ated at the juncture of the two arms. The long arm goes into the bottle, and to the short arm a piece of tubing, with catheter attached, is fixed. The tube is filled by suction, and is controlled by the tap. Air is absent from the tube, because it is completely filled with the liquid. On raising the vessel and undoing the tap, the liquid, which may contain an antiseptic, runs through the catheter into the bladder. Pressure can be graduated by raising or depressing the glass vessel. There is also a tap at the end of the catheter, which allows the bladder to empty itself when full. The apparatus is portable, and can be adapted to any bottle, and may be used for washing out either the bladder or uterus.

III. REMOVAL OF LARGE ENCYSTED "WEDGEWOOD" BALL PESSARY FROM VAGINA.

By W. J. Beatty, L.R.C.P., etc., Fellow London Obstetrical Society, Fellow Edinburgh Obstetrical Society, Fellow British Gynæcological Society, Stockton-on-Tees. Communicated by Dr Freeland Barbour.

Mr President and Gentlemen,—I have the pleasure of showing you to-day a large ball pessary which had become encysted in the vagina of an old lady, and which I enucleated and removed.

The history is as follows:—

Mrs H., aged 68, consulted me for enlargement in left groin, with an offensive discharge from vagina. She informed me that about sixteen years ago she suffered from falling of the womb, when she was examined by her medical attendant, who advised her to wear a ball pessary to keep the womb in position, and for which purpose he inserted a large wood ball pessary, ordering her to take it out every week and wash it. This she was able to do for about twelve months, but at the end of this period she failed to remove it, as owing (she says) to its greasy condition, it kept slipping from her fingers, and as she had left the town where the doctor lived who inserted it, she felt a delicacy about consulting another medical man, and feeling no inconvenience, she simply syringed out the vagina two or three times a week. She was always able to move the pessary until about six years ago, and has never suffered any inconvenience except troublesome constipation, and latterly a constant desire to go to stool, until a month ago, when she felt a little pain in the left groin, and found a slight enlargement there, and about a week later had an offensive discharge from the vagina.

On examination I found an enlarged gland in left groin, and in the vagina a large round tumour only slightly movable, situated to the left and posterior wall of the vagina, over which I made an incision and removed the large ball pessary which I now have the pleasure of showing to the members of this Society.

Remarks.—As to the enucleation of the pessary there was little

difficulty, but I had considerable difficulty in removing it from the vagina,—the same difficulty, in fact, as my patient herself had, *i.e.*, its greasy condition, and being globular, it kept slipping from my fingers, but at last by fixing it against the perineum with the fingers of my right hand, I succeeded in expelling it by external pressure on the perineum with the palm of my left hand.

In conclusion, I may add that since its removal the glandular enlargement has gone, constipation greatly relieved, and the constant desire to go to stool has quite disappeared.

The pessary had become quite soft, and I was able to make a section through it with an ordinary table-knife.

Professor Simpson said he had never seen a ball pessary embedded in the vagina, but he had met with shelf, wooden, and india-rubber ones encysted there, and producing ulceration. He also remembered a Hodge pessary embedded in the roof of the vagina which had caused ulceration, and over which granulation tissue had grown, which required to be cut through before removal could be effected. It was interesting to note the symptoms in Dr Beatty's case, the irritation giving rise to inflammation of the inguinal glands, a condition which might have been mistaken for cancer.

IV. NOTE ON A CASE OF DYSTOCIA FROM DORSAL DISPLACEMENT OF THE ARM.

By A. H. Freeland Barbour, M.D., F.R.C.P.E., Lecturer on Midwifery and Diseases of Women in the School of Medicine, Edinburgh, etc.

Cases of dystocia from this cause are so very rare that the following one is worthy of record.

I was sent for to a patient in connexion with the Fountainbridge Dispensary, with a message that she was a multipara, and had been in labour for more than twelve hours without any progress.

On examining the case, I found the following condition.

Abdominal Palpation.—The head of the child was still at the brim; the uterus contracted on it, but no pains present; the fœtal heart was weak and heard to the right side.

On *vaginal examination* the os was dilated; membranes ruptured; head high, transverse, with occiput to the right, and both fontanelles on a level.

I should have mentioned that the waters had broken eight hours previously; and that the pains, which were strong then, had died away. It was a case, then, of uterine inertia, with the head for some reason or other not engaging, and the question was what to do—whether to put on forceps or turn. I discussed the question with the students who had charge of the case, and said that as the head was partially extended that was a reason for turning; and