The uncovered portion of the cornea was normal, as was the iris as far as it could be scrutinised, and the anterior aqueous chamber. The conjunctiva covering the lower lid was more red than natural; in other parts, it was healthy. The patient was sometimes troubled by a copious flow of tears, which were not scalding; also with occasional brow headache. The left eye was quite well. His appetite was impaired.

An operation for the removal of the tumour was proposed, but declined by the patient; and I lost sight of him. If he had consented, the eye, which was certain, as the tumour increased, to be destroyed by inflammation, etc., the results of pressure, would have been saved, and useful vision regained. Tumours occupying a like situation have been removed successfully by V. Stöber* and Rau.† They require careful dissection by the knife, and the application of escharotics to parts which do not admit, from their close union to the cornea, of removal by cutting; also to any after reproductions of the tumour. When their connexions with the surface of the cornea are particularly intimate, the surgeon must endeavour to cut off their vascular supply by excision of portions of conjunctiva in their immediate vicinity, or by application of a stick of pointed lunar caustic to their main feeding trunks. A combination of these means may be needed. Tumours the seats of which are limited to the epithelium of the cornea present generally either a granulated or a warty appearance. Of the one, Mr. Wardrop, in his *Morbid Anatomy*, has given a good drawing; of the other, Mr. Bowman has recorded an interesting case in his *Lectures on the Eye*. But when they originate from the sclerotic conjunctiva and its subareolar tissue, they more frequently assume a lobed or lobulated form. In a case that I had an opportunity of examining, the disease ensued in a youth, from an attack of purulent ophthalmia, that had been at its onset inefficiently treated; the tumour appeared to contain, within a lobe that extended over the cornea, fat.

The grounds for believing that, in the case detailed by me, a piece of straw was retained under the sclerotic conjunctiva, and gave rise to the formation of tumour, may be briefly stated as follows:—The history of the case shows a close relationship between the morbid growth and the accident, for in six months afterwards it had attained size sufficient to obstruct the lid and the vision of the eye by covering the cornea: an hypertrophied and fungous condition of the conjunctiva has been proved, by dissection in other cases, to follow the impaction of a foreign body beneath the superior conjunctival fold: and, had the conjunctiva been simply wounded, and no foreign body left behind, a pedunculated tumour, if one of any kind, and not a sessile growth, would have been the consequence, as, for example, after the operation of strabismus.

CASE IX. DESTRUCTION OF THE LEFT EYE FROM INJURY; NEURALGIC AMAUROSIS OF THE RIGHT OF FOURTEEN WEEKS DURATION, SIMULATING SYMPATHETIC INFLAMMATION OF THE RETINA AND CHOROID, CURED BY REMOVAL OF A FOREIGN BODY FROM THE CORNEA. A young man, weak and emaciated, and affected with frequent dry cough, presented himself at the Eye Infirmary for advice, July 1st, 1853. The *right* eye was unable to bear the light of day, which was clouded; the *left* was blind, tolerant of light, and collapsed in its anterior chamber. Of the latter, the following account was obtained:—Fourteen weeks previously, a chisel broke in his hand, and a portion of it wounded the left eye severely, then and for ever destroying its vision. He was immediately taken as in-patient to a medical charity, and in five weeks the eye was comfortable, with the exception of occasional pains. The right eye, three days after the accident, became dim—for a day or two he could see nothing whatever with it; after which red flashes continually played before it; and at this time objects were seen more distinctly at the distance of a yard and a half than at any other range. It was examined, water

dressing applied, and an encouraging prognosis given. The eye gradually grew worse.

Present State. There were oculodinia, intolerance of light, and epiphora. Suspecting from the history, that I had to deal with a case of sympathetic traumatic ophthalmia, as a preliminary to the investigation of the internal structures of the eye, I directed him to sit with his back to the window, and to endeavour to read some printed capital letters of more than an inch in height. With considerable hesitation, he named five of them, when his visual power became exhausted. He said that the first letter appeared dim, which strengthened my impression of the case being one of chronic posterior internal ophthalmia. An examination, however, of the eye in profile, and in a subdued light, discovered upon the cornea a small dark foreign body opposite the superior circle of the iris, which was brown, and of normal appearance; not a shade of opacity dimmed the former membrane. The foreign body—a particle of stone—of the size of a very small pin's head—was firmly set in the cornea, and required much force to displace it, indicating that ulcerative action, which is usual in such cases, had not taken place. The patient was ordered a blister to the temple, and to take five grains of cinchona three times a day. Good diet. In less than a week, his eye was tolerant of light, and its vision perfect; the cough had nearly left him, and his general health had improved much.

This case is illustrative of the difficulty of discovering a dark foreign body when placed opposite an iris of brown colour, unless the organ be viewed in profile; a precaution which, I am almost sure, was not observed prior to my seeing the case, otherwise the particle of stone would not have escaped notice from the able surgeon who had care of the patient before his admission at the Eye Infirmary.

Birmingham, May, 1854.

CASES ILLUSTRATING THE DIAGNOSIS OF DISEASES OF THE HEART.

By W. O. MARKHAM, M.D., Assistant Physician to St. Mary's Hospital.

THE subject of Diseases of the Heart has been of late perhaps more extensively handled than any other of medical investigation; but that much still remains to be investigated, in the matter of their diagnosis, pathology, and treatment, is proved by the experience of those who have carefully studied this class of diseases. With respect to their diagnosis, we have the latest and a most high authority assuring us that physicians have in general gone much further in a minute and accurate discrimination of the various maladies which affect the heart, than a wise and cautious experience justifies. "I cannot," says Dr. Stokes, "even at the risk of being charged with understating the position of physical investigation at the present day, avoid expressing my opinion that a too great positiveness marks some of the statements in our standard works, and that the difficulties of special diagnosis are still infinitely greater than many might be led to believe." Some persons who peruse Dr. Stokes's pages will doubtless think that he often carries his caution too far, and that he sometimes halts in his judgment where the facts would seem not to warrant hesitation; but every wise observer will thank him for the wholesome lessons of "prudence and modesty" which are inculcated throughout his work.

That we have much to learn yet concerning the diagnosis of diseases of the heart, any one may readily discover by even a superficial investigation of the subject; he may arrive at the fact simply by comparing the discrepant statements of various authorities, and will obtain the positive demonstration of it when he comes to test his book-learning by the touchstone of clinical experiment. Hence further observation is required; and from the results of well-recorded observation alone can our stock of knowledge in this matter be increased. I have ventured to offer here some cases of diseases of the heart, which have been faith-

* *Annales d'Oculistique*, 1852, p. 182.
† *Wharton Jones' Manual*, p. 459.

fully recorded, and most particularly in the sense of their diagnosis. I have thought it better not to encumber them with the details of history, treatment, and complications; for this would have been to risk the chance of letting slip from view the main object under my consideration.

Ignorant as we are of the *whole* of the causes which contribute to the production of the *sounds** of the heart, how can we yet expect *certainly* in our determination of the causes which give rise to its *murmurs*? This is the idea which has been present to my mind in noting down these observations. I have endeavoured to record exactly what I heard during the life of the patient, and to bring the statement as nearly as possible into connexion with the condition of things revealed by *post mortem* appearances; and knowing, moreover, the difficulty of correctly appreciating facts of this nature even when they lie before us, I have seldom recorded any which have not been recognised by some other observer, and in particular by my friend Dr. Handfield Jones.

After simply stating, as briefly as possible, the physical signs observed before death, and the *post mortem* record, I have deduced therefrom such facts and conclusions as appear to me reasonably to result.

CASE I. DILATED HEART: FATTY DEGENERATION; HEALTHY CONDITION OF VALVES; LOUD FIRST BRUIT HEARD DURING LIFE; CAUSE OF THE BRUIT. April 12th, 1854. Mrs. F., aged 47, had probably long suffered from emphysema of the lungs. At the time of her entrance into hospital, the functions of the respiratory and circulating organs were extremely impeded; her face was blue, swollen, and puffed; the body was generally anasarcaous. Respiration was hurried and difficult. The heart's action was very irregular; its sounds were indistinct; a soft first bruit was heard only at the epigastrium, immediately over the xiphoid cartilage.

April 18th. To-day the first bruit was heard loud and distinct over the ensiform cartilage, and also over a line running outwards towards the apex of the heart, which lay low, and to the left of the nipple: it was also heard from the apex upwards to the left of the nipple. The first and second sounds were clear and natural over the aortic valves, and upwards along the aorta. A crumpling noise was audible with the first sound over the lower part of the middle third of the sternum. Percussion over the heart was extensively dull.

April 19th. The first bruit was heard as before. The second sound was everywhere loud and distinct over the precordial region. The blowing first bruit was most distinct at the ensiform cartilage. At the base of the heart, about the left of the nipple, a roughness was heard with the first bruit.

This woman died on the following day.

On *post mortem* examination, the heart was found much enlarged, weighing twenty-three ounces; it was pale and dirty looking, soft and flabby to the feel. Its cavities were all filled with dark semi-fluid black blood. Both ventricles were much dilated: the left was of natural thickness; the right as thick as or thicker than the left. The muscular tissue (examined by Dr. H. Jones) of both was in an advanced stage of fatty degeneration. A patch of roughness, from recent deposit of lymph, was observed on the back of the right auricle, and near it a loose flocculus of newly formed lymph. All the serous cavities contained more or less serous effusion, with the exception of the right pleura; the right lung being everywhere adherent, its lower lobe nearly solid, its upper lobes emphysematous and of irregular shape, the middle lobe having anteriorly a long tongue-like border projecting from it. The left lung was emphysematous. The abdominal organs were all highly congested with dark blood. Bloody serum was found in the peritoneum.

This case illustrates the fact that a cardiac murmur, not

aortic or arterial, may exist coincidently with a healthy condition of the valves of the heart. The fact is generally admitted, but its demonstration is rare; and the explanation ordinarily given of it too exclusive and absolute, viz., that the murmur arises from regurgitation of the blood, brought about "by enlargement of the orifices of the heart, consequent on the dilatation of the cavities". In the present case, such explanation is unsatisfactory; and for the reason that the orifices of the heart were not enlarged in proportion to the dilatation of the ventricles,* and that, to all appearance, the mitral and tricuspid valves were perfectly competent to the complete closure of their respective orifices. That the aortic and pulmonary valves were competent, was proved by water being retained in their vessels, when poured into them, without flowing back into the ventricles.

May we not very rationally, in the present instance, seek in the degenerated condition of the muscular fibre for the explanation of the bruit heard during life?

It is very comprehensible that valves may be healthy in their structure, and capable, and yet not perform their due offices; for it is certain that their perfect closure may be prevented by causes quite extrinsic to themselves, and other than their diseased states, as, for instance, through some imperfection in the muscular act by which that closure should be effected. A perfect contraction of the heart assuredly involves these considerations—that the muscular tissue of the ventricle and of the papillary muscles is healthy in its structure, that its vitality is efficient, and that the muscular action takes place in a right direction. But are these conditions fulfilled in cases of the nature here described? Are we not rather justified in the belief that the muscular act, in so far as it is concerned in the closure of the valves, is defective, or ill adjusted, when we consider the fatty condition of the muscles, and the displaced direction of their action? It is impossible to admit that, under such circumstances, the action of the papillary muscles (which, if perfect, continues during the whole period of the heart's systole) can be normal, or that such simultaneousness of action between these muscles and the walls of the ventricle, the least derangement of which, we may *a priori* conclude, would throw the valvular apparatus out of gear, can exist. But this deranged action will cause defect in function, and hence ensues regurgitation, and then, as far as we know also, of necessity a bruit.

The argument here used applies equally to the action both of the tricuspid and mitral valves. It is more than probable that the bruit heard in this case proceeded from the right as well as the left side of the heart; that is, that both sets of valves were defective in function: and this opinion I rest on the circumstance that, in the first instance, when the respiration and circulation were much oppressed, the bruit was heard only over the ensiform cartilage; and that, to my own observation, it was always heard loudest at that point. That the bruit arose from the left side, also, may be inferred from its clearness over the apex and upwards to the left of the nipple, and from the high degree of impediment suffered by the circulation.

That neither the valves of the aorta nor of the pulmonary artery had anything to do with the production of the murmur is clear, from their competence, as proved above; and from this also, that, over their site during life, no bruit was audible, but, on the contrary, their healthy sounds were heard.

The recognition of the fact that murmurs, neither aortic nor arterial, may exist coincidently with a normal condition of the valves, is admitted to be of considerable interest in a practical point of view; but the fact becomes of greater interest if regarded in the sense in which it has been here discussed, viz., that such murmurs may have not one only, but several, and very different causes for their production.

That there is still something yet further to be explained concerning these murmurs may also be inferred from the well known fact, that they are frequently observed to arise

* To prevent the use and repetition of the words "normal" and "abnormal", etc., I would remark that whenever I speak of "sounds", I mean the healthy sounds of the heart; and when of "bruits" and "murmurs", its unhealthy sounds.

* The orifices of the heart were certainly not much larger than natural in this case, the mitral admitted three fingers and the tricuspid four.

During the progress of certain acute diseases, typhus, the exanthemata, rheumatic fever, etc., all trace of them vanishing with the disease which produced them. In such cases, their causes have been attributed, not to any abnormal condition of the orifices of the heart, but to some deranged states of the blood, though what that pretended murmur-producing quality of the blood is has never yet been pointed out. There is indeed no proof whatever that what is called the watery state of the blood has anything to do with the arterial and venous murmurs so frequently heard in anæmia. Is it unreasonable to suggest, judging from the analogy of cases such as here described, that these cardiac murmurs may depend upon deranged muscular action of the heart? How can we account for the bruit as heard in the following case, except upon this supposition?

A roaring bruit, as it was described to me by Mr. I. B. Brown, was heard over the heart of a lad the day before I saw him, and this, together with great disturbance of the pulse and much pain at the epigastrium, caused naturally enough considerable anxiety to his friends. A purgative, however, relieved all the symptoms, and caused the bruit to disappear; and when I saw him, the heart's sounds were perfectly healthy, and the lad, a remarkably fine healthy fellow, as well as ever he was in his life. It appeared that he had been fatigued during the day, and on returning home, hastily swallowed a full meal, and drank a bottle of soda water, and then ran a race with another lad: indigestion and disturbed action of the heart were the not unnatural consequences; and may we not very reasonably conclude that such irregular action of the heart produced faulty muscular contractions, and that thus the closure of the valves was rendered incomplete, and so the bruit established?

If, in accordance with these views, we were to attempt a classification of cardiac murmurs, we should find them placed as depending, so far as regards their intrinsic causes, as follows:—1. Upon diseased conditions of the valves. 2. Upon temporary deranged actions of the muscular structure of the heart, caused by certain acute diseases, and other disordered states of the body. 3. Upon a permanently or occasionally disordered action of its contractile power, arising from the structural disintegration of its tissues, or from mechanical hindrances to its proper muscular movements. 4. From unnatural enlargement of the heart's orifices.

Another fact may be referred to as illustrated by this case. The first sound was heard distinctly over the ascending aorta, but over the ventricles it was replaced by a bruit; consequently we may fairly argue, that the first sound heard over the aorta is not produced by that cause which in health produces the first sound heard over the ventricles, but arises in the vessel itself; this position, which has long been maintained by German pathologists, has hitherto received little favour in this country. In the very latest English work published on auscultation, the first and second sounds, wherever heard over the thorax, are indiscriminately set down as of cardiac origin alone.

I may add as worthy of note, that a friction sound is recorded as being noticed with the first bruit, the day before the patient's death, about the base of the heart and to the left of the nipple. Could this have had its origin in the roughened surface over the auricle at the back of the heart?

This case teaches also, I think I may fairly say, that there are points of pathology whereof clinical observation gives us knowledge, and whereof the knife of the pathologist would lead him to take no account. As a mere anatomist examining the valves of this heart, the physician would, I believe, unhesitatingly say that they performed their function; but clinical observation proved that they did not, and thus is he compelled to seek elsewhere than in their own diseased condition, for an explanation of the failure in function of the valves.

CASE II. HYPERTROPHY OF HEART; LOUD FIRST BRUIT OVER LEFT SIDE OF HEART; INCREASED SECOND SOUND OF PULMONARY ARTERY; HEALTHY CONDITION OF VALVES. August 22nd, 1853. E. S., aged 14. Four months ago she had pains and swellings in her ankles, probably of a rheu-

matic character, but in no other joints; as these went away her heart began to palpitate, and since then difficult breathing and palpitations never left her. The heart's apex was felt beating beneath the sixth rib and to the left of the nipple; its impulse was heaving and extensive; a loud first bruit was heard over the left side of the heart, loudest immediately beneath and to the left of the nipple, but no second sound there was audible. The second sound of the pulmonary artery was remarkably loud; it was heard like a beat about the third left costal cartilage; and a thrill could be felt with it along the second and third left intercostal spaces. No bruit was heard over or along the aorta; its sounds were perfectly healthy. The first bruit was distinctly audible over the scapula. The cervical veins were not swollen.

Sept. 2nd, 1854. The heart's impulse was violent, felt far to left of the nipple and beneath the sixth rib; no second sound heard anywhere beneath the nipple over the heart. A loud first bruit was everywhere heard beneath the nipple, loudest at the apex and to left of the nipple; not heard along the aorta. The pulmonary artery second sound was remarkably loud, *heard like a beat* about the third costal cartilage. The aortic second sound was not increased in intensity. Percussion was extensively dull over the precordial region.

The breathing and pulse were rapid. The cervical veins were unaltered. Wheezings, occasional high pitched râles, and small and fine bubblings were heard at the end of inspiration beneath the left clavicle. A first bruit was distinctly heard behind over the clavicle. The pulse was small and weak. There was no œdema.

Oct. 27. Breath short. Cervical veins not swollen. Pulse small, regular, and rapid. The pulmonary artery second sound was very loud, and a thrill was felt with it; no second sound was distinctly heard beneath the level of the nipple, but it was heard over the lower part of the sternum (over right ventricle).

Nov. 1. A thrill with the second sound was still felt along the second and third intercostal spaces. During this month the symptoms increased in severity, the signs remaining unaltered, and caused the girl's death on the 26th November.

Post mortem. Both lungs contained many well circumscribed lobular-like masses, some as large as a walnut, which were condensed and dark red, and so rendered by hæmorrhagic effusions. The *left lung* was compressed and much diminished in size, apparently by the enlarged heart. The pericardium was generally adherent by old attachments; the right auricle of the heart much dilated lying to right of centre of sternum; the root of the pulmonary artery lay on a level with the second left costal cartilage, the root of the aorta and its ascending portion immediately to the right on a posterior plane, and about the centre of the sternum. The mitral and tricuspid valves each admitted three fingers; the mitral valves were slightly thickened; the other valves healthy. The heart weighed 14½ ounces. The liver was low down; all the abdominal organs were highly congested with dark blood.

The foregoing case has already been elsewhere noticed* by my friend Dr. T. K. Chambers, under whose charge it was at St. Mary's Hospital, but it is worthy of being placed on record here.

That the first bruit here heard was a mitral bruit, may be fairly inferred from the facts, that the cervical veins were not swollen, which they must have been, had regurgitation taken place through the tricuspid valves; that the tricuspid valves were found healthy after death, and the orifice they enclose not enlarged; that the second sound of the pulmonary artery was remarkably increased in intensity, showing a direct impediment to the passage of the blood from it into the lungs, produced by its regurgitation through the mitral orifice; that the function of the lungs was throughout seriously disturbed, and for a similar cause; and that the orifice of the mitral valves appears to have been as large as that of the tricuspid valves, *i. e.*, admitting, equally with these latter, three fingers to be passed through it.

Perhaps, in this case, we may safely infer that the regurgitation was brought about by the enlargement of the heart and the dilatation of the mitral orifice; but I consider it worthy of note, as possible, that the muscular action of the organ might have been impeded in its force or right direction, by the extensive adhesions of the pericardial surfaces, and by the attachments of the sac externally to the thoracic walls.

The increased loudness of the second sound of the pulmonary artery, as heard over the third left costal cartilage, was well marked, and was here a striking confirmation of the mitral regurgitation.

May, 1854.

PERISCOPIC REVIEW.

MIDWIFERY AND DISEASES OF WOMEN.

REPORTS ON BRITISH AND FOREIGN MIDWIFERY.

FIRST REPORT. BY JOHN ROSE CORMACK, M.D., F.R.S.E.

WITHOUT engaging, and indeed without attempting to follow a systematic arrangement of topics, it is proposed in future to give some classification to obstetric gleanings from cotemporary authors, and to mingle some remarks with these gleanings. We hope in this way to render the periscopic survey of midwifery more interesting, more practical, and more easily referred to.

Upon the present occasion, it is proposed to arrange the materials (notwithstanding their miscellaneous character) under the following heads:—

- I. TREATMENT DURING LABOUR.
- II. INDUCTION OF PREMATURE LABOUR.
- III. DISEASES CONSEQUENT UPON LABOUR.

I. TREATMENT DURING LABOUR.

POSITION OF THE PATIENT DURING LABOUR.

In this country the patient generally lies on her left side when the assistance of, or the examination by, the practitioner is required. In France, on the other hand, she is placed usually on her back. Sometimes the patient brings forth resting upon her arms and knees; but there is so much indelicacy and so little advantage in this position, that we believe it is in small favour among the refined classes in any country. An English country surgeon, however, in very large obstetric practice, recently informed me that a great number of women in his district preferred being delivered on their knees. They kneel against a part of the bed: and, when they are delivered downstairs, though their sleeping-room be above, he has often known them to walk up a ladder to bed after all was over!

Perhaps the position of lying on the left side is preferred in England from its being the most delicate, and also from its being quite suitable for the accoucheur in most cases. In tedious labours, ease is often afforded by the practitioner permitting an occasional change to the dorsal or some other attitude. It is important to remember that custom cannot always be allowed to determine the position in which our patient is to be placed; and that a routine system, whether it be English or French, ought to be departed from in numerous cases, as exigencies arise, and in accordance with the suggestions of practical science. With this remark, we would call attention to some suggestions recently published by M. HUBERT in the *Ann. Méd. de la Flandre Occidentale*.

M. Hubert says, that if turning is to be performed in a shoulder presentation, with the abdomen of the fœtus looking towards the back of the mother, it can be more easily accomplished when the patient is lying on her back. If the abdomen of the fœtus has the opposite aspect, its lower extremities will be found in contact with the anterior wall of the uterus, and therefore dorsal decubitus would be objectionable, because the attendant could not reach the feet, except by vigorously pushing forwards his hand in a state of pronation. In cases in which the waters have been discharged, should the patient be on her back, the arch of the pubis by compressing the forearm will soon benumb it, and so render it useless, and prevent its penetrating as far forward as may be necessary to accomplish turning. On the other hand, if the patient be placed on her elbows and knees, the operator can proceed very easily by introducing the hand in a state of supination, and pursuing in a line

almost straight and horizontal from behind forwards the anterior walls of the uterus. This attitude is, however, repulsive to most patients, and fatiguing if long continued. M. Hubert suggests a method by which he conceives all its advantages may be obtained without any of its disadvantages being incurred. He leaves the patient on her back, till he has succeeded in passing his right hand beyond the cervix; after which he causes her to bend her right thigh and leg, and then, whilst she turns, or is being turned, upon her left side, he gets her flexed limb below his right arm. He is enabled by this manœuvre to carry his hand along not only the left antero-lateral, but also along the anterior wall of the uterus, in search of the feet. When he has brought down the feet, he replaces the woman upon her back. M. Hubert affirms that he has in several cases obtained all the advantages from the plan now described, which he could have derived from placing the patient in the prone position, resting upon her elbows and knees.

RIGIDITY OF THE VULVA OBIATED BY INCISION WITH THE VIEW OF PREVENTING RUPTURE OF THE PERINEUM.

When the vulvar opening is too narrow for the passage of the child, art must interfere to save from rupture the less resistant perineum. If this be not judiciously and promptly done, we may have a laceration involving the vulva, the perineum, and the anus. It is therefore important to consider the proper operative proceeding in such cases. The French and German periodicals have lately contained several notices upon this subject, to which it seems important briefly to direct attention.

As M. PAUL DUBOIS pointed out many years ago, the incision ought to be made at the lower part of one of the sides of the passage. In this way the perineum and anus are out of danger from an extension of the incision during the expulsive efforts of the uterus; and the healing process is better accomplished, because the lateral wound which is made is out of the irritating influence of the lochial discharge. M. Paul Dubois recommends the incision—which is to be from one to two *centimètres* in length—to be made with a pair of common scissors rather than with the bistouri.

ESCHELBERG prefers the bistouri. During the interval between the pains, he introduces, upon a director, a Potts' bistouri between the head of the fœtus and the rigid vulvar ring: upon the recurrence of the pains, he so places the bistouri that its cutting edge is turned downwards and obliquely as regards the raphe, from which he keeps it about half a *centimètre* [one-fifth of an inch]. He then allows the incision to be accomplished solely by the pressure of the fœtal head: and he says that he is never in any fear of the incision so made being of too large a character.

INCISION OF THE CERVIX UTERI IN CERTAIN CASES OF DIFFICULT LABOUR.

A rigid condition of the os and cervix may prove so formidable an impediment to labour as to justify incisions. This occasionally happens when the parts are in a healthy state; but it occurs more frequently from the existence of malignant induration. Incisions may also be made with propriety when the os is undilated and it is necessary to apply the forceps, in consequence of the head of the fœtus being retained in a transverse position at the superior strait of the pelvis. In such circumstances it cannot affect by its pressure the natural dilatation of the cervix. The two following cases [reported in the *Journal de Méd. et de Chir.* for March 1854] which illustrate the advantages of incision of the cervix in each of the conditions referred to, occurred lately in the practice of M. P. DUBOIS, at the Hôpital de la Faculté.

CASE I. On the 13th Feb., at 2 A.M., a woman at the full term of her pregnancy was taken with labour pains. On the 14th, at 2 P.M., dilatation of the os was complete. She continued to suffer on the 15th; and on that day at 10 A.M., M. Dubois found the cervix stretched, and an annular stricture causing an evident impediment to the spontaneous termination of labour. Two incisions were made in the opposite sides of this ring by means of a probe-pointed bistouri [*bistouri boutoné*], and shortly afterwards the child was expelled.

CASE II. On the 17th Feb., a woman with a deformed pelvis could not bring forth in consequence of the head of the fœtus occupying a transverse position at the superior strait of the pelvis. Death of the fœtus being imminent, M. Dubois incised the cervix right and left, and being thus enabled to apply the forceps, extracted a child, which was well formed and full of vigour.

In incising the cervix, it is perhaps safer to operate with blunt-pointed scissors guided upon the finger, than with the probe-pointed bistouri; but if care be taken either instrument