about two months) enveloped in its membranes, and with the placenta attached. At the upper part of the uterus there was a rupture, close by the right Fallopian tube, large enough to contain three fingers, looking like a sac the walls of which were extremely thin.

There was no communication between it and the interior of the uterus, which weighed exactly eight ounces. The heart was fatty and somewhat flabby, and was perfectly empty, as were also all the large bloodvessels. The other organs of the body appeared perfectly healthy. The head was not examined. The uterus, etc., etc., has been sent through Mr. Dorian to the Museum of the Royal College of Surgeons. I have no remarks to make on the case, except as to the absence of the graver symptoms, until within so short a time of the death. The blood had evidently continued oozing out, until there was no more to come; the apparent desire to pass water was evidently caused by the pressure of the clots, etc.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Sept. 22nd, 1882.

GEORGE ROSS, M.D., PRESIDENT, IN THE CHAIR.

Pathological Specimens.—Dr. Shepherd exhibited a specimen of ossification of the sacro-iliac synchondrosis. On separation of the bones, the articular surfaces appeared quite healthy, but those of the lumbo-sacral articulations were somewhat diseased. This condition is sometimes found to be congenital, but in the case under notice Dr. Shepherd thought it was of rheumatic origin.

Subject of Paper.—Dr. Alloway narrated the following case: The patient, a woman, aged 24, was attended by himself and Dr. Rodger in her confinement. She had been in labour about 12 hours. Occipito-posterior position. Ether was administered, and Simpson's long forceps applied. During traction the head suddenly slipped from under the pubic arch and carried away the perineal body, sphincter ani and the recto-vaginal septum for fully two and a half inches in its extent upwards (length of index finger). The immediate operation was done, which was a combination of Simon's and Emmet's. The rent in the bowel was first united by interrupted sutures of strong grey thread, the only material obtained at the time. The perineum was united in the ordinary way, care being taken that the lower or Emmet's suture was entered low down on a level with the lower margin of the anus, on the left side, passing upwards and inwards over to the opposite side, and downwards to the point corresponding to its entrance on the left side. The vagina was well washed out with carbolized warm water, the parts anointed with vaseline, and the patient's knees tied together. The carbolized injections were continued every two hours by a very faithful nurse in attendance. On the fourth day diarrhœa set in, which could not be arrested until several days had elapsed, it being due to the milk the patient was taking. The fluid fæces passed between the sutures into the vagina. Patient became very despondent, thinking she was ruined for life. On the 10th day carbolized injections reduced to twice only. On the 15th day removed all the perineal sutures, except Emmet's. This was left until the 18th day, when it and all the internal sutures were removed through the bowel. There was still a small fistulous opening in front of the sphincter. This, however, had completely closed by the 22nd day. From this out the patient made a perfect recovery. Was examined some months afterwards, and exhibited no laceration of the cervix, unless it had completely healed, and had a perfect perineum. Uterus normal depth. Dr. Alloway drew attention to the fortunate accident of diarrhœa having set in shortly after the operation, and alluded to a paper just then published in the *New York Medical Record* (July) by Dr. H. T. Hank, of the Woman's Hospital, New York, upon the advisability of intentionally keeping the bowels loose during the whole period of treatment, from the second day after operation. Dr. Alloway attributed much of the successful issue to this circumstance.

Discussion on Paper.—Dr. Kennedy spoke of the great frequency of laceration of the perineum, especially in occipito-posterior positions of the head, in spite of the most skillful precautions on the part of the accoucheur. In such cases he favored the method recommended by Dr. White, of Buffalo, of making lateral incisions on both sides as soon as the perineum becomes distended, thus preventing laceration through the perineal body, which is always more slow to heal. His experience was limited to laceration through the sphincter, which he always treats by immediate operation,