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(2) The employment of professorships should be thrown open to the public for Indians, Europeans, as well as I.M.S. officers, through general competition. In case of I.M.S. professors, compulsory retirement or transfer should not be compelled.

(3) All the medical colleges must have board of directors, in which the members of independent practitioners should predominate.

(4) Health officer and deputy sanitary commissioners, as suggested by the Government of India in its despatch to local Governments, should be under direct control of the Governments.

(5) The annual recruitment of I.M.S. through the competitive examinations in England should be reduced by one-third. The latter portion to be opened for private medical practitioners in India by selection on the following conditions:—

(*a*) The highest qualifications of British and Indian universities must have preferential claims.

(*b*) The regard for experience of some years' practice, either in the recognised hospitals or privately, must be in forefront.

(*c*) The pay and pension should be one-third less than the members of I.M.S.

(*d*) The pay and grade of the service should be according to the number of years' experience.

(*e*) The age-limit for employment and retirement should be extended.

(6) The employment of military assistant surgeons in the civil work should be discontinued, or the standard of their education be raised.

(7) The status of civil assistant surgeons should be maintained, but their pay should be increased.

(8) Hospitals in principal towns should be thrown open to competent private medical practitioners for their honorary work as surgeons, physicians and specialists, etc.

Such is the outline of the present movement on the part of our medical brethren in India, and it is satisfactory to note that the Government in India and the Secretary of State are in favour of improving the position of the medical profession in that land. The problem is one of considerable difficulty, but is of high importance, and it ought to claim careful consideration, not only of statesmen, but also of those medical men who possess a practical acquaintance with Indian medical affairs.

CYSTIC DISEASES OF THE CHORION.

By J. FOSTER PALMER, M.R.C.S., L.R.C.P.

WE are sometimes told, even by members of the profession, that medical treatment is chiefly based on empiricism; that its advances are usually due, not to pathological research, but to the adoption of some popular superstition or old woman's remedy. This may have been so in the treatment of rheumatism by the salicylates. It was certainly not so in the treatment of "Cystic Diseases of the Chorion." The old pathology was hopelessly wrong. Cases were looked upon as enormous developments of hydatid cysts, and, it would appear, as incurable. In the Museum of St. George's Hospital are four cases thus described, two of which, at least, one under Sir Benjamin Brodie, and the other under Mr. Cæsar Hawkins, died of hæmorrhage without being diagnosed. In the present day no fifth year's student would let such a case slip through his fingers. Since the researches of Paget, Cruveilhier, Gierse, and Mettenheimer on the subject, such a result would be almost impossible if the case came under observation at all. Indeed, it is said that the natural tendency is for the diseased structures to be expelled by uterine action. The cases referred to, however, show that this is not always the case.

The pathology of this condition is now known. In a normal pregnancy the chorion is practically surrounded by villi, which pass to the uterine wall. By the end of the fourth month, however, these villi have entirely disappeared, except in one spot, where they have taken on special growth, and have developed into an integral portion of the placenta. In "cystic diseases of the chorion," however, they do not disappear, nor do they take on special growth at one point. Instead of this, some morbid process sets in, the whole of the villi become dropsical, and swell out into innumerable small vesicles, and the further development of the ovum becomes impossible. The vesicles, it is true, bear a certain resemblance to hydatid cysts, so that the mistake of the older surgeons is not surprising. This is what occurs in the earlier months of pregnancy. Later on the process is naturally confined to the placenta, and the symptoms are somewhat different.

Many years ago I was called in to see a patient said to be about four and a half months pregnant. There was considerable hæmorrhage. The os uteri was dilated. This was about eight p.m. I ordered ergot to be taken every half-hour, and saw the patient again at eleven p.m. I then removed a portion of the ovum. It was completely degenerated, and filled with hydatidiform cysts. The hæmorrhage ceased, and the remainder, or what appeared to be the remainder, of the ovum came away spontaneously in about half-an-hour. One or two small remnants passed a day or two later with slight pain. Recovery was rapid and complete.

About ten months later this patient again consulted me with symptoms of anæmia and menorrhagia. She stated that she had aborted six months previously, and believed that she was not now pregnant, the hæmorrhage having come on at the catamenial periods only. When I saw her, however, it was continuous, though not excessive. There was a decided odour of decomposition about the discharge, and the patient suffered from great nervous irritability. About a fortnight later hæmorrhage came on suddenly in great abundance. Finding the os uteri somewhat dilated, I removed a portion of the ovum and administered ergot, after which a large mass came away, full of hydatidiform cysts, as on the former occasion. The mass was partially decomposed. Recovery, of course, took place more slowly than on the former occasion.

This being, apparently, the third consecutive abortion, I recommended twelve months marital separation. This treatment was, I believe, commenced, but could not have been completed, for eighteen months afterwards the patient was delivered of a healthy boy.

There are two principal theories as to the cause of this condition. Is it an active or a passive one? As to the condition itself, there is now no doubt. The vesicles are formed from the villi or their cells But is it due to a passive dropsical swelling following the death of the fœtus, or is it an active cystic enlargement of the cells *causing* the death of the fœtus? According to the latter view, which is that of Paget and Mettenheimer, the cells, when once they have begun to take on the formation of cysts, proliferate, and seem to be capable of almost unlimited reproduction. The question arises whether, in the case above described, the second growth of cysts may have been merely a continuation of the first. According to Paget's view of their formation this seems to be at least possible. If the cysts, when found, are capable of reproduction, there appears to be no reason, short of death from hæmorrhage, why the process should not go on for years. In cases like this it is impossible to be certain that every portion of ovum has been removed. If a single cystic villus remains attached to

the uterine wall it may form the nucleus of another mass of cysts, which, after a time, might reach the same proportions as the first. It is true that in this case abortion was said to have taken place between the first and the second expulsion of cysts. This, however, is more than doubtful. It depended only on the patient's word. No medical advice was thought necessary. If the hæmorrhage had been at all considerable a doctor would have undoubtedly been called in, after the great alarm caused by the previous case. Sufficient hæmorrhage to suggest abortion to the patient, accompanied, perhaps, even by small portions of the diseased ovum, may well have occurred after the first expulsion, either from some uterine or ovarian congestion, or from a partial detachment of the collection of cysts. Indeed, the decomposed condition of part of the ovum seems to suggest some partial previous detachment. If the fact of this continuous proliferation were established, it would confirm in an unmistakeable manner the view of cyst formation taken by Paget and Mettenheimer, as such action would be practically impossible if the cyst formation were merely the result of passive exudation due to the death of the fœtus, as held by Gierse and Meckell.