences. The fluxes from the utero-vaginal tract may be enumerated as:—1. Hæmorrhagic discharges (excluding those of pregnancy or parturition); 2. Menstrual discharges—menorrhagia and dysmenorrhœa; and 3. Altered discharges—leucorrhœa.

1. A lady was attacked with violent flooding four weeks after a miscarriage. Here the recurrence of the monthly determination was the principal cause; the uterine muscular fibres not being in the same state of development as they possess four weeks after child-birth, when they have power to prevent by compression any such occurrence. But, non-completion of the requisite changes after the expulsion of the contents of the uterus, is also to be taken into account. Uterine disorder is often noticed after the birth of a dead child. A case of this sort is recorded, in which peculiar uterine conditions were present, coupled with typhoid fever. The following is somewhat similar. A lady was confined with a dead child; after which menstruation was profuse, and with clots; and in four months she was attacked with low fever, accompanied by intense hysteria. Excessive and painful menstruation continued for some time; but at length was replaced by leucorrhœa. Two years later she was suffering from symptoms treated as ulceration of the os uteri, with the speculum and caustic, but which were in reality, merely due to relaxation of the vagina permitting the uterus to fall a little from its place. Cure was speedily effected by means restoring the tone of the vagina. This patient had suffered from hepatic symptoms. In another case there was congestion of the uterus after the birth of a dead child. In another, irregular, painful, and excessive menstruation, with uterine leucorrhœa, following the birth of several dead children. Circumstances pointed to previous uterine derangement. In these cases, the death of the fœtus is probably caused by previous uterine disorder, which becomes more prominent after the birth, and thus is noticed as following the birth of a dead child.

2. In other cases, menorrhagia was associated with plethora; with hysteria; with debility and want of vital power; with lactation; alternating with leucorrhœa, the vagina relaxed, and the womb low down; and especially with hepatic derangement, and with habitual drunkenness. Disordered liver, however caused, is frequently found to accompany increased, difficult, or painful menstruation; the obstructed portal circulation favouring a tendency to pelvic congestion.

3. Leucorrhœa frequently alternates with, or succeeds and replaces dysmenorrhœa and menorrhagia. A lady, subject to frequent attacks of painful congestion of the liver, was also a great sufferer from dysmenorrhœa. Some years after, leucorrhœa alternated with the dysmenorrhœa; and ultimately, there were symptoms

dropping of the womb, with enlargement and congestion of the os uteri, from relaxation of the vagina. Another lady, subject to hepatic derangement, suffered from excessive and painful menstruation. Miscarriage was caused; and after a time, leucorrhœa came on. In these disorders, the uterus itself remains free from any structural alteration. But a common sequel of long continued leucorrhœa is, relaxation and weakening of the mucous membrane of the vagina. Former disturbed menstrual conditions may have ceased; the menses themselves, from one cause or other, may have ceased; the leucorrhœa accompanying former menstrual disturbance may remain, or again, it too may have ceased; while the consequences of these successive occurrences, which have very likely been forgotten, the relaxation of the vaginal mucous membrane, may be giving rise to a number of structural alterations. The commonest of these is, partial descent of the uterus, the os uteri being lower than natural, and often resting on the floor of the vagina. This condition, if unrelieved, may last long, and cause much distress. If it be suffered to continue, another change takes place. The os uteri thickens and enlarges, or may even ulcerate. Other well known effects of relaxation of the vaginal mucous membrane may be, either vaginal rectocele, vaginal cystocele, or prolapsus uteri, diseases which may last for years, long after the uterine fluxes which have preceded them have ceased.

Thus the sequence of events is: 1. Menorrhagia or dysmenorrhœa, due to vascular fulness about the uterus, often connected with obstructed portal circulation; 2. leucorrhœa; 3. Relaxation of the vagina, permitting the womb to fall a little from its place; 4. Consequent enlargement of the os uteri, perhaps with ulceration; 5. Some kind of prolapsus.

Transactions of Branches.

BATH AND BRISTOL BRANCH.

CASE OF MONSTROUS BIRTH.

By JOSEPH HINTON, M.R.C.S., Hinton, near Bath.

[*Read November 27th*, 1862.]

THE mere fact of the uterine contents being monstrous in form may not in any way interfere with the parturient efforts of the organ, and the delivery may prove perfectly natural, albeit the said contents may have faint resemblance to "the human form divine"; whilst, again, with scarcely any extreme deviation, the monstrosity may complicate the delivery, and render our diagnosis exceedingly difficult. To this latter category my case belongs.

A few weeks ago, I received an urgent message to attend a woman, who was in labour before she anticipated. From the messenger I could gather nothing as to the nature of the case, and nothing very satisfactory as to the duration of the labour. On this latter point, I have since received very conflicting accounts; the current report being that the woman had been several days in labour; that some six-and-thirty hours before my arrival, the pains had been so violent, that the completion of the labour appeared imminent; but that soon, and without any reason, these pains died away wholly, and she had scarcely experienced any since. The midwife declared that she had sent off immediately on discovering that something was coming down, which she could not understand. The patient was a young and apparently healthy primipara. Her condition was not the most satisfactory. She was cold and shivery, often drowsy; her pulse small and feeble; in fact, she was decidedly prostrated. She did not consider herself more than seven months advanced. On examination, I found a mass, of the size of a cricket-ball, outside the vagina; it gave somewhat the sensation of the placenta but smoother. Unable to arrive at any conclusion as to its nature by the touch, I exposed and carefully examined it, but for some minutes I was equally staggered.

Its odour and appearance resembled that of strangulated intestine in a sloughing condition. The closer the examination, the more convinced was I that the mass was intestinal; at last, I fancied I detected something that might pass muster as a diminutive appendix vermiformis. A vaginal examination was made with difficulty. I traced the mass within what I believed to be the posterior edge of the os uteri; but was unable to detect any other presenting portion. I was led to diagnose total deficiency of the abdominal walls in the fœtus, and that this presenting mass was the fœtal intestines. With much difficulty, I succeeded in reaching a knee, and bringing it down; the foot was very broad and flat, with scarcely any great toe; the cuticle separated very easily, although the patient considered she had felt the child in the morning. The other foot was then brought down; it resembled its fellow. The nates and abdomen, such as it was, were then brought to view. To the inexpressible horror of the midwife, the former boasted a very respectable tail about two inches long, and a quarter of an inch in diameter; it was devoid of hair.

In endeavouring to deliver the remainder of the fœtus, the spine gave way. I then brought down both arms. The third finger on the right hand was a stump. I used all the force I dared with the arms unsuccessfully; the head was not in the pelvis, the neck being much stretched; the abdomen was still large. I therefore left the patient quiet and she fell asleep, whilst my instruments were sent for. Whether during this interval any portion of a large hydrocephalic head had so given way, as to allow the escape of a portion of the fluid, I cannot say; but on introducing my fingers to guide the blunt hook, a large quantity of serum escaped, and possibly an attempt at delivery might have been perfectly successful. I decided, however, on passing the hook; and, fixing it in a portion of bone I could detect, which proved to be the left orbit, I drew out with tolerable ease an enormously elongated head, like a thickened bladder, with the cranial bones hanging loosely in the interior. The placenta was soon expelled; it was large but healthy, except in the funis. The child was a male.

The head was exceedingly large; the body was not larger than that of a seven months fœtus; the nails were unformed; the features were most revolting; two holes represented the nose, whilst, extending into this feature, was a very wide hare-lip, the lip itself being scarcely visible; the palate also was deeply cleft. The cranial bones appeared loose within a very thickened scalp. Within this there was still a quantity of fluid; there was also a small cerebral mass. The spinal column was much distorted, being bent with the bow part forwards. The abdominal parietes were wholly deficient; the left kidney appeared almost in its normal position; the right was amongst the convolutions of intestine; so also was the liver. I could not make out exactly how the funis was attached, as it had suffered from the general condition, and had given way in the delivery. Some drops of meconium oozed from the anus.

When I placed the monster in position for taking a rapid sketch, I was struck with the resemblance in face to a man whom I used often to see in Bath, who walked by the aid of two sticks, on the balls of his toes, and has, I think, hare-lip, etc. At any rate the expression was very similar, and the same impression was conveyed to the mind of the midwife. However, the patient, when questioned, denied firmly having experienced any fright at any time during the pregnancy. She allowed that she knew this man, and that, about five months ago, he pointedly came across the street to her to beg.

Here, the patient, if her statement can be believed, and there appears no reason for doubt, was unaware of