OBSTETRICS.

VARICOSE HÆMORRHAGE FROM THE CERVICAL ZONE OF THE UTERUS, COMPLICATING LABOUR.

Dr. Murray draws attention in the Obstetrical Journal to a remarkable form of hæmorrhage that occurred in one of his patients, of which the following is a history:—Mrs. B., aged 27, first labour, full term of gestation: in a weak state of health and of a nervous temperament. She was about to retire to bed, when she felt blood running from her. She sent for a physician—Dr. Kirby—who plugged the vagina, and all bleeding ceased. The os uteri was then only partially dilated, and the liquor amnii had not escaped. Dr. Murray was then called in in consultation. Dr. Murray removed the plugs, and found that the os uteri had become fully dilated, that the membranes were tense, and that very little hæmorrhage was going on. No portion of the placenta could be felt. A full dose of ergot was given, the membranes were ruptured, and the labour progressed quickly, and terminated favourably.

Thirteen months after the patient was seen by Dr. Murray, at Dr. Kirby's request, in her second labour. Hæmorrhage had again set in, as before, without appreciable pain. Dr. Kirby had plugged the vagina, but a small stream of dark blood escaped continuously. On removing the plugs, Dr. Murray found the os uteri dilated to the size of a crown, the membranes unruptured, and the fœtal head presenting. The cervix felt large and pulpy at its posterior aspect, and was rather low down in the vagina. No trace of the placenta could be felt on the most careful examination. The pulpy part yielded on pressure with the fingers, and coincidentally the bleeding diminished. The same treatment as before was adopted, with the same results. Cases somewhat similar to these have been reported by M'Clintock and Mr. Roberton, of Manchester, but their issue was less satisfactory, both patients dying.

GYNÆCOLOGY.

THE OPERATION OF ENUCLEATING UTERINE FIBROIDS.

By Dr. Alfred Meadows, London.

The operation of enucleation should be conducted upon a definite plan, and according to some fixed principle; and both may, I think, be summed up as follows:—First, that these uterine tumours should be regarded as essentially *foreign* bodies. Secondly, that Nature's method of dealing with these foreign bodies is to expel them; we see this often in the case of polypi, and occasionally even in large submucous fibroids. Thirdly, that for her success in this matter a dilated or dilatable os, and uterine contraction, are the only essential requisites. Fourthly, that it is the duty of the physician, when these conditions are absent, to step in with his art and imitate the process. Fifthly, that for this purpose the cervix must be opened up, and the uterus be stimulated to contraction. Lastly, that both these objects will be greatly facilitated, in the case of interstitial tumours, by their forcible detachment from the position in which they are embodded, thus making them more and more foreign to the organ where they are lodged.

Now as to details. The conditions of success are, as I have said, an open os, uterine contraction, and detachment of the tumour. As to the first, I am strongly opposed to the method of dilatation, and in favour of free division. I have seen infinitely greater evils result from dilatation than from division. Moreover, the former is inadequate to the subsequent steps of the operation, because—and this applies especially to cases where the tumour is large—I think it is most important that the process of detachment should be conducted gradually, and in successive portions, so as not at one time to expose a very large surface to the risk of inflammation and purulent absorption. If the cervix be divided, it is done once for all, and is ready for the successive steps of the operation; whereas in dilatation the same process has to be repeated every time that we resort to detachment.

My plan, then, is, first to divide the cervix freely in two or three places, taking care to prevent reunion of the divided surface, and always to plug the vagina for a few hours after the division is made. In about a week, or at most a fortnight, from this time, supposing that all has gone on well, I introduce the finger up to the tumour, and, with whatever force is necessary (sometimes a good deal is required, sometimes but very little), I break through the tissue covering the tumour at the point where it joins the healthy uterus. Once within what I call the intracapsular space—that is, the space between the tumour and the uterus,—there is according to my experience, very little difficulty indeed in passing the finger freely round the tumour in all directions, breaking down its loose cellular attachments, and, in short, shelling it out from its uterine bed. As I have said, I greatly prefer not doing this at once, but in successive steps. When the tumour is in good part detached, but not before then, we may advance to the next step in the process, and endeavour to procure its expulsion. This we do by the administration of any of the various oxytoxic agents, of which ergot and borax are certainly the best. Sometimes I have used galvanism, with evident success; but in this matter I do not think it is of much importance what we use, for, if the tumour is only well separated, the uterus will usually contract most efficiently, and all the more readily, no doubt, because of the irritation to which it has been subjected by the previous operations. The last step in the operation is the removal of the tumour by means of the écraseur in the same way as has been already recommended in the case polypoid growths. I have once succeeded in entirely enucleating such a tumour without the use of the écraseur; and I do not at all see why in some cases we should not be able completely to detach it with the finger, just as I have done again and again in post-mortem cases. Where we are dealing with a very large tumour, it may occasionally be necessary to remove it in successive portions. I had a case of this kind under my care some time ago: the uterus was occupied by one of these interstitial fibroids, and was of such a size that the fundus reached fully up to the umbilicus. In that case, after I had detached a good part of the tumour, the uterus contracted so vigorously upon it that in four days a large mass was forced into the vagina, and I was compelled to remove it before waiting for the subsequent separation and removal of the remaining portion. Ultimately, however, I got it all away, and the patient came to me the other day perfectly well.

Such, then, is the plan of enucleation which I am in the habit of practising, which I recommend strongly as by far the best way of treating these cases of insterstitial fibroid, and which, if conducted with all due care and in properly selected cases, is, I am convinced, not nearly so dangerous an operation as it has been represented.

PRACTICAL MEDICINE.

OXIDE OF ZINC IN INFANTILE DIARRHŒA.

Dr. E. Mackey, of the Children's Hospital, Birmingham, expresses himself as being strongly in favour of the use of oxide of zinc in the diarrhœa of children, which he regards as preferable to chalk and kino. Oxide of bismuth has tonic and antispasmodic properties, a combination in a non-irritant substance exactly suited to many cases of the malady. Chalk is good, but sometimes irritates, and sometimes fails. Acids are good, but sometimes gripe, and sometimes injure the teeth. Opium should be absolutely forbidden for infants that cannot be closely watched. Bismuth is very good, and zinc resembles it, with better nervetonic powers, whilst it is much less expensive. Oxide of zinc has given him (suitable diet being premised) excellent results in all the varieties of infantile diarrhœa, notably in those complicating hooping-cough; it is not to be forgotten in the profuse sweating of rachitis. The dose may be one grain for any age under two years, and may be well given with a little syrup, mucilage, and dill water, three or four times daily, not on an empty stomach.—*Brit. Med. Jour.*

THE DIARRHŒA OF CHILDREN.

In a short paper on the diarrhœa of children, in the British Medical Journal, Dr. Eustace Smith remarks that teething infants are excessively sensitive to slight changes of temperature, and the protection of the body from impressions of cold should be the first precaution to be adopted in all cases of abdominal derangement in children. Dr. Smith states that it has long been his practice to recommend the application to the belly of a flannel binder, which should be applied low down on the abdomen, and be firmly wrapped round the hips and buttocks, and should be broad enough to cover the body as high as the waist. This, with a dose of castor-oil to remove irritating matters from the bowels, will ease at once almost all cases of acute functional diarrhœa in children. In all cases when the child is not at the breast, milk should be excluded for a day or two from the diet. Its place can be supplied by whey, veal broth, and barley-water in equal proportions.