Comparatively few articles appear nowadays in periodical medical literature bearing on the subject of puerperal infection; but this scarcity is not to be ascribed to a final and satisfactory solution of all the problems which have been associated therewith; indeed Dr. J. R. Goodall of Montreal (Canadian Med. Assoc. Journ., iv. 589, July 1914) points out that obstetrical opinion is in a very fluid condition at present, and that there is a marked tendency to abandon the more heroic methods of attack for milder forms of treatment and even for abstention from all forms of interference whatever. Dr. Goodall further indicates that the changed viewpoint affects not only the treatment of cases in which infection has occurred, but also that of cases in which, so far, only the risk of infection taking place is present. Prominent in this second group are the instances of membranous retention following upon expulsion of the placenta. The recent literature dealing with this matter was discussed in these pages no longer ago than September (vide p. 256) and need not be returned to now; but it will be remembered that there existed an extraordinary divergence of opinion as to the best method of treatment with a view to the prevention of septic absorption, and that whilst some authorities counselled what was practically a policy of non-interference under all circumstances, others took more or less active measures according as a large or a small part of the membranes was retained. Dr. Goodall, it is to be noted, is in favour of non-interference; he refrains from any form of treatment which entails invasion of the uterine cavity; but he does introduce treatment and is not content with a policy of laissez-aller. His management of such a case consists in sitting the patient up in bed, removing all vulvar pads and perineal binders, placing the patient on a sterile pique, and administering continued small doses of combined ergot and quinine, or repeated small doses of pituitrin; sometimes he puts an ice-cap on the fundus uteri. In another group of circumstances, retention of a portion of the placenta, Dr. Goodall pursues a plan of “masterful inactivity unless hæmorrhage enters as a marked feature” into the case; when there is hemorrhage and the patient’s condition is good he removes the piece of afterbirth immediately, but when she is weak or exhausted he packs the uterine cavity with gauze and in twenty-four hours takes out the packing and the placental fragment with it if hæmorrhage still continues.

More important questions arise and more divergent plans of treatment are employed when puerperal infection has actually occurred.
Curettage, with a sharp or a blunt instrument, digital scraping, intra-
uterine douching: which is it to be?—or is it to be nothing? Dr. Goodall is, on the whole, strongly conservative in his management of puerperal infection. When there is chill and fever on the fourth day, a large and tender uterus, a soft and patulous cervix, and a cessation of the lochia, it is not necessary to conceive that there must necessarily be retention in the uterus of some of the products of conception; the treatment called for is neither curettage with a blunt nor much less with a sharp instrument; even the finger is not free from risk, and the plan to be preferred, according to Dr. Goodall, is to ensure drainage and to sustain the strength. Not even the fetidity of the case, indicating the presence of saprophytic organisms, is a sign that we may curette with safety, for these are generally instances of mixed infection, and, besides, there is always the risk of the presence of thrombo-phlebitis, when of course any handling of the uterus may set loose a clot to work mischief. The cases of infection, in which the symptoms already named (boggy uterus, soft patulous cervix, fever and chill on third or fourth day) are complicated by the presence of hemorrhage and of anæmia resulting therefrom and from the toxic haemolysis, should be dealt with in the same way in most instances: there is no need for, but only harm from, uterine exploration (under anaesthesia), douching, or packing; but in a few instances Dr. Goodall adopted the plan of gently drawing down the cervix and of packing the uterus with plain or iodoform gauze for twenty-four hours. The author admits that haemorrhage is the one symptom which forces him occasionally to invade the infected uterus. He is opposed to intra-uterine douches even in the cases with fever and a copious fetid, café au lait coloured lochia and much mucus; he thinks the douche causes increased absorption of bacteria and toxines, chills, and sometimes death. The douche fluid may very easily be driven through into the peritoneum; further, whilst the bactericidal power of such douches is very problematical, their chemical influence on the tissues is real enough. Finally, the conclusion is expressed that neither the anti-streptococcic serum nor vaccines are of much value. The safe lines of treatment are the encouragement of drainage by the sitting posture in bed, by cleansing vaginal douches under low pressure, by giving the patient water to drink in large quantity and a sustaining and nutritious diet, and by the use of stimulants if necessary; in a sentence—drain and the strength maintain.

In another Canadian medical journal (The University of Toronto Medical Bulletin, ii. 14, 14th May 1914) an individual case of puerperal streptococcal septicæmia is discussed by Dr. B. P. Watson. The patient was admitted to the Toronto General Hospital on the sixth day of the puerperium after a labour which had not been interfered with, but after a pregnancy in the latter part of which she had been nursing a child with a discharging ear. On the third day there had been a
rigor and fever had continued; the abdomen was distended but the uterus was not tender; there was free vaginal discharge, fetid and blood-stained; both the cervix and the perineum were slightly torn and sloughy; the uterus was larger and softer than normal, and the os was patulous. Both the uterine and cervical secretions gave a pure growth of streptococci, and streptococci were also found in the blood. The treatment consisted in vaginal douching with perchloride of mercury (1 in 2000) followed by sterile water, and then the cervix was exposed through a speculum, and the uterus was irrigated with a solution containing a drachm of tincture of iodine to a pint each of alcohol and of water. The douche was not repeated, for the discharge quickly lost its fætor and lessened in amount. The woman was kept in the Fowler position for drainage, and was given 5 grains of quinine and half an ounce of whisky every four hours. Twenty-five c.c. of polyvalent antistreptococcic serum were given each day for three days, but no result seemed to follow from it. The patient drank freely of water, and the bowels were kept freely open by magnesium sulphate and soap and water enemata. Under this and no other treatment the patient recovered, and it is noticeable that improvement set in soon after a local exudate appeared in the left broad ligament, perhaps causing auto-vaccination. An important matter from the standpoint of prognosis was the occurrence of recovery although streptococci were found in the blood for eleven days. It is interesting to note that in certain details Dr. Watson's case supports the general lines of treatment laid down by Dr. Goodall; it shows, for instance, the value of the Fowler position, the inefficacy of the serum injection, and the usefulness of the vaginal douching and of the copious administration of water along with stimulants. It may be safely concluded that the tendency to abandon intra-uterine measures in puerperal infections is correct, although possibly ere long a note of warning may have to be sounded to prevent a too complete cessation of all local treatment.

Retroflexion of the Pregnant Uterus.

Dr. O. J. Rapin (Revue méd. de la Suisse Romande, xxxiv. 462, July 1914) deals not so much with ordinary cases of retroflexion of the gravid uterus which if recognised early and treated promptly (by replacement and pessary) seldom give rise to serious trouble, as with those other cases in which from the existence of adhesions and consequent fixation and incarceration, abortion threatens. What is the best treatment to employ in these complicated and dangerous abortions? Dr. Rapin points out that a purely expectant line of management may be followed. Under these circumstances, if the uterine contractions increase and the cavity of the organ empties itself more or less completely of its contents the obstetrician need not necessarily interfere; if, however, the emptying be incomplete he may require to scrape out
the interior. After the abortion and consequent diminution in size of the uterus it may be possible to replace it and keep it in position with a pessary; but in many instances this happy result will not follow, and the uterus will remain displaced, too large in size, and the site of endometritis and of other troubles. Then it may be necessary to operate at a later date in order to set the uterus free. The purely expectant method, therefore, can hardly be relied upon to give a good permanent result.

A second plan, that of expectancy with certain auxiliary means, may be adopted. The object of this plan is to lessen the uterine pains and to gain time for the attainment of mobility by the fixed organ. Whilst, however, it is true that as the pregnancy goes on the adhesions may stretch or relax, it is seldom safe to trust to this, for the bladder difficulties may increase, pyelonephritis may be superadded, and even a fatal termination may be reached. A third method of treatment is to put the patient under the influence of narcotics and at intervals to try to replace the uterus whilst the woman is still narcotised; this plan, however, entails a long period of time, and in the end it may require to be supplemented by operation.

Dr. Rapin next points out that if these plans are all ineffectual it has generally been considered that the only other line of treatment must be the induction of abortion in order to save the life of the mother; but he thinks, and rightly, that this is hardly an ideal aim or end to have in view, and he pleads that the progress which has been achieved in abdominal surgery ought to make possible another and a better plan. It is well to lay it down as axiomatic that the life of the foetus should be sacrificed only when there is no other means of saving the mother. The abdomen may be opened, as Dubrisay and Jeannin pointed out in 1903, the uterus may be replaced by the hand, and intra-peritoneal shortening of the round ligaments may be done; but as early as 1895 Jacobs had already treated ten cases of retroflexion of the gravid uterus by laparotomy and hysteropexy. Dr. Rapin refers to quite a number of cases reported by Ferfasser, Marchener, Manchet, Jacobs, Mairs, Cristofoletti, and Gouilloud in which after laparotomy the pregnancy went on to the full term and a living child was born, whilst the mother was at the same time cured of her displacement and of the troubles associated with it. Further, ventrofixation is in the author's opinion to be preferred to intra- or extra-abdominal shortening of the round ligaments; and he closes his article with a full description of the details of a case in which, in 1911, he opened the abdomen, replaced the retroflexed uterus, and attached it to the anterior abdominal wall. Although abortion was threatening at the time of the laparotomy, the pregnancy continued, a living child was born at term, and later it was found that the mother's uterus was in its normal position. Further, another normal labour occurred later, showing that the ventrofixation had not prevented conception, had not shortened
pregnancy, and had not complicated confinement. It is without doubt along lines such as these indicated by Rapin that progress in the management of the anomalies of pregnancy must proceed; it is always a less high ideal to sacrifice the child's life for the mother's than to endeavour to save both; indeed there is a time coming in which the word ideal will not be applied to it at all, but quite another term.

J. W. B.

THERAPEUTICS.

UNDER THE CHARGE OF

JOHN EASON, M.D., F.R.C.P.

PELLAGRA.

Those who have had much experience in the treatment of pellagrins agree on one point, namely, that in the milder cases the symptoms will almost always disappear in a relatively short time if the patients are kept in hospital on a liberal mixed diet, with plenty of fresh meat.

The difficulty is that many pellagrins are mentally defective and refuse to comply, and it is necessary to use all available psychotherapeutic methods in order to succeed with the dietetic treatment.

Cases in which there is mild diarrhoea should not be treated with a reduction in the quantity of the food, as metabolic studies have shown that the assimilation of food is unimpaired in this condition.

Constipation is favourably influenced by an increase of fats, such as olive oil, butter, cod-liver oil, etc., or by the continued administration of castor-oil.

Advanced cases of pellagra, and especially the so-called typhoid pellagra, are often unimproved by any available treatment, and end fatally in a shorter or longer period of time.

Turning to the efficacy of drug treatment, Lombroso advocated the administration of arsenic in the form of Fowler's solution as a specific for the disease. His extremely optimistic attitude appears to be shared by few, although this drug is employed also by some in America.

Cacodylates and salvarsan have also been tried. Possibly arsenic in any form may be beneficial in many cases of pellagra associated with a loss of body weight and malnutrition.

Sodium chloride was also used by Lombroso for the treatment of pellagra in children especially. Very little can be said in favour of this or the dozens of other drugs suggested at different times for the treatment of this disease.

Another phase of the treatment concerns the well-known relation between pellagrous erythema and exposure to sunlight. Patients have