my opinion, that Findlay died from strychnia. He appears to have
taken it wilfully, as it was intrusted to his care by his master, for
the purpose of destroying vermin. The quantity swallowed cannot
be exactly ascertained. The deceased was in his usual health at
seven A.M., and was found dead at ten A.M. Judging from the re-
port of his comrades, I believe about ten or twelve grains had been
taken from the phial since it had last been seen by them.

Forfar, 10th February 1846

PART SECOND.

REVIEWS.

Lectures on Natural and Difficult Parturition. By Edward William Mur-
phy, A.M., M.D., Professor of Midwifery, University College, London, Ob-
stetric Physician, University College Hospital, and formerly Assistant Phy-
sician to the Dublin Lying-in Hospital. London: 1846.

Midwifery is not a neglected branch of our profession, if we may judge from
the number of works in connection with it, which are constantly issuing from
the press of this and other countries. We rejoice to know that this depart-
ment is cultivated with zeal and energy; for its importance, and the respon-
sibility connected with its practice, can hardly be over-estimated. The ordinary
physician, in difficult and doubtful cases, has time to consult authorities, or take
the opinion of a professional brother; and the same remark applies, to a certain
extent, to cases which fall under the care of the surgeon; but in the practice of
midwifery—in most cases of difficulty—there is little time for consultation, or
even reflection, and a false step taken can often never be retraced. Hence the
necessity of every one who practises midwifery being thoroughly versant both
with its theory and practice.

The work before us is from the pen of a gentleman whose name is already
familiar to those who cultivate this department. His practical experience, ac-
quired while Assistant Physician to the Dublin Lying-in Hospital, and likewise
as Obstetric Physician to the University College Hospital, must be very consi-
derable; and knowing this, we opened the volume with the expectation of find-
ing truly practical dissertations on Parturition. We have, to a certain extent,
been disappointed. The practical is by far the least valuable part of the work.
Important practical details are wanting in almost every section; while obviously,
by a little care, every portion might have been rendered of a more useful cha-
acter. While we thus express our sentiments regarding the general character of
the undertaking, we must say, that we have found it is by no means an un-
instructive volume.

The First Lecture embraces the Anatomy of the Pelvis, so far as it is con-
nected with the process of parturition. It is clear, concise, and accurate; and we
have discovered in it nothing wherewith to find fault. We select a few pas-
sages, which we consider worthy of attention; and in the accuracy of which we
perfectly coincide.

The first quotation we will adduce refers to the Form of the Inferior Portions
of the Iliac Bones, and the manner in which the head of the child is propelled
through the lower part of the pelvis:
"The inferior portion forms a part of the true pelvic cavity, and principally consists of the ischium. Its internal surface is bounded by the obturator foramen on the one side, and the ischiatic foramen on the other; it is smooth, and corresponds to the acetabulum on the external surface. This surface is called (in obstetric language) the plane of the ischium, because the head of the child glides upon it in its descent, and passes forwards under the arch of the pubes; but if carefully examined, it will be found to consist of two planes, very slightly inclined in opposite directions, and divided by a line passing from the pectineal eminence to the spine of the ischium. In some pelves this is more obvious than in others; but when the soft parts are attached, this will be found nearly corresponding to the reflections of the peritoneum which form the broad ligaments. Thus, the internal surface of the ischium, before the soft parts are removed, presents two broadly curved surfaces, one anterior, the other posterior; these greatly contribute to facilitate the rotation of the head of the child in passing through the pelvic cavity. The anterior plane terminates at the obturator foramen, an opening nearly filled with membrane, giving support to the internal and external obturator muscles, and offering less resistance to the advance of the head forwards than if it consisted of bone. The obturator foramen is bounded by the ischio-pubic ramus, the pillar of the arch of the pubis. It presents a smooth surface, bevelled off towards the arch; and when the head passes from the obturator foramen upon it, this inclination greatly assists its exit under the arch of the pubes. The posterior plane terminates in the ischiatic foramen, and the portion of the head which comes upon it glides in a similar manner upon the coccygeus and pyramidal muscles, and shorter sacro-ischiatric ligament towards the hollow of the sacrum. Thus the inclinations of these surfaces oblige the head to pass through the pelvic cavity in a spiral direction. The pubic portion of the bone is smooth on its internal surface, which also greatly favours its advance." Pp. 2—4.

In describing a Horizontal Section of the Brim of the Pelvis, the author very properly remarks,—

"The lateral measurements are taken from the same point" (the promontory of the sacrum) "to the pectineal eminences on either side; these are about 3½ inches, but are very seldom found exactly equal. It is necessary to recollect these distances, because of the effect sometimes produced by their inequality. For instance, if the promontory be very much directed towards the right pectineal eminence, the head would be at once prevented entering the brim if it preserved its usual position, that is, with its anterior part opposite the right sacro-iliac synchondrosis; but if it took the other direction, so that the same part was applied in the same way to the left side, it would pass quite easily. Hence, in the same patient, one labour may be difficult and another easy, merely from the accidental position of the head." P. 12.

We concur in the following observation regarding the Bi-parietal Measurement of the Head:

"The bi-parietal measurement of the head is generally stated to correspond to the conjugate or antero-posterior axis of the brim; and as the former is 3½ inches, the latter 4, only half an inch is allowed for the soft parts, even in the best-formed pelves; consequently, the least diminution of the conjugate axis causes a difficulty: a greater one becomes an obstruction. Hence, among accoucheurs, it has been an anxious problem to determine the smallest conjugate diameter (as it is improperly called) through which the head can pass without destroying the child.

"Its solution has been attempted by comparing the bi-parietal measurement of the head with the conjugate of the pelvis; and it has been stated by Dr Joseph Clarke (a high practical authority), that if the conjugate be less than 3½ inches, a living child cannot pass the brim of the pelvis. But in all these discussions, it has been too confidently assumed, that these two measurements of the head and the pelvis exactly coincide. They do not; on the contrary, as the head is entering the pelvic cavity, the parietal protuberance next the pubes descends lower than that next the sacrum, so that the bi-parietal axis lies obliquely downwards, and so it remains more or less until the occiput escapes under the
The part of the head, therefore, which would be felt lowest in the pelvis cavity is this parietal bone. By this means nature avoids the difficulty which would often arise, if both parietal protuberances descended in the same plane.

"Thus you perceive, that the head slightly rotates on its longitudinal axis also; and in order to effect its passage through the pelvis, combines four distinct movements:—two of them upon the vertebral column, one in the lateral, and one in the antero-posterior direction:—two on the head itself, one on its longitudinal, and a second on its transverse axis. By the combination of these motions, the passage of the head is ultimately effected." Pp. 17, 18.

The Second Lecture discusses the varieties of the form of the pelvis, and the methods of ascertaining its dimensions. The exceptions to the standard pelvis the author proposes to divide into deviations and deformities,—

1st, The pelvis may be too large, and may lead to injurious consequences, although the process of parturition be not hindered. The uterus may pass into the vagina, or even appear at the vulva, predisposing to prolapsus uteri. The too rapid expulsion is certainly not one of the greatest evils of a pelvis of too large dimensions. The author believes that, when the parturient uterine action is called into operation, it must continue a certain time after the immediate existing cause is removed, alternately contracting and dilating; hence the danger of hemorrhage taking place.

2d, The pelvis may be too small. The pelvic bones of a female otherwise well formed may be disproportional to the size of the child’s head; and,

3d, The development of the pelvis may be arrested from various causes. Illustrations are given of a child’s pelvis, and that of an adult female, which show exceedingly well their comparative dimensions. There is much truth in the following statement, and at the same time we fear it is too seldom attended to in practice:—"The development of the pelvis may be almost completed, and yet be too small for the passage of the head; and as the difficulty may happen just at the time of puberty, it becomes an objection to early marriages. During the growth of the pelvis, the transverse and oblique measurements of the brim are constantly increasing, and the outlet becoming wider; but they do not begin to exceed the antero-posterior until after puberty, as may be readily perceived in the altered shape and carriage of the female at that time. At puberty, therefore, these measurements may only equal the antero-posterior: the outlet and perhaps the cavity being still in diminished proportions. Thus the young girl, although perfectly well-formed, but pregnant at too early an age, may be the victim of a difficult labour, simply from this cause." P. 25.

We agree in the following statement:—"The obstacles which the female pelvis may present to the passage of the head, when it approaches the characters of the male pelvis, deserve your attentive consideration. The triangular shape of the brim is not generally an impediment, because, although the transverse measurement is diminished, the oblique is sufficiently wide, and the head will usually pass into the cavity. But here, all the difficulties seem to centre; anteriorly, the symphyses pubis is narrower and more unyielding; even a deposition of bone is sometimes found behind it, which may be extremely dangerous, if the intervening soft parts are pressed against it by the head: posteriorly, the promontory of the sacrum offers no opposition, but the sacrum itself being straighter, there is less facility in the head performing the lateral rotation which has been already described to you, and this difficulty is still more increased by the convergence of the ischio-pubic rami. The head is obliged to descend much lower in the pelvic cavity before it can escape under the arch of the pubes, and it is prevented from doing so in consequence of the space being so much lessened by its funnel-shape. In addition to this, the tubers and spines of the ischia are more ossified, the one thicker and rougher, the other larger and more projecting; thus, as the head advances, its passage becomes more and more impeded, until it is ultimately arrested, perhaps close to the outlet. In women of this description, it is possible, also, that the head of the child may be more than usually ossified, and the action of the uterus is always strong, so that a most disadvantageous combination of circumstances
may take place in a healthy pelvis of this kind. On another occasion we shall have to refer to it; at present, we would only request you to notice its anatomical peculiarities, as it is important thoroughly to understand them; and here again we would observe, that the bones of the extremities will be a useful guide. The wrists and ankles are large, the phalanges thick and short; hence the old popular opinion amongst midwives, that 'a thick, short hand is a bad sign when a woman is in labour,' has a more just foundation than what, at first sight, might appear reasonable." P. 28.

Accurate representations of the varieties in the conformation of the pelvis, arising from rickets, mollities ossium, and similar diseases, are given, and their bearing upon practical midwifery explained. For the various measures which have been proposed from time to time to ascertain the dimensions of the pelvis, we must refer to the work itself.

Parturition is defined to be the action of the uterus to expel its contents when the fetus is sufficiently mature to sustain respiratory life, and Denman's division is adopted:—the first being the dilation of the os uteri, the second, the expulsion of the child; and the third the separation of the placenta. The author's exposition of the action of the external layer of muscles we hold to be correct. "The external muscular layer slowly contracts for some time before labour has actually commenced, and draws the uterus gradually towards the pelvis. By this means, also, the fundus is maintained in its proper direction, and prevented from inclining too much to either side. This gradual contraction is unaccompanied by pain, and therefore is not taken notice of; but its effect in altering the size of the abdomen, and making it less prominent, has always been observed and noted as a premonitory sign of labour. These fibres also serve a useful purpose when the dilatation of the os uteri commences. The fundus being thus supported, the fibres on the internal surface contract more efficiently." Pp. 45, 46.

The author does not believe that the os uteri possesses circular fibres resembling, in their action and formation, ordinary sphincter muscles. He thinks the manner in which the os uteri dilates supports the opposite view. "Its expansion is very gradual, it yields slowly to the power described, and does not resemble the comparatively sudden relaxation of a sphincter muscle." P. 49.

We beg, with deference, to tender our dissent from the unqualified language here employed; in general, the dilatation of the os uteri is a gradual process; but there are numerous exceptions. It is by no means uncommon to find a very rapid dilatation.

In the following passage the Influence of the Liquor Amnii is clearly pointed out, and at the same time not over-estimated:—"If the uterus exerted its full power upon the undilated os uteri, and if the unyielding head of the child were driven forcibly against it, the almost certain consequence would be, that the irritation would excite increased resistance, and ultimately terminate in inflammation of the mouth of the uterus. To obviate such an effect, nature interposes a fluid medium between the power and the resistance. The liquor amnii contained within the membrane occupies the cavity of the uterus, and when its parietes contract upon it, the force exerted is (as we have explained) by this means accurately conveyed to the os uteri. When the latter dilates in the slightest degree, the fluid insinuates itself within the smallest opening, and expands it by a direct lateral pressure against its edges. The power of the uterus is thus made to act in the most favourable manner for distending its mouth.

"Other advantages are also gained. The os uteri may dilate irregularly; but any attempts to overcome forcibly the undilated portion is prevented when the force is conveyed through a fluid, which, while it readily yields to an undue resistance, still maintains an equable pressure upon the edges of the os uteri. Any irregularity in the action of the uterine fibres is also, to a certain extent, obviated, because these contractions, although irregular, being still conveyed by the fluid, are thus equally communicated to the os uteri. Further, so long as the tissue of the uterus intervenes, it is necessary to moderate the great power which the uterus is capable of exercising to dilate it: this is effected by the
liquor amnii. The force conveyed by a fluid, you are aware, does not act in one direction only, but is distributed to every part of the surface to which the fluid is applied. The force, therefore, which is exerted to expand the mouth of the uterus, being communicated by a fluid, is not only directed against the os tincte, but against the fundus and sides of that organ. The fundus, consequently, is opposed, not only by the os uteri, but by its own action reflected by the liquor amnii. Hence, so long as the fluid remains, and the os uteri is undilated, the more powerful the action of the fundus, the greater is the resistance to it. The actual force employed is therefore very moderate, and any sudden or violent effort at distension is altogether obviated. You may observe this in the character of the pains during this stage. You will find that however severely they may commence, they last but a short time, and the effect on the os uteri is comparatively slight. If these short though severe pains be contrasted with the long-continued and powerful pains which follow them, when the liquor amnii is discharged and the os uteri dilated, the difference in the effect will be sufficiently obvious. As a means, therefore, of conveying the whole muscular power of the uterus upon the os uteri—of moderating and equalising the force employed—of dilating the mouth of the uterus without exciting irritation—the liquor amnii is of essential importance.” Pp. 50, 51.

We cannot give our assent to the following statement.

“The immediate effect of contraction, commencing at the fundus, would be to compress the liquor amnii, which of necessity forces its way before the head, on to the mouth of the uterus. The fluid, in this position, re-acts against the head with the same power that it is compressed, and therefore pushes it up until the increasing contraction of the fundus forces the head down again; so that you perceive the phenomena quoted are quite consistent with the statement that uterine contraction begins at the fundus; in fact, it could not be otherwise so long as the waters remain in the uterus.” P. 52, 53.

Our experience leads us to believe that instead of the fluid reacting against the fetal head, and pushing it forwards, that the part at which resistance is least gives way, or, in other words, the membranes are pushed further down.

We admire the author’s exposition of the benefits arising from the unruptured membranes during the expansion of the os uteri; they are well calculated to expose the fallacy of a doctrine which, we fear, is too frequently embraced by young obstetricians, that by rupturing the membrane at an early period, the duration of their attendance will be diminished.

The following passage is worthy of attention:— “If the os uteri become inflamed, rigidity is the result of it; the os tincte grows hot and tender, is swollen, and becomes rigid. This alteration may arise from any irritation; premature rupture of the membranes, for instance, by which the head is brought into direct contact with the undilated os uteri. It is also often induced, not by accidental causes, but by too much meddling, making too frequent examinations, attempting to dilate the os uteri artificially, &c. You cannot, therefore, be too cautious in this respect. Sometimes the head of the child presses so unequally upon the os uteri as to excite inflammation in it. The head may not be directed exactly in the axis of the brim, but may rather rest upon the pubic portion of it, compressing the anterior lip of the uterus with every pain. While the remaining portion of the mouth of the uterus expands, this remains undilated, and forms a band in front of the head. When the membranes are ruptured, the pressure is so much increased, that the anterior lip often inflames and grows quite rigid. Again, there are cases where the os uteri is driven down with the head into the pelvic cavity, and the whole circle of the os tincte compressed so tightly against the pelvis as to produce inflammation; further dilatation is arrested, the os uteri is rigid, and if it remain long in this condition, slough may be the result; the whole os tincte has been completely separated in this manner, and expelled with the head of the child.” Pp. 57, 58.

The Fourth Lecture is decidedly good; but it is not quite so practical as we could have wished. We will content ourselves with a single passage, which we consider correct and well-expressed:— “In some instances, from an accidental
cause, the forehead is driven down too far, so that the head, becoming fixed in the pelvis transversely, its progress is thus arrested. It is essential for you to understand this cause of delay in the second stage, because it is very easily corrected; and any ignorance respecting it might lead you into the erroneous impression, that the head should be delivered by instruments, because it was so long fixed in its position. When this accident takes place, the anterior fontanelle may be observed to be remarkably distinct; you readily trace out its lozenge shape, and feel the four sutures distinctly at each of the angles. The finger also passes very easily between the pubes and the head, so that there appears to be rather more space in that situation than usual. Finding, therefore, this evidence of room in the pelvis, the anterior fontanelle perfectly within reach, and at the same time the head not advancing, you have sufficient proof of this deviation. It is described by many authors as the premature separation of the chin from the chest of the child. The mode of correcting it is sufficiently simple. The head should be dislodged from its position in the interval of a pain, and the fingers pressed against the frontal bone until the uterus again contracts; the occiput will at once descend, and the labour proceed without further difficulty. There are rare instances in which the forehead descends completely into the cavity of the pelvis, and becomes the presenting part; when this occurs, the displacement cannot be corrected, as in the former instance; and the position is so unfavourable that the head soon becomes arrested in its progress. It acts upon the pelvis something like a wedge, the forehead being the narrow end, and the occiput and neck of the child its broad base. The more the head advances, the more the difficulty is increased. When this accident takes place, the exploring finger feels the frontal bone traversed in the centre by the frontal suture; there is therefore some resemblance to the vertex position, but it may be easily distinguished, because the forehead is smaller than the occiput, and the anterior fontanelle being near, can be very easily traced. The inexperienced observer would imagine, that there was more space than usual in the pelvis for the passage of the head, and might not be able to explain why its progress should be delayed; but if the finger were passed sufficiently high, he would soon perceive, that the head was completely wedged in the pelvic cavity.” Pp. 68, 69.

The Fifth Lecture embraces the management of natural labour. We are afraid the practical reader will find points of very great importance altogether omitted, or introduced in a manner little calculated to impress the mind.

We must tender our dissent from the following statement:—“This diarrhoea is always salutary, because it secures the important object of having the intestines unloaded.” P. 78. Diarrhoea, instead of being, as is here asserted, always salutary, is, we maintain, never safe immediately preceding delivery.

The author should have stated, that the first consideration of the accoucheur, in making an examination early, is to ascertain that labour has actually commenced. The directions given are sound.

We fully concur in the accuracy of the following statement. Here, as everywhere else, the best policy is to state the truth, or at least not to raise false hopes, which most unquestionably diminish the confidence of both patient and attendants. The advice tendered here, and in other practical treatises, is too frequently neglected—sometimes, perhaps, through a mistaken kindness, with a view to soothe and tranquillise an impatient sufferer. Dr Murphy says—“The second question, as to the duration of labour, cannot be too cautiously answered. The friends may ask, 'Is everything right?' but 'How soon shall I be well?' is invariably your patient's anxious question. In order to tranquillise and encourage her, it might seem pardonable to state a period for the termination of her sufferings, earlier than what you know will be the case. But such a practice would be extremely injudicious, because when the time had passed in which she expected a relief to her anguish, her disappointment would lead to impatience of further suffering, if not to a secret dread that the delay arose from some cause dangerous to herself. The result might be a suspension of the uterine action, and a still further prolongation of her labour. Along with this,
being proved, as it were, a false prophet, your patient may lose all confidence in your opinion and judgment.” P. 84.

In the Sixth Lecture the management of natural labour is continued. In our opinion, it is defective in many practical points, and several important directions are altogether omitted. Let us take an example.

"If you attempt to draw the perineum back over the head, it will be stretched too suddenly over the bi-parietal measurement, the widest part of the head. If, on the other hand, you push the head too much forwards, pressing with the pains from the sacrum towards the pubes, the same effect will be produced in a different manner; you force the parietal portion of the head too rapidly through the vulva. At this point, it is better to continue the same moderate counter-pressure, to make no attempt to hasten the delivery, and to allow the head to pass along the hollow of the hand, in the same manner as it moved along the curve of the sacrum. When the head is passing out of the vulva, you should then direct it forwards toward the pubes; and when it is delivered, examine carefully lest the funis may be coiled round the neck. If such be the case, and that it is only a single coil, it will generally be sufficient to draw down a little more of the funis, and loosen it. A single coil seldom retards the delivery of the child, or arrests the foetal circulation; but two and even three coils are sometimes met with, and the child placed in great danger of strangulation. In these cases, as much of the funis as possible should be brought down, and the coils so loosened that one may be drawn over the head. There are cases where this cannot be done, and the only resource left is to tie and divide the funis, and extract the child as soon as possible, in order that respiration may be established. This operation is hazardous to the child’s life, and can only be viewed as the lesser of two evils.

"If the funis be not found about the neck, the perineum must still be supported until the next pain, usually a tardy one, expels the shoulders. The same caution must be exercised as before, lest the arm or hand should lacerate the perineum as it is coming out of the vulva. This should be particularly attended to in the second positions of the head.” Pp. 96, 97.

Now, the first statement is undoubtedly correct; but the second is erroneous. Pressure of the head from the sacrum towards the pubes tends to relax the labia, and contributes to a safe and easy delivery. We think every practical man will admit, that if the cord is of sufficient length to permit of its being drawn over the head, it cannot prevent the egress of the child; hence the direction is unnecessary. If various coils surround the neck, and the dimensions of the cord do not allow any portion of it to be drawn over the head, there is no necessity for tying and dividing it. A much more judicious method is to push it over the shoulder, so as to render the pressure less, and diminish the risk of strangulation.

In speaking of the Expulsion of the Placenta, the author says—"A very moderate pressure on the fundus at this time is often sufficient to expel the placenta completely out of the vagina; but if not, it can be drawn out by the funis quite easily, directing the funis forwards in the axis of the vagina. But if the uterus should not obey the stimulus at first, do not persevere; it is always more advisable to wait for some time, than to use too much irritation. Neither should you attempt to remove the placenta by the funis alone. By great violence, it is true the funis may be broken, or the uterus inverted. I do not attribute to you such awkwardness; but by pulling frequently at the funis to ascertain if the placenta be separated, you may excite an irregular contraction of the uterus. Passing the fingers into the vagina is often sufficient to excite the action of the uterus; and drawing the placenta by the funis may excite it still more. If the uterus contract, and the order of its action be not secured by the means already pointed out to you, the great probability is, that being nearly emptied of its contents, the lower fibres will contract first, and retain the placenta. Thus, by pulling too much at the funis, the placenta may be retained. By a little caution, and by moderate pressure on the fundus of the uterus, you will generally secure its favourable separation. This being accomplished, the next and con-
cluding object of your attention is to preserve the uterus in that state of contraction which is so necessary to prevent subsequent hemorrhage. We have already explained to you the efficiency of the abdominal muscles, when they are strong enough to contract firmly upon the retiring uterus.” P. 98.

We must protest against pulling at the funis under any circumstances. It is an unscientific method of completing delivery, and is replete with danger. Instead, therefore, of cautioning students against “pulling too much at the funis,” the directions ought to be, that traction at the cord is never justifiable.

In the Seventh Lecture Dr Murphy discusses Difficult Labours. He admits of two subdivisions. “1st, That in which labour is merely prolonged beyond the average period, without being at any time unusually severe. It is then called ‘tedious labour.’ 2ndly, That in which, without reference to time, there is a powerful struggle carried on by the uterus to overcome some unusual resistance. This may be called by the expressive term ‘laborious labour.’” P. 105.

Over-distension of the Uterus by the Liquor Amnii is the first cause of tedious labour referred to. We quite agree with the author that the best plan in such cases is to puncture the membranes within the os uteri, as high as can be reached, so that the fluid may be allowed gradually to escape. As soon as the over distension is thus relieved, the pains increase in strength and frequency, and labour generally proceeds rapidly to its conclusion.

Extreme Obliquity of the Uterus is the next cause mentioned. We give a single quotation on the subject, because we believe both of the methods condemned by the author may be occasionally necessary. “The mouth of the uterus is often greatly displaced in these cases; it is directed very much towards the promontory of the sacrum; and hence, in order to correct the obliquity, some have advised, that the forefinger be passed within the opening, and the os uteri drawn towards the centre of the pelvis. How is it possible to alter the pendulous fundus by such means? But if, in order to correct the position of the fundus, it is also necessary that it be raised by the opposite hand, the introduction of the finger is not required, because then the mouth of the uterus will correct itself. Such means, therefore, should be avoided, because they are calculated to excite irritation. Some serious mistakes, however, may be made as to the cause of delay, when the os uteri is absent from its usual situation.” Pp. 107, 108.

The gradual escape of the liquor amnii, hysterical excitement, and mental despondency, are the other causes enumerated under this division. Under the latter head, the first case which is detailed is unsatisfactory in the extreme. The patient was admitted into the Dublin Lying-in Hospital in a state of utter desititution, and died notwithstanding the most vigilant administration of stimulants and nutritious diet. An inspection would have cleared up the whole mystery.

Under the second division of causes that render labour tedious, is Rigidity of the Passages. “If the os uteri be much exposed to irritation, it is rendered rigid; the lips become swollen, hot, and tender: when these signs of commencing inflammation present themselves, the cervix is less disposed to yield to the action of the uterus, and becomes rigid. One of the most frequent causes of this kind of rigidity is the gradual escape of the liquor amnii, by which the head of the child descends upon and irritates the cervix. If this irritation be long continued, you have to contend, not only against the effect of inflammation, but also against a spasmodic contraction of the circular fibres of the body round the child. When this happens, an additional resistance is offered to the action of the fundus. In the treatment of it, therefore, promptitude is necessary. If the patient be strong, plethoric, and disposed to make violent straining efforts, a free depletion from the arm would be of much use; it diminishes the tendency to inflammation, and produces a feeling of exhaustion in the patient, which induces her to bear her pains more patiently. In order to ensure such an effect, depletion may be followed by tartarized antimony, in small doses,
so as to excite nausea. Women who may have been previously very violent and intolerant of their pains, are soon subdued when the sense of exhaustion that attends sickness is excited. If, on the contrary, your patient be of an opposite temperament, this treatment cannot be employed; local depletion is preferable; a dozen of leeches may be easily applied to the cervix uteri; warm emollient enemata may be given, and if the woman be much fatigued, or if the pains become feeble and irregular, an anodyne is often very beneficial; some sleep is procured, the irritation of the cervix is diminished, the spasmodic contraction of the fibres disappears, and the pains return with more regularity and strength.” Pp. 114—115.

We doubt very much the utility of applying leeches to the cervix uteri during the progress of labour. However good it may be in theory, its practical benefits must be very limited.

The cervix uteri is frequently rendered rigid from the accidental compression of the head against the pelvis.—“The head of the child may rest on the pubic side of the pelvis in such a manner as to compress the anterior lip of the uterus, and prevent its dilatation. A band is thus formed before the head, which, when long pressed upon, is swollen, tender, and rigid. The treatment of the cervix, when in this state, has become a kind of vexata questio in obstetric practice. Some practitioners of station and experience have advised, that the anterior lip of the os uteri be pushed up by the fingers, above the head, in the interval of the pain, and there maintained, until the returning contraction of the uterus drive the head below it; while others of equal reputation deem such practice to be objectionable, and calculated rather to increase than to diminish the difficulty, by exciting more inflammation. I may mention the late Dr Hamilton, of Edinburgh, as holding the former opinion, and Dr Collins of Dublin, the latter, as a proof how men of very extensive experience often arrive at opposite conclusions on what would seem to be a simple practical point. It is my duty neither to draw you into controversy, nor to give you too dogmatic an opinion on a question so nicely balanced by authority. I must assume, on the evidence of Drs Hamilton, Burns, and Breen, that this kind of artificial dilatation may be accomplished in some instances with safety and success. My own experience, however, confirms that of Dr Collins, and is opposed to this practice. The opportunities I have had of putting it to the test have taught me, that success is by no means so easy as it is described to be; that the anterior lip may be pressed back again and again, and yet return to the same situation as before; that it is difficult to get the head to pass the introduced finger; and that these attempts, when unsuccessful, only increase the swelling and inflammation of the soft parts.” Pp. 115, 116.

We do not agree with the author regarding the pushing up of the anterior lip of the os uteri. We have frequently succeeded most successfully in this practice, and we know it has succeeded admirably in the hands of others.* If we remember rightly, it is not exactly in this kind of case in which Drs Hamilton and Burns contend for dilatation.

Considering the importance of the subject of this lecture, we expected, that when the acute and well-stored mind of Dr Murphy was turned to it thus particularly, a more complete account would have been given of it. Imperfect uterine action is the proximate cause of laborious labours; and many of the causes which induce this imperfect action are altogether omitted.

In Lecture Eighth are detailed the Various Causes which may Retard or Arrest the Progress of the Fetal Head in its Passage through the Pelvis. We select a passage.

“The Head may not be able to enter the Brim of the Pelvis.—This may happen when the head is hydrocephalic, or the brim of the pelvis much deformed. In the former case, the moment it is ascertained, as we have al-
ready stated to you, the head must be perforated. In the latter, it is of importance to determine the degree of disproportion in the brim, in order to decide on the practicability of delivering the child. In the extreme deformity of either the ovate or cordiform brim, when the antero-posterior measurement is perhaps only an inch or an inch and a half, it would be impossible to do so per vias naturales; and therefore the Casarian section, or what might be called delivery per vias præternaturales, becomes a question for your consideration. But the deformity may not be extreme, and yet the head be prevented entering the brim. It is such cases as these that cause the practitioner the most embarrassment, and which present to him the greatest difficulty as to the course he should pursue. It is for the purpose of determining the rule in these cases, that our professional mechanicians have contrived an endless variety of pelvimeters. It is for this object that the profession have made many fruitless efforts, and even entered upon no little controversy, to determine the least possible space through which the child might pass. I shall not occupy your time uselessly with their discussions, but shall only point out to you the errors you must avoid. Recollect that the child must be delivered by destructive instruments, that its sacrifice is involved in the question you have to consider; and this remark applies equally to those who have the temerity to apply the forceps when the head is above the contracted brim of the pelvis. Whether the forceps or the crotchet be employed, the result to the child is the same; the only difference being, that in the former case the hazard to the mother's life is greatly increased. You must not, therefore, place implicit confidence in the accuracy of the measurement that you make of the pelvis, and at once proceed to operate, because it is, or you think it is, within the space through which the head may pass: you might be altogether deceived; and every experienced practitioner knows how often he is deceived in the estimate he forms of the space in the pelvis, although the utmost care may be taken to determine it. Do not, therefore, trust to pelvimeters, however ingeniously contrived; rather let time, and a close attention to the symptoms which present themselves decide your practice. When the character of the labour is changed, when inflammation begins in the passages, when the premonitory symptoms of exhaustion appear, when, after a reasonable time has elapsed (say six hours), without the head making any progress, although the os uteri is quite dilated and the pains have continued regular and powerful:—when any of these conditions are met with, and you have reason to think, from an examination of the pelvis, that the brim is too contracted, then, but not until then, are you justified in interfering. The simplest, and, we might add, the most efficient pelvimeter, is the hand of the practitioner. If it be the educated hand of the experienced obstetrician, the evidence is certain; but even the attentive student may acquire much accuracy by observing a few simple rules." Pp. 129, 130.

We recently met with a case where the head of the child was prevented from entering the pelvis on account of an exostosis arising from the promontory of the sacrum. It was hard and unyielding, and larger than a hen's egg. The fetal head has, in three instances, required to be broken down; on the last occasion, delivery was accomplished with great difficulty, the obstruction having become larger. The patient died exhausted three weeks afterwards. She had unavailingy been urged to allow premature delivery to be induced.

The Ergot of Rye, we are convinced, is administered far too indiscriminately, especially by young practitioners. The number of children which perish from its influence is very great. 1 No remedy ought to be prescribed more prudently and more cautiously. Dr Murphy remarks:—"When there is the least reason to apprehend exhaustion, promptitude in delivery is imperative; but before interference is thus called for, much may be done to prevent its necessity. Rest is very important in these cases, because it is an evidence that the over-excited nervous system is tranquilized, therefore, when the pains are becoming weak, or return only at long

1 For information on this subject, vide Monthly Journal, vol. for 1844, (June,) p. 536, (August,) p. 723.

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intervals, a moderate dose of opium is often of great service: if the patient sleep, even for a short time, the uterine action is renewed with much more power. I have expressly stated a moderate dose of opium, because the case now under our consideration is that in which the same medicine has produced the most opposite effects, according to the dose administered, and, consequently, it has sometimes been discarded, because it has been misapplied. The object which it is intended to accomplish by opium, is to subdue the nervous irritation which precedes exhaustion, and to restore, by rest, the energy of the uterus. The effect produced by too large a dose may be to paralyze all nervous power, and thus at once to cause uterine exhaustion. You must therefore exercise proper caution in the use of it. Twenty to twenty-five minsims is generally sufficient for the purpose. After a temporary rest has been thus produced, if the uterus still continues to act feebly, ergot of rye may be given in an equally cautious manner, carefully attending to its influence on the pulse, and especially on the circulation of the fæces. If in either case, after giving this medicine, the rate of the pulsations be diminished, you must not persevere in its employment, otherwise the death of the child may be the result. It is also necessary to be careful to avoid the use of secale cornutum, if the delay in this stage arises from great disproportion between the head and the pelvis. It must be obvious to you, that in a case like this it would be very dangerous to use a means of exciting the action of the uterus, over which you can have no control. A preparation which excerts a specific influence on the uterus, which often causes the most violent action, and that not returning at intervals, as ordinary pains do, but which excites a continuous effort of the uterus to expel the child, is not the safest to employ, when there is much resistance opposed to this action. The remedy, when cautiously administered, is useful, however, in those cases where the delay chiefly arises from want of power in the uterus, which may be exhausted if not thus artificially stimulated to action.” Pp. 139—141.

The Accidental Obstructions to the Passage of the Head, enumerated by Dr Murphy, are Ovarian tumours and Polypi.

"Ovarian Tumours sometimes descend into the pelvic cavity, and obstruct the head of the child. If the tumour consist of several cysts, the smallest may pass down between the vagina and rectum: cases are also recorded where very large tumours are found in the same situation. One of these cases is given by Dr Merriman, along with a very accurate drawing of the tumour. Their contents vary so very much in their consistence and density, that they are not always easily recognised; but if there be any sense of fluctuation, or even if the tumour be very elastic, the probability is, that it is an ovarian cyst, containing fluid more or less deeply seated. Unless the size be great, it is possible, that the head may press the cyst against the sides of the pelvis, and pass below it; a small tumour also may be pushed back towards the brim of the pelvis, when the pains are absent, and perhaps be prevented from again descending when the action of the uterus returns; if by neither of these modes the removal of the obstacle can be accomplished, the only resource left is to puncture the tumour and allow the fluid to escape. This may be done, although there be no distinct sense of fluctuation, because the fluid is often thick, like honey, and may be deep-seated, which will communicate to the fingers an elastic feel rather than one of fluctuation. Besides, if a mistake be made, and you should puncture a polypus or a fibrous tumour, no great injury is done. It is when a sense of fluctuation is distinct, that caution is required, especially if the tumour should appear towards the pubic side of the pelvis. The bladder has sometimes prolapsed before the head of the child, and presented a fluctuating tumour. It is not necessary to tell you, that this should not be punctured. But the danger of these cases does not generally arise from the delivery being obstructed, but from the effect which labour produces on the disease; the tumour is necessarily exposed to a great deal of irritation; the patient is weakened, if not exhausted by the struggle which takes place; and, when labour is concluded, she is quite unequal to combat the effects of that irritation. Dr
Merriman has collected the history of eighteen cases of ovarian tumours obstructing parturition. One half of the mothers died, three recovered very imperfectly, and six only may be said to have escaped: sixteen of the children were still-born, and four were born alive." Pp. 165, 166.

A very interesting case of ovarian disease, preventing the escape of the head, was detailed, by Mr Lyon of Glasgow, in our volume for 1845, page 885. In that instance the tumour had found its way downwards, behind the rectum. The Cæsarian section was performed, but, as our readers may recollect, the patient unfortunately sank.

Polypus.—We coincide in the views of Dr Murphy regarding the treatment of this complication. He says—"If it be small, and detected early in labour, it might also be in your power to prevent the tumour descending. It might be pressed back when the pains cease, and so retained until the head passes beyond it. But if neither can be accomplished, if the tumour remain an impassable barrier, it should be removed, not by ligature, but by excision. The polypus should be drawn down as much as possible by a forceps proper for the purpose, a temporary ligature applied, and the stem cut through." P. 168.

On the co-existence of pregnancy and uterine polypus, the author remarks:—"It is not likely that the ovum could be brought to maturity, if a large polypus occupied the cavity of the uterus; it is therefore fair to assume, that when a polypus is found to impede parturition, it must be attached to the mouth of the uterus, and therefore it can be the more easily traced to its origin, so that you have every facility to assist your diagnosis." P. 168.

An interesting case in point is narrated by Dr Macfarlane of Glasgow, in the late Medical Journal of that city, Vol. i., p. 416. The original being now scarce, we quote the narrative.

"Mrs S., aged about 30, residing with her father, a respectable farmer, about four miles to the south-east of Glasgow, was taken in labour of her first child, on the morning of the 13th October, 1825. On visiting her at 10 o'clock in the evening, I found the pains regular, but indicating only the first stage of labour; the os uteri dilated to the size of a dollar; its edges soft and natural; the membranes protruding slightly during uterine action, and the child's head presenting. About one o'clock of the following morning, the os uteri was fully dilated, the membranes had given way, and the bearing-down efforts were forcible. About four, the child was born; it was feeble, and from its premature appearance, tended to corroborate her own opinion, that she was hardly eight months gone in pregnancy. In half an hour, she had a slight bearing-down pain, by which the placenta was partly protruded. On attempting to remove it, by gently pulling the cord, a greater resistance was encountered than I expected, from its depending and apparently detached situation. This was ascertained, by introducing the finger, to arise from the adhesion of the placenta to a large, firm, globular tumour, which filled the vagina, and rested on the perineum. The centre of the placenta opposite the cord adhered to the apex, and the rest of the placenta embraced the sides of the tumour; from which, however, it was nearly detached. While making this examination, the placenta was wholly separated and extracted, and the hand speedily introduced into the cavity of the uterus, to ascertain the nature and connexions of this tumour. I imagined at first, that the uterus was inverted; but the absence of every bad symptom for half an hour after the birth of the child, and the circumstances of the cord having been free and of sufficient length, and no force employed, rendered this opinion less probable. The tumour was easily pushed up before the hand, when a firm polypus of immense size was found growing from the very centre of the fundus uteri, which, from its weight and descent with the placenta, had caused a partial inversion. When this point was rectified, I examined the tumour more minutely. It was of almost cartilaginous hardness, and intimately attached to the uterus by a pedicle as thick as the wrist. About two inches and a half from its origin, its size gradually increased, and the depending part was larger than a child's head at birth. It was smooth to the feeling, except at the apex, where the roughness was occasioned by the attachment of the placenta. I grasped the neck of the tumour, and by supporting the fundus
uteri with the other hand, applied to the parieties of the abdomen, while I made gentle attempts to move the pedicle, I ascertained the extent and firmness of its attachment. This was evidently such as to render any attempt to twist off the tumour, more likely to lacerate the substance of the uterus than the pedicle. During this examination, which did not occupy above a minute and a half, blood was profusely issuing from the apex of the tumour. It was prevented from escaping while the hand was in the vagina, but rapidly accumulated within the uterine cavity. The clots were scooped out, and the uterus excited to contract as much as was compatible with the presence of such a large body within its cavity. By this means I did not expect that the hemorrhage would be arrested by the pressure of the contracted uterus on the surface of the polypus, as the apex of the tumour, from which the blood flowed, was lying in the vagina, but only that general diminution in the size of the uterine vessels, which takes place after every natural labour, with a consequent reduction in the quantity of blood sent to the polypus. It was found, however, when the hand was withdrawn, that blood continued to flow freely from the vagina; and in a few minutes the pulse became indistinct, and she complained of approaching syncope. The pillows were removed from under her head, cloths moistened with cold water were freely applied to the vulva and abdomen, and the windows of the apartment thrown open. For half an hour a few ounces of fluid blood were discharged, after which there was no external hemorrhage. The symptoms, however, continued to increase, and became still more alarming. The lips were colourless, the body cold and clammy, the pulse feeble, fluttering, and sometimes for three or four minutes imperceptible, with laborious breathing, and great jactitation. About half-past five, in consequence of the alarming appearance of the patient, and the great anxiety of the friends, a messenger was dispatched to request the immediate attendance of Professor Towers. In the meantime, the cold applications were continued, pressure was applied over the fundus uteri, and with some difficulty she was persuaded to swallow a quantity of undiluted whisky, every three or four minutes. Some laudanum was procured in the neighbourhood, and ten drops of it, mixed with half a glass of whisky and an equal quantity of hot water, were given every ten minutes. Mr Towers arrived at half-past seven, and on introducing his hand, he found the tumour of the kind, and in the situation I had previously explained to him. He removed a few small clots on withdrawing his hand; but the hemorrhage had ceased for nearly two hours. At this time she was extremely exhausted, and had a most alarming appearance. The stimulants were regularly administered; either whisky or brandy, joined with laudanum or the black drop, (a bottle of which Mr Towers had brought with him), was given, as often as the pulse became imperceptible. She was at times insensible, and her anxiety and restlessness were uniformly aggravated for about half a minute after the stimuli were administered, when the pulse became rather more distinct. When she slumbered for a minute or two, she always exhibited symptoms of great distress when she awoke. Bottles of hot water were applied to the extremities and trunk, but her incessant restlessness prevented them from being effectual in raising the temperature; and hartshorn was applied to the forehead and nose. These means were assiduously employed during the whole day, with the effect of only rousing her at intervals, and rendering the pulse a little more distinct for a few minutes, when it again sunk, and the train of urgent symptoms immediately re-appeared. About four o’clock p.m., the pulse became more perceptible, the breathing more calm, and the countenance less anxious. I gave her then a draehm of laudanum in a glass of brandy, which in a few minutes procured sleep, that lasted for an hour. After this her pulse became fuller, and the colour of her face and heat of skin somewhat improved. At six, I left her in charge of one of my advanced and most intelligent pupils, Mr (now Dr) Hugh Wood of Dunfries, with orders to remain with her during the night, to administer small quantities of brandy for an hour or two till re-action was fairly established; and if for two hours the pulse continued to improve, to desist from the stimulants, but to give beef-tea at short intervals during the night.

"On the following morning, she was remarkably easy. The pulse was rather
full, and about 100 in the minute. She had considerable heat of skin; slight uneasiness in the hypogastrum; urgent thirst; headache and vertigo; the lochia were plentiful. She was enjoined to be kept quiet and cool; to have gruel; to omit all kinds of stimuli, and to take a dose of castor oil.

"On the 15th, she had severe pain in the hypogastrum, occasioned by inability to void urine. The catheter was employed with immediate relief, and had to be introduced twice daily till the 25th; and as the discharge was foetid, injections of tepid water were frequently thrown into the vagina. The depending part of the polypus was within half an inch of the vulva. It completely filled the vagina, and pressed on the neck of the bladder. In a few days, from the acrid quality and abundance of the discharge, which resembled dark bloody serum, the vagina and labia became painful and excoriated. Frequently bathing the parts with a cold infusion of camomile, and injecting three times a-day a strong decoction of oak-bark and alum into the vagina, afforded her considerable relief.

"On the 21st, the discharge was less irritating and offensive. She had pain only when the bladder was distended, and the pulse had fallen to 90, but was weak. The antiphlogistic regimen was now a little relaxed, and she was allowed beef-tea, chicken-broth, arrow-root, and similar mild nourishment.

"From this period, she slowly recovered, and was able to be out of bed in about three weeks; but she was for some time longer much annoyed when in an erect position by the weight of the tumour, and she was only able to void urine when lying on her back, with the head low, and the breech elevated. In about three months, the tumour had decreased so much as to give her little uneasiness either from its bulk or weight. It was then about the size of a large orange; and I have reason to believe, from her own statement, as well as from that of her husband, that it has not been increasing; but although I have often seen her since that time, I have had no opportunity of making an examination. She has never enjoyed good health since her delivery; she continues pale and sallow; and altogether, she appears as if ten or fifteen years had been added to her age. She has at variable intervals had repeated attacks of hemorrhage, with an almost constant discharge of a thin dark coloured fluid like moss water, or of mucus more or less mixed with blood. I have often prescribed for the relief of these symptoms, but every attempt has hitherto failed in persuading her to submit to ligature of the tumour."—Macfurlane, ut supra cit.

In Lecture Eleventh, Dr Murphy discusses the Obstetric Operations, and the Use of the Vests and Forceps. We consider this one of the most imperfect lectures of the series; it bespeaks a want of experience in the use of the forceps.

Our limits permit us to attend to a few points only.—The author says—"The Operation, when the Head is resting on the Perineum, may be undertaken in cases similar to those in which the vestis is employed, and is preferable, if there be any diminution in the transverse measurement of the outlet. The preliminary steps of this operation are the same as for the vestis; but it must be remembered, that the temperature of these, as well as of all obstetric instruments, should be raised to that of the vagina, and they should be greased before being introduced into the passages. Having made these previous arrangements, the pubic blade of the forceps, with the lock looking upwards, must be passed over the head in a similar manner to the vestis, and when so placed, the handle may be raised towards the pubis, and there maintained by an assistant in its exact position. The handle should not be moved to the right or left side, because it is of great importance to observe the precise direction of the pubic blade when the sacral blade is being introduced. Taking, then, the lock of the former as your guide, as soon as the pain ceases, pass two fingers of the left hand between the head and the perineum, and holding the sacral blade lightly by the handle with the right hand, endeavour to guide it so along the introduced fingers, that the edge of the sacral may pass along the lock of the pubic blade." Pp. 177, 178.

Now, why speak of the pubic and sacral blades? Is the forceps never used except when one ear is to the pubes, and the other towards the sacrum? or, is
the car always to the pubes when the head is resting on the perineum? We think not.

In speaking of the Treatment when the Head of the child is At rested, Dr Murphy says:—"It appears to me, that four hours would be quite sufficient to allow the head to remain in the same position, to authorise your interference. But if there be the least indication of pain, swelling, or heat in the passages, you should not delay one moment from the time that these symptoms present themselves, when you are satisfied that the forceps may be applied. Promptitude is the secret of success, and in nothing is it more evident than in the case we are supposing. It is possible the pains may be strong and frequent; and it is generally a safe recommendation not to interfere, so long as the uterus seems to have sufficient power, but rather to wait until the pains become feeble, or the action of the uterus is suspended." P. 180.

The first of the above directions we consider correct; but we certainly do not agree with the author in thinking that it is generally a safe rule not to interfere, so long as the uterus seems to have sufficient power, but to look on until the pains become feeble, or the action of the uterus is suspended.

We think the author right in condemning the doctrine laid down by Dr F. Ramsbotham in the following passage:—"Although agreeing with Dr F. Ramsbotham in many of the principles of his practice, I feel myself opposed to him on this question. The summary of symptoms which he gives, to authorise the use of the forceps, when labour does not continue twenty-four hours, seems to me to be founded upon a principle very hazardous to the safety of the mother. He states:—'If, then, the pains are subsiding gradually, or have entirely disappeared—if the strength is failing, the spirits sinking, the countenance becoming anxious—if the pulse be one hundred and twenty, one hundred and thirty, or one hundred and forty, in the minute, the tongue coated with white slime, or dry, brown, and raspy—if there have been two or three rigors—if, on pressing the abdomen, there is great tenderness of the uterus—if there be green discharge—if there be preternatural soreness of the vulva, with heat and tumefaction of the vagina—if the head have been locked for four hours, and made no progress for six or eight hours—if the patient be vomiting a dark, coffee-ground like matter—if there be hurried breathing, delirium, or coldness of the extremities—then we are warranted in having recourse to the forceps, although the labour have not lasted the limited period of twenty-four hours, or even twelve; and we should be acting injudiciously to allow the case to proceed until the last four symptoms appear, without relief being offered.' Dr F. Ramsbotham enumerates these symptoms, to authorise the delivery of the locked or impacted head—a case in which I have already stated, that I do not think the forceps can at all safely be employed; but to apply the instrument when inflammation has advanced to such an extent as to engage the constitution in an irritative fever, and only to deliver before the last four symptoms of exhaustion appear, and that, too, when the head is impacted, seems to me to be dangerous in the extreme." P. 181.

The Operations which save the Parent only are considered in the Twelfth Lecture, and the History and Use of Obstetric Instruments in the Thirteenth. With neither of these lectures have we any fault to find. They are excellent.

A series of Aphorisms close the volume. We append a specimen.

"LX. The rules that govern the Application of Instruments are founded upon three principles—

1st, To preserve the lives of the mother and child. If this be doubtful, 
2nd, To preserve the life of the mother without reference to the child. When this cannot be done, 
3rd, To save the child if possible."

"LXI. The instruments used for the first object are the Vectis and the Forceps. For the second, the Perforator, the Crotchet, the Craniotomy Forceps, the Osteotomist, the Cephalotribe. For the third, the Cesarian section is performed."

"LXII. The vectis is intended to act as an extractor, to assist the feeble ac-
tion of the uterus, to correct mal-positions of the head, or to overcome any usual resistance of the perineum. It is not therefore an instrument of much power, and its use is limited to the removal of slight impediments to the passage of the head.

"LXIII. The forceps is more generally used in the practice of midwifery, and is an instrument of much more extensive application. It may be employed when the head is at the outlet, in the cavity, or in the brim of the pelvis. The short forceps is used in the two former operations; the long forceps in the latter.

"LXIV. The following general rules must be observed before these instruments are applied:—

"1st, It has long been established as a general rule, that instruments are never to be used in the practice of midwifery; the cases in which they are used are therefore to be considered merely as exceptions to this rule. [Denman].

"2nd, But such cases can very seldom occur in the practice of any one person; and when they do happen, neither the forceps nor any other instrument is ever to be used in a clandestine manner. [Denman].

"3rd, The first stage of labour must be completed, that is, the os uteri must be dilated and the membranes broken before we think of applying the forceps or the vectis. [Denman].

"4th, The difficulties which attend the application and use of the forceps are far less than those of deciding upon the proper time when, and the case on which, they ought to be applied. [Denman].

"5th, The lower the head of the child has descended, and the longer the use of the forceps is deferred, the easier in general will their application be, the success of the operation more certain, and the hazard of doing mischief less. [Denman].

"6th, Care is also to be taken that we do not, through aversion to the use of instruments, too long delay that assistance we have the power of affording with them. [Denman].

"7th, A rule for the time of applying the forceps has been from the following circumstances:—That after the cessation of the pains, the head of the child should have rested for six hours in such a situation as to allow the use of the forceps before they are used. [Denman].

"8th, But this, and every other rule intended to prevent the rash and unnecessary use of the forceps, must be subject to the judgment of the person who may have the management of any individual case. [Denman].

"LXV. Before the vectis is applied, you must first observe those preliminary measures necessary in all obstetric operations. The urine should be withdrawn with an elastic gum catheter of rather large size (No. 10), and without the stilette. It is always safer to use a catheter of this kind, because there is less risk of injuring the urethra, if it should be compressed, than if the unyielding sliver catheter be employed. An enema should also be administered, and when the bowels are relieved, the patient, lying on her left side, must be drawn as near to the edge of the bedstead as possible. The pelvis must be raised more than usual, and if the patient has been lying on a bed, and not on a mattress, it would be advisable to place a hair cushion under the hips. The vectis should be placed in warm water, and anointed.

"LXVI. Introduce two fingers of the right hand between the head and the symphyses pubis. Passing them on either side of the symphyses, the tip of the ear will be felt without difficulty. The finger must remain applied to it while the vectis is being introduced. It should be held about the middle, between the two forefingers and thumb of the left hand, and the handle directed downwards and backwards towards the coccyx, in order that the blade may lie flat upon the head, when the instrument is passing between it and the fingers of the right hand. When the blade is so applied, press it gently forwards with a slightly oscillating motion, until the edge reaches the lobe of the ear, which is now placed exactly between the finger and the vectis. The handle must therefore be depressed still more, in order that the edge may pass over the ear. When
this is safely accomplished, the finger may be withdrawn, and the vectis passed forward to its proper position.

"LXVII. ‘Then, grasping the handle of the instrument firmly in the right hand, wait for the accession of a pain,’ [Denman], (which, although absent before, almost always returns when this new irritation is applied to the uterus,) and draw steadily with it. ‘When the pain ceases, let the instrument rest, and on its return repeat the same kind of action, resting and acting in imitation of the manner of the pains.’” [Denman.]

“Carefully avoid using the vectis as a lever; and in order to do so the more certainly, it is better to pass two fingers of the left hand between the head and the perineum, and to grasp the shank of the instrument with the remaining fingers; counter-pressure is thus made similar to the forceps, and the vectis may be used solely as a tractor.

“LXIX. When the head begins to advance, and to press strongly on the perineum, the introduced fingers may be withdrawn, and the vectis maintained in its position, rather for the purpose of acting with if the pains should again become feeble, than to extract the head by its means, if the uterus be sufficient to expel it. Thus the perineum will be better secured from injury.

“LXX. When the vectis is used to correct mal-positions of the head, it is better to operate with one not too much curved. One blade of the forceps will often answer in these cases.” Pp. 249—252.

We trust that the author will see the propriety of rendering the next edition of his excellent work more practical in its character: this, to so experienced a master of Obstetric Science as Dr Murphy, will not be a difficult task.

The work is illustrated with well-executed woodcuts. K.

Irish Watering Places; their climate, scenery, and accommodations, including Analyses of the principal Mineral Springs, by Dr R. Kane; with Directions for Invalids. By Alexander Knox, M.D. 12mo, pp. 336. Dublin: 1845.

We are indebted, we regret to say, to the author’s bad health for this useful and attractive guide to the Irish Watering Places. “The proposal to substitute a prolonged tour in Ireland for banishment to the continent having been acceded to by his kind and judicious physician, the next object was some suitable mental occupation; and this the author hoped to find in visiting and examining on the spot the most celebrated bathing places of his native country. He was the more confirmed in his purpose on reflecting that, whilst the mineral waters of every other part of the world have been amply described, those of Ireland have been almost entirely neglected, as they are not even mentioned by Christison or Pereira, and are only slightly alluded to in the Cyclopaedia of Practical Medicine. In Thomson’s Dispensatory alone we find a meagre and insufficient account, and that of only a few of them.” Preface. Dr Knox has well supplied the profession and the public with what was wanting. Along with medical and hygienic details, there is agreeably mingled historical, geological, and botanical notices.

Dr Knox enriches his work with papers kindly furnished by medical friends in various parts of Ireland.

ISLAND OF COVE.

The Essay on the Island of Cove, near Cork (written by D. H. Scott, Esq., M.D., of Cove), is very excellent. It is the best account by far which has yet been given of this suitable retreat for the pulmonary invalid, and may be referred to as a good model for similar works. Like Madeira, the Cove has a particularly equable climate. We subjoin some of the most important passages, regretting that our narrow limits oblige us greatly to mutilate this admirable memoir.