that is inseparable from a free division of the conjunctiva, Mr. Walton has long advocated the importance of making as small an incision as possible; and for several years he has, by accurately operating, cut through no more than actually covers the insertion of the muscle. But although this fulfilled the desired intention as far as the circumstances could admit, the entire desideratum was not obtained, a greater or lesser degree of vacancy at the inner corner of the eye yet remained, and the objectionable fungous granulations would still sprout from one or other edges of the wound, but almost always the inner. To overcome these imperfections, he has tried different plans and methods. The suggestion of severing the muscle with a very narrow knife, either curved or bent at an angle, and introduced through an aperture in the conjunctiva large enough only to admit the blade, has been fully tested and rejected by him, because of the great uncertainty of completing the operation, especially where the commissure of the lids is small, or the eye sunken, or the conjunctiva very loose. But there is no greater objection to it than when the subconjunctival tissue is thickened, no uncommon occurrence, and one that cannot be foretold. It is hardly necessary to remark that the first and main object in treating strabismus, by practical surgery, is to set the eye straight. Although Mr. Walton is an ardent admirer of subcutaneous myotomy and tenotomy, wherever they can be employed, he has not seen any adaptation of either to squint that can be so well relied on, or is so generally applicable, as the plan he usually adopts.

He is aware that some surgeons operate by making an horizontal incision, and after securing the muscle, introduce the scissors and use them beneath the membrane. His objections to this, from what he has seen and his personal knowledge, are the uncertainty of taking up all of the rectus; less uncertainty, it is true, than when the knife is used subconjunctively, but an uncertainty still exists, and besides this, the likelihood of the ineffectual application of the scissors. But the horizontal slit does not prevent the fungous growth alluded to; it is required to be larger than is generally supposed, in order to admit the scissors, and hardly therefore comes under the spirit of the term subconjunctival; added to which, it does not entirely prevent dropping of the caruncle. With no slight experience, he adheres to his old method modified or improved by the suture system; for he holds that, in consequence of the anatomical disposition of the parts, he can be certain always of having effectually operated, only when it can be ascertained by sight, that no portion of the rectus is undivided; till in fact the hook is seen to traverse a certain space free.

The preliminary steps of the operation, to which it is necessary to allude, may be disposed of in a few words. Mr. Walton makes a small vertical cut through the conjunctiva, just over the tendon of the rectus, and at about a line from the margin of the cornea. After the muscle is divided, there is always a considerable separation of the superficial wound, the retraction being chiefly on the inner side; in other words, the conjunctiva gapes in a remarkable manner. It is immaterial through which lip the suture is first placed, and the choice of side may be made a matter of convenience. A small, but not very diminutive needle, not sharp at the edges, because it should pass with as small a hole as practicable, and armed with an ordinary ligature, is what he uses. Let us suppose that the parts are to be stitched from without inwards. He lays hold of the lip of the conjunctiva with a pair of forceps, and passes the suture as near the edges as possible. Having drawn the thread through, the other lip is taken up (and it requires often to be sought for, because it retracts much and folds on itself,) and treated in the same manner. If the needle is passed at some distance from the edge, there would not only be inaccurate adaptation of the surfaces, but the conjunctiva would be rendered tighter than natural, a condition that might influence the position of the eye. Two sutures are generally employed, one at the upper, the other at the lower part of the wound. As in other parts of the body, Mr. Walton does not cut the threads short off, but leaves a certain length of end, that they might be the more readily found when required for removal. As a rule, the sutures are taken away on the third day. Often, at this time, they have partially or entirely ulcerated through.

Not only does no irritation proceed from this method, but the traces of the operation are very much sooner lost. A patient is not aware that sutures are present. Union is rapid and certain. Fungous granulations do not sprout. The natural disposition of the tissues at the corner of the eye are interfered with less than under any known plan of operating. Eversion and prominence of the eyeball must, we are sure, be in some degree prevented by it.

Original Communications.

CASE OF LABOUR ATTENDED WITH COMPLETE OCCLUSION OF THE OS UTERI.

By JOHN HATTON, Esq., Consulting Surgeon to the Chorlton-upon-Medlock Dispensary, Manchester.

[Read before the British Medical Association, July 30th, 1857.]

ABOUT seven o'clock on the evening of June 19th, 1857, I was sent for by Mrs. Morris, midwife, to see Ellen Faulkner, residing under 9, York Street, Chorlton-upon-Medlock; who, the messenger informed me, was in labour. I was told, moreover, that the midwife could not make out the presentation.

On reaching the house, I ascertained that the woman's age was 40; that she had been married three years; that this was her first pregnancy; and that she had been in labour since the preceding evening. The midwife, who was first called to her at eleven o'clock in the forenoon of to-day, informed me that since that hour, the pains had been regular and severe; but that there had been no discharge of any kind, and that she could not satisfy herself as to the presentation of the child. On introducing the finger, I came upon the smooth ample surface of a globular body, pretty low down in the vagina, behind which, on pressing upwards in the absence of a pain, I detected what I imagined to be either the head or the breech of the fœtus. I now sought for the os uteri, but in vain. The vagina being amply dilated, I larded my left hand, and carried it up the hollow of the sacrum to the promontory, when its progress was arrested by the reflection of the mucous membrane on the before mentioned smooth expanded body, the fingers everywhere passing over an unbroken surface; no os uteri could be found. I must confess that I was puzzled, having never before met with anything in a labour involving so much obscurity; and when I repeated my examination, it was with the same unsatisfactory result.

Under these circumstances, I sought the aid of my friend Mr. Robertson (whose experience is so well known, and whose matured judgment is at all times so readily given to his professional brethren). He came to the same conclusion as myself; viz., that no os uteri could be detected, observing that "you might almost as well feel for one in a smooth iron plate." We repeated our examination very carefully, and now imagined that we detected a slight degree of puckering or rather roughness on the surface of this body, not in the centre of it, but rather towards the left side of the pelvis, which roughness we concluded might possibly prove to be the site of the imperforate os uteri.

The poor woman had now been twenty-four hours in labour; and as the pains were strong and regular, accompanied with occasional attacks of vomiting, and as the smooth tumour presenting in the vagina was evidently nothing else than the lower portion of the womb largely dilated and expanded by the pains, we determined to puncture in the supposed situation of the os; and this we effected by means of a pair of sharp pointed curved scissors, when out gushed a quantity of liquor amnii. This opening we extended with a blunt pointed bistoury. We could now feel the head presenting naturally, and we also discovered that we had punctured so exactly through the os uteri, that its smooth, thin, rounded anterior lip formed a portion of the margin of the opening which we had made. The aperture was speedily enlarged by cutting it in four directions, in the form of a cross, to about the size of the mouth of a tea-cup; and on the instant it became occupied by the fœtal head.

Chloroform was given in the hope of promoting dilatation, but without much effect; and as the woman was shewing signs of exhaustion, by almost incessant vomiting, a clammy skin, and a feeble pulse, and moreover, as the pressure of the child's head, from the pains having become stronger and more expulsive, must soon lacerate the opening, we decided still further to enlarge it with the bistoury, and to effect delivery. The woman had not felt the movements of the child for a considerable time; and as we could not detect by means of the stethoscope any sign of fœtal life, a sense of duty compelled us to open the head, which was easily effected with Mr. Robertson's one-bladed perforator—more than two hours having been allowed to elapse from the time of perforating the uterus with the curved scissors. After the contents of the cranium had been freely evacuated, the craniotomy forceps

were applied—one of us guarding the edges of the os uteri and the perineum, whilst the other made traction very slowly with the forceps. Thus cautiously proceeding, our efforts ere long were crowned with success; and the child passed into the world without causing the smallest injury to the soft parts of the mother. The placenta soon followed, the uterus contracted, and there was no hæmorrhage. The vomiting immediately ceased; a drachm of laudanum was administered; and we left her comfortable.

June 20th. This morning the poor woman is perfectly easy; she has had no vomiting; she has passed a tolerable night; the pulse is only 64; and she has thrice voided urine.

7 P.M. The patient is perfectly comfortable, with a nice moisture on the skin; there has been no vomiting.

June 21st. She is rather feverish this morning; pulse 88, and slightly intermittent. The lochial discharge is pretty free. No inconvenience has arisen from the secretion of milk. I ordered half an ounce of castor oil.

June 22nd. The castor oil has operated freely. She is now free from feverishness. The lochial discharge is scanty and rather offensive. The weather is very hot. She was ordered to be well washed, and the bed clothes and linen to be changed.

June 23rd. She expresses herself as being so well that she wants to get out of bed and sit up. From this period she rapidly recovered, and took no medicine, except an additional dose of castor oil.

July 25th. To-day we endeavoured to take a photographic view of the os uteri, but were unable to procure a distinct impression upon the glass, in consequence of the light being insufficient. The parts are perfectly healed; the os uteri appears to be almost as though it were a natural one, with the exception of the cicatrices of the crucial incision.

REMARKS. In the course of an extensive midwifery practice, I have never met with any case at all resembling the present. Judging by a digital examination, there might never have been an os uteri. The case is enveloped in mystery, in so far as the woman has never, from what I can ascertain, had any symptoms which would lead to the conclusion, that there had been disease of the womb. She states that she has menstruated regularly from the age of sixteen; that she occasionally suffered some degree of pain previous to the discharge; and at times that she has had slight leucorrhœa.

At the time I attended this case, I could not call to mind ever having heard of a similar one, nor could I gain any information on the subject from my English works on midwifery; but on referring to the article "Dystocie" in the *Dictionnaire de Médecine*, by MM. Desormeaux and P. Dubois, I met with the following observations.

"Imperforation of the neck of the womb becomes an obstacle to parturition, only so far as it is accidental, and the result of disease which has occurred since conception. The existence of this complication was for a long time denied. It is true that accoucheurs have allowed themselves to be deceived by an obliquity of the uterus; and that the uterine orifice has sometimes escaped the most minute examination, even in cases where the cervix has been placed under the eye of the physician. But it is also demonstrated by facts of anatomical pathology, that the orifice becomes completely obliterated, in consequence of inflammation of the mucous membrane which invests it. Such a state of the uterus renders the vaginal Cæsarean operation necessary, as described in the observations of Flammant and Lobstein, those of Caffé and others, in order to give birth to the infant; for it is the only resource which art possesses against this complication."

Chomel again, in the same work, observes: "Sometimes the uterus is imperforate, and the obliteration is due to a membrane which appears to be a continuation of the vaginal mucous membrane, that is to say, that beyond this membrane, the uterine cavity exists as in ordinary; such was the anomaly spoken of by Benevoli, cited by Boyer in his *Maladies Chirurgicales*."

On referring to the *Lancet* for 1851, I find the particulars of two cases recorded; one by the late Dr. Sheppard of Stonehouse, and the other by Dr. Roe of Plymouth.

In the case of the former, however, he could detect a puckered fossa which admitted the tip of his finger; and Mr. Whipple, who assisted him, was able during his examination to break down the intervening false membrane between the sides of the neck and os uteri; in the instance before us, we had nothing of the kind to guide us. In Dr. Sheppard's case, moreover, the os uteri was of a semi-cartilaginous character, indicating pre-

vious disease, whilst, in ours, there was no manifestation whatever of this.

The circumstances which justified our opening the foetal head, appear to have been somewhat analogous to those in Dr. Roe's case; for I am fully persuaded that, if we had longer delayed the operation, the poor woman must have succumbed.

LARGE TUMOUR OF THE BACK, OF FORTY-SEVEN YEARS DURATION.

By WILLIAM COLLYNS, Esq., Surgeon, Alington.

MARY WILLS, aged 77, at the age of 30 first felt a soreness and pain in her back, high up between the scapulae. She then ascertained that there was a small swelling in that situation, of about the size of a chestnut; but, as the pain ceased, she took no further notice of it for about ten years. At that time, finding it had increased to the size of a large orange, she showed it to me. I found it to be an indolent tumour, rather soft, as if containing medullary matter, not at all adherent to the skin or fascia. It caused no pain, and very little inconvenience. I proposed to remove it, and frequently urged an operation; but she would not consent, and for a long time avoided me.

I did not see her after this for twenty years, when the tumour had grown to an immense size. I prevailed on her to let me take her to Exeter in the year 1848, to show it to the South Western Branch of the Association, then about to assemble there. It was then estimated at the weight of 25 lbs.; and one of the members offered to remove it at once, but she would not consent.

On recently returning to this neighbourhood, after a long absence, I was astonished to find that the woman was still alive. She had been confined to her bed for two years, and was wasted to a mere skeleton. The tumour, which had increased in 1853 to the supposed weight of 40 lbs., had also been gradually wasting, but was still of an enormous size, hanging half-way down her back, with very large veins passing under its flaccid skin. It gave no particular pain, though tender on being examined, and raised up. The length of the tumour now is 2 feet 9 inches; the breadth, 16 inches; the circumference, just below its upper part, is 12 inches; round the lower part is 24 inches. She is a pauper, and her means of subsistence on 3s. a-week, allowed by the Board of Guardians, are very limited; and she has not received any allowance for a nurse, because she has a husband, who is allowed by his late employer 5s. a-week, being a cripple, and unable to do any labour. Being unable to pay for a nurse, she has employed a widowed daughter, and has maintained her for two years; whose great care and attention to cleanliness have no doubt prevented sloughing and consequent suffering.

British Medical Journal.

SATURDAY, AUGUST 15TH, 1857.

DEATH OF DR. MARSHALL HALL.

It is with deep regret that we announce the death of Dr. Marshall Hall, one of the most distinguished physiologists that has graced the present century. For a long time past this eminent physician had been suffering from an affection of the throat, supposed to be cancerous; and on Tuesday last, he succumbed to the disease. Like a true man, he continued his valuable exertions almost to the last. We trust to be able, at an early period, to give a sketch of the life of this eminent labourer in the field of physiological inquiry.