tinued to pass from the wound for more than a fortnight. The slough (for the two spots of gangrene had by that time coalesced) separated on the eleventh day of her stay in the house, and the wound assumed a healthy appearance. The communication with the gut appeared to contract to two small sinuses, from which air might be seen to bubble up. After the first fortnight, the faecal discharge intermitted for about a week, and finally ceased about a month after her admission. Large bed-sores, however, formed on the back, involving all the coverings of the sacrum, and it was from the exhaustion occasioned by these that she seemed to sink. No other symptoms were observed except constipation of the bowels, which persisted during the rest of her life, requiring the constant exhibition of gentle purgatives. She died on the 26th of December.

I subjoin the notes of the *post mortem* examination, made by Dr. Ogle:—

There was a large and deep sore above the pubes, and in the right groin, which had healed to a great extent. The muscular walls of the abdomen were, to all appearance, perfectly natural. The general surface of the peritoneum was natural. The great omentum was tied down by adhesions between it and the abdominal parietes below and in front of the caput coli and a small knuckle of the ileum; and the appendix caeci were also attached to the parietes in the same neighbourhood. The former intestine adhered by a long band; the latter was closely united to the abdominal wall. The appendix was exceedingly thickened and indurated, but, nevertheless, quite pervious, as far as the point at which it adhered to the parietes. Owing to the general thickening and hardness of the parts around these adhesions, it was impossible to demonstrate the exact spot where ulceration had existed in the appendix caeci, but there had doubtless been such ulceration originally.

The transverse colon was adherent to the under surface of the right lobe of the liver; and in the latter a large collection of pus was found, communicating with a foul discoloured cavity, formed by ulceration of the walls of the gall-bladder and the neighbouring portion of the substances of the liver. One or two small biliary calculi were found. The state of the gall duct could not be ascertained. The other viscera were natural.

Original Communications.

PLACENTAL PRESENTATION.

By SAMUEL BEECROFT, Esq., Hyde, near Manchester.

Mrs. H., aged 34 years, a weak delicate woman, had had three living children. I visited first time April 1st, 1855, when she stated that she had been flooding for a few days, but the discharge was not very great; she said she was about a month from her time. I prescribed rest and astringents; and there was not much discharge until the night of the 12th, when she parted with a large quantity. The hæmorrhage had ceased when I saw her; and, on a vaginal examination, I found that the os uteri just permitted the introduction of the finger. I detected, as I thought, a placental presentation. As there was no hæmorrhage going on, I recommended a continuance of the previous treatment. All went on well until the 14th, when hæmorrhage returned with great violence, and reduced her so much that, on finding the os uteri dilated about the size of a shilling, and lax, I thought that I could deliver her without any great difficulty, and at once determined to operate.

As anticipated, I did not find the difficulty very great. By inserting the fingers separately, the os uteri kindly dilated, and I passed my hand without great force into the uterine cavity, turned and carefully brought away the child, which was alive, but very feeble, its body dragging the placenta along with it, as, on separating the child, a

portion of it was visible, protruding through the os externum.

The poor woman bore the operation very well; but the hæmorrhage still continued, a constant draining away of blood going on; and, although pressure was constantly kept up in the abdomen by myself and pupil, and though the womb felt small and contracted, and notwithstanding the application of cold, the introduction of the hand within the uterine cavity (which was scarcely admissible), the administration of ergot, opium, brandy, etc., she gradually sank, and died in somewhat less than three hours from delivery.

I was allowed to make a *post mortem* examination, and found the uterus not larger than usual, its interior containing nothing; it was very pale, with the exception of a few inches round the circumference of the os uteri, which presented a raised pile of bright red capillaries, against which I supposed the placenta had been placed. Here, in one spot, there was slight ecchymosis; and, meandering in the submucous tissue, there was a moderate sized vein, though I could not detect its open mouth. The whole of the walls of the inferior portion of the uterus were very thin, and apparently deficient in muscular development, which I thought might arise from the position of the placenta interfering with its growth.

REMARKS. I have had three cases of complete placental presentation, besides the one now related; two terminated favourably, one of which made a rapid and complete recovery, while the other ultimately did well, though suffering from extreme debility for months afterwards. In both of these cases the hæmorrhage had not been so profuse as to make delivery compulsory until the os uteri was moderately dilated. The third case was such an one as Mrs. H.'s case, the os uteri at the time of delivery scarcely being of the size of a shilling; though, from the frequent recurrence of hæmorrhage placing the woman in such a critical state that I was afraid to leave her lest she might have a violent recurrence of it, which might be fatal, I felt called upon to deliver her, the operation being somewhat difficult, as the os uteri was rigid. She continued afterwards in a very dangerous state, from the great loss of blood; and some slight discharge still existed, though, on the whole, I thought her doing well, until, the friends imprudently bringing her downstairs on the seventh day, a return of severe hæmorrhage took place, and she died a few hours afterwards.

If I might venture an opinion, from the experience of these cases, I should say it would be advisable to defer delivery to the utmost possible limits; for it does not to me appear improbable that, if by any treatment we could wait until the os uteri was pretty well dilated, the placenta would be from this cause so much detached that afterwards, on delivery, the bleeding uterine surface would not be so extensive, and consequently less danger of hæmorrhage. I would also wish to know if the plug has been fairly tried, and if it has not succeeded in checking the hæmorrhage, when effectually applied, in cases of undilated os uteri, so that it might have time to dilate prior to commencing delivery; for it appears reasonable to think that on its use no blood could escape into the uterine cavity; and, as none could escape externally, and as the plug might stimulate the uterus to contract, its use appears rational.

In Mrs. H.'s case the operation was borne well; and I have no doubt she would have recovered, if the hæmorrhage—which I think came from the uterine capillaries—subsequent to delivery, had not recurred.

P.S. Since writing the above, I have seen Dr. Barnes' paper, read before the Medical Society of London, on 22nd of December last; but I am afraid that neither he nor Dr. Cohen has discovered the true principle of treating cases of the kind above described; as we occasionally find, as in the last case I had, that in partial placental presentations, when the os uteri is so much dilated that the cervical portion of the placenta must be detached, hæmorrhage still goes on, and delivery is required.