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OF

MEDICINE:

A MONTHLY RECORD OF THE MEDICAL AND AUXILIARY SCIENCES.

तदेव युक्तं भैषज्यं यदारोग्याय कल्पते।
सचैव भिषजां श्रेष्ठो रोगेभ्यो यः प्रमोचयेत्॥
चरकसंहिता।

That alone is the right medicine which can remove disease:
He alone is the true physician who can restore health.
Charaka Sanhitá.

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THE
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TREATMENT OF WHOOPING COUGH.

By Dr. Paul Chiron, M.D.

Aconitum Nap.—At the beginning of the whooping cough, at the period of invasion. Cough dry, wheezing, incessant, each time that the child coughs, he carries his hands to the throat in grasping it. High fever, dry skin. This medicine is exclusively directed to the inflammatory element and the dry cough. The indication of Aconite is rapid and short duration of the whooping cough, but in return it is often reproduced. It can recur all the time that the inflammatory symptoms tend to re-appear and always take a marked predominance.

Ambra.—Cough increases when there are enough persons; cough hollow, spasmodic, barking, worse on talking or in bed, with high sound. Frequent eructations. Hoarseness. Pressure on the stomach and hypochondrium. Tickling in the chest. Acidity of urine. Fœtid breath. Prostration, anxiety, insomnia. Excoriation in the throat and trachea. Wheezing of the trachea during inspiration.

Anacardium.—Chagrin can cause the proxysmal cough; dyspnœa. Cough entirely shakes the patient; paroxysms of cough for three or four hours, excited by tickling in the throat. During the night without expectoration; during the day expectoration of mucus white and insipid or yellow, purulent and

bitter. Cough increased on speaking, or after eating (not during the time of taking food). Vomiting of food relieves. Enough of sneezing. After the cough yawning and somnolence. This medicine is almost entirely indicated for children who have bad character of the cough.

Ammon. Brom.—Cough comes suddenly. Cough dry, spasmodic, intensely re-appearing one after the other, and sometimes with moments of interval. *Cough sometimes continues during all hours,* particularly at night, being in bed. Sensation of irritation and tickling with heat and burning.

Angustura.—Violent cough, excited by profound irritation in the trachea. In the morning and during the day abundant expectoration of yellow mucus. Hoarseness from accumulation of very tenacious mucus in the larynx. Respiration intermittent, spasmodic; intense dyspnoea.

Antimonium Crudum.—Whooping cough with cough which gradually becomes more and more feeble, as if the pharynx will be closed. Without expectoration at night; during the morning expectoration of red, tenacious mucus, vomiting of drinks only. Involuntary urination. Feebleness or loss of voice. The entire body is shaken. Aggravation in hot room, by the sun and heat of fire. Desire for fruits and sour things.

Antimonium Tart.—Whooping cough provoked all the time, the child is angry or takes food. The cough progresses to vomiting of mucus and food.

Arnica.—Fit of coughing excited by sensation of repetition or sore in the trachea, bronchi and larynx. Cough generally dry, often with expectoration of frothy blood, mixed with clotted blood or glairy mucus of bad taste which the patient swallows down. Cough worse at night. Coughs until blood flows from the nose and mouth. The child cries during and after the fit; he places his hands upon the chest to sustain him during the cough. Swelling and redness of the left cheek with heat of the head and coldness of the feet. The child feels a painful sensation in all the parts of the body as if he was bruised. Cough during the day, but more frequent and more

intense in the evening until midnight. Cough aggravated by anger, movement, heat, and after drinking. Intercostal neuralgia.

Arsenicum.—Whooping cough whose duration is interminable, either it had been neglected or the treatment had been fruitless. Great prostration. Coldness of the surface of the body. The face is pale and takes the colour of waxy yellow. Each attack of cough is immediately followed by diarrhœaic stool.

Asafœtida.—Cough hoarse, resonating, short, with sensation of asthma in the trachea. Oppression and burning in the sternum with frequent inclination to cough. The chest seems as if compressed by a heavy weight which prevents pulmonary expansion. Slow and small pulse.

Badiaga.—Serious access of spasmodic cough with expulsion from the bronchi of yellow and viscous mucus, which is often violently thrown out of the mouth. It terminates by sneezing or fluent coryza. Aggravation after midday or in the evening with headache, pain in the posterior part of the pupil, light blow in the ears. Face pale, of ashy colour; pains, acute lancinating in the chest, principally under the scapulae, painful sensibility of the muscles and skins of all the body.

Baryta Carb.—Whooping cough of old men or atrophied children with roughness in the throat and sensation of tickling in the pit of the stomach. Without expectoration at night or in the morning; difficult expectoration of mucus, yellowish, tenacious, as like starch often foul. Aggravation when he is with humid feet or when he sleeps in a cold chamber, lying on the left side. Swelling and suppuration of the tonsils after slight cold. Loss of voice. The chest is obstructed by mucus. Drowsiness and chilliness day and night.

Belladonna.—Cough barking, dry, convulsive especially at night, with profuse bleeding from the nose, redness of the face and injection of the conjunctiva; signs manifest with congestion of the brain. The attack is announced by a disagreeable sensation in the stomach. Little or no expulsion of mucus which is never without pain. Waking at midnight by an

attack of cough which lasts sometimes an hour. Redness of the throat and palate which are painful to touch or during deglutition. Continued fever.

The patient feels the fits of coughing to come and the fits terminate by those of sneezing. Without the fits, the pulse is frequent and full; the palms of the hands are hot; the appearance is more or less red, sleep is agitated; without speaking the fits are interrupted very often.

Bromium.—Cough crampy, harsh, barking or hissing, caused by tickling in the throat, as if he has respired the vapours of sulphur. Without expectoration. Aggravation by movement, deep inspiration, and the fume of tobacco. Depression and melancholia. Sensation of bruise in the throat. Abundance of insipid mucus in the mouth. Dyspnœa, difficulty of respiration, shivering.

Bryonia.—The child never coughs so much as after eating or drinking and the cough is relieved by vomiting of food. Bryonia may be necessary all the time when complication of the lung and pleura will exist. Shooting pain in the chest, during cough and deep respiration in the interval of the fits.

Calcarea Carb.—Period of dentition. Fontanels largely open. The fits of coughing always become less after coughing. Tracheal rhonchus.

Capsicum.—Cough barking, frequent and short, particularly in the evening; after being in bed; itching and tickling in the throat. On coughing pain in the throat as if an abscess would burst. Head seems to burst on coughing. Constant tingling in the throat bringing dry and convulsive cough.

Carbo Animalis.—Cough with hoarseness and suffocation, caused by dryness and excoriation in the larynx and trachea. At night without expectoration; during the day expectoration grayish, greenish sometimes purulent, of irritating and sour taste. Sensation as if the head is tossed about; epistaxis; the abdomen as if shaken. Asthmatic respiration. In the morning hoarseness, during the night aphonia. Sensation of coldness in the chest.

Carbo Veg.—It can be given at all times when the cough has characteristic symptoms with aggravation at night, pain in the throat on swallowing, shooting pain in the head and chest, or in the more advanced period of the disease, in the case of obstinate vomiting, if the cough has lost its frequency or intensity. When after each fit of cough the child resembles as if exhausted, with heat of the head and face, and the skin almost cyanosed. Aggravation more strongly in the evening and before midnight, having the concomitant symptoms of coryza, sneezing, lachrymation, and hoarseness.

Castanea Vesca.—During the day, light pain in the middle of the right lung. Great lassitude.

Causticum.—Cough stubborn, hollow, short with hoarseness in the morning. Cough excited by tickling in the throat and by the presence of adherent mucus difficult to detach and the infant is obliged to swallow for want of knowledge to spit. Aggravation by cold air and remaining in a current of air (a draught of cold water calms the cough). Nasal catarrh dry at night, fluent during the day. Agitation, drowsiness in the day, insomnia at night. Constant chilliness. Abundant sweat in copious air. Amelioration by food. Involuntary emission of urine during cough. It is applicable to thin children. Causticum takes away the cough and restores at the same time the constitution.

Cepa.—Cough hoarse, dry, resonating, spasmodic which causes splitting and smarting pain in the larynx. The pain is so intense that the patient tries to obstruct the cough. Aggravation by remaining in a hot chamber and in bed. Amelioration by copious air. Abundant coryza fluent and acrid with watering of the eyes. Constant sneezing; weakness in the hip and loins, lassitude. Autumnal epidemics.

Cerium Oxalicum.—Vomiting and epistaxis at each fit of cough.

Chamomilla.—It is applicable to children. Cough dry, especially nocturnal. Agitation during the day, the child could not remain in one place, it wants to be carried in the arm all

the time, it appears to him besides that it causes relief; at night frequent wakings with cries, moanings, anger and at the access of anger cough is immediately provoked. Fever especially at night, one cheek is more red than the other. Vomiting, flatulent colic with swelling of the abdomen; diarrhœa often at night with slimy stool, green and simply mucus. Excessive excitement and irritation of the nervous system, so that it makes the temper of the child entirely insupportable. To children of more advanced age, with great sensibility to pain, Chamomilla is called for.

Chelidonium Majos.—Cough spasmodic, violent, excited by tickling in the larynx, by sensation of dust in the trachea, throat and the posterior part of the sternum, which is not alleviated by the cough, with great effort bringing tears in the eyes. The attack lasts long, succeeded by a short interval and awakens the infant when he is profoundly asleep. Spasms of the glottis and mucus expectoration. Anxiety, difficult expectoration. Stools are light coloured or perfectly white or bright yellow; rapid emaciation. Aggravation of cough in the morning, and in copious air; amelioration by keeping in rooms.

China.—Infant grows weak by a long persistent whooping cough; nervous erethism with adynamia; abundant mucus in the throat and chest; loss of appetite from exhaustion. (*Chin. Ars.*)

Cina.—Violent paroxysms occurring frequently, excited by a sensation coming from the bottom of the throat by a quantity of mucus adherent to the throat. In the morning without expectoration; in the evening expectoration of a white, glairy substance without taste, detaching with difficulty. In obstinate children with black hair and eyes. *Before the fit,* voracious appetite, pain in the stomach, mucous diarrhœa, itching of the anus, and fluent nasal catarrh; *during the fit,* loss of consciousness, pale face, cold sweat on the front of the head, bleeding from the nose and mouth, tonic spasm of the legs, suffocation and rigidity of the body; *after the fit,*

fretting when he is touched; vomiting of food, mucus and bile; difficult deglutition of liquids; gurgling in the abdomen. The thorax appears very narrow; insomnia with cries and weepings. After the coughs a gurgling bruit is often heard at the pit of the stomach as if liquid is being poured into a bottle. Attacks of sneezing, moaning, gnashing of teeth; the child has fear to speak and move, apprehending that a fit of cough may recommence. Obstinate children with black hair and eyes *(Belladonna)*; children tranquil, mild, with blond hair and blue eyes.

Coccinella.—At the end of the cough. The patient expectorates a quantity of flowing, albuminous mucus; sensation of coldness in the buccal cavity.

Coccus Cocti.—Cough dry, short, with sneezing all the day. Cough violent, very spasmodic with efforts to vomit and abundant expectoration of thick, viscous mucus resembling albumen. The expectoration rather comes at night, the cough being more ordinarily dry during the day. Nocturnal cough which awakens and does not allow more sleep. Tickling in the upper part of of the larynx; fit always comes at 11 P.M., with lively colouration of the appearance and congestion of the brain. Urine clear and abundant. Children become very nervous. Cough is much prolonged after the whooping cough.

Coffea.—An intercurrent remedy can render service in whooping cough to children very irritable and nervous, tormented by agitation and insomnia without any trouble to the digestive function.

Conium Mac.—It is of great usefulness to the scrofulous. The fits of cough come more particularly at night and are generally followed by vomiting bringing mucus with food. Children complain of pain in the abdomen on coughing.

Corallium Rubrum.—The fits are so violent that children lose their respiration and their appearance becomes purple and black. Cough spasmodic, short and sudden. Suffocation before the attack and great exhaustion afterwards; particularly indicated for aggravation at the last part of the night and in the morning.

Larynx and trachea are more obstructed than the chest. Mucus in the throat and chest is perceptible. The least change of weather brings cough to the patient. Loss of appetite and thirst. Vomiting after the fit of cough of a quantity of viscous and stringy mucus.

Crocus Sativus.—Whooping cough complicated with chorea; paroxysms in the morning accompanied by ludicrous gestures and continuous caresses followed by an hour of excessive excitement. The child strikes, bites and becomes ungovernable. At last he sleeps; after the resting sleep he wakes by crying and is attended by repetition of all the former scene. Cough violent, dry, exhausting, relieved by placing the hand on the pit of the stomach.

Crotalus.—Debilitated infant. Weakness of the heart. After fit, the appearance is pale, blue, and only slowly reappears the natural colour. Attack followed by swelling of the face and haemorrhagic spots, bleeding from the nose, or abundant frothy, stringy, and bloody expectoration.

Cuprum Aceticum.—Convulsions occurring at the time of the whooping cough, spasms of the flexors predominating. Cough with repeated and prolonged attacks of suffocation, during which the child is stiff and loses consciousness. Spasmodic pressing of the chest, convulsion in the place of cough and when the convulsion ceases the cough comes on. Loss of consciousness after each fit of cough. Obstruction of respiration during the cough. Bluish appearance of the face and lips. After cough vomiting, mucous rales or wheezing in the chest, except at the time of the convulsive spasms. Relief by draughts of cold water. After the attack, the child shows desire to drink cold water. Drowsiness between the attacks.

Daphne Ind.—Cough with vomiting and yellowish, frothy, expectoration, sometimes streaked with blood. Fatiguing cough which prevents sleep.

Digitalis.—Cough hollow, deep, spasmodic, caused by a sensation of roughness or excoriation in the palate, mouth and trachea. Without expectoration in the morning; in the

evening expectoration of mucus rare, resembling jelly. Aggravation at midnight and in the morning, by taking cold drinks and food, by walking, conversation and sitting. Pulse very slow, accelerated by least movement. Chilliness with heat and redness of the face. Heat with cold sweat on the front part of the head; one hand is hot and the other cold; desire for bitter foods, vomiting of food at the first sight, then of bile. Great prostration after the attack.

Direa Pal.—Cough day and night with vomiting. Dyspnœa, suffocating cough; hoarseness and excoriation of the larynx; takes cold easily. This medicine is often indicated after *Carbo Veg.*

Drosera.—Cough short, rapid, comes on suddenly by violent fits which are repeated very frequently with signs of suffocation. Pain at the lower part of the sides on coughing, the child carries the hand to the painful part. Shrill bruit characteristic of the whooping cough during inspiration and after each fit of cough; vomiting of food at the first sight and after food, of stringy mucus. The attack of cough only ceases when the child spits out or vomits a small quantity of mucus. Bleeding from the nose and mouth. Little or no fever, if he has fever, it is shown by the regular attack of chilliness and heat. Thirst after shivering. Hot sweat at night. Face purple only during the attack of cough. The cough exasperates him by the heat of the bed; the attacks are more frequent coming after midnight. Cough comes most frequently in the case of *Drosera*, after repeated vomitings, the sputums are streaked with blood. Without appetite; constipation, and moroseness.

Dulcamara.—Whooping cough excited by abundant secretion of mucus in the larynx and trachea followed by an easy expectoration of mucus without taste and often of red blood. Hoarseness. The medicine is indicated when it is pretty certain that the invasion has been caused by moist weather and after having taken cold.

Eupatorium Perf.—Cough hoarse, bursting, tearing, excited by painful sensation of excoriation and of heat in the bronchi, without expectoration. The patient supports his chest with his hands when he coughs. Pain and breaking sensation of the whole body. Aggravation at night and by movement. *(Arnica).*

Euphrasia.—Suffocating cough with abundant tears and fluent coryza. Expectoration in the morning only of insipid mucus as of water, difficult to detach. Cough only during the day, never at night. Aggravation in the evening, when he is awake, by wind. Acrid and watery nature of all the secretions.

Ferrum Met.—Spasmodic cough. Without expectoration at night, in the morning expectoration streaked with blood, purulent, glairy, sometimes frothy and of sweetish, putrid or sourish taste. Aggravation at night up to midnight. During this period, the mucus remains adherent, but during the day and during movement it is easily detached. Indicated to drunkards, those who abused drinking of tea, or those persons who have taken enough of *China.* Cough spasmodic, bursting, after each meal and followed by vomiting of food.

Helleborus Nig.—With regard to whooping cough, when come the superadded symptoms of cerebral congestion characterised by sleep, with half-opened eyes; more particularly indicated at the time of dentition or to feeble and delicate constitutions.

Hepar Sulph.—Croupous cough mixed with whooping cough; easy cough, hoarse voice. Abundant haemorrhage from the nose and mouth after each cough, when the cough is dry he feels its approach. The cough is increased in the morning, cough with menaces of suffocation. After the fit, vomiting and the child cries very much.

Hydrocyanic Ac.—Violent paroxyms of cough or cough frequently excited by sensation of pricking which commences in the larynx and extends to the whole of trachea, accompanied by dryness of the mouth and larynx. Respiration slow, feeble, and anxious with enough of sonorous rales.

Hyoscyamus.—The child can not lie down without the cough coming immediately, it never increases and the cough ceases

as soon as he sits up. Cough dry, spasmodic, attack violent, especially at night, with difficult respiration, threatenings of suffocation, fixed look, and injected appearance. Tremulousness and coldness of the hands and feet. Convulsions.

Ignatia.—Depressing emotions. Cough hollow, spasmodic, excited at night by an irritation in the supra-sternal fossa, and in the morning by tickling just over the epigastrium, generally without expectoration. Pricking pain in the throat is relieved by taking food; sensation of emptiness and feebleness in the epigastrium; dyspnœa and crises of suffocation; inspiration slow, expiration rapid; the chest appears very small; spasmodic yawning.

Iodium.—Spasmodic cough excited by an insupportable tickling in the larynx and supra-sternal fossa. The morning is without expectoration, at night expectoration of mucus abundant, tenacious, yellow or bloody. Aggravation, by heat, walking, conversation and ascending. Vomiting of food follows after each meal; canine hunger; epigastric pain. Emaciation, induration of glands; skin dry and dirty.

Ipecac.—Dry cough accompained by sufficient anguish of suffocation. At the time of the fit suffocation, the body stiffens and the appearance is reddened or becomes violaceous. At each inspiration it appears that he will get a new fit. Bleeding from the nose. Enough mucous rales are heard in the bronchi. Aggravation after midnight up to the morning. Tendency to diarrhœa, stools soft or diarrhœaic at night.

Kali Bich.—Cough suffocating, dry, barking, increases in the morning and after food. Generally amelioration follows after expectoration of mucus viscous, stringy, thick, difficult to detach and which adheres to the throat, in the interior of the mouth and at the lips.

Kali carb.—Spasmodic cough with attack of suffocation. The fits come especially after midnight towards 3 A.M., in the morning, or at the commencement of the day, ameliorated by vomiting of food taken in the evening. Little expectoration. Coldness and sensation of emptiness in the abdomen. Flatulence,

constipation owing to inertia of the rectum; dry catarrh of the nose; wheezing respiration; tingling and spasms in the chest with sensation of emptiness; swelling of the upper eye lid.

Kali Iod.—Whooping cough becoming chronic. Wasted children. Aqueous diarrhœa, light coloured.

Kreosotum.—Cough hollow, wheezing, spasmodic, occasioned by a sensation of roughness, excoriation and tickling in the chest and throat without expectoration. Bitter taste of food not perceived till the time of deglutition; nausea, efforts to vomit during pregnancy; sensation of bursting in the abdomen, great desire for sleep; profound sleep.

Lachesis.—Cough spasmodic, bursting, occasioned by a sensation of tickling in the stomach; difficult expectoration of little aqueous mucus during the day which he swallows; the patient has tendency to take deep inspiration; sensation of flapping of wings around the larynx; hoarseness and aphonia; livid swelling of hands and feet. The child does not awake, otherwise he will be attacked by a fit of cough; he is feeble and presents all the characters of great prostration.

Lactuca.—Great constriction of the chest as if there is a heavy weight on it; dyspnœa at night which prevents the patient from sleeping. Cough spasmodic, obstinate, shaking the chest and abdomen. Dry cough with dryness of the throat, and tickling in the pharynx.

Laurocerasus.—Adynamic state; when paralysis of the lungs threatens at the last period.

Ledum Palustre.—Cough spasmodic, hollow and disturbing. Cough preceded by obstruction of respiration. After the cough, the child staggers as if the head was attacked by vertigo. Spasmodic contractions of the diaphragm which makes the respiration more frequent and analogous to that which accompanies violent sobs. During the cough he sometimes expectorates fresh red blood. Attack commences with tetanic stiffness and bending of the body on the back (opisthotonus) and followed by a very violent fit of cough with expectoration of bright, frothy blood.

Lobelia.—Violent torturing cough comes by an attack of long duration with expectoration of stringy mucus which adheres to the pharynx; excessive dyspnœa. Sensation as if there is a great quantity of mucus in the larynx; nausea and profuse sweat.

Lycopodium.—Cough with expectoration during the day of an abundant quantity of purulent and bloody mucus, of salty taste and irritant odour. Yellow colour with circumscribed redness of the cheeks. Heaviness of the stomach; vomiting of food and bile; distension of abdomen; constipation; flatulence; asthma; rhonchus in the chest; threatening paralysis of the lungs.

Magnesia Mur.—A grievous complication of whooping cough is the want of appetite, because the infant being deprived of nourishment becomes weak and presents each day less power of resistance to the malady. If the absolute want of appetite is accompanied by clean tongue, no medicine is more preferable than Magnesia Mur. in the convulsive period.

Magnesia Phos.—Violent attack of spasmodic cough during which the face becomes blue and turgid.

Mephitis.—Attack of cough during day and night and general aggravation at night. Cough purely spasmodic. Bronchial rhonchus during the cough. Mucous rales at the upper part of the lungs. Sensation of excoriation in the chest; vomiting after each fit. Heat, excoriation in the fauces, hoarseness. Slight fever during the day, stronger at night. Eyes injected with blood.

Mercurius Sol.—Nocturnal cough, with abundant sweat at night. The cough has this peculiarity that two fits ordinarily follow one after another with a short interval, the child being perfectly calm during the interval. Profuse bleeding from the nose during cough and each time that there is an attack of cough. Fluent coryza and running from the nose of watery and acrid matter. Great nervous susceptibility; symptoms announce the presence of something in the intestines. During

the attack of cough, green diarrhœa as of spinach which escapes involuntarily.

Mezereum.—When the attacks are especially frequent and intense; at night in bed; when the child eats or drinks anything hot. (Dig. after drinking cold water); cough producing vomiting of food. To scrofulous infants who have engorged glands or it is better applicable with diseases of bones.

Moschus.—At the last period, when the expectoration almost ceases. Spasmodic cough with vertigo and constriction of the chest and trachea; one cheek is hot without redness and the other red without heat; speechlessness; diarrhœaic stool at night, beyond that the patient does not know; drowsiness; coma.

Naphthaline.—Spasmodic cough excessively violent, attack during the whole day.

Natrum Mur.—Whooping cough accompanying intermittent fever with spasmodic cough; excessive headache, increasing during heat so that it becomes intolerable. Violent shock in the head. Watering of the eyes. Tears flow on the face each time that he coughs; dirty yellow colour. Painful sensation of dryness in the larynx and trachea; hoarseness, pain in the cervical glands.

Niccolum.—Dry and painful cough; great dyspnœa; the child desires to support his head and holds during the cough; little or no expectoration; great hoarseness, he could speak at the height of his voice.

Nitric Ac.—Cough spasmodic, bursting, barking, caused by tickling in the larynx and epigastrium. Epectoration in the day of black blood mixed with clots or yellowish acrid pus, and of irritant odour; foul breath; pricking in the scapula and sacral region; sensation of pricking as if a piece of wood presses on all the affected parts. Irritant nocturnal sweat having the odour of urine; emaciation; salivation.

Nux Vomica.—Dry cough comes after midnight till the morning with vomiting, anxiety, attack of suffocation and the face strongly coloured. Hæmorrhage from the nose and mouth.

Constipation. During the attack pain in the umbilicus as if it will be torn into pieces.

Opium.—Symptoms of cerebral congestion. Stupor. Hot perspiration, irregular respiration with great anxiety. Constipation.

Phosphorus.—Hoarseness, almost total loss of voice by the effect of cough. Pulmonary complication; mucous rales, short respiration, great weakness. Drowsiness, thirst and diarrhœa.

Pulsatilla.—Cough very easy at the beginning, can be especially heard at night. Cough is accompanied by tears, sneezing, fluent coryza without acridity, with loss of taste and odour. Slight hoarseness and tendency to vomiting after cough. Vomiting of food or only mucus. Sometimes diarrhœa, especially at night. Heat of the body with cold extremities. Absence of thirst, constant chilliness more marked at night.

Rumex Crisp.—Cough dry, bursting, incessant, very fatiguing, caused by tickling in the supra-sternal fossa. Sensation as if a feather is put here and in the bronchi, following the respiratory movements, making tickling which provokes cough. Aggravation by inhalation of cold air or pressure upon the trachea in the supra-sternal fossa; hoarseness; unsteady voice; fluent coryza. Sensation of pricking in the upper part of the left lung.

Sambucus.—Cough hollow, dull, suffocating, excited by spasm of the chest. At night without expectoration; in the day, expectoration of mucus rare, difficult to detach, having sweetish putrid or saltish taste; aggravation towards midnight, by repose, cold and dry air, when he is in bed with his head low; dry heat during sleep, which comes still more forcibly on awakening.

Sanguinaria.—Cough dry in the morning on awakening and it never ceases till the patient is put right with pain in the chest, relieved by emission of gas, dyspnœa after midday till the night; nocturnal diarrhœa.

(To be Concluded).

EDITOR'S NOTES.

Typhoid Test.

The following is from *the North American Journal of Medicine*, June, 1906:

"A 1-1000 aqueous solution of methylene blue may be used in testing urine and the results appear to be as reliable as the familiar Diazo test. The reaction may be found as early as the second or third day and commonly continues during the disease. To a test-tube two-thirds full of urine add five or six drops of the methylene blue, which becomes emerald green if the reaction be positive; bluish green if negative."

Many tests to diagnose the typhoid fever have come to the field. If this urine test proves true, then it is a step in advance. It is generally not practicable to get blood from private patients.

Homœopathy in Chicago.

The British Medical Journal of June 16th writes of the waning influence of homœopathy thus:

"CHICAGO, as we learn from the *Chicago Medical Recorder*, has for many years been the chief centre of homœopathy not only in the United States, but in the world. More students, perhaps, have graduated in homœopathy in that city than in the rest of the world combined. Our contemporary, however, sees signs of a decline in the sect. The two principal schools have within the last two years become amalgamated and the fusion is generally attributed to reduced attendance at both. It would appear, moreover, that the education given in the sectarian institution is markedly inferior to that of the regular schools. Owing to the policy adopted by the Chicago Medical Society in admitting professed followers of Hahnemann to membership simply on their agreeing not to practise any exclusive line of treatment, there has already been a large secession from the ranks of homœopathy. Homœopathy throve as long as it was persecuted; toleration has reduced its adherents to their proper relation to the general body of the profession. The *Recorder* ends with the expression of a belief that 'the days of homœopathy are probably numbered.'"

It is all ignorance to speak of the waning influence of homœopathy in Chicago or America. *LaSimilia est mort! Vive le Similia.*

Remedies in Mumps.

The North American Journal of Homœopathy for June, indicates the use of the following remedies in mumps:

"The chief remedies are belladonna, mercurius, and rhus. In testicular complications; pulsatilla, aurum, clematis, conium; in ovarian metastasis: apis, pulsatilla, lachesis.

Aconite is useful only in the beginning for the aconitum prodromal febrile syndrome—dry, hot skin; hard, rapid pulse, unrest, etc.

Belladonna.—Much oftener useful, especially if the mumps be right-sided, with great heat and shining redness of the part. Sharp, sudden shooting or sticking pains are prominent and the affected part is exceedingly painful to the touch. The mouth is dry and swallowing difficult. There is also congestion to the head with oversensitivity of vision and hearing.

Mercurius.—Of value with boring pain, < at night, great sensitiveness of the affected glands, offensive odor from the mouth, suppuration threatening. As soon as suppurative symptoms appear, mercury is the best remedy.

Rhus.—Extensive swelling, leaving indentation from pressure by the fingers. Dark red swelling or tendency to a rosy red inflammation. Especially useful in a secondary adenitis after scarlatina.

Lachesis.—Left-sided mumps, with a purple induration of the part. The patient is < after sleep; also in left ovarian metastasis.

Pulsatilla.—Notably in double mumps; greatest value in orchitis or ovaritis.

Conium.—Where the swelling is markedly hard and long-lasting.

Pilocarpinum muriaticum 3 was recommended by Dr. Burnett, as a sort of specific in mumps."

Stomatitis Remedies.

The North American Journal of Medicine for June, writes of the remedies for stomatitis thus:

"Kali chloricum, 3x trit. 0·15 ctgms. every hour is the chief remedy, and is used in swelling of the salivary glands without much secretion and with tendency to ulceration of the mucosa.

Belladonna 3x, every 4 hrs. with extreme dryness of the mouth, heat, redness and burning.

Borax 1x, 0·15 ctgms. hourly if the mouth is hot and dry, and the affection be localized in the mucosa of the cheeks, with aphthous tendencies.

Mercurius sol. 3 every 4 hrs. The classic remedy in stomatitis with ptyalism, spongy, white, swollen gums, swollen cervical glands and green or dark green diarrhoea.

Muriatic acid 6. every 4 hrs. Burning in the mouth; ulcers of bluish base and ill-defined borders, the mucosa denuded of epithelia, and swelling of the cervical glands.

Nitric acid 6. The symptoms resemble mercury, but there are excoriations in the corners of the mouth. If there be a tendency to gangrene—arsenicum or lachesis.

Arum tri. 12. (When given in lower dilution it should be freshly prepared.) The buccal cavity is covered with malodorous mucus.

Rheum 3.—If the stomatitis be mercurial in origin—also nitric acid and hepar.

Argentum nitricum 6.—In nervous, dyspeptic individuals."

Lodging-house Keepers and Infectious Diseases.

The Lancet of June 30, says:

"A claim brought by a young lady musician against a lodging-house keeper at Scarborough to recover her luggage was met recently by a counter-claim of a very unreasonable character, which fortunately was not allowed to succeed. The plaintiff took rooms with a view to occupy them during an engagement at a local place of entertainment and three days afterwards learnt that there was a case of measles in the house, when she naturally left at once. The landlady, however, refused to give up her lodger's boxes and when the latter brought her action to recover them counter-claimed for payment for the lodgings in lieu of notice. His honour Judge RAIKES made short work of the landlady's case, pointing out that a common misfortune had put an end to the contract, a misfortune of which lodging-house keepers must run the risk and of which they must take the consequences when it occurred. In other words, an event beyond the control of the parties had made it impossible for the lodging-house keeper to carry out her bargain by supplying a lodging of such a character as the plaintiff must be taken to have bargained for and the plaintiff could not be made to pay for one which might render her liable to the infection of measles. The judgment was for £4, to be reduced to 1*s.* on the return of the box, and for 8*s.* 8*d.* due in respect of the accommodation which the plaintiff actually enjoyed, the costs in each instance to follow the judgment."

The previous occurrence of any infectious disease in a house should be made known to the tenant who is about to engage rooms or the

whole house. The want of service of the notice on the part of the landlord is sufficient to annul any engagement by the tenant. In India the law is very lax. We know that a few tenants were harassed in Calcutta for occupying houses without the knowledge that cases of plague previously occurred in those houses. Even the District Plague Officers did not come to their rescue though their help was sought. To our knowledge such a case happened in a house in Blochmann street. The lady tenant was harassed beyond measure and the Small Cause Court did nothing to afford relief. We hope that the above mentioned case will form as a precedent to such occurrences.

It is not possible for the tenant to know whether the house is infected unless the tenant takes residence for a few days. The ignorance of the fact on the part of the tenant rests on the secrecy observed by the owner of the premises. For the studious mischief not to inform the tenant of the fact of previous infection, the tenant gains the right to quit the house as soon as possible. The owner can only get the rent for the period which was occupied by the tenant. If it be the right of the tenant to leave an unsafe house, that unsafety will, surely, be extended to infectious dwellings.

A case of Eruption of the Skin from Mercuric Chloride.

The Lancet, June 30, thus describes the eruption after application of Mercuric chloride :

"THE patient whose case is here described was an Italian girl, 20 years old, very robust, and of a healthy constitution. She suffered from a subaxillary abscess which I incised. For the disinfection of the skin I used, in accordance with my constant practice, washing with a solution of mercuric chloride of strength 1 in 1000 and I employed less than one litre of the solution. The local treatment was very simple, sterilised gauze wet with the same solution being in contact with the skin and covered with dry sterilised cotton wool and a bandage. When I saw the patient on the next day I found that the skin of the entire axilla, of the subaxillary region, and of a portion of the adjacent lateral anterior and posterior regions of the thorax was of a scarlet colour and dotted all over with small vesicles containing pus. The girl complained of a sensation of smarting and severe itching. The lesion was very similar to a burn of the first degree. The affected region corresponded exactly to the area which had been in contact with the corrosive sublimate even for a brief

period. The same lesion also existed on part of the anterior and posterior aspect of the axillary folds where gauze sterilised and wetted with the solution of corrosive sublimate had been applied. The girl told me that several years ago she had suffered in the same way from the use of a solution of mercuric chloride employed by a medical man and that he was surprised at the effect produced. Three days afterwards the abscess was almost healed but over the whole of the affected surface there was subsequent exudation of a serous fluid mixed with a very small quantity of pus. From the first appearance of the lesion I made no further use of sublimate or any other disinfectant. I only washed the parts every day with sterilised water and cotton wool and then covered them with sterilised gauze and cotton wool. Powdered bismuth subnitrate was also sprinkled upon the skin and sterilised gauze and cotton wool were applied. The lesion disappeared in a few days."

The eruption of Mercuric Chloride is another revelation to the Old School. It is another wonder that it is getting so many discoveries in a year. *Light more light! Light more light!*

Pulmonary Tuberculosis in Calcutta.

The Lancet, June 30, writes:

"CONTINUED observation and research confirm Professor HIRSCH's statement that pulmonary tuberculosis is a disease of all times and all countries. It is true that in certain regions of the earth the disease is all but absent, such as in the Arctic regions, deserts, and in places situated at high altitudes—that is to say, as Dr. A. RANSOME has pointed out, just where the population is most scanty. Wherever population is dense there will the death-rate from pulmonary tuberculosis be found to be high. The lack and neglect of ordinary hygienic precautians, as is well known, considerably encourage the prevalence of disease. No race is exempt, although some writers have stated that Jews are less afflicted with tuberculosis than are Christians. The evidence on this point, however, is conflicting and as Dr. PERCY KIDD has stated, there is reason to believe that this favourable estimate applies only to the well-to-do members of the community. Further investigation must decide whether the alleged immunity exists or not. Some nationalities, on the other hand, seem to be more prone to be attacked than others. Professor HIRSCH states that among the Kanakas—the natives of New Caledonia—two fifths of the total mortality is due to pulmonary tuberculosis. Some of the other black races also readily acquire the disease.

Some of the above points are well exemplified by a report recently issued on "Phthisis in Calcutta, 1905," by Dr. T. FREDERICK PEARSE special health officer. For some time it has been recognised that pulmonary tuberculosis is very prevalent in Calcutta and is responsible for a high percentage of the deaths. The returns of the causes of death, however, have not been trustworthy since they were based on the mere statements of relatives and friends at the several burning ghats and burial grounds, The exact prevalence of the disease, therefore, could not be correctly estimated. During the year 1905 every death, except those occurring in hospital, was inquired into by the officers of the plague department, and from the clinical reports and histories obtained it has been possible to estimate much more accurately than before not only the total extent of this disease but also its incidence in the several parts of the city. The value of these inquiries is shown by the fact that less than 50 percent. of the deaths from pulmonary tuberculosis were recorded as such in the usual way at the burning ghats and burial grounds. The disease is shown by the report to be much more prevalent than was previously supposed and more fatal than was formerly estimated from the registers. For the year 1905 there was 1648 deaths returned by the plague department as being due to pulmonary tuberculosis. This number constitutes the apparently low rate of 1·9 per 1000 of the population of the whole city. In Bombay the rate is 3·8 per 1000 and for the Indian jails 2·98 per 1000. Dr. PEARSE considers that this apparently low rate for Calcutta is brought about by the exceptional age and sex constitution of the population. Two-thirds of the population are males, and pulmonary tuberculosis in that city being only half as fatal amongst males as amongst females this disproportion reduces the total rate. Again, there is a large excess of persons between the ages of 20 and 50 years, especially males, which also tends considerably to lower the total rate. The excessive prevalence of pulmonary tuberculosis amongst females in Calcutta is, then, one of the most striking features of the investigation. Among males the death-rate was only 1·4 per 1000, which is almost as low as the general rate for England. Whilst among females the rate was more than double—viz., 2·86 per 1000. Equally noticeable is the extreme prevalence of the disease amongst Mahomedan females, the rate for whom works out at no less than 4·6 per 1000. The reasons for the excessive rate amongst the women are not difficult to find. It may be interesting first to notice the comparative incidence amongst males and females respectively in this country. The late Dr. WILSON FOX, from statistics officially

compiled by Dr. W. OGLE, showed that if all ages be included the difference in the death-rate of each sex from "phthisis" is so small that the rates may be considered as practically equal to each other. But if instead of taking the aggregate rates—that is, the death-rates of each sex *en bloc*—the rates at each successive age period are considered, there are found to be remarkable differences between the sexes. In the first quinquennium of life (0—5 years) the male and female rates are nearly the same, the male being only very slightly the higher. In the five age periods, covering between them the interval between the ends of the fifth and thirty-fifth years of life, the female rate is in marked excess of the male rate, the excess being especially notable in the periods from 10 to 20 years of age. At no age, however, is the difference between the liability of the sexes to tuberculosis so marked as in Calcutta. After the thirty-fifth year in this country the male rate becomes the higher and remains so in each age period to the end of life. It is then in the conditions of female life in Calcutta that the reasons for the excessive mortality of the women from pulmonary tuberculosis must be sought and not in any peculiarity of the sex. These conditions are to a certain extent known and may be summed up generally, as Dr. PEARSE remarks, as "deficiency of fresh air." Owing to the confined life which the native women lead in India, especially amongst the Mahomedans, all the requirements for the rapid spread of the disease are fulfilled. This want of good hygiene is further emphasized by the relative occurrence of tuberculosis in the different classes of dwelling. The disease is found to be much more common amongst the population dwelling in huts than in those who habit pucca houses. The former are much more densely crowded than the latter. The average number of occupants per room in a hut is stated to be 2·4, and it is therefore not surprising that tuberculosis should be so prevalent under such conditions.

From this report it is evident that pulmonary tuberculosis is accountable for a large number of deaths in Calcutta and that it is the conditions of domestic life amongst the natives which are mainly responsible for the high mortality amongst the women and to remedy this state of affairs would be a gigantic undertaking. The opinions of the local medical men as to how much might be accomplished by the institution and enforcement of sanitary laws would be interesting. Judging, however, by the difficulties that occur in attempting to deal with epidemics of plague, it is to be feared that an almost insurmountable task presents itself in trying to prevent the spread

of tuberculosis. A total change in the manner of living of the natives would be necessary before any real improvement could be expected. There are, however, many native medical practitioners who could doubtless effect some benefit by an attempt to instruct their patients in the elementary precautions necessary to prevent infection. The deep-rooted prejudice that exists amongst the natives against sanitary reforms would probably be one of the chief obstacles but the present loss of life from tuberculosis is deplorable and calls for some attempt to remedy it."

The Indians are aware of their shortcomings. It is not always true that Indian women can not enjoy healthy atmosphere. They generally ascend the uppermost terrace to enliven themselves with free air. The Hindu Shastras always enjoin sanitary measures. It is utter ignorance of Indian life, to speak of the insanitary condition of most of the Indian houses. Wherever any bad condition exists, it is due to poverty, as in *bustis*. The constant occurrence of famine every year testifies to the fact. The *kinthals* of low Europeans and Eurasians are worse than the bad Indian homes. Another clinical fact which goes against the seclusion charge is that two cases of tuberculosis are rare in the same house as is often the case in England. The true cause of the spread of tuberculosis is the milk of the consumptive cows, against which the Health Office has taken no effective step. The inaction of the department finds excuse in charging others with uncleanliness. As an example of the inactivity of the office, we may point out that the Health Officer often writes in his reports the presence of innumerable cholera bacilli in the water of the Tolly's Nulla. No warning has ever been given of the danger of bathing in that river.

The increase of death of Mahomedan females from phthisis is open to doubt. Most of the cases so returned are deaths from chronic bronchitis. We generally observe tuberculosis (galloping consumption) more among males than females.

Physiological Glycosuria of Pregnancy.

The British Medical Journal, 16 June, has the following :

"Rudaux (*La Clinique*, May 15th, 1906) distinguishes between glycosuria and pregnancy. It is normal for sugar to exist in the urine of parturient women, of nursing women, and of a certain number of pregnant women. During pregnancy the hepatic gland secretes an abnormal amount of glucose, partly as the result of the hyperactivity of all its functions, which involves also the glycogenic

function, and partly to supply the mammary gland with the materials which it requires for the exercise of its function. A systematic examination of urine during pregnancy shows that after the sixth month it is not uncommon to detect as much as 3 or 4 grams of glucose in the urine, and that as term approaches this glycosuria tends more and more to become lactosuria. The mammary gland is preparing for the active exercise of its function after parturition. If the liver only secretes a small quantity of glucose, it will be entirely transformed into lactose by the mammary gland, and as it is not yet utilized it will be reabsorbed by the blood and excreted in the urine. If an excess of glycogen is secreted, only part of it will be converted into lactose; the remainder will be eliminated in the urine at the same time as the lactose, and both glycosuria and lactosuria will be present. When there is hyperactivity of the glycogenetic function, the urine may contain as much as 20 grams of glucose without being accompanied by any of the other characteristic symptoms of diabetes. The proof that this glycosuria is physiological and not pathological lies in the facts that the pregnancy is normal, and that it disappears a few days after parturition, when the function of the mammary gland is established. The glycosuria of pregnancy is more common among multiparae, especially among those who have already nursed their offspring, and indicates that the mother will be able to nourish the child well. It is questionable whether women who have suffered during pregnancy from a severe or prolonged toxæmia of hepatic origin will be able to supply a milk containing sufficient lactose, for an inefficient liver must react equally upon the glycogenetic and the antitoxic functions."

The difference between normal and abnormal glycosuria admits the presence of normal glycosuria. We know from clinical experience that normal emission of sugar in urine is possible in certain cases especially with vegetarians. The clear limit of distinction, in many cases, is still wanting. It may be reasonable to infer normal glycosuria in pregnant females, but the difficulty of the assumption is great in other cases. It is known that normal glycosuria occurs in certain Indians who are much addicted to sweets as Jains and Marwaris.

CLINICAL RECORD.

Foreign.

IS WETTING THE BED WITH CHILDREN CURABLE?

By Dr. Staeger, Bern, Switzerland.

I will here adduce five cases of bed-wetting, all of which were cured within a short time through *Nux vom.* 3 :

I. On August 2, 1905, a mother came to my office with her daughter seventeen years old, with the request that I might cure her child of the affliction of wetting the bed. Her daughter looked slim and had bluish-violet rings around her eyes; she was eminently nervous and continually turning red and again turning pale. From her childhood she had wet her bed and the affliction did not disappear with her puberty. I gave her *Nux vomica* 3 in liquid form, directing her to take three times a day five drops.

Two weeks later the mother reported that the daughter had only wet the bed once the last two weeks. Before this, it had frequently happened every night, or at least two or three times a week. I gave her the same remedy once more, and after two more weeks the mother told me there had been no more relapse. The woman was lately in my office and confirmed the permanence of the cure.

II. The seven-year-old sister of this patient suffered from the same ailment and was also permanently cured by the same remedy.

III and IV. On the 3rd of October the lady principal of an orphan asylum came to me with two boys, five and eight years old who, for months, had wet the bed every night. The younger boy came from quite a neglected family and had received wine and beer even when he was three years old. The older boy showed movements as of chorea, both with hands and feet. The principal had tried everything she could think of and had also been to see several allopaths, but without results. Both received *Nux vom.* 3. and both are to this day free from their trouble. The principal is very thankful and cannot comprehend that a few drops out of a little brown bottle should have such medical power.

V. A mother in the Canton of Zurich wrote to me on September 3, 1905: "Honored Doctor—Your two bottles have done wonders. My husband and myself are astonished and cannot thank

you enough. Just think, since Adolph has taken the remedy he has not wet his bed even once. I entreat you, dear Doctor, to send me one more bottle, so that if the trouble should reappear, we may have the wonder worker right at hand."

The boy was seven years of age, and according to the descripton of the parents, he was of a nervous disposition and wet his bed every night two or three times. The wonder-worker was *Nux vomica* 3.

I have here purposely adduced only *Belladonna* cases. I could just as well have given cases cured with *Cina, Belladonna*, etc. I only desired to show by my selection the indications which point to *Nux*. Whoever individualizes exactly will have extraordinary success, especially in this ailment. But everything must be done through strenuous distinction. *The physician's penetrating look cannot be supplied by any number of books, be they ever so excellent.* I would impress this on over-anxious souls who may think that I have not revealed the whole secret.—*Homœopathic Envoy*, July 1906.

PYROGEN IN SEPSIS.

In pyrogen, an *isopathicum*, we have a valuable remedy for cases of serious sepsis; sepsis *per se* as in septicemia and sapremia as well as in cases complicated with sepsis such as typhoid, phthisis in the later stages, gonococcal endometritis, pelvic peritonitis, etc. CASE. Woman, aet,. 29, married six years, had had one still-born child, and later had aborted in the third month with great loss of blood. She suddenly and violently became ill with peritonitis, (chill, pulse 130-40, temperature 104·9 degrees, extreme sensitiveness of abdomen to the slightest touch,) the first and most acute stage of which was met by Bryonia 3. The temperature fell gradually to 101-102 degrees; as the result of the attack, there developed a tough exudation as large as a child's head in Douglas' culde-sac and the right parametrium, a swelling of the left ovary, and a light septic mitral endocarditis. The condition persisted for weeks unchanged; about 6 weeks after the beginning of the trouble violent rheumatic pains appeared in the right sciatic region accompanied by irrepressible unrest in the previously quiet patient and followed by a profuse menorrhagia with the passage of clots as large as the fist, (4 weeks previously the menses had appeared

for a few hours only, in traces.) Pyrogen 10x, gtt. v. morning and evening was then given; with a rapid return of temperature to normal, a fall of the pulse from 110 to 80, and in three weeks the exudate had shrunk to the size of a small apple. No other remedy was used. Dr. Boeckh.—*The North American Journal of Homœopathy*, July 1906.

IGNATIA IN SCIATICA.

E. T. aet. 53, suffering from a classical right sciatica (Valleix's Points: painful points in peripheral neuralgia where the nerves find exit through fasciæ or bony canals; Lasegne's Sign: differentiating sciatica flexion of thigh upon hip is painless or easily accomplished when the knee is bent). The pains were fulgurant, in violent shocks, < at night, forcing the patient to continually change position. During the day he suffered little. Nux vomica, indicated by the fulgurant pains was given, gtt. xv. of the tincture daily, for three days without relief. It was replaced by ignatia gtt. v. tincture. The first night there was marked amelioration which continued. Rhus tox. 3 was given to complete the cure—indicated by the > from motion. It failed completely and the patient returned to his original condition. Ignatia was then represcribed and the patient was cured in a few days.—Dr. Jousset, *L' Art Medical.—North American Journal of Homœopathy*, July 1906.

LACTUCA VIROSA—CASE:

Child aged eleven years, has incessant spasmodic cough, caused by a tickling in fauces and preceded by a sense of suffocation. Cough threatens to burst the chest, and is accompanied by headache—the worse the cough the worse the headache. Is either sleepless, or lethargic.

Pathogenetically we have:

"Headache, with affections of the respiratory organs. Difficult breathing; suffocating breathing; constant tickling cough; incessant spasmodic cough, as if the chest would fly to pieces. Sleep, restless; impossible to get to sleep; deep comatose sleep. The worse the cough the worse the headache".—*The North American Journal of Homœopathy*, June, 1906.

Gleanings from Contemporary Literature.

THE MANAGEMENT OF A CASE OF LABOUR.

DELIVERED AT THE UNIVERSITY OF BIRMINGHAM.
BY C. E. PURSLOW, M.D., M.R.C.P.,
HONORARY OBSTETRIC OFFICER, QUEEN'S HOSPITAL; INGLEBY LECTURER FOR THE YEAR.

EDUCATION OF MEDICAL STUDENTS IN MIDWIFERY.

Dr. Ingleby was a strenuous advocate for the better recognition of midwifery by the authorities in the medical world and by the examining boards, and for more thorough teaching of the subject, and after quoting Dr. Ingleby's views on this subject, the lecturer proceeded as follows:

Matters have improved as regards the education of the medical student in midwifery since Dr. Ingleby's day, but are still very far from satisfactory, attention was drawn particularly to this by Dr. Dakin in his presidential address at the Obstetrical Society of London last year. Dr. Dakin compared the careful instruction in medicine and surgery which the student is compelled to undergo, by the examining boards, at the hands of members of the hospital staffs, with the casual way in which he is allowed to get his practical knowledge of midwifery; all that is wanted from him in this respect being a certificate "of attendance on twenty labours," and this may be signed by "one or more legally qualified practitioners." No rules are laid down as to what should constitute "attendance."

The teaching of midwifery will never be placed upon a satisfactory basis until each medical school has its own lying-in hospital or lying-in wards attached to its general hospital, attendance in which, under the recognized teachers of the subject, must be compulsory; and the certificates of those teachers alone should be accepted by the examining Boards; in this connexion I welcome the proposed re-establishment of a lying-in hospital in this city, and trust that it may be made available for the instruction of medical students.

THE MANAGEMENT OF A CASE OF LABOUR.

Early Management of the Mother.

The anxieties and responsibilities of the medical attendant begin as soon as the patient engages him to attend her in her expected confinement; and the first question which arises is, should he insist on making an abdominal and vaginal examination of every patient?

A few obstetricians refuse to attend cases in which they are not allowed to make such an examination. My own view is that, though such an examination may be theoretically advisable, it is by no means always practically expedient, and it should only be insisted on when in a primipara there is a history of rickets in childhood, or the presence of an actual deformity as distorted spine, or bent legs, or dwarfed stature, suggesting rickety

pelvis, or kyphosis suggesting kyphotic pelvis, or disease of the hip-joint, loss of a leg or lateral curvature suggesting some form of oblique pelvis.

In a multipara the history of previous labours may always be taken as a safe guide, and examination only insisted on when the occurrence of previous difficulties in delivery suggests a contracted pelvis. The patient should be kept under careful observation during her pregnancy; the diet should be regulated, and the urine systematically and carefully examined, particular attention should be paid to the presence of albumen in the urine and, if this is found in a catheterized specimen, the patient should be put under appropriate dietetic and hygienic treatment without delay.

The Doctor and Nurse.

The next question is the engagement of nurse, and in this matter the medical attendant should certainly be consulted. Harmony between nurse and doctor is most essential, and from the point of view of puerperal infection the nurse is quite as important as the doctor. It is extremely annoying and unjust to an obstetrician that after taking most careful antiseptic precautions he should sometimes have his case infected by a careless and septic nurse.

If a nurse has passed through a course of instruction at a lying-in hospital she will, at all events, have been rendered fully aware of the importance of cleanliness, and as a rule, may be trusted to be safe. If the medical attendant has any doubt he should carefully instruct the nurse before the time of labour on the antiseptic measures he wishes her to use.

The state of health of both doctor and nurse is important, and any purulent discharge in either is decidedly dangerous. Any suppuration about the hands, such as onychia, should be held to an absolute contraindication to midwifery practice for the time being. Suppurating aural or nasal discharges are also dangerous, and, if not held effectually in check, should unfit any one for midwifery practice.

Dr. Mendes de Leon of Amsterdam, in a paper read before the British Gynæcological Society two years ago, drew attention to the important part played by the expired air of the surgeon and attendants in producing sepsis in abdominal surgery, and although so far as I am aware it has not been proposed to wear gauze veils for obstetric work as is now done in some hospitals for operating, still we should at least be careful that there is no focus of infection in the mouth, such as necrosing and suppurating stumps, and the mouth should be well washed out daily with antiseptic lotion.

It is advisable for an obstetrician, as for an operating surgeon, to avoid long hair, and if a beard is worn at all it should be short and well trimmed.

One may sum up by saying that the most scrupulous attention to personal cleanliness in both doctor and nurse is absolutely essential to obtain successful results in midwifery practice.

The lying-in Room.

The choice and preparation of a room is the next question, though frequently the doctor is not consulted in this matter.

The best ventilated and quietest room in the house should be chosen, and it should not be near the water-closet. Fixed lavatory appliances, connected with the drains, are, in my opinion, always objectionable in bed-rooms, and certainly no room containing them should be chosen for a confinement. It is well to have an open fire-place in the room, and I must confess to a strong preference for open coal fires over any other form of heating for a bed-room.

A single bed, with firm mattress, should, if possible, be used. The mattress should be protected by a mackintosh covered by a clean folded sheet, or the cotton-wool sheet supplied in obstetric outfits for the purpose and it is a distinct advantage to have the patient in such a position that she can place her feet against the foot of the bed and pull upon a sheet attached thereto, as this aids the expulsive efforts.

The Patient During labour.

The patient should, when possible, have a bath at the onset of labour, and then put on clean clothing, vest, and nightdress, the latter being tucked up round the waist, a clean skirt, and clean stockings.

After labour has commenced the patient should be strictly enjoined not to make use of the watercloset, but to use clean utensils in the bedroom, and these should be at once removed by the nurse.

If the patient has not been able to have a bath the nurse can, at all events, wash the vulva with soap and water. To any one who considers the matter for a moment it must be obvious that the vulva in many women harbours innumerable germs, and in this connexion we should welcome, as obstetricians, the more rational form of dress which women have largely assumed of late years. It is highly desirable that all women should wear some form of bifurcated and closed garment for the lower extremities, so that contamination of the vulva by the dust and germs of the streets, which may be swept up by the skirts, should be prevented.

Abdominal Examination.

Much has been written of late years about abdominal palpation in labour and no one can deny its great value. Some have gone so far as to claim that labour may be conducted throughout without vaginal examination; and though this is undoubtedly true as regards lying-in hospitals, it can not apply to every case in private practice, and for this reason: By abdominal palpation one can diagnose the position and presentation of the child, its adaptability to the pelvis, the presence or absence of liquor amnii, and the character and strength of the pains; but one cannot ascertain the state of the cervix, and it is the latter which is mainly our guide as to the time the labour may be expected to last and the wisdom or otherwise of leaving the patient. Therefore, while advising that vaginal examinations should be as few as possible—and in many cases one will suffice—I cannot endorse the advice of those who would forbid them altogether.

Preparation of the Hands of the Obstetrician.

I should like, in the first place, to lay particular emphasis on the importance of guarding against contamination of the hands as far as possible in our daily work. I feel sure that there is room for improvement in this respect, and that the "aseptic conscience" of each of us should be so developed as to prevent us at any time needlessly infecting our hands with septic matter, and to make us always on our guard against contamination.

For examining and operating upon septic cases of all kinds rubber gloves are strongly to be advised. I never examine cases of puerperal sepsis to which I may be called without first putting them on. I find that all the manipulations required can be quite well performed in them.

In connexion with this question of safeguarding the hands from septic contagion there are two points in everyday gynæcological practice to which I wish to draw attention.

The first is that the free use of grease in making gynæcological examinations is a great preventive of contamination of the skin of the examiner's hand.

The second is that, after the surgeon has made a vaginal examination, the nurse almost invariably hands him a piece of cotton-wool with which he is expected to wipe his finger. It is, in my opinion, a mistake for him to make use of this; it is far better that he should at once plunge his hands into hot water and wash them in the usual way.

There are many different ways of preparing and sterilizing the hands, but practically all agree in commencing with a thorough and prolonged scrubbing in soap and water, using a nailbrush; it is always well for the obstetrician to carry his own nailbrush. After rinsing off the soap the hands should be immersed in some antiseptic solution. Personally, after the preliminary scrubbing with soap and water, I soak my hands in a 1 in 2,000 solution of mercury perchloride, again using the nailbrush.

There is a tendency on the part of some practitioners to make too much of a fetish of the chemical antiseptic, and correspondingly to neglect the soap and water; the latter is, in my opinion, by far the more important agent.

The coat should be removed, the shirt cuffs turned up, and rings, if worn removed before commencing to prepare the hands.

Vaginal Douches.

As regards the question of an antiseptic vaginal douche before labour, personally I do not advise that one should be used, and I think that there are many strong objections to it, the most important being that by using the douche the natural lubricating secretion, which is thrown out so freely in the early stages of labour, is washed away.

It is well for the nurse in every case to give a rectal enema at the beginning of labour, and, when the bowels act, special care should be taken in cleaning afterwards to ensure that faecal matter does not contaminate the vulva.

Vaginal Examinations.

The question of a lubricant next engages our attention. A lubricant is not absolutely necessary, and can be dispensed with, but, in my opinion, it is preferable to use one, as the introduction of the finger is thereby facilitated and rendered less painful; this applies particularly to primiparae.

Another strong argument in favour of using a lubricant is that the latter undoubtedly protects the skin of the examiner's finger, and renders inoculation of syphilitic or septic poison less probable. The late Mr. Lawson Tait strongly supported the use of grease from this point of view. He said in his book on *Diseases of women:*

It must not be forgotten that this is one of the most important objects in the use of grease in vaginal examinations.

Whatever preparation is used, the lubricant should always be carried in collapsible tubes and not in pots or boxes; a little may be squeezed out on to the finger, and the remainder is not contaminated.

Rupture of the Membranes.

If the membranes have not ruptured at the time of the examination, it is always advisable to make a second examination when this event occurs, as a change in the presentation may sometimes then take place, but more particularly because it is at this stage that the cord occasionally comes down; unless this condition is detected by vaginal examination, the child's life may be lost for want of the appropriate treatment.

The Second Stage.

During the course of the labour the vulva should be cleansed at frequent intervals, and, as the head descends and commences to press out faecal matter, this should be wiped away by pledgets of wool dipped in hot perchloride solution, taking care to wipe in a direction away from the vulva. If the fingers of the obstetrician or nurse become soiled with faeces, the hands should be at once thoroughly washed, and afterwards immersed in the perchloride solution.

As soon as the head reaches the vulvar orifice the parts should be kept clearly in view until the labour is completed.

I believe that much may be done in the way of prevention of rupture of the perineum by preventing the head from making too rapid an exit, and by pushing it forward against the pubic arch and assisting its extension.

The head may be pushed forward and extension favoured by placing the thumb or finger on the strecthed-out tissues at the sides of and behind the anus and pressing forward. I do not favour the placing of a finger in the rectum, as, in addition to the disadvantage of fouling the finger, the rectal mucous membranes may be readily damaged by this proceeding. An additional means by which the perineum may be saved is by taking care that the thighs are extended at the moment of greatest stretching; this particularly applies to the right thigh, which is held up by the nurse

at this stage, and, unless she is directed otherwise, she will flex it strongly on the abdomen.

My experience of ruptured perineum has been that many of the worst cases have been those in which the child was born without any assistance before the arrival of the accoucheur.

The incision of a tense perineum has never commended itself to me, and is not, I think, much practised in this country; the main objection to it appeared to me to be that one can never tell with certainty that a perineum is going to rupture, and if incisions are practised as a regular procedure a perineum will frequently be incised which, except for the zeal of the obstetrician, would have escaped damage; to what length incision is carried out in Germany may be judged from an article by Fleishman, who recommends.

The use of the median episiotomy incision in place of the lateral incisions which are commonly advised, on the ground that it gives more room, has cleaner edges, and more equal surfaces, and is not so liable to extend deeply; he has considerably extended the indications for its use, and it is often his first procedure in forceps delivery in elderly primiparae. Not infrequently by the use of median perineotomy it has been possible to save the patient from forceps operation.

I think that I may say that the latter would be regarded by us as the lesser evil of the two.

Uterine Inertia.

Delay in the first stage with the membranes unruptured may be prolonged over several days without any harm resulting, and I have known the uterus to remain absolutely inactive, with the os open to the size of a crown piece, during six or seven days; some of the mot marked examples of this condition have been in the poor patients of the hospital and lying-in charity, and the inertia has been due, I believe, to muscular weakness from insufficient food during the latter part of pregnancy.

If the membrances have ruptured, delay even in the first stage may become serious, and the mother may show dangerous symptoms of exhaustion, and active treatment may be indicated.

The usual treatment, however, of inertia in the first stage is to give the patient nourishment and to endeavour to obtain sleep, administering sedatives if required.

As regards oxytocic drugs, I do not think that the value of quinine is sufficiently appreciated. Five grains, in powder, repeated two or three times will often have a marked effect.

The administration of sugar has been proposed as a remedy for exhaustion of the voluntary and involuntary muscles of labour. I have tried it with, I think, good results; it has at all events the merit of being harmless.

I think that the majority of those who attend midwifery cases will agree with me that a certain, not inconsiderable, percentage seem unable to terminate their labour without assistance, and require forceps to com-

plete the second stage no matter how persevering the woman or how patient the accoucheur.

Posture in Labour.

I believe that this failure of the natural powers to complete delivery is to be ascribed in part to what may be called the unnatural position assumed by civilized woman at the latter part of the second stage of labour. Dr. Robert W. Felkin, in a paper read before the Edinburgh Obstetrical Society in 1884, entitled Notes on Labour in Central Africa, gives account of the customs of numerous tribes, with illustrations of the positions adopted during labour, and the latter show that some form of semi-erect or squatting posture is universal.

The question of posture in labour is gone into very thoroughly in a book entitled *Labour Among Primitive Peoples*, by Dr. Engelman.

After describing the attitudes assumed by uncivilized peoples in all parts of the world, he sums up as follows :

The care with which the parturient women of uncivilized people avoid the dorsal decubitus, the modern obstetric position, at the termination of labour, is sufficient evidence that it is a most undesirable position for ordinary cases of confinement.

The reasons given for its undesirability being that no assistance from gravity is derived in that position, and that the abdominal muscles cannot act to advantage. It is clear that the strict dorsal position as taught on the Continent of Europe and in the United States is the one referred to, as Dr. Engelman says :

The English method, on the side, with the body bent forward and the thighs drawn up, is much more advantageous, in so far as the abdominal muscles act better.

He says, however, that the proper position for the termination of the second stage is—

the semi-recumbent position in bed, the body at an angle of 450, the hips resting on a hard mattress, thighs well flexed.

And states :

This is the easiest, most comfortable, and appears to afford the greatest relief and the greatest freedom from pain, coupled with the greatest effect of the uterine contractions, relaxation of all the parts, and free play of the abdominal muscles.

He points out, moreover, that in this position the perineum has a certain amount of support from the mattress on which the patient is placed.

Whether we agree with the above or not, I think that all obstetricians may, with advantage, follow the advice of Dr. Engelman that in labour the patient should be given greater liberty, and should be permitted to follow her instinct, in regard to her movements, more freely than is now customary.

The attitude assumed by women of the poorer classes in this district approaches somewhat to that described by Dr. Engelman as the most

efficient. The bed is rolled up from the mattress, and the patient lies on her left side, with her shoulders raised up to a considerable height by the rolled-up bed; this position is inconvenient for the accoucheur, but one cannot doubt that it is advantageous for expulsion.

The worst attitude of all is the usual left lateral on the modern spring bed; the latter invariably skins down towards the middle, and if the hips are brought to the edge of the bed, as is usual, they are at a distinctly higher level than the remainder of the body, and the expulsive powers are consequently working against gravity instead of being favoured by it.

The Use of Forceps.

I am firmly convinced that the timely application of the forceps when the head is on or near the perineum and does not advance, in spite of strong pains, is beneficial.

If forceps are used and chloroform is given, very little of the latter is required, less than 1 drachm being amply sufficient in many cases. It is most important not to give chloroform to such an extent as to render the regular pains not easily discernible, and it is essential that traction should only be made during a pain.

Opinions differ as to whether the forceps should be taken off when the head is distending the perineum. Personally I am in favour of keeping them on until labour is completed, as by their means the head can be kept well forward under the pubic arch, and the strain on the perineum considerably relieved; moreover, the speed of delivery can be exactly regulated, and I think that these advantages more than compensate for the small amount of extra room required by the blades of the forceps.

Occipito-Posterior Positions.

A frequent cause of delay in the second stage is a persistent occipito-posterior position of the vertex, and I have found that some of these cases can be most successfully treated by rotating with the forceps, after other means of rectifying the position have been tried in vain.

To do this it is absolutely necessary that the diagnosis should be exact, and that a clear and correct idea of the direction in which the head ought to rotate should be formed; when this has been done the forceps may be applied, and as traction is made gentle rotation in the required direction should be made also; if this is successful it will be necessary to take off the forceps and reapply them before delivery is completed, unless short forceps are used.

Rupture of Perineum by Shoulders.

It is not uncommon for the perineum to be ruptured by the passage of the shoulders after it has stood without damage of the head. This may frequently be avoided by preventing the shoulders from emerging together, and thus distending the perineum to the full extent of the biacromial diameter; and in order to do this the anterior shoulder should be extracted first.

THIRD STAGE.

We find that there is a general consensus of opinion that the management of this constitutes the most important part of the obstetrician's duty. Dr. Ingleby said :

If the skilful management of the placenta is justly deemed a great attainment in the practitioner, it cannot be doubted that it is of great importance to the patient, whose life indeed may be said to depend immediately upon it.

We may with interest and advantage consider the varied views which have been held in the past as to this part of the obstetrician's duty. [After reading extracts from several old books Dr. Purslow continued :]

All modern writers of text books ignore the reasoning of Denman, and advise some assistance during the third stage ; the usual method recommended is, that the hand should be placed on the uterus during the latter part of the expulsion of the child, and, after that is completed, that the uterus should remain more or less continuously under observation by the hand, and that if it becomes flaccid gentle kneading should be used to induce contraction again : as soon as there is evidence that the placenta has left the uterus, as shown by the diminution of its circumference, the uterus is firmly grasped and pressed downward in the direction of the axis of the pelvic brim thus forcing the placenta out of the vagina. In the words of Galabin :

In this expression the contractile upper segment of the uterus acts simply as a piston, by means of which the pressure of the external hand is transmitted to the placenta lying in the relaxed lower segment and vagina.

If there is no descent of the placenta at the end of about half an hour it is advised that the uterus be stimulated by pressure and kneading, and, as it becomes hard, that it be squeezed ; and, if the placenta can be felt to leave it, that the pressure be continued downward in the direction of the pelvic axis, as above.

In contradistinction to the usual teaching of the present day, Dr. Horrocks takes the extreme line in non-interference, and would not even advise following down the uterus during the expulsion of the child, or placing the hand on it after delivery, to ascertain if it is contracted ; he says that if there is no visible haemorrhage and the pulse is good we may safely assume that all is going on well without examining the uterus.

The difficulty so often experienced in the third stage of labour in civilized women as compared with its ease and shortness in the uncivilized is undoubtedly partly attributable to the position assumed by the former. Among the uncivilized some form of external pressure by the woman herself, or her attendants, is almost universal, but, as pointed out by Engelman, the position assumed is invariably the standing or squatting, and thus gravity comes to the aid of the expulsive efforts. In the usual obstetric position the woman is unable in many cases to extrude

the placenta from the vagina without artificial assistance; thus von Campe (quoted by Hirst) in 120 observations found that in twenty-four instances the placenta had not been expelled within twenty-four hours.

It is strange that there should be any difference of opinion as to the surface of the placenta which presents at the os uteri and vulva, but on looking up the matter I find that all writers are not agreed on this; the majority state that some point on the amniotic (fetal) surface presents, thus Champneys found, in a careful observation of 70 cases, that only two presented by the maternal surface. Hirst states that

The placenta is usually expelled like an inverted umbrella, the fetal surface coming first, with the membranes trailing after it; it occasionally, however, escapes edgewise.

Dakin says:

The placenta never, unless its lower edge was originally close to the internal os, presents by its edge, but by some spot on its fetal surface from ¼in. to 3½in. above its lower edge, in most cases about 2in.

Playfair alone amongst the authors whom I have consulted describes the maternal surface as presenting; thus he says:

The uterine surface of the placenta is generally expelled first, the cord being within the membranes,

and he gives a diagram to represent this.

I have paid particular attention to the phenomena of the third stage of labour, and have watched it carefully in each case, and I have come to the conclusion that the placenta normally presents by the amniotic surface, as described by Hirst and Dakin, and that the description of Playfair is absolutely wrong. Moreover, I have formed the opinion that presentation of the maternal surface is almost always brought about by too early or too forcible application of expression to the fundus, and is invariably attended by tearing and retention of more or less of the membranes.

It is well known that attempts to press out the placenta too soon after the birth of the child are very liable to be followed by difficulty with the membranes, and the explanation I venture to give is this:

If pressure is made while the placenta is still partly attached to the uterus, the effect is to drive the blood, which is lying behind the placenta, into the most dependent part of the bag formed by the already detached and inverted portion of placenta and membranes, and if this pressure is forcible and continued, the blood is forced through the membranes at their junction with the placenta, and the maternal aspect of the edge of the placenta is thus allowed to present; when the membranes have once been torn in this way they may easily be completely detached, and I have no doubt that it has been within the experience of some of my audience, as it has been my own, to occasionally see the placenta expelled entirely bereft of its membranes, in cases where there has been much difficulty with the third stage.

This unsatisfactory result will very rarely be seen if ample time is given for the placenta to separate and no attempt is made to squeeze the uterus

forcibly, gentle kneading to encourage uterine contractions being all that is required.

I believe violent squeezing of the uterus shortly after the child is born to be a most disastrous proceeding, and one of the reasons for the still extensive prevalence of puerperal fever. Crede himself in his later years considerably modified his method, and in his latest writings directed that, in the absence of any serious hæmorrhage, about thirty minutes should elapse before the placenta was expelled.

The same forcing of blood through the membranes, tearing them away from the placenta, may occur as the placenta is being expelled from the vulva; and it is upon three cases in which I saw this happen that I have based the explanation above given. In these cases the amniotic surface of the placenta first appeared in the usual way; then, as pressure was being made from above, the edge of the placenta with the adjoining membranes appeared, and on further pressure the membranes could be seen to give way and the maternal surface appeared, several clots at the same time escaping from the interior of the torn bag of membranes. It is probable that in these cases the outer edge of the membranes had not been completely detached.

The same result might conceivably result from violent bearing-down efforts of the patient without assistance from the accoucheur; but in each case in which I observed it external pressure (Crede method) was applied.

When the placenta is in the vagina there is less likelihood of the accident I have described occurring, if in addition to pressure on the fundus, gentle traction on the cord is also used to assist the exit of the placenta; less pressure is needed on the uterus, and the placenta and membranes come away intact in a more satisfactory way than when the Crede method alone is used. We may regard the amount of traction on the cord as compensating for the loss of the assistance of gravity which, as we have already seen, is obtained in the more natural position assumed by the uncivilized woman for this stage of labour.

It seems to me that in the reaction against the old, bad, and dangerous method of dragging out the placenta from the uterus by pulling on the cord, some writers have gone too far in laying down the rule that the cord should never be pulled upon, even when the placenta is lying outside the uterus.

Since writing the above I have read a most valuable address by Dr. G. F. Blacker on the Management of the Third Stage of Labour. He says that there are three ways in which the placenta may be expelled: First, the inverted fetal surface leading; secondly, folded upon itself; third, the maternal surface leading; and adds:

It is more especially when the placenta is expelled in the last-named way—which occurs, according to Varnier, in 9 per cent. of cases—that retention of membranes is liable to occur.

In the Queen's Hospital Maternity some 400 to 500 cases are attended annually, and during the sixteen and three-quarter years in which I have

been in charge there has been no death from *post partum* hæmorrhage. This good result I attribute partly to the fact that the students attending the cases are not hampered with other work, and consequently are not tempted to unduly hasten the delivery of the placenta.

Conclusion.

To sum up, my own views as to the mechanism and treatment of the third stage are:

That in all but a small percentage of cases the uterus is able to separate and expel the placenta from its cavity without assistance.

That the time required for this varies greatly. In some cases the placenta appears to be separated by the same pain which expels the body of the child, and in a very few minutes will be found in the vagina; in other cases half an hour or more is required. Delay and difficulty is more particularly experienced in cases in which the previous stages of the labour have been tedious, and especially when delivery has been effected by forceps under chloroform, after many hours of ineffectual pains.

That the vigorous squeezing of the uterus, so commonly practised a short time after the child is born, interferes with the mechanism of detachment, and leads to tearing and separation of portions of membrane, or even in some cases of portions of placenta.

That, although squeezing is not advisable, it is well to place the hand at frequent intervals upon the uterus, as otherwise, in some cases, the uterus may distend with blood to a dangerous extent; if this distension is felt to be taking place, gentle kneading movements, to ensure contraction, may be used.

That a considerable proportion of women appear to be unable to expel the placenta from the vagina, and that this failure is partly due to the lack of the assistance of gravity when the woman is in the recumbent position.

That it is a mistake to rely solely on forcible pushing downward of the uterus in order to procure the expulsion of the placenta from the vagina, and that much better results are obtained when less pressure on the uterus is employed and the exit of the placenta is assisted by gentle traction on the cord.

AFTER-TREATMENT.

When the placenta and membranes have been examined and found to be complete the patient should be cleaned up. I think that it is at this stage that remissness is sometimes shown, and I am strongly of opinion that the toilet of the vulva should be performed by the medical attendant himself, and not left, as is so often done, to the nurse or, among the poor, to the ignorant and dirty neighbour who is officiating in that capacity. I am convinced that some cases of puerperal fever arise through this rule not being observed.

In addition to cleansing the vulva with an antiseptic lotion, it is well to trim the hair of the labia with scissors, if it is at all long, as its removal much facilitates the subsequent task of keeping the genitals clean. When

the cleansing is completed, a clean napkin or antiseptic pad should be applied to the vulva.

As regards douching after labour, there is great divergence of opinion; my own practice is: If I have found it necessary to pass my hand into the uterus, as for removal of the placenta, I give an intrauterine douche myself, at the conclusion of the labour, of some antiseptic, as lysol, *not* perchloride, as the latter is readily absorbed from the inner surface of the uterus.

I have tried the various forms of apparatus used for this purpose, including the Higginson's syringe, the reservoir douche, and the Rotunda siphon douche, and have come to the conclusion that there is nothing at once so clean, safe, and satisfactory as the apparatus we have used for some years in the Queen's Hospital maternity; this consists of a glass funnel, about 2½ ft. of rubber tubing, and a glass vaginal or uterine tube. The solution is prepared in a jug and the funnel is given to the woman in attendance with directions to keep it full from the jug; by this means there is no risk of air getting in, as will happen with a Higginson's syringe; neither is there any risk of the apparatus being fouled by any backflow, as is the case with even the best Higginson's syringe.

The pad on the vulva must be changed at intervals, particularly after evacuation of the bladder or bowels, and a fresh one substituted. The same pad must on no account be replaced.

After evacuation of the bowels the parts must be cleansed with antiseptic lotion, great care being taken that the vulva is not contaminated with fæcal matter.

As regards the repair of lacerations of the perineum, the needle to use for this purpose should be one with a strong curved stem, and a handle which will give a good grip. Cullingworth's perineum needle is one of the best, and is the one I always use. There is no better material for suture than silkworm gut; this can now be obtained prepared, and with its ends cut off, and the very stoutest salmon line gut should be chosen for this purpose; it is readily sterilized by boiling.

The most usual fault in repairing the perineum is that too small a needle is used, and the deeper structures, particularly the torn muscle, are not secured; the result is that the skin may heal, forming a bridge underneath which is a communication between rectum and vagina. I have dealt with several cases in which this condition had resulted, in the gynæcological ward of the Queen's Hospital.

After the patient has been placed on her back in bed, it is usual to apply a binder to the abdomen, though this should not be done until at least half-an-hour after the birth of the child, and not then, unless the condition of the uterus and of the pulse is satisfactory.

Some modern authorities state that a binder is not necessary, and has no good effect in preserving the figure, but even if that be granted, no one can deny that the binder has an immediate good effect in driving the blood from the large veins of the abdomen, and so preventing any tendency to

cerebral anæmia, and this is particularly useful if the loss of blood has been at all great. I do not agree with the plan followed by some accoucheurs of putting a hard substance, as a book or pincushion, over the uterus before applying the binder.

There are some points in connexion with the management of the puerperium to which I desire to call attention.

First, with reference to retention of urine, which not infrequently follows a prolonged or a forceps delivery, before having recourse to the catheter, hot fomentations, preferably with antiseptic lotion may be tried, and sometimes they are efficacious. If the catheter is required the question arises, should it be passed by touch or by sight? I am strongly in favour of the latter plan, but, before giving my reasons, I should like, with your permission, to quote verbatim the directions given in Herman's *First Lines in Midwifery*, as this is a book extensively read by students and midwives:

To Pass a Catheter.—Place the patient on her back, with the knees drawn up. Cleanse the parts by gently wiping them with wool dipped in 1 in 2,000 sublimate solution. Take the catheter in the right hand, and hold it about 2 in. from the tip. (It is a good thing to put about 3 ft. of India rubber tubing over the open end of of the catheter; the urine is then conveyed out of the bed into a utensil on the floor.) Stand on the patient's right side, and pass the right hand holding the catheter under the patient's right thigh. Pass the left fore-finger over the abdomen between the labia into the vagina. Then draw it upwards exactly in the middle line until the pulp of the forefinger feels the orifice of the urethra. The meatus urinarius feels very like one of the small linen-covered buttons with which underclothing is often fastened: a little ring, with a slight depression in its centre. When you feel this, draw the finger upwards till it is just above the meatus, and then with the right hand pass the point of the catheter below the tip of the left forefinger into the urethra. If you cannot succeed in thus quickly finding the meatus by the touch, it is better to look than to annoy the patient by prolonged attempts at passing the catheter by the touch alone.

The manœuvre above described is not easy to perform, and requires some practice; moreover, I venture to think that it is by no means the best way of passing the catheter, and that there are several objections to it.

In the first place, it increases the risk of cystitis, as it is impossible to be sure that the orifice of the urethra and its immediate neighbourhood have been wiped free from discharge unless they are clearly seen, and some of this may be carried into the bladder on the catheter.

Then, again, the manipulation about the external genitals introduces an added risk of septic infection, and, as shown in Dr. Knyvett Gordon's paper, septic infection during the lying-in period is much more common than is usually supposed.

Before passing the catheter a clear view should always be obtained of the urethral orifice; this can be done with the patient lying on her back

by separating the labia with the fore and middle fingers of the left hand. The urethral orifice and its neighbourhood should then be cleansed with an antiseptic, and the catheter, which is held in the right hand, inserted. It is, in my opinion, better to use a small basin to catch the urine than to attach a tube, as the latter makes the catheter more difficult to manipulate, and a further disadvantage is that it is not so easy to see if the urine is escaping properly.

A glass or metal catheter should be used; the latter is perhaps safer for a nurse's use, as cases have occurred in which a glass catheter has been broken during the movement of restless patient. The catheter is best rendered aseptic by boiling.

It is a good plan to allow the patient's body to be lifted up in bed into the vertical position, after the third or fourth day, for a few minutes daily, to facilitate the escape of the lochia. Care should be taken that the patient does not lie too persistently on the back, and she sould be encouraged to lie on either side at intervals. There can be little doubt that many cases of retroflexion arise from the too persistent assumption of the dorsal decubitus during the puerperium.

As regards length of puerperium, I am accustomed to regard a fortnight as the minimum period after a normal confinement; few women realize the importance of sufficient rest after parturition.

My experience in the out-patient room has led me to the conclusion that almost all the cases of bad procidentia, which are so numerous and so unsatisfactory in treatment, are due to women getting up too soon after confinement and, whilst the uterus is heavy and its supports lax, doing hard work.—*The British Medical Journal*, June 30, 1906.

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