The special primary condition in retroflexion is relaxation of the uterus and of the ligaments of the cervix. In prolapse there is tension and atrophy of the ligaments of the cervix and vagina always accompanied by atrophy of the muscular structures in the pelvis.

COLOSSAL OVARIAN CYST.—McGillicuddy (*American Gyn. and Obst. Journal*, April 1895), publishes for the first time a case in which the operation was performed in 1882 by Garclon. The abdomen of the patient was 69 inches in circumference at the umbilicus and 47 inches in vertical measurement from the sternum to the pubes. On 3rd July 1882, Garclon tapped the cyst, removing 132lbs. of fluid. On 8th July 1882, he performed ovariotomy, removing a pair of simple, non-adherent ovarian cysts, which with their contents weighed 70lbs. She died on the second day. Before operation the great tumour hung down as far as the knees, the abdominal wall chafing the front of the thighs.

APPLICATION OF FORCEPS IN OCCIPITO-POSTERIOR CASES.—Professor S. Tarnier (*Journal de Medicine de Paris*) points out that spontaneous delivery may take place in one of two ways when the occiput is posterior: in one case the occiput undergoes a long rotation forwards so that an occipito-posterior is converted into an occipito-anterior case; in the other, the occiput remains behind in the hollow of the sacrum, and if the perineum is yielding, and the pains strong, the head is delivered in this position, the posterior fontanelle being the first part of the child's head to be born. Supposing that the occiput does not rotate forwards, and the head does not advance, an attempt should be made to rotate it forwards with the hand, and this can often be accomplished because the head still remains movable. If the occiput is to the right, the left hand is introduced and the head seized, the thumb being placed behind the ear. The head is then rotated from right to left and from behind forwards, and the hand retained in position, because otherwise the occiput will again turn backwards owing to the fact that the shoulders have not rotated with the head.

The right blade of the forceps should now be introduced, and after being placed in position is entrusted to an assistant to hold. By this means when the left hand is withdrawn, the head is still retained in place. The left blade is then applied and the blades locked. On making traction, further rotation takes place, as the head descends. When the occiput cannot be rotated forwards by the hand he recommends the following plan:—The blades of the forceps are applied in one of the oblique diameters of the pelvis; so that if the occiput looks to the right sacro-iliac synchondrosis the left blade is opposite the left sacro-iliac synchondrosis, and the right one opposite the right obturator foramen. When the forceps are in position the first thing to do is to flex the head, and this can often be accomplished by pulling on the traction rods. If, in spite of this traction, the posterior fontanelle still remains high up and difficult to reach, the handles of the forceps should be carried forwards at the same time that traction is maintained on the cross-bar connected with the rods.

The head will thus be flexed, and the next thing to do is to aid rotation. This can be done by making the handles of the forceps describe a wide arc of a circle while traction is being made. The occiput having thus been rotated forwards, it will be seen that the concavity of the forceps now looks towards the hollow of the sacrum. If the perineum is resistant, it is best either to take off the forceps and reapply them, or to allow the head to be expelled by the uterine pains after the blades are removed. If the pains are inefficient, a manœuvre described by Ritgen may be employed, which consists in introducing a finger into the rectum and pressing on the forehead. In some cases, according to Tarnier, it is not necessary to remove the forceps, and by carrying the traction rods upwards and forwards the danger of cutting the perineum with the points of the forceps, is obviated. He concludes by alluding to the fact that the manœuvre which is in France associated with the name of Ritgen was really first described by Smellie.

KEDARNATH DAS, M.D.

TRANSLATION FROM FRENCH JOURNAL.

THERAPEUTIQUE CONSERVATRICE DE LA SALPINGITE. Par le Dr. Turgard (Suite et fin). Chronic salpingitis may be cured, and all means ought to be tried to avoid to the patient a mutilation and to let her undergo an operation which, although often benign and successful, yet may cause her premature death.

The general treatment must be symptomatic. In order to relieve pain, narcotics, cataplasms, rest. Against fever quinine ought to be given. To sustain strength iron and quinine preparations are useful. Constipation, which is so frequent in this disease, must above all be relieved; so much for the *medical treatment.*

The *local treatment* is the most important. *Curettage,* although counter-indicated in acute cases, in chronic cases the treatment of curettage is most useful. This treatment has been accused of causing inflammation of the ovaries and tubes or appendages of the uterus, rupture of the salpingitic fluids and accidents of death. Boute—(*Revue des Maladies des Femmes Janvier-Fevrier*, 1894.) But these accidents can be avoided if curettage is performed without bringing the uterus down. In that way adherences are not drawn and dragged upon and not torn. A speculum, to expose the cervix, will be

required ; the cervix can be immobilised by a Tenaculm forceps. After curettage an injection into the uterine cavity of tincture of iodine at an interval of six to seven days is recommended. Between the injections intra-uterine applications of glycerine créosotée 1 : 3½. After each application a plug of borated glycerine is to be given, or of a solution of pyoktannine.

Drainage is also useful and can be done in cases of salpingitis opening into the uterus. For drainage aluminium or caoutchouc tubes can be used.

Drainage is most beneficial, helping to modify the mucous membrane of the uterus. This might also be attained by introducing into the cavity of the uterus small medicated tubes (Crayons medicamentary) which act on the septic endometritis which has caused the salpingite infection. Massage and electricity in many of these cases are dangerous. This mode of treatment can only be adopted in old peri-salpingitic exudation, or in peri-ovarian salpingitis. However, there is danger that the liquid collected in the tube might be expressed into the peritoneum.

Mr. Anvard has, with good results, tried *compression*, applied on the iliac fossa by means of a bag containing shots; such a bag is placed, the patient lying down on the fossa iliaca corresponding to the tubal disease.

Condamin (*Lyon Médical*, 1894, *et Bulletin Médical*) has recommended the so-called *columnisation du vagin*, which means to plug the whole of the vagina with tampons of glycerine.

Lately Mr. Chéron, in order to cure perimetritic exudations, has tried *injections of artificial serum*. This serum contains :—

Ascide phenique	1
Chlor. de sodium	2
Phosphate de soude	4
Sulphate de soude	8
Aqua dist.	100

These injections are made in doses of 5, 20, 40, and even 100 grammes in bad cases. These injections raise the arterial tension, always low, in such cases ; they act also on the symptomatic anæmia in stimulating the vitality of such patients. The phenique acid has perhaps something to do with the results of these injections.

Chéron thinks that the combined soda salts gave better results than the solution simply pheniquée (Chéron—*Revue Medico-Chirurgical des Maladies des Femmes*, 1893-94).

In a good many cases on applying these different methods of treatment one may cure salpingitis, but both the patient and the doctor require a strong dose of patience.

Incision.—Puncture per vaginam is indicated in inkysted collections of fluid.

Incisions ought to be performed in purulent collections which are easily accessible by the vaginal culs de sacs. With complete antiseptic precautions these incisions are not more dangerous than to open an abscess in the throat. A drain is introduced into the cavity ; daily douches and modifying injections ought to be given.

Puncture is especially recommended by Mr. Laroyenne de Lyon (*Lyon Médical*, 1886). His pupils exposed the results at the *Congres de Bruxelles en* 1892. Mr. Laroyenne invented a special trocar for these punctures. His method gave him excellent results. Several of his operated cases became afterwards pregnant, which is an evidence of success. Certain operators, after having performed laparotomy, finding the appendages of the uterus little diseased or altered, have simply ruptured the adherences and re-established the permeability of the tube in detaching the agglutinated fringes, afterwards passing a catheter and introducing an injection. Others went further : Martin and Skutsch have either resected a wall of the cavity or an extremity of the tube forming a new ostium abdominale. Skutsch called this operation salpingostomy. Mundé of New York (*Transactions New York Academy of Medicine* 1893, page 195), already in 1888 proposed to liberate the tubes, to express their contents into the uterus and to inject through the fringed extremity a solution of 1 : 5,000 of bichloride of mercury. He acknowledges, however, never to have practised this method, as in those he cperated he never found the tubes healthy enough to find it useful to preserve them.

Certainly, if the last-named operation can be performed, that is to say, to detach the adherences, to express the contents of the tubes, and to make an intra-tubal re-injection, one ought to preserve the organ ; however, it seems that it is going too far with the conserving method in practising Martin's and Skutsch's operation, which are longer and more serious than simple salpingostomy, and which preserve to the patient only a stump of an organ, probably lost for further functions.

A. BAUMLER, M.D.

Selections.

TUBERCULOUS INFECTION THROUGH THE ALIMENTARY CANAL.

By Sheridan Delepine,
Professor of Pathology, Owen's College.

("The Medical Chronicle," May, 1895.)

When a truth, whether scientific or other, goes against the interests of a large and powerful class of the community, it is generally ignored or resisted till a more powerful class enforces its recognition. For the last 30 years farmers and butchers have been roughly disturbed by mere scientists, medical observers, and veterinary surgeons, who have come to the conclusion that it is not safe for man or beast to feed on tuberculous products.

At first the observations of Villemin, Chauveau, Gerlach, Günther and Harmz, Toussaint, Peuch, Bollinger, Jöhne, etc., though conclusive enough, were not accepted as quite con-