nomenclature was inaccurate, had no logical consistence, and should of course be altered.

I am not bigoted in regard to this matter. It might, for instance, be possible to define position as "the relation of the dorsal aspect of the presenting part to the upper strait of the pelvis." This would, however, involve the alteration of the nomenclature in face-cases to "left-fronto anterior," etc., and would be an unfortunate necessity, but much better than adhering to a nomenclature that is contradictory and confusing.

I must apologise for bringing this subject up again, but I found that some of my friends objected to the brevity of that communication, and I have therefore expanded and explained it in some points.

Professor Simpson was not quite satisfied with Dr Hart's criticism of the ordinarily accepted definition of positions. Position had reference not only to the transit of the presenting part of the child through the pelvis, but to the relation of the child while still in the cavity of the uterus, for it was often of importance for the practitioner to be able to determine this, as, for example, in a case of placenta prævia where he wished to turn. The proposed change seemed to be mainly desirable in the case of face presentations. These, however, were abnormal varieties of the normal head presentation, and as all the movements were the converse of the movements in vertex presentations, it did not appear to him (Prof. Simpson) inappropriate to have the name of face positions reversed also. The proposed nomenclature seemed more complicated than that which it was intended to replace.

Dr Ballantyne doubted whether an improved nomenclature for the positions of the fœtus would be readily adopted by the profession. The old names had a very tenacious hold. He was not aware that any recent text-books had adopted the suggestions for uniformity in obstetrical nomenclature made at the Washington Congress in 1887.

Dr Berry Hart held the definition Prof. Simpson advocated to be no definition at all, but merely to mean that from the position of the back you could diagnose "position." In saying that change was desirable in face presentations Prof. Simpson conceded the point in dispute.

V. A FIRST SERIES OF TWENTY COMPLETED ABDOMINAL SECTIONS.

By D. Berry Hart, M.D., F.R.C.P.E., F.R.S.E., Lecturer on Midwifery, Surgeons' Hall, Edinburgh; Physician Royal Maternity and Simpson Memorial Hospital, Edinburgh; Assistant Gynæcological Physician, Royal Infirmary, Edinburgh; President, Edinburgh Obstetrical Society.

It is a most valuable custom, begun long ago by Sir Spencer Wells, for those who perform abdominal sections to publish their

results. The great value of this is that we obtain an accurate idea of what is being done in this important department, and, above all, get the mortality and morbility of the work.

The first point one has to settle in such a record is on what principle to record one's cases. A very natural plan is to record separately the great classes of operations,—hysterectomies, ovariotomies, appendage operations, and so on. This has its advantages, as we now know that the mortality in such depends not on the fact of its being an abdominal section, but really on the nature of the tumour removed, and the method with which its pedicle has to be dealt. The mortality in hysterectomies may vary from ten to forty per cent., whereas that of ovariotomies and appendage cases may be very small. The indications for abdominal section have, however, so much extended that I have in my first series included all my completed cases, reserving my merely exploratory ones for a separate communication, as mere exploratory incision has in itself practically no mortality. By bringing all my completed cases into one series I raise the rate of mortality, but it is at any rate free from any suspicion of statistics dependent on a classification that collects the successes and excludes the deaths.

In regard to the method employed, it was based on the teaching of Lister and Keith. Lister taught his pupils the great importance of the clean touch and perfect asepsis, and always deprecated the use of the spray in abdominal cases. To his teaching I owe more than I can express. To Keith, however, is due highest honour from all gynæcologists. His teaching on abdominal section is marked by genius, and to him we owe most of our knowledge of the right technique of operative work. His insistence on the importance of careful peritoneal toilette and asepsis have done more than anything else to save life, and every worker in this field must feel personally grateful to him.

I give no details on method, as that is now well known, and has already been brought before us by Drs Macdonald, Halliday Croom, and Brewis, in their valuable papers.

It will be seen that the nature of the cases is varied. In the eleven ovariotomies and parovariotomies, seven were simple and four difficult.

The first complex case was one where the cyst had ruptured for several months. There was a large amount of free fluid, and on deep pressure a more solid portion. On opening the abdomen the stickiness of the free fluid made the nature of the case evident, and on passing my finger to the more solid portion it passed through a rounded hole about the size of a shilling into the cyst. Careful sponging and drainage led to a perfect and uninterrupted recovery.

In a second (Case 13) the tumour was exceedingly large. On opening the abdomen, complete adhesion to the anterior wall was

found. The adhesions were carefully separated, mainly by sponging, and when the operation was completed there was considerable collapse. The abdominal wall was raw and oozing, but without points for ligature. She speedily rallied under stimulation, was drained for five days, and made an uninterrupted recovery.

Table of Twenty Completed Abdominal Sections.

Ovarian, Parovarian, and Ruptured Ovarian.

No.	Date.	Diagnosis.	By whom sent.	Remarks.	Result.
1	Feb. 6, 1886	Multilocular ovarian	New Town Dispensary	...	R.
2	Aug. 6, 1886	,, ,,	Dr N. L. Walker	...	R.
3	Sep. 29, 1886	,, ,,	Prof. Grainger Stewart	...	R.
4	Mar. 9, 1887	,, ,,	Dr Altham	...	R.
5	Sep. 16, 1887	Parovarian	Infirmary	...	R.
6	Ap'l 11, 1889	,,	Dr Graham	...	R.
7	Aug. 28, 1889	Multilocular ovarian	Infirmary	...	R.
8	Mar. 24, 1890	,, ,,	Dr Altham	...	R.
9	Aug. 15, 1890	Ruptured ovarian	Dr Spence	Drained	R.
10	,, 15, 1890	Ovarian	Infirmary	...	R.
11	,, 24, 1890	,,	Dr Benny	...	R.
12	Mar. 28, 1891	Dermoid	Dr Garland	Drained; many adhesions	R.
13	Ap'l 11, 1891	Ovarian	Dr Keddie	Very large; many adhesions; drained	R.
14	,, 11, 1891	,,	Dr Wyse	Omental and intestinal adhesions; drained	D.
		Uterine Appendages.			
15	Oct. 11, 1887	Appendages	...	Intolerable dysmenorrhœa and menorrhagia	R.
16	Sep. 9, 1889	,,	Dr Smith, Mid-Calder	...	R.
		Broad Ligament.			
17	April 2, 1891	Small broad ligament	Infirmary	...	R.
		Hysterectomies.			
18	Mar. 25, 1888	Narrow pelvis	Dr S. Stirling	Cæsarean Sect. (Porro)	R.
19	Ap'l 29, 1890	Broad ligament cyst	Dr Troup	Uterus removed	D.
		Ruptured Fallopian Tube Gestation.			
20	Ap'l 19, 1886	Ruptured tubal gestation	Infirmary	Drained	R.

The third difficult case, and the only fatal one in this section, had some omental and intestinal adhesions. What gave me concern was, however, the passage of some of the cyst fluid into the abdomen when the cyst was tapped. The fluid was thin, the cyst wall collapsed quickly, and thus some escape happened. I made a very careful peritoneal toilette and drained. On the third day, however, some distension began in the region of the ascending colon; the patient's pulse went up almost at once to 140, and she died on the fourth day. At the post-mortem, peritonitis was found around the ascending colon, and there was pus in the pouch of Douglas. The woman was not in good health, and had mitral

stenosis; but it is possible that some fluid passed behind the cæcum and set up mischief despite continued drainage. One of these sections was a small dermoid with torsion of the pedicle, and entirely adherent.

In all the ovariotomies I tied the pedicle with silk and used the Staffordshire knot.

For diseases of the uterine appendages there were only two operations. In both the indications were the same—severe dysmenorrhœa and menorrhagia—and in both the cure was perfect. There is now no doubt that the removal of ovaries and tubes in well selected and long observed cases is of the greatest value.

The only other case I wish to comment on is one of a broad ligament cyst so inseparably connected to the side of the uterus that I had to remove the uterus by the supra-vaginal method. This was the second death in the series, and was undoubtedly due to the unfortunate necessity for hysterectomy. In four of the cases drainage was employed, and proved of the greatest service. In Case 14, however, it was less valuable than I thought, and misled me as to the amount of effusion.

Of the other cases, that of Porro's operation and one of ruptured Fallopian tube gestation are rare and of interest, but I have elsewhere commented on them.

In the successful cases there were no complications except in two, where there were stitch abscesses. I thought that in one there had probably been blood effused in the abdominal muscles from the needle penetrating a vein, and that this had suppurated.

In conclusion, I have to thank the House Physicians at the Buchanan Ward for their valuable aid, and especially Professor Simpson for his valuable teaching and advice.

VI. NOTE UPON NINE CASES OF ACCIDENTAL VACCINATION.

By R. W. Felkin, M.D., F.R.S.E., Lecturer on Diseases of the Tropics and Climatology, Edinburgh School of Medicine.

Perhaps I ought to apologize for bringing before the Society such a simple subject as that of accidental vaccination, more especially as I simply wish to call attention to a number of cases which I have seen during the past few years.

The first case was that of a woman, T. S., aged 25, whom I saw on the 8th of November 1883 with the late Dr Moinet. The woman complained of a sore upon her left labium. I failed to recognise its character, but Dr Moinet told me that it was a case of accidental vaccination, and on inquiry we found that her child had been vaccinated a fortnight previously. The woman's right index finger was also vaccinated, and I had not been shown it at first.