fibrous polypi growing from the cervix. In one case he delayed operating and introduced a sponge-tent, in order to open up the os uteri more freely. The patient, who had long suffered from hæmorrhage, died before he had been able to operate. He regretted having recourse to the sponge-tent, and was sorry, especially after seeing the size and trifling attachment of the polypus, that he had not at once removed it by means of the knife or scissors.

CASE OF CENTRAL RUPTURE OF THE PERINEUM.

By R. Wilson, M.D., Alloa.

(*Communicated by Dr Matthews Duncan.*)

January 27, 1875.

I was asked, about 10 A.M. on the forenoon of Friday the 3d April 1874, to attend Mrs N., æt. 26, in her first confinement. On visiting her shortly afterwards, I learned that she had had more or less severe pains in the abdomen since 3 A.M., and, on examination per vaginam, found the os uteri hardly admitted the point of the finger, while the vaginal surface was free from secretion. I ordered her a dose of castor-oil, and asked the person in attendance to send for me when she thought it necessary. I was sent for about 4 P.M., and on my arrival found the pains very constant and severe, the membranes ruptured, and the head pressing strongly against the perineum, with a rigid vulva. At once I supported the perineum with my hand, and for nearly an hour continued to do so, the vulva in the interval becoming greatly relaxed. The head was now so far protruded, that I expected its exit each pain, but suddenly the perineum became thinned, gave way, and the head, receding from the vulva, escaped through the laceration, followed immediately by the body. I separated the child, passed the fingers through the vulva, and in a short time removed the placenta by the natural way. On examining the parts, the fourchette and sphincter ani were found entire. I resolved to bring the parts into apposition by means of the quilled suture, and, with the assistance of my friend Dr Duncanson, did so next morning.

The ordinary precautions in such cases were taken, and everything seemed to be going on well, till the Tuesday morning, when, to my great disappointment, the wound was found to be partly gaping; the patient, having been restless during the night, caused the looped end of the wires to slip from off the quill.

The surface of the lacerated wound being in a sloughy state, I ordered poultices containing carbolic acid to be applied for a few days; then stuffed the wound daily with lint, soaked in carbolic oil, and in three weeks after the day of her confinement the wound was entirely healed, the perineum being very slightly puckered.

Dr Burns had seen cases where the central part of the perineum was torn, the fourchette remaining uninjured, but never one in which the head had come through the rent.

Dr Hammond remarked that Dr Polson of Friockheim, in Forfarshire, had informed him that a case had occurred in his practice in which central rupture of the perineum had taken place, and the child and placenta had come away through the rent; the mother recovered completely without treatment.

Dr Keiller had frequently seen cases similar to those referred to by Dr Burns, but never one like that related in this paper, in which the central laceration and expulsion were complete. He knew of such cases, and had seen preparations of the kind. Severe lacerations of the perineum were most common in cases of contracted outlet, where the pubic angle was small and the head consequently pushed far down against the perineal structures, before the movement of extension of the head took place. He was of opinion that in most cases the tear began in the centre, and that when the head came to be pushed out through the vulva, the perineum gave way from behind forwards; he had repeatedly examined and proved this in cases. The great principle to guide us in the management of these cases was to save *the central point* of the perineum, where the various perineal muscles meet; if it be torn through, these muscles pull the parts more asunder, and the wound consequently, being difficult to keep in apposition, gapes. Hence it was sometimes better, where such a laceration was to be feared, even to make incisions at the sides of the perineum, and so save the central or middle tendinous point. Where the accident has taken place, he placed most

reliance on a few strong and deep sutures in the back part of the wound. It was unsatisfactory to put in too many, as the front part generally sloughed, and the stitches gave way. He referred to a preparation in Professor Simpson's museum, where a fistulous opening was left after this accident to the perineum. In this, as in Dr Wilson's case, the child had escaped bodily through the extensive central laceration, leaving the vaginal and anal borders of the perineum untorn.

Dr Simpson said that the case referred to occurred at Bathgate, and he had got the preparation on the death of the patient, a long time afterwards. He had seen the perineum torn in this way in a syphilitic case. He thought the sloughing in Dr Wilson's case was due to the quilled stitches being drawn too tight: he had seen this happen in an early case of his own. He could corroborate Dr Keiller's remarks about the rending most commonly beginning behind and extending forwards. The tear was generally central, but he had a case under treatment now where it was more to one side. He agreed with Dr Keiller that it was better, in cases of very tight perineum, to take the matter into our own hands, and make incisions on either side.

THE LATE DR L. R. THOMSON, OF DALKEITH.

FEBRUARY 10, 1875.

Dr Matthews Duncan said that, before entering upon the public business, he should like to refer to a loss the Society had sustained in the death of an ex-President, Dr Thomson, of Dalkeith. He would not offer any panegyric on the deceased, for he felt assured that it was unnecessary; suffice it to say that, as was well known to the Fellows, Dr Thomson had, more particularly during the tenure of his office as President, shown a warm interest in the affairs and prosperity of the Society, and endeavoured to the utmost of his powers to promote its success.

Dr Peel Ritchie referred also in feeling terms to the demise of Dr Thomson, and proposed that the Secretary should be instructed to communicate to his representatives the unanimous sense of the Fellows as to the loss sustained, and their warm sympathy with the family under their bereavement.

Professor Simpson seconded the motion, and briefly referred to the interest Dr Thomson had taken in the welfare of the Obstetrical Society.