and in this way it may be continued with advantage for many weeks, and even months.

Chlorate of Potassa, like glycerine, has won various opinions as to its influence upon consumption. By one physician it has lately been considered even as a *specific*, whilst by others it has been deemed altogether a failure. After a careful analysis of its effects in the twenty-five cases, I came to the conclusion that it was very far from a *specific*; and that its usefulness was seldom apparent, except in those cachectic cases in which it and allied remedies are frequently serviceable.

Quinine, in doses of one or two grains twice and sometimes three times a day, although well suited apparently to a few of the twenty-five cases, generally produced disappointment; its effects being, as a rule, inferior to those of many other tonics. It would seem that quinine, like chlorate of potass, is chiefly useful in a certain class of cachectic patients, in which, irrespective of the tubercular condition, such agents are very generally prescribed. Several of the patients, however, who had scarcely benefited by the quinine alone, improved subsequently under the combined influence of quinine and iron.

Phosphoric Acid was prescribed in doses of fifteen minims two or three times a day. In three or four cases, it seemed to produce pain in the bowels, with nausea and loss of appetite; although, as a general rule, it agreed very well. Only three cases improved materially under its influence; whilst several of those in whom there was a moderate improvement benefited much more under other treatment. Phosphoric acid may be classed amongst the mineral acids as a general tonic in phthisis, but seems to me inferior to some of them, especially the *hydrochloric*.

The following table shows the general effect of these various agents upon the twenty-five cases in which they were administered.

	Considerably improved.	Slightly improved.	Not improved.
1. Phosphorus	4	5	16
2. Liquor Potassæ	1	2	22
3. Hydrochloric Acid	11	6	8
4. Iodide of Iron	10	4	11
5. Iodide of Potassium	6	5	14
6. Chloride of Sodium	8	6	11
7. Vinum Ferri	13	3	9
8. Glycerine	4	2	19
9. Sesquichloride of Iron	12	5	8
10. Chlorate of Potassa	5	4	16
11. Quinine	7	5	13
12. Phosphoric Acid	3	8	14

It must not be forgotten, in estimating the therapeutic value of these different substances, that this is illustrated by the table rather *comparatively* than *absolutely*; since we must not exclude from its proper share in the result the combined influence of hope, rest, good diet, and general hygiene, under which, even by itself, many phthisical cases are well known to undergo very considerable improvement. The figures, indeed, can only be taken as a fair expression of the *comparative* usefulness of the various agents as therapeutical auxiliaries to general treatment.

The experiments to which I have thus briefly alluded, and which will be found more fully described in my papers in the *Medical Times and Gazette*, appear to be suggestive of the following general conclusions.

1. Since, during the administration of each one of the agents described above, several cases of phthisis were observed to run through the various phases of the disease, some even to a fatal termination, it is obvious that, whatever the amount of benefit which in some cases followed their use, no one of such agents deserves the title of "*specific*".

2. It may, therefore, fairly be concluded that the good effected by any of these agents was due to their respective tonic and upholding influence upon the general system.

3. In the majority of phthisical cases, steel (especially the sesquichloride of iron) and the mineral acids appear to be the most effective; but tonics generally are productive of more or less improvement.

4. Since, however, even steel and mineral acids, as well as other useful tonics, are undoubtedly inert in a certain proportion of cases, it is not improbable that there are varieties or modifications of phthisis, each of which may require a particular treatment. As there are special varieties of many other diseases, requiring special modes of treatment, and yielding to none other, it is possibly the same with consumption.

I would observe, in conclusion, that I think we are too apt to consider and to treat phthisis as a separate and always similar disease, disregarding the almost endless varieties it presents. Whether such varieties are dependent upon original differences in the nature of the disease itself, or are determined by peculiarities in the individuals it may attack, we at least have before us a large field for experimental therapeutics. My own idea is, that the time is not distant when observation and experiment will show that, under certain at present obscure conditions of system, phthisis assumes definite and special forms, each of which requires definite and special management; and that the "therapeutics of phthisis", which many may now consider both unsatisfactory and unpromising, will contribute, some day or other, to great and unexpected results. I am not so sanguine as to look for a *specific* in consumption; but that the disease will ultimately prove as amenable as many others to proper management, is, I hope, not a mere day-dream.

TARTARISED ANTIMONY AS A REMEDY IN STRUMOUS OPHTHALMIA.

By William Price, M.D., Surgeon to the Metropolitan Infirmary for Scrofulous Children; Surgeon to the Metropolitan Establishment for Scrofulous Adults, Margate.

A short but valuable notice, from the pen of Mr. Edwin Chesshire, appeared in a recent number of the British Medical Journal, on Tartarised Antimony as a Remedy in Strumous Ophthalmia. That the plan of treatment therein recommended is both little known and little practised, I am fully convinced; and my object in again bringing the subject forward in these pages is to endorse the statements of Mr. Chesshire, in the hope of inducing practitioners to follow this mode of treatment on a more extended scale.

During the past six years, 109 cases of strumous ophthalmia, occurring in children under 15 years of age, have been admitted into the Metropolitan Infirmary at Margate. Out of this number, thirty-eight suffered with photophobia; and twenty-five had either vascular corneæ or phlyctenular ophthalmia. They had been all, or nearly all, treated by the administration of tartarised antimony in small but repeated doses; and, save in a few instances, with the most marked and decided benefit.

My attention was first directed to this plan of treatment in the Paris schools; and the success I there witnessed attending its employment, induced me early to forsake the more routine practice of giving cod-liver oil and tonics. It must not be supposed that I have overlooked the beneficial effects of sea-air and a liberal diet upon the London poor when removed to this salubrious climate; for the cases mentioned have been generally those in which the children had resided some short time by the sea-side.

Amongst a large number of private cases annually coming under my care, I cannot call to mind a single instance in which tartarised antimony has been prescribed. From this circumstance I gather, too, that surgeons rarely resort to, or do not sufficiently appreciate its singular efficacy in certain cases of ophthalmia occurring in scrofulous subjects, in the adult as well as in the child.

Transactions of Branches.

SOUTH-EASTERN BRANCH: WEST KENT DISTRICT MEETINGS.

LACERATION OF THE PERINÆUM.

By WILLIAM HOAR, Esq., Maidstone.

[*Read at Dartford, April* 20, 1864.]

I HAVE made choice of the subject of Laceration of the Perinæum during Labour, not because I have anything of my own to relate concerning it, but in order to draw from those around me their experience and practice; and I think all will agree that it is a matter of no small importance.

There are, of course, various degrees of laceration; from the merest "nick" in the fourchette, to the terrible rent passing through the sphincter ani into the rectum; but, having regard to treatment, I divide them into two classes; viz., 1, that extending as far as (not through) the sphincter; 2, through the sphincter into the rectum.

We will consider: 1. When it occurs; 2. How it occurs; 3. The best means of preventing it; 4. Treatment.

Before proceeding to these points, it is hardly necessary for me to allude to the anatomy of the part, which is very simple; but we must not forget the semilunar membranous fold, a little behind the fourchette, which, however it may be torn in the first days after marriage, is not unfrequently a distinct item in the resistance offered to the passage of the fœtus in a first labour, and in which one form of laceration commences.

1. The most usual occasion on which laceration of the perinæum occurs is, of course, a first labour; although, in cases where the first child is small and the labour much protracted, it may occur at subsequent labours for the first time, if the fœtus be very large and the labour rapid.

2. How does it occur? What is its cause?

It is generally laid down that the most frequent—nay, almost the only—cause of laceration of the perinæum, is the passage of the head through the vagina, and the vulva especially; and, no doubt, that is sometimes the cause when the head is large and hard, the perinæum rigid and unyielding, and the pains rapid and powerfully expulsive. In such cases, I believe, the rent first begins in the semilunar membranes on the inner surface of and within the vagina; and extends outwards and forwards to the margin of the perinæum, and backwards towards the anus.

I am of opinion, however, that there is a far more frequent cause of laceration, whenever it does occur, which acts subsequently to the expulsion of the head. I make it a rule, immediately after the head has passed through the vulva, during the lull that almost always occurs after those terrific pains that have expelled it, to ascertain that the margin of the perinæum is entire; and having satisfied myself that such is the case, I have been astonished to find, when the whole fœtus has been born, a laceration of the perinæum. I could not, for a long time, make up my mind as to how this state of things was produced. I thought it must arise from the passage of the pelvis of the fœtus; but, after close observation in the few cases that have come before me, I am convinced that, in most, if not all, it occurs at the moment when the hands, folded over the chest, emerge through the vulva. And it is not difficult to understand how this may happen; the chest, we know, is not much less in girth than the head; it well-nigh fills the calibre of the vagina; by itself, it would readily and easily follow the head, without damage to the wall of the vagina; but, upon it, increasing its dimension considerably, and that not equally, but at one point especially, with a sharp angular projection, are the hands; which, I believe, when the perinæum is not soft and yielding, or when the chest of the fœtus is unusually large, cause the tissues, tightly stretched over them, to give way.

3. How is the accident to be prevented?

I do not hesitate to say that, occasionally, laceration of the perinæum is inevitable, and its occurrence does not necessarily indicate want of either skill or attention.

In unusually rapid labours, where you have a wide shallow pelvis and an os uteri that dilates quickly, with a rigid unyielding perinæum, a large fœtal head, and powerfully expulsive, quickly recurring pains, the occiput comes down upon the perinæum in a few hours; there has been no time for preparation of the external parts, as it were; and, with the most vigorous efforts possible to restrain and hold back the head from making a hasty exit into the world, you cannot succeed, but find, to your disappointment and annoyance, a considerable rent in the perinæum. These cases do and must occasionally occur. In ordinary labours, I believe, there is no better plan than using the left hand, protected by a napkin, to steadily and gently support the perinæum; at the same time, during each pain, when the head is pressing on it, drawing it forwards so as to stretch and elongate it. In the subsequent stage, after the passage of the head without damage to the perinæum, the prevention of laceration is easy, but not practicable, by the same means of supporting with the hand; the shape of the parts over which the tissues are stretched forbids it. The most efficient means is to take advantage of the interval of ease which almost always occurs after the expulsion of the head, and hook down the arms, one after the other, by sweeping them over the chest, thus removing the prominence over the sternum entirely or rendering it less salient. This proceeding is, of course, rarely necessary after the first labour, except in cases where the perinæum is rigid or the fœtus very large.

4. Treatment of laceration when it has unfortunately occurred.

We need not be over much disturbed at the appearance of the rent, unless it extend into the rectum through the sphincter (a very serious case); for that which, directly after labour, appears a terrible slit of enormous extent, in the course of a few days will seem a trifling lesion, which, with care and attention, readily heals, and is of no material consequence; the only points to insist upon are quiet, rigid cleanliness to be observed by the nurse, and care to ensure that the evacuation from the bowels be soft and lax. Sutures are of no use, but rather undesirable; they soon ulcerate out, and only alarm the patient and her friends.

In the more formidable case, where the rent extends into the rectum, one need not despair. I have never had such cases; but records of them exist. The last that I have found is recorded in our JOURNAL in 1861 by a Dr. Robertson. He kept the patient per-