they may form an opinion on the galvano-caustic mode of operating, I will finally state my own conviction, that it is only in exceptional cases that the galvano-caustic apparatus should be substituted for either caustics (were it not for the cumbersomeness of the apparatus, it should always supersede the common actual cautery), the *écraseur*, or cutting instruments. Hence, I would not advise every practising surgeon to possess himself of the instruments; but, since these exceptional cases not unfrequently occur, I would have each surgeon aware of this mode of operating; and in each large district there should be an operator possessed of the apparatus, to whom application could be made, in a case where this plan of operating was indicated.

Before the introduction of the *écraseur*, the galvano-caustic mode of operating was more required than now; and it is probable that our having heard so little of it recently in England, may depend on the employment at present of the *écraseur* by those who otherwise would have used the galvanic apparatus.

ACCIDENTAL SEPARATION OF THE PLACENTA AT THE SEVENTH MONTH OF PREGNANCY:

ALARMING SYNCOPÉ: INDUCTION OF PREMATURE LABOUR: RECOVERY.

By G. E. STANGER, Esq., Nottingham.

Mrs. H., aged 36, mother of three children, healthy, and moderately robust, had arrived at the end of the seventh month of pregnancy, when she took a long walk on the 20th March, 1861. On her return home, and even before she arrived there, she felt extremely faint, and was scarcely able to walk. She soon became so alarmingly exhausted, that a messenger was sent for me in great haste, as her husband thought she was dying. On my arrival, at 3.30 p.m., I found my friend, Mr. Higginbottom, in attendance. The patient was lying prostrate on the bed, blanched, and in a state of syncope. She could only speak in a whisper; but she complained that her body felt very large, hard, and distended. The pulse was very indistinct and fluttering, and her whole appearance indicated extreme danger. She was not aware that she had used any undue exertion, or that she had slipped or injured herself in any way; but I felt convinced that hæmorrhage had taken place into the womb, and was in all probability still going on. The abdomen was as large as might be expected at the expiration of the full term of pregnancy. No fetal sounds could be heard; and the patient remarked that she had not perceived any movement of the child after leaving home in the morning. At this time there was not the slightest hæmorrhage externally; neither was there any indication of the approach of labour; and, on examination *per vaginam*, the os uteri was in its normal condition.

Under these circumstances, both Mr. Higginbottom and myself felt some difficulty in deciding what course we should pursue; for, on the one hand, we feared that, if we did not interfere, and the hæmorrhage continued, she must inevitably sink; and, on the other hand, if we attempted to induce premature labour, the blood might flow more rapidly as soon as it was allowed to escape from the womb, and death might ensue before we had accomplished the delivery.

We determined, therefore, to wait for a time, especially as there seemed to be now and then an attempt to rally; and we hoped that the os uteri might begin to dilate.

She continued in much the same state during the evening. Mr. Higginbottom remained with her the whole time, as I was only able to call occasionally, in consequence of another engagement.

At 10 p.m., the symptoms not being in any degree improved, we decided on the propriety of bringing on labour; but, before doing so, we requested the opinion of Mr. Wright, the senior surgeon to the Nottingham General Hospital. Mr. Wright at once recommended this practice, and considered that the situation of the patient was so critical that it was doubtful whether she would survive the operation. Soon after this advice had been given, hæmorrhage began to take place from the vagina in considerable quantity; and the syncope became still more alarming. I, therefore, immediately introduced a straight silver catheter into the uterus, and let off the liquor amnii. By the conjoint and persevering efforts of Mr. Higginbottom and myself, the os was sufficiently dilated to allow of a foot being brought down; but so rigid and unyielding was it that it was a long time before we could succeed in laying hold of the second foot, and even then the exertion required to extract the body was so great that the head was separated from the trunk, which, of course, greatly retarded the operation. We succeeded, however, at length, in removing the head; and we were rejoiced to find that during the two hours that we were engaged in effecting the delivery, very little hæmorrhage occurred. The placenta was removed without any difficulty, being already partially, if not altogether, separated. Slight hæmorrhage occurred about half an hour after; and great faintness and exhaustion continued for many hours; but the flooding was checked by the application of firm pressure. The patient recovered in a few days without any drawback.

REMARKS. I think it can scarcely be questioned that the plan which was pursued in this case was the only practicable one. Whether the operation ought to have been performed earlier, may, perhaps, admit of some difference of opinion. If I were to meet with another case of the kind, I should, as soon as I was satisfied that a separation of the placenta had taken place, puncture the membranes, and then wait for the appearance of urgent symptoms before I forcibly dilated the os uteri.

The following case will shew the danger of delay in such instances.

Several years ago, I was summoned to a patient at the same period of pregnancy as the above. She was a person of remarkably lax habit, and had copious floodings in several of her confinements. On this occasion she had been exerting herself at the garden in pulling up vegetables, and went home very much fatigued. When I saw her, at 6 a.m., she was very much depressed, tossing about in bed, and bathed in cold perspiration. She said that she felt as if she should burst; and the abdomen was very hard and distended. There was no appearance of hæmorrhage externally; but I felt satisfied that blood was being effused into the uterus, and was convinced that she could not continue long, unless something was done for her. I sent a messenger immediately for Mr. Wright; but she died before he arrived.

I made a *post mortem* examination of the body the same day, in conjunction with my friend, Mr. Thomas Wright. We found the placenta separated throughout its whole extent, and the uterus distended by an enormous coagulum.

In this case, doubtless, the hæmorrhage had been going on slowly during the whole night; and there seems very little question that, if the patient had been seen sufficiently early, and prompt measures had been adopted, her life might have been saved. I apprehend that some sudden exertion or strain in these cases produces a slight separation of the placenta; that the blood which is then effused acts as a wedge to detach more and more of it, until in time the whole mass may be separated without any blood escaping from the womb. I do not remember to have met with any account of such cases in obstetric works; and I should be glad if some-

of the readers of the JOURNAL would favour us with their experience in relation to this subject.

I think it worthy of remark that no stimulants were administered in the case first narrated. I am satisfied, from my observation of the effects of brandy in cases of flooding, that it tends rather to favour the continuance of the hæmorrhage than otherwise; and, therefore, I have for some years entirely discontinued its use in such cases, and I believe that my patients have had, not only less hæmorrhage, but a more rapid recovery, in consequence.

Reviews and Notices.

THE PHYSICAL EXAMINATION OF THE CHEST IN PULMONARY CONSUMPTION AND ITS INTERCURRENT DISEASES. By SOMERVILLE SCOTT ALISON, M.D. Edin.; Fellow of the Royal College of Physicians, London; and Physician to the Hospital for Consumption and Diseases of the Chest, Brompton. Pp. 447. London: Churchill. 1861.

APART from its merits or demerits in regard to details, this work of Dr. ALISON is one of no commonplace kind; since it opens up the way for a discussion on the practical utility of the modern aids to diagnosis, in the prognosis and treatment of disease. Are these aids to be regarded as improved substitutes for, or only as auxiliaries to, those general semeiotic indications which have in all past ages formed the main guide of the physician? This is a wide question; and to endeavour to answer it in its details is not our duty on the present occasion. Still we may, in a word, express what we believe to be the *juste milieu*—that the information derived from the physical aids to diagnosis has proved of the highest value to medicine; but that, in nearly all, if not in all cases, it requires to be conjoined with and tempered by the observation of symptoms, in order that it may be made applicable to diagnosis, and (what is of the highest importance) to prognosis and treatment.

These reflections on the bearings of the now pending case of physical signs *versus* symptoms have arisen out of the remarks with which Dr. Alison commences his book. He there, at first sight, throws in the weight of his authority—the authority of a physician to a special hospital for diseases of the chest—in favour of physical signs.

"If," he says, "the question were proposed to me, whether, in the case of a patient supposed to suffer from pulmonary consumption, I would be disposed to regard as the more decisive of the question, evidence afforded by symptoms, or that given by the physical signs ascertained by the examination of the chest, I would reply, that I should much prefer the physical signs as the grounds on which to form my judgment." (P. 1.)

His main reasons for the preference here indicated are: that the symptoms of pulmonary consumption are more common to it and other maladies, and are more variable in their accession, than are the physical signs. There can be no doubt of this as a general rule: but he also admits (here virtually contradicting a theory advanced a few years ago by a highly talented and industrious colleague of his at the Brompton Hospital) that

"In a large number of cases of phthisis, at an early period of the first stage, there is much reason to confess

that physical signs are little developed. Numerous examples of phthisis, at an early part of the first stage, present themselves without our being able to detect physical evidence that can be held to be decisive. Even in examples of the disease of some months' standing, occurring in my own practice, physical signs have been so ill-marked as to have justified suspended judgment; and it has only been by means of subsequent evidence, that a decided conviction could be arrived at that the disease was all along pulmonary consumption." (P. 3.)

This candid avowal of the occasional fallibility of physical signs is sufficient to shield Dr. Alison from the charge—which might have arisen out of the paragraph first quoted from his book—of unduly exalting them as absolute and indisputable. And when, after this, he shows how percussion and auscultation in chest-disease in a measure take the place of examination of the secretions, or of ocular observation of disordered structure or function, in diseases of other organs, he goes no further than we are disposed to follow him. The point, then, at which we arrive, is this: that, as soon as physical examination of the chest can be brought to offer any indications in a suspected case of phthisis, these indications must be received as our principal guides in determining the presence or absence of the disease, and its actual stage.

Turning now from the general question to the book itself, we find that it is divided into three parts: of which the first, containing thirty-nine chapters, is devoted to the elaborate examination of the signs presented in the several stages of phthisis; the second, containing six chapters, to a description of the various means of investigating the condition of the respiratory organs; while the third consists of a reprint of various papers bearing on physical examination, which have been published by Dr. Alison in sundry periodicals. To attempt to analyse or criticise *seriatim* a work of such detail, and in regard to some of the special points in which so many different opinions may be held, is a task far too great for our space. Our attention, then, must be limited to a few salient points.

A principal peculiarity in the work is the assigning to perforation or pneumothorax a place as a *fourth* stage of consumption. Dr. Alison says that "he has found perforation or pneumothorax so common an event, and it is signalised with such strongly marked characteristic signs, that he has been induced to make this pathological condition a stage by itself—the concluding stage of the disease."

Perforation, Dr. Alison says, is a natural consequence of progressive excavation; and it would be almost inevitable, but for the presence of pleural adhesions in the third stage. Yet he is satisfied that it does occur in a considerable proportion of advanced cases of phthisis; and that it is not more often recognised he attributes to its occurrence at a period when the condition of the patient not only denotes examination to be useless, but generally calls for non-disturbance and quietude.

"The physical signs," says Dr. Alison, "of the fourth or perforation stage are very remarkable and interesting. A greater difference holds between these signs and those of other stages of phthisis than between those of any two of the other stages. The most conspicuous signs of the fourth stage, in reference to auscultation and percussion, are absolutely new, and not a mere increase of those of another stage. They take the place