have a very active life, and the disease is therefore slow in its progress. If we look to cancers of the uterus, we may see apparent contradictions to this statement, but apparent only. In the first place, a large proportion of so-called cancers of the uterus are really epithelial growths, seated on extensive cancroid ulcerations. Genuine cancers of the uterus are not so common, and when they are of the acute type, their course resembles that of cancer of the parotid in the old, both in rapidity and severity.

I shall conclude the present papers by drawing attention to one fact which alone would almost prove the identity of scirrhus and encephaloid, and their diversity from all other forms of growth: namely, that the primary scirrhous growth is followed by secondary encephaloid, and that in no case have any of the cancroid forms been attended with such a result. Fibro-plastic, when incompletely removed, breeds fibro-plastic, generally locally, rarely at a distance. Epithelioma, in like manner, is followed by outbreaks of epithelioma: and we may fairly challenge the production of one case in which an experienced microscopist, with good glasses and a knowledge of the case, has come to any other conclusion. This fact, incontestibly proved by the researches of earnest microscopists, is not invalidated by the opposition of those who have no knowledge of the microscope, and without, it may be, either time or inclination to learn.

(*To be continued.*)

ART. XI.— *On "Placenta Previa."* By R. W. O'DONOVAN, M. R. C. S., Belturbet.

IN giving the details of the four cases of "placenta previa" which I have met with in a practice of seventeen years, my object is to further the desire for obtaining professional statistics, and to assist with my mite the valuable records of obstetrical science.

CASE I.—May, 1842. I attended Mrs. Murry, a farmer's wife, aged 40, residing three miles from me: she was the mother of several children, all of whom she gave birth to without further assistance than that of an ordinary midwife. For ten days previous to my attendance she suffered from uterine hemorrhage, constant, but not severe. When I saw her she was dreadfully blanched—the bed saturated with blood—restless, excitable, and frightened at her state. On examination, I

found the vagina full of coagula, its structure soft and dilatable; the os uteri dilated to the size of half-a-crown; the placenta, rough and rugged, covering the entire opening. As it was my first case of this variety of "preternatural labour," I plugged the vagina well, and waited for an hour, that the os uteri might become further dilated before I should introduce my hand; at the expiration of this period I found the mouth of the womb considerably more patent. I could not satisfy myself whether the placenta was placed equally over the os or not; but, having gently insinuated the points of the three first fingers of my right hand in a conical form within the lips of the os uteri, and by a careful rotatory motion gradually dilated the os, pressing my fingers at the same time steadily against the placenta, I thus, with patience, and without much difficulty, dilated the os, and at the same time separated the placenta from its abnormal position; then, passing my hand above the placenta posteriorly, I ruptured the membranes, searched for and laid hold of both feet, and rapidly drew the child into the pelvis, and delivered as speedily as possible. The child was quite blanched and dead; with a cold hand on the uterus, I induced good contraction, and forced away the placenta by external pressure; with careful bandaging and padding the contraction was kept up, and the woman ultimately did well. She suffered from the consequences of hemorrhage, viz., "tinnitus aurium" and distressing palpitations, for a long period, and, indeed, never recovered her healthy complexion. This woman died of typhus fever after three or four days' illness, in the latter part of the year 1847.

Case II.—April, 1847. I attended Mrs. M'Donald, aged 28, also a farmer's wife, living four miles from me; she was the mother of four children. I found her alarmingly exhausted, pallid, very restless; pulse 90, jerking and compressible; she stated that about three weeks previously she first perceived a small gush of blood; it then ceased for one or two days, appeared again, and so continued, with intermissions, until the last three days, when it became constant, increasing in quantity, accompanied by occasional severe cutting pains.

On examination, I found the vagina distended with large clots, and the os uteri dilated to the size of a penny; the edges soft and dilatable, the placenta distinctly felt through the opening, and the fœtal head discernible above the pubes. I introduced my hand, forming my fingers into a cone, thus gradually dilating the os, and pressing against the placenta at the same time; it separated at its posterior attachment; I then, without

difficulty, ruptured the membranes, seized the feet, and quickly delivered the child, which was dead.

In the management of this case I experienced great difficulty from the extreme excitement and nervous irritability of my patient, who plunged and twisted about in the bed, screaming in a dreadful manner, and constantly calling out, "Leave me to God!" I can never forget the scene, which was trying in the extreme. She made a good recovery, and has borne two children since, without requiring medical assistance.

CASE III.—October, 1848. I was called to attend, with Mr. ——, an old apothecary, Mrs. B., aged 45, residing seven miles from me, in her fifth accouchement. In the previous December she miscarried, but from that period enjoyed good health to the third day previous to my visit, when she was attacked with slight cutting pains, which were attended with alarming hemorrhage, followed by repeated faintings; this state of matters continued until my visit at 2 P. M. I found her pale, exhausted, restless, and excited; pulse feeble and thready, with difficulty counted. The vagina was plugged with coagula, the os dilated to about the size of a crown-piece, soft and dilatable; the placenta covering the opening, distinctly felt; it was impossible, however, to say with exactness whether it was placed more anteriorly or posteriorly. Having removed the coagula, I proceeded to dilate the os, pushing before me the placenta in the manner detailed in the previous cases. Having detached the placenta, which also separated from the posterior wall of the uterus, I ruptured the membranes, seized both feet, and quickly delivered the woman. As the two previous children were dead, I felt an intense anxiety to try whether artificial breathing and warmth could restore animation, though the idea did not hold out much, if any, promise of success, as life appeared to be quite extinct. I left the mother in charge of Mr. ——, with instructions to remove the placenta, bind and pad tightly, and give her some wine; after the lapse of an hour's patient perseverance the little child began to gasp; at this moment hearing some bustle in the room where the sick woman lay, I proceeded there, and found my patient dead! the uterus distended with blood, the binder loose, and not padded; there was no external hemorrhage. The infant did well.

CASE IV.—April, 1857. Was urgently called to see Mrs. F., aged 33 (residing about ten doors from me), carrying her fourth child; she had been ailing all day, but continued occupied with her usual business: a few moments before I was sent

for, sharp cutting pains came on, accompanied by a profuse flow of blood; having been put to bed, I examined her, and found the os uteri dilated to the size of a shilling, the lips soft and full, vagina soft and dilatable, placenta felt distinctly through the opening. The third case having given me painful evidence of the impossibility of one professional man affording the necessary amount of care to the parent and child, I requested the assistance of another medical man, and carefully plugged the vagina. At the close of an hour's interval, the dilating pains having continued without intermission, the plug was removed from the vagina, and was followed by a considerable discharge of blood. Dr. Wade having made an examination, and agreeing with me as to the necessity of prompt interference, I at once proceeded to dilate the os and deliver my patient in the manner adopted in the previous cases. The placenta separated from its anterior attachment; having ruptured the membranes, I found the feet presenting, and having seized them, I quickly delivered without encountering any difficulty, Mrs. F., being exceedingly gentle and easily managed; the child was alive. I removed the placenta by external pressure. Mrs. F. recovered well, and was able to nurse her child; she, however, suffered from extremely severe after-pains, which yielded to an external and internal anodyne treatment. I have found a liniment holding chloroform in suspension rubbed over the uterine region, in this and similar cases, of great advantage.

Placenta previa (beyond all question the most fearful obstetric complication that the practitioner can be called on to contend with), whether considered in relation to the child, the mother, or the character of the medical attendant, requires that the *best practice*—that which affords the greatest chance for preserving the lives of both parent and offspring—should be well engraven on the mind; for, as a general rule, in the country at least, he can seldom have the benefit of a consultation, seldom time for a moment's reflection, while the life-blood of two human beings is rapidly welling away in his presence. Doubt, hesitation, or rashness may be equally fatal to both: it is not too much to say, therefore, that a thorough knowledge of what is best to be done under the circumstances is a matter of the deepest moment—fraught with the luxury of a recovered patient's thanks, or, on the other hand, a life-long regret.

That the best practice is not as yet *un fait accompli*, the records of the profession abundantly prove. On one side, the writings

of such men as Professor Simpson, Dr. Radford, and others, are opposed to the practice and opinions of men *at least* their equals. This divergence of opinion among men of rank is liable to produce doubt and hesitation, particularly in the minds of young practitioners. Whether the results of my own experience will tend to throw any light on the subject or not, I do not pretend to say; for statistical facts, though of unquestionable importance, can only lead a certain undefined distance on the road of inquiry, because it is quite impossible to aggregate a given number of cases, where all the details are exactly similar; and equally impossible to define or describe clearly and accurately those minute differences which are at once discernible to the practical physician.

While I cannot avoid differing with the teaching of men eminent in the profession, I do so with the utmost diffidence in myself, and the greatest possible respect for them, and with the conviction that my ideas are not entirely devoid of interest, being deduced from facts.

The first stage of the operation appears to me to be that which calls for the most careful investigation, being beyond question the most tedious, most difficult, and most trying to the patient and her attendant: in its management Dr. Churchill advises that "the points of the fingers be gently yet firmly insinuated within the os uteri, and then passed between the placenta and cervix, on that side on which we believe the placenta to be narrowest." My objection here is that the action is grounded on an assumption, and that the result may turn out diametrically opposite; for it is perfectly impossible to calculate with certainty at which side the placenta is narrowest, unless, indeed, in "partial presentation," and to such a case the teaching has no reference. In my four cases it was not possible to determine with any approach to certainty whether the placenta was equally implanted over the os and cervix uteri or not; in three it was found the greatest portion was placed anteriorly; in the fourth the reverse was the fact.

The primary idea in the action being the separation of the placenta, appears to me to be also erroneous. I consider the primary motive should be the dilatation of the os and cervix uteri, and, as a consequence, the detachment of the placenta; and, acting on this view, I dilate with a rotatory motion of my fingers, pressing my fingers at the same time steadily against the placenta, and forcing it from me, as the act of dilatation proceeds. Thus three important steps in the delivery go on "pari passu"—the dilatation of the os uteri, the suppression of

the hemorrhage, and the detachment of the placenta: nor is this distinction unreal or of little importance,—time, which is all important, is saved; and every moment taken from the entire period of delivery adds considerably to the chances of a happy result.

Dr. Barnes' theory of "hemorrhagic circles" is so novel and so interesting, I shall leave its consideration to men of his own status, with one remark: if the dilatation of the os uteri be not alone the cause of the hemorrhage, but also the means of its *arrest*, as he asserts, and in which opinion I fully concur, surely sound judgment would guide us to quicken and terminate this stage of the labour as expeditiously as possible. And if the surgeon can succeed in detaching the placenta to the extent of *three inches all round the os*, or "lower polar circle," as he defines it, the necessary contraction to close the bleeding vessels, and so prevent dangerous flooding, should, I conceive, present an aperture of from three to four inches, through which the hand, if presented with tact, steadily and gently, should pass; and the hand, having once entered the cavity of the uterus, should not, in my judgment, ever be withdrawn until it is accompanied by the child: there can be no possible motive for not doing so if the feet present; and beyond all question this is the safest practice for both parent and child. If the prostration of the mother is so great as to require some moments of rest, she will thus be in the best position to benefit by it, the hemorrhage being stopped, and the child within reach of the operator's hand, without having to introduce it a second time. But if the feet do not present, the operation of turning is not in reality either difficult or dangerous while the child is suspended in the "waters;" while, on the contrary, it becomes both difficult and dangerous if attempted after the waters have been allowed to drain off, and the uterus has contracted round the body of the child.

Besides, such a practice puts the patient to the agony and suspense of two operations, the first consisting of the dilatation of the os uteri, the detaching of the placenta, and rupturing of the membranes; and the second, the re-introduction of the hand, and turning the child, if then possible, and if not, the use of the crotchet.

It is my sincere and solemn conviction that this is not a state to which a patient or her offspring should be reduced by her medical attendant. I am equally convinced that all the resources of art and scientific skill should be brought to bear to shorten the entire period of the labour. Every woman anxiously

looks forward to the moment when the doctor commences any manual operation, with an earnest expectation that he is about to deliver her. Is it a matter of no importance to disappoint her—to shock her nervous system even in the slightest degree at such a moment! In ordinary cases a very trivial shock or disappointment has been productive of the most alarming consequences—how much more should it be dreaded in cases like the present, where, from the loss of blood, the nervous system is depressed often to the lowest state of irritability!

ART. XII.—*Additions to the Statistics of Fractures.* By DR. OSCAR HEYFELDER, of Munich[a].

DURING the years 1825 to 1854, in the University Hospital at Erlangen, there were treated 562 fractures, being an average of 18·7 per annum. The average number of the surgical patients received there every year is 634; from 1825 to 1829, inclusive, it was 450; from 1829 to 1839, inclusive, 350; from 1839 to 1844, inclusive, 650; from 1845 to 1854, 1000. For the last thirteen years the surgical clinique was under the direction of Professor T. F. Heyfelder. And out of 634 patients there were 18·7 fractures, or 1 in 34. So the proportion obtained by our statistics during thirty years does not agree with that obtained by Dr. Middledorpf[b] during three years in the Allerheiligen Hospital at Breslau; there the proportion of fractures to the surgical patients was 1 in 25.

The difference may be thus explained in some degree,—that Erlangen (22,000 inhabitants) is a much less town than Breslau (116,235 inhabitants). This hospital, therefore, admits much less surgical cases than a larger town, and especially less fractures; as well as extraordinary cases, particularly operation cases, which come to the latter from all the neighbourhood, and even from remote districts, to be treated in the University Hospital.

Of the 562 fractures, 50 were of the head, 65 of the trunk, 241 of the upper, and 196 of the lower extremities. Their

[a] [As in a former communication by Dr. Oscar Heyfelder in our pages, we altered his idiomatic style as little as possible, we feel under so much obligation to him for the trouble he must have taken to pen his observations in the English language, that we have wished to present his valuable essay to our readers as far as possible in his own words.—ED.]

[b] Beitrage zur Lehre von den Knochenbrüchen. Breslau: 1853.