punctum and canaliculus, there is no fault in the excretory apparatus, in the conduits from the eye. An irritable conjunctiva, causing hypersecretion of the lacrymal gland, is probably the origin of the evil.

I avoid entering into a consideration of the many phases that a diseased lacrymal sac may pass through, and which have been described as mucocele, relaxation of the sac, and so forth, as it tends to no practical end, and only mystifies and puzzles. These are all merely more or less aggravated symptoms of an unhealthy mucous membrane, of which the prejudicial effect is the most exercised, where the lower end of the duct—the part encased by bone—is strictured.

A strictured duct requires to be mechanically treated, and as there is a morbid state of the canal, by which an accumulation of the secretion it causes merely interrupts the free passage of the tears, and which state may be remedied by constitutional and topical measures; and as there may be stricture with but faintly apparent morbid action, and with little or scarcely any escape of new products or accumulation, when the sac is pressed, it often becomes a nice matter to diagnose between them. For many years I have sought for the indication in question; and now I rely on two simple facts as the most sure and unerring guides. These are the state of the canaliculi, and the condition of the parts about the lacrymal sac as conveyed to the touch.

When one of the canaliculi, especially the lower, is choked at the inner end, there is, as far as I have observed, almost invariably, stricture of the duct as well. Again, when there is decided thickening of the parts over and about the lacrymal sac, so that the edges of the bones cannot be felt as in health, there is that condition that needs dilatation. These rules have fewer exceptions than any that I know of. A profuse discharge, even of purulent matter, through the puncta, generally associated with stricture, is not in itself, as I have frequently ascertained by actual exploration, an unerring sign of obstruction. On the other hand, all degrees of narrowing of the duct, and even complete occlusion, may exist, without the escape of pus, and but little of any secretion.

It is the chief object of this lecture to show how to effect the process of dilatation in a strictured duct, because it demands special teaching.

I am quite satisfied that the mere occasional probing is not in itself sufficient. Besides, it is so tedious and so very disagreeable that both public and private patients rebel against it. I may add that when there is really that degree of structural change which unequivocally calls for instrumental treatment, the wearing of a style is the less irksome, the more beneficial, and the quicker plan.

It is a great modern improvement to introduce the style through the canalicular entrance into the lacrymal sac, instead of the old plan through the skin on the face. I think that it may always be done, except when there is a lacrymal fistula, especially with necrosis. The method of doing it is this: The lacrymal director is passed into the punctum and along the canaliculus, till the point enters the sac, and rests against the lacrymal bone. With a fine scalpel this canal should be slit up in its whole length, and, as I think, a little of the sac as well. In certain instances, when, for example, a patient cannot be seen as often as I would wish, I introduce the style, if practicable, at once; but generally I effect it by a slower process, dilating the duct by degrees. Primary union is very apt to follow the operation on the canaliculus, in part or in whole, and the new channel should be reopened with the director or probe each day, till no longer required.

I generally explore the duct in the first instance with a tapering steel sound, and then with a small silver wire; and should there be much stricture, and some difficulty in reaching the floor of the nose, I do not withdraw the

wire, but cut off the upper part and turn the end down on the eyelid with pliers in the form of a little hook. After a few days, the calibre of the duct is increased, and the style may be more readily introduced. The styles should be made of standard silver. The head should be curved into a hook, or wrought into a little tail, the extremity of which rests just over the eyelid. Several wires should be kept that the lesser might be employed till the largest can be used. Different lengths, too, are needed; for in each application the foot should reach the palatine process of the superior maxillary bone forming the floor of the nose. There is then no risk of the style slipping down; nor of the upper end producing irritation from pressure; nor ulceration, and so forming a false channel to rest on. Messrs. Weiss of the Strand keep all the instruments that I use.

The stricture may prove to be very tight—so dense, indeed, that it cannot be penetrated by the probe or the style. It must then be divided by the style-knife, which ought to be pressed down till the resistance is overcome.

The success of the entire proceedings rests on the accurate passage of the style. Liability to failure consists in the tendency there is to penetrate the lacrymal bone rather than in line of the duct. I know of no more common mistake in ophthalmic surgery than for a false passage to be made in attempts to open the nasal duct, and to probe it; and the liability is still greater when the canaliculus is made the channel after the manner now described.

I can give no rules for guidance beyond those of acquiring anatomical knowledge of the part, which a single dissection on the dead body will afford; of exercising great care; and never to be satisfied that the right passage is reached, till the probe touches the floor of the nose; when the lacrymal bone is penetrated, the probe passed into the fauces as far as it may be thrust.

From time to time, the style should be removed and cleaned, and if it should ever become uncomfortable or irritating, the cessation of wear for a day or two generally makes it afterwards tolerable. Some patients wear it at night only. As to the duration of its application, I continue it until all inflammatory action has been subdued, which is indicated by an absence of all purulent or other secretion of an unhealthy nature from the duct.

I can declare that I have obtained an amount of success during the last five years which often astonishes me when I reflect on the nature of the cases treated. In the majority, I have had perfect results. In some, there has been immense amelioration, it being only at times when, perhaps, the conjunctiva is swollen from catarrh that a little defective working in the excretory channel is felt. In some few, the reintroduction of the style for a few days, or longer, has been needed. In not a single case treated in my private practice have I failed to afford some substantial relief.

CASE OF SUDDEN PARTURITION.

By C. BLAKELEY BROWN, M.D.

ANN S., aged 26, began to feel ill about 3 o'clock P.M. on March 14th. While resting on the bed, she felt, as she thought, a "call of nature"; and, while sitting up, gave birth to a fine full grown child, which falling on the floor, the funis was broken off about eleven inches from the navel. She took her child and lay down with it for some time; when, feeling easier, she dressed herself, went to the door of the house, hailed a cab which she saw passing, and, getting into it with her baby, was driven to Queen Charlotte's Hospital. On her arrival there, she walked out of the cab up several steps with the child in her arms, before the doors of the hospital could be opened; and, having entered, would have walked

up stairs, if the matron had not insisted upon her being carried. This occurred between 8 and 9 P.M. When she was put to bed, the matron discovered that the placenta had not come away: this she removed without difficulty, and found the torn funis to correspond with that still on the child, which she tied and cut, and from which there had been no hæmorrhage whatever. Both mother and child are now in the convalescent ward, and have had no bad symptom, or seem to be any the worse for their journey.

Transactions of Branches.

BATH AND BRISTOL BRANCH.

CASES OF PUERPERAL CONVULSIONS, WITH REMARKS ON THE USE OF BLOOD-LETTING.

By J. G. SWAYNE, M.D., Physician-Accoucheur to the Bristol General Hospital, and Lecturer on Midwifery at the Bristol Medical School.

[Read February 26th, 1863.]

THERE is, in the present day, a strong tendency to decry all methods of treating disease which do not harmonise with the stimulant plan now so much in vogue. Hence, I believe, some well established and highly successful remedies are in danger of being abandoned, whilst others are being substituted for them which are of doubtful efficacy, and have not yet been sufficiently tested by experience. This remark applies especially to the use of bleeding in puerperal convulsions, and, in illustration of it, I now bring forward the following cases, embodying my own experience of that disease.

CASE I. In 1842, I attended M. F., a primipara, living in Albion Row, Bedminster. The os uteri was rigid and unyielding. The feet presented. Convulsions came on, preceded by drowsiness, when the os uteri was dilated to the size of a shilling, and before the membranes gave way. I bled her to thirty ounces, and hastened the delivery. The child died in convulsions a few hours after birth. The mother had one or two fits after the bleeding, but recovered well. Purgatives and antispasmodics were used.

CASE II. In 1842, I was called to attend S. H., a multipara, living in Eugene Ward. She was suddenly taken with convulsions previous to labour, and before any one could be sent for, was delivered during one of the fits of a healthy living child. I bled her to twenty ounces, shaved her head and applied cold lotion, and administered an enema of assafœtida and turpentine. The convulsions continued in a mitigated form for two or three days, gradually abating in frequency, and disappearing altogether about the end of a fortnight.

CASE III. In 1847, Mr. Wheeler requested me to see Mrs. L., a primipara, aged 30, whom he was attending. Labour pains came on in the morning of the same day, accompanied with convulsions, which increased in severity. Mr. Wheeler had bled her before I arrived, to twenty ounces, and had given her one drop of croton oil and ten grains of calomel, and a strong turpentine enema. But as the fits still continued, he requested me to see her. I went to her at 8 P.M. She was then quite insensible with stertorous breathing, and pulse varying from 120 to 160. The bowels had been freely opened, and the stools were black and offensive. The labour all this time was steadily proceeding. When the os was pretty well dilated, I ruptured the membranes and let the labour go on naturally. She had now had no fit for three or four hours, but just when the head was pressing on the perinæum she had another convulsion. We therefore determined to hasten delivery by the forceps. This was soon done, and she was safely delivered of a still-born child which had apparently been dead for two

or three days. Soon after delivery her breathing became less stertorous, and her pulse less frequent, and in about twelve hours she had regained partial consciousness. For two or three days after this she remained in a maniacal condition, but this gradually passed off, and she made a good recovery.

CASE IV. In 1850, I saw Mrs. J., a primipara, living in Stokes Croft, in consultation with Dr. Herapath, who had been attending her. She had been in labour twenty-four hours, and about four hours before I saw her was attacked with epileptiform convulsions. When I saw her the convulsions returned about every twenty minutes, there being complete unconsciousness in the intervals. She was a thin spare woman; but as there was much congestion of the vessels of the head, we bled her to twelve ounces. The pulse was now frequent and rather weak. The fits were mitigated after the bleeding, but the pains were feeble, and the labour made very little progress. We then waited between two and three hours, when the insensibility still continuing and the fits returning at intervals, we determined to effect delivery. As the os was not sufficiently dilated to admit the forceps, craniotomy was performed, but with considerable difficulty. The woman remained completely unconscious after delivery and in a state of extreme collapse, accompanied with restlessness and jactitation. We gave her liberally brandy, ether, and ammonia, but she did not rally for some hours. However, in the following night she became partially conscious, and ultimately made a good recovery, except that she was slightly salivated by some calomel which was given during labour.

CASE V. In 1853, Mr. Godfrey requested me to see Mrs. G., a lady whom he was attending in her first confinement. The labour had been very tedious, and the head had been some hours at the outlet of the pubis, notwithstanding that ergot had been given. The patient had had two convulsions before I arrived, and had been bled to twenty ounces. When I saw her, the head was in the same position and did not move, notwithstanding two or three very strong pains. These pains were followed by a severe convulsion, and we deemed it prudent to wait no longer. I therefore delivered her with the forceps. There was no convulsion after delivery, but the detachment of the placenta was accompanied with some hæmorrhage and tendency to syncope. We therefore gave her brandy, ammonia, and laudanum. The child was healthy and strong, but for some hours had contraction of the flexors of the left fingers and thumb. The patient did not completely regain consciousness until the third day, but ultimately did well.

CASE VI. I was sent for by Mr. Corbould, to see Martha M., in Cox's Buildings, St. Philip's. She had been previously healthy, and was seven months pregnant with her first child. She was attacked with convulsions about 8 A.M., June 28th, 1854. When first seen about 11 A.M., she had had three fits, and was almost entirely unconscious, breathing slightly stertorous. There were no symptoms of labour, and not the slightest dilatation of the os uteri. She was bled to about ten ounces. She seemed somewhat relieved by this, so much so that she was able to get up in bed, and understood what was said to her. After some interval, however, she had another very severe fit and became comatose, and the convulsions returned twice or thrice every hour until 3 P.M. Cold was applied to the head, and an enema of turpentine and castor oil given. The fits now became more frequent and severe; Mr. Corbould therefore applied twelve leeches to the temples, gave her a drop of croton oil, and placed mustard poultices on the calves of the legs. As the convulsions still continued with abatement, Mr. Corbould requested me to see her. Finding the pulse apparently unaffected by the previous depletion, I bled her again from the arm to ten ounces. After this, the pulse became weaker and more