joint, "mixed up with a great deal of hysteria". The patient, a stout healthy young woman, seemed to have a facility of throwing the toe of the diseased limb on the ankle of the opposite side, with hysteric shortening, like actual dislocation. It is probable, in such instances as this, we have the opposite limb stretched out so as to relieve a fancied or real irritation in the hysteric articulation, or we may have a condition allied to hemiplegia. Mr. Erichsen ordered the compound steel mixture and good diet, and some fomentation if necessary. This patient is much improved by the treatment.

HYDATID TUMOUR IN THE MAMMARY GLAND

Mr. COOPER FORSTER removed a very interesting tumour from a woman's breast at Guy's, on the 8th inst. At first sight, it had all the appearance of a fibrous growth, and had much of that hardness which might be mistaken for scirrhus. When enucleated, however, from the mammary gland, it proved to be a bunch of hydatids, enclosed in a thick cyst, till opened, when it seemed very like a small bunch of grapes: each hydatid was most perfect in outline. The mammary gland is not an usual situation for such parasitic developments; the liver, the peritoneum, the muscles, the brain, the spleen, kidneys, and bones, rather being affected; so that the case is worthy of notice, as one of the pathological contingencies to be calculated on in diseased breast. The parent hydatids contained large quantities of the *echinococcus hominis*: and it was something of a satisfactory nature to be able to tell the poor woman that the growth was purely accidental, and in no way allied to cancer.

Mr. BIRKETT removed a large mass of encephaloid cancer from another patient on the previous operating day. The contrast was something very remarkable.

RECURRENT FIBROID TUMOUR.

Mr. PAGET operated on a large recurrent fibroid tumour on one of his last days of operating at St. Bartholomew's. The growth appeared as a huge cauliflower shaped granulation, lying over the femoral artery, in the third part of its course, near the knee. There was a good deal of hæmorrhage. The woman bore the operation well, though this had been the seventeenth time it had been performed. The character of the growth, as to its malignancy or non-malignancy, judging from the constitutional effects on the system, the affection of neighbouring glands, or the microscopic peculiarities of its constituents, had undergone less change than might have been expected. The woman appeared healthy for a person undergoing a seventeenth operation.

In another of Mr. Paget's recurring fibroid cases, the last production removed by the knife was scarcely to be distinguished from encephaloid; so that these fibrous growths form a link, as it were, between the so called innocent or benign and true malignant formations: indeed, clinical experience, rather than the microscope, must decide in many instances.

VALUE OF THE TREPHINE IN MOLECULAR NECROSIS OF LONG BONES: DANGER OF TUBERCULOUS DEPOSITS OR TUBERCULOUS VOMICE IN BONES BURSTING INTO JOINTS.

Mr. ERICHSEN operated, on the 18th ult., in a case of what he termed molecular necrosis of the centre of the tibia. The articular ends of the long bones, according to this eminent surgeon, are peculiarly liable to this affection; the end of the tibia very commonly; that of the humerus more rarely, but next in order. Chronic osteitis, as we have seen in the practice of Mr. Stanley, is also another form of disease, as well as cysts in bones, which occasionally call for the use of the trephine.

The case was that of W. P., a man apparently in good health otherwise, but who had suffered severely from pain in his knee. The limb affected was rather wasted and shrunken than swelled. About five years ago, he stated, he had an acute attack of what was most probably synovitis of the knee joint, for which he was treated at Mar-

gate, and subsequently in some of the London hospitals. He had issues on each side of the knee, and the joint became quite ankylosed. For the last three years previous to admission to hospital, he has suffered much from severe pain at the inner side of the head of the tibia, with nocturnal exacerbations of this agony, the pain being of a gnawing, throbbing character: yet one could detect no enlargement whatever of the bone, or obvious cause for so much suffering. One tender spot alone could be traced in the bone, but no enlargement or periosteal thickening.

Mr. Erichsen decided on the 18th ult., to trephine the tibia; and the man having been placed accordingly under the influence of chloroform, an incision was made over the painful part of the bone. The crown of the trephine was next applied, and sank readily into the cancellous structure, as though the shell of compact tissue had been thinned or eroded. It was very doubtful if pus came away; one of the assistants observed what he thought were indistinct traces of such a deposit. Some dark soft spongy bone was, however, next gouged away, the wound stuffed with little bits of lint, and cold lotions applied, to moderate the inflammatory action which might arise in such close contiguity of the knee-joint itself. The patient has done well, and has lost all his pain, while healthy granulations have sprung up. Mr. Erichsen believes that tubercular deposits may occur in bone, a very marked instance of which we conceive we saw recently under the care of Mr. Lawrence at St. Bartholomew's. A tuberculous vomica, in point of fact, may burst into a joint like that of the knee. K.

Original Communications.

PLACENTA PRÆVIA.

By GEORGE KING, Esq., Bath.

Two or three years ago, there was a good deal of controversy going on in our journals on the subject of placental presentations, and the treatment to be adopted. The detachment of the placenta or any portion of it, and the flooding that must necessarily follow before labour, must at all times create some little uneasiness in the mind of the practitioner, and would be likely to alarm the patient; and we may be pretty sure that the interposition of art and manual assistance will be required to complete the labour. On examination in these cases, we generally find a small portion of the placenta presenting. But it is not often that we find the whole mass of placenta blocking up the uterine outlet. Having met with such a case a few weeks since in consultation, I think the history of it may be interesting, and perhaps instructive to my fellow-associates.

CASE. June 3rd, at about five o'clock in the morning, I received a note from a friend in the country, wishing me to come to his assistance immediately. The case was one of flooding, with presentation of the placenta. On arriving at the house, which was seven miles distant, at about seven o'clock, I understood that the patient was a very timid nervous lady, who had had seven or eight children, and always "good times"; the nurse and those about her having generally done what was necessary, without the interference of the medical attendant. The lady had a great objection to men-midwives, as she had always had such easy labours. The husband and family were the more anxious and alarmed at the untoward circumstance that had occurred.

I was informed that at three o'clock in the morning the patient felt a desire to pass urine, for which purpose she got out of bed, when a frightful flooding came on which filled the *pot de chambre*. She fainted, and fell on the bed in a seemingly lifeless state. My friend, her medical attendant, was immediately sent for. On his arrival, the hæmorrhage had ceased, and the patient was in bed, much exhausted

from the discharge. On examination, he found the os uteri slightly dilated; but there was no pain, and he rightly diagnosed the case to be one of the placental presentation. The state of the patient was reported to the husband, who wished assistance to be procured: I was therefore sent for.

On my arrival, I learnt that the patient had only a few days before returned from a watering place, where she had been to consult a physician about the health of her son. The opinion was very unfavourable, and this seemed to prey on her mind. She came home full of mental anxiety, and with her body distressed from fatigue. This condition of mind and body, and the loss of blood she had sustained, had placed her life in imminent peril, and had ill prepared her for what she had to undergo. After sundry little foolish obstacles had been got over about my seeing her, I was permitted to make an examination, the result of which was not very satisfactory, as there was no pain and no hæmorrhage. I was not justified in pushing the examination sufficiently far to enable me to form a perfectly accurate opinion of what was going on. The cervix uteri was flabby; there was no pressure on the os, nor was it much dilated; the index finger indicated a smooth unyielding surface, certainly not like a shreddy piece of placenta. As our object and aim was to secure the patient against the continuance or recurrence of the hæmorrhage, there being no syncope, I was satisfied there could be no internal discharge going on; and therefore thought it wise to discontinue my exploration, and wait till the patient rallied a little.

About midday, the nurse informed us that the patient had a pain, and she thought the discharge was returned. We directed her to bring us the napkins; their appearance clearly proved that the membranes were ruptured. My friend made an examination, and reported that the os uteri was rather more dilated, and that there was a slight discharge. We talked over the case, and agreed that the time was come for us to do something in order to save our patient. We thought that if we could excite the action of the uterus a little, we should be doing good; and that a dose of ergot would stimulate the expansive action of the uterus, and promote its contractile power after its contents had been withdrawn. But the surgery was four miles off. Having, however, servants and carriages and horses at our command, these appliances for annihilating time and space were set in motion, and the ergot was soon procured. A drachm was boiled, and the decoction given to the patient. In about half an hour afterwards, there was a slight action of the uterus, and we proceeded to deliver. It was arranged that I was to find the child, and my friend was to complete the delivery; nothing was to be left for the mother to do.

When I began the operation, I did not find the os uteri so much dilated as I expected. The neck of the uterus was very lax, and I had much difficulty in dilating it. The moment I came into contact with the placenta, the flooding came on. The whole mass of placenta was impacted in the cervix uteri, not adherent. The part of the placenta presenting at the os was near the insertion of the cord, and where the membranous lining is very firm and strong, and the vessels large and very vascular, it required great force to push through it. The moment my hand reached the cavity of the uterus, there was a most awful gush. It poured off the bed into the vessel in a frightful manner. Although I knew most of it was liquor amnii which had passed through the placental mass, it had a very sanguineous appearance. The quantity was great, and must have been a great shock to the patient's system; it shook the nerves of her attendants. I found the child lying across, one hand imbedded in the placental mass. I soon found one of the legs, and without searching for the other, pulled it down in order to put a stop to the discharge. My friend finished the delivery, while I firmly grasped the uterus through the walls of the abdomen; and we had the satisfaction of bringing into the world a fine living child, and having the mother doing as well as could be expected.

About ten days after the confinement, she complained of a pain in one of her legs, which ended in phlegmasia dolens. This was treated first with calomel and leeches, and subsequently with bandaging the limb, and now all is going on well.

REMARKS. The above case is one of accidental hæmorrhage; and I think the child was the innocent cause of the accident from the situation in which I found its hand. I have no doubt that it had been thrust through amnion and chorion into the placental mass when I found it. By this accident a small quantity of the liquor amnii escaped, which got mixed with the blood within the membranous lining of the placenta (in removing a placenta entire, we generally find a large quantity of fluid blood in it); this was the sanguineous fluid which was expelled by the first action of the uterus after the accident, and which, from its quantity, produced such a shock to the system of the patient as to cause syncope, and create much alarm to the family. The first effect of the reaction of the uterus was to propel the placenta already implanted in the cervix uteri to the os; and this put a stop to the flooding, and prevented any further mischief.

The attack of phlegmasia dolens that followed (or *crural phlebitis*), which I think is a much more expressive term, might have been expected after such a labour. Dr. F. H. Ramsbotham says: "Those who have suffered a lingering and painful labour, and particularly those in whom profuse uterine hæmorrhage has taken place before or after delivery, are by far most frequently the subjects of this affection." This patient had both these pre-disposing causes to a high degree.

Clinical Lectures:

DELIVERED IN

ST. BARTHOLOMEW'S HOSPITAL, LONDON.

BY

F. C. SKEY, Esq., F.R.C.S., Surgeon to the Hospital.

NO. IV.

ON LITHOTRITY: THE USE OF CHLOROFORM IN THAT OPERATION.

I WISH to-day to say a few words about a case of lithotritry we have had in the hospital. The subject is one of some extent, but I do not propose to enter into it at any great length, as this is one of the last days of the summer session. When it is remembered that the deaths from lithotomy are certainly 25 per cent. on the whole number of cases, and something almost frightful in old patients, you will at once recognise the very grave necessity which exists for a proper appreciation of the relative dangers of the two operations, and the different details connected with both.

The operation of lithotritry is now as perfect as perhaps it is likely to be, chiefly through the labours of Heurtebout, and, in later years, of M. Civiale (recently in London). It is not as "showy" an operation for the great operator as lithotomy; but our duty to society should be our first thought—what is best for our patient; and our duty to the profession and ourselves will come in better after that.

I will mention a case, and on that hang a few observations as we go along. This case is the instance of a clergyman who was unfortunately afflicted with stone in his bladder. When I first saw him, my stonest lithotrite almost failed to crush the stone, it was so unusually large. I succeeded, however, in breaking it sixteen or seventeen times, and did not leave a trace of it. I broke it once. I broke it twice; but I was particularly struck with this fact, that one does not know the specific amount of irritability of the bladder in each case till manipulation with the lithotrite shall have been performed a few times. A stone gives pain, I think, in some not very indirect proportion to the size of the stone; and the capacity of the bladder to hold water is