had expired.* Her labour was quick and natural, and the membranes and placenta were quite healthy. She is now suckling a fine infant, and doing well.

What was the source of the fluid in these cases? It evidently came from the sac of the amnion in the first case; and in the second case, it appears to have had a similar origin.

Excessive discharges are spoken of by writers on midwifery as taking place in pregnant women from the vagina and membranes of the ovum to the extent of many quarts; but the sudden and profuse loss, followed by shrinking of the abdominal parietes, leave little doubt but the cavity of the amnion furnished the fluid in the two cases under consideration. In the first case, the patient did not go her time; the infant was puny and feeble, and a part of the placenta and membranes diseased, as might have been expected; but in the latter case, it is remarkable that the woman in her weak and delicate state should have dragged through the full term of utero-gestation, and then have given birth to a healthy child. She never remembered to have been so large in her previous pregnancies, and often expressed a dread of having two children at a birth. The other patient also said, at an early period of her pregnancy, that her size was much greater than formerly.

A dropsical condition of the amnion would account for the patient's great size. During gestation, she suffered severely from painful flatulence and dyspepsia, hiccup, short dry cough, and great œdema of the legs and ankles. Her breathing was so embarrassed that she frequently sat up during the night, or propped herself up with pillows, from fear of lying down.

During my limited experience I had never before met with two such cases; and I must own that they entailed considerable anxiety.

RETROVERSION OF THE GRAVID UTERUS: THE BEST POSITION DURING ITS REDUCTION.

By Thomas Skinner, M.D., Liverpool.

The Association did me the honour to publish in the Journal for 1860 a series of papers on Retroversion of the Gravid Uterus. As objections have been made in reference to the position of the patient recommended in my essay, as well as to the hand being introduced into the rectum rather than into the vagina, I must beg a little space to answer these same objections.

The position which I have put forth, and which I still maintain is the best, is "the patient upon her left side, the pelvis well raised, the shoulders low, and the thighs as much flexed upon the abdomen as possible." (Journal, 1860, p. 949.) It is objected to this position that it ignores the aid of gravitation; but I cannot see how it does so. I think that the position sufficiently favours gravitation; and that in the great majority of cases it will be found quite enough so for all practical purposes.

It has been recommended in preference, that the patient should be placed with the lower extremities in bed, the pelvis over the side of the bed, and the elbows and hands on the floor; and the observation has been made that this position can be maintained for a considerable period. I cannot agree in this opinion, as in Mr. Wall's and many other cases where this position was tried, the taxis had to be stopped and renewed at intervals, the position being found to be both irksome and tiresome. This position is further open to the following objections, namely, that of raising unnecessary fears on the part of the patient; of being most repulsive to the natural modesty of even the most callous of the sex, and the fact, that the reduction has been and can be easily accomplished without it; besides, to invert a female in the puerperal condition should never be done if it can be avoided, as it determines the blood to the head and chest, harasses the breathing, and entirely prevents the aid of anæsthetics.

With regard to the statistics of the point at issue, I may state that I have collected all the facts on record connected with seventy cases of retroversion of the gravid uterus; of these, nine were placed with the lower extremities in bed, and the upper extremities on the floor. In five of them, the taxis was successful, while in four, it entirely failed; of the four failures, three died. In the remaining sixty-one cases, although the position assumed is not positively stated in all of them, yet there are sufficient facts to lead me to infer that they were not inverted. They were placed chiefly upon the left side, upon the back, and a few of them on "all-fours." In the great majority of these sixty-one cases, the taxis (chiefly on the left side or back) was successful; and in a few of them, catheterism alone, without the taxis, was sufficient to reduce the displacement. In fourteen cases, the patients died. Add to these statistical facts, that I have myself repeatedly reduced the retroverted gravid uterus with ease; and that I have never employed any other position but the one I have recommended (except once in a difficult case, where I placed the patient on her back); and I think that we have sufficience of guarantee, not only of the success attending the practice; but of evidence that the profession hitherto have not generally adopted the practice of inverting the patient; nor do I think that they are likely to do so even now, except under the pressure of circumstances, or as a *dernier ressort*.

It has been argued, that inverting the patient is best, because the uterus is pear-shaped. Let me remind those who think so, that the uterus begins to lose this form about the third month; that between this term and the fifth month (the most prevalent period for the occurrence or the detection of retroversion), it gradually becomes spherical; after which, and up to the full term of gestation it again becomes pyriform.

Lastly, objections have been made to the hand being slowly introduced into the rectum (as a last resource, and when all other means have failed, puncture of the bladder or uterus being excepted), and there seems to be some doubt entertained as to the possibility of doing so. There need be no doubt, as the operation has already been done by several of the most distinguished members of the profession, and with comparative success; as instance, in Mr. Weir's case, when all the most approved methods had been attempted in vain. The operation, or a somewhat similar one, is performed very frequently for *fissura ani*; I have seen Professor Simpson do so; and I have repeated the operation myself with the greatest ease. It is not nearly so difficult an operation as *à priori* we might be led to suppose, especially when we resort to the use of certain adjuvants I have alluded to in my essay, namely, steaming, the warm bath, inunction, venesection, tartar emetic, opium, and more particularly the use of chloroform.

As the rule in ordinary cases, I have recommended the first *two fingers* of the right hand *per rectum*.

* See an interesting case of Retrocession of Labour, by Dr. Charien, recorded in the *Half-Yearly Abstract of the Medical Sciences*, vol. xxx, p. 256.

Oleum Morrhuæ Ferratum. Fifteen parts of proto-sulphate of iron are precipitated by fourteen parts carbonate of soda; the precipitate expressed; and after the addition of little water, digested for two hours and a half in a water bath, with two hundred and fifty parts cod liver oil. The deep brown mixture readily becomes clear in a bottle, and soon thickens on exposure to the air. The oil is said to contain about one per cent. of iron. (*Amer. Jour. Phar.*)