Midwifery Practice in Lancashire

by Robert Hamm MBE

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For the past 5 years my lot has been that of an assistant in a Lancashire practice. The town in which I was placed contains about 75,000 inhabitants, but the surrounding district is thickly studded with villages and detached houses, and the nature of my principal's practice is such, that most of my experience has been gained among these villages. The staple and only industries of the town and its adjuncts are the manufacture of cotton and the production of coal. My midwifery

midwifery experience is that to which I shall confine my thesis as on the whole it has, as it seems to me, been the most varied and practical. Although the cases I have personally attended number only some 500 all told, yet in presence of one who understands the system carried on in this part of Lancashire I think I am justified in claiming as within the Sphere of my work at least twice that number.

In this town poverty and prejudice combined make the custom of calling in a woman to take charge of the labour extremely common; while on the other hand the long distances to be travelled and the not too easy means of locomotion have often made me too late to find the

case

case "still going on". If a woman is in the habit of having easy labours she does not think of calling in anyone but a midwife to attend her, finding this cheaper and not realising the risks. Hence, except in the case of the better class patients the doctor is only called in, when from some reason the midwife thinks something is not going right, or more frequently to rectify the blunders of that, in most cases, ignorant person. At a moderate computation therefore, my experience has been, I think, as my statistics will prove quite that of 1000 cases. I am confirmed in this estimate by comparing the number of abnormalities which I have found with that generally given by the authorities. This I shall show in detail.

Not

Not too much reliance can be placed on the record of ordinary or cranial positions, for in a certain proportion of these cases the labour was too far advanced to be able to diagnose with certainty the exact presentation. Thus for example at any rate, in cases found in the second position one could not always make out if it had previously been in the third and so on. Still out of the almost 500 cases there were 420 in which, for purposes of classification the notes are fairly reliable: while in considering the frequency of such difficulties as transverse or even breech cases the proportion is for obvious reasons calculated up to 500 cases.

But of the total number of cases 490 in all, there were 465 cranial presentations

presentations, 3 Facial, 6 Breech, 8 of the Superior extremity. Of the superior extremity and funis I had one case, and of the head and funis 3 while of the placenta (ie placenta praevia) I had no less than 4 cases. On analysis of these figures we get;

Head	Facial	Breech	Transverse	Placenta
95.1	.61	1.22	1.63	1.44

No remarks need be made on these statistics. They are as accurate as could be made in the midst of a busy practice and all they show to my mind is, either that the proportion of cases other than cranial is larger than is generally believed or, and of this there is greater likelihood, that the doctor in this district is only called in when one or more midwives have tried

tried and failed to deliver.
Moreover the number of cases observed is perhaps too small to be of more value than as a humble contribution to the statistics of others. Why the proportion of breech cases should be less in some degree than that generally observed when every other variation from the cranial is so much more common is, it seems to me, accidental and is at least inexplicable.
To proceed to the analysis of the cranial presentations. Of these 65 were irrecognisable in detail but of the remaining 400 the percentages show in most respects a fair resemblance to those usually given but in one or two points they differ considerably.

Total

Total number of cases

	1st Cranial	2nd	3d	4th
465	258	73	56	13
per centage	64.5	18.25	14.	3.25

It will thus be seen that the figures show the second position to have been quite as common as the third even making due allowance for the likelihood of rotation previous to my arrival. I am quite convinced that these two positions and probably the 4th also, though of the latter my instances are too few to be of any particular value, are more common than is generally allowed in most text-books. If they are inaccurate it is not from design, nor I hope from want of care in observation but simply from the many circumstances which place a man in general practice

practice at a disadvantage as compared with a Specialist in a lying in hospital. Incidentally I may state the relative proportion of multiparae to primiparae as about 2 to 1 - viz;- 161 of the women never had children before. I dont suppose this is much value. The oldest woman I have delivered was aged 46 years and a very difficult labour it was, while one of my primiparae was a woman aged 40 who was seized with puerperal convulsions but after a very trying and difficult labour (a breech presentation) recovered. Before proceeding to the more important part of the subject viz;- the dangers and difficulties of labour it may be as well here to find Space for a few incidental notes

notes on subjects connected with the treatment of parturient women I shall refer to the following topics; (1) Use of ergot in labours (2) Forceps as an adjunct to labour (3) Presence of midwives as met with in Lancashire, (4) Use of chloroform

Use of Ergot. When circumstances demanded I have frequently used the drug in the hope of hastening labour but not always with the best results. It seems to me that the virtues of this much lauded drug ~~have not~~ have been much over-rated even when given to women at the full time, in the form of the liquid extract which is usually the only one available.

In the first place one cannot always count upon it even acting at all in the way of stimulating uterine contraction

contraction. In a fairly large proportion of cases apparently suitable it had absolutely no action whatever, while if it did act and that without producing the desired effect viz:- the rapid expulsion of the child it very often resulted in the death of the child and as for the mother, to say the least, was not conducive to her comfort and safety. In more detail, the nearly continuous contractions of the uterus if they fail to expel the child within a reasonable time involved such pressure on the cord that the child almost without fail was born dead. I have also been told by one who has had a large midwifery experience that the use of ergot tends to produce retained placenta, with its

its consequent peril to the woman. I cannot say, however, that I have ever experienced this danger.

There are some cases where it must be admitted, in the usual therapeutical language it "acts like a charm". These are cases where there is nothing impeding the labour except failure of the pains. In such cases a wearied accoucheur is often delighted to find the child advancing steadily and safely and the labour soon brought to a normal close. Finally therefore my experience has led me to trust rather to nature and to be very chary of interference by means of this drug unless when confident that its use will bring the labour soon to an end.

Forceps. It is needless to say that I have found the forceps indispensable

indispensable in certain cases.
I have used them in all 23 times.
Of these, two were cases of convulsions
where speedy delivery was required
both in the interest of mother and
child, 3 for contracted pelvis and
the remainder for various other causes
as inefficiency of pains, rigidity
of the parts especially in aged women
or exhaustion of the woman.
The brief details of one or two cases
may be interesting. I was summoned
early one morning by another
practitioner to assist him with a
case. The case was one of a multipara
in which the head, from slight
contraction was arrested at the brim.
He had successfully applied Assalini's
forceps but for some reason or other,
which the result showed to be
some defect in the forceps no
progress

progress could be made. They locked properly and a fair amount of traction could be applied but in the long run they always slipped without any advance being gained.
In fear and trembling (as it was my first case) but with implicit faith I cautiously applied Simpsons long forceps and procured the desired effect.
After all is said and done, in this part of Lancashire one ought to be very chary of using the forceps for the sake of one's professional reputation, one dare not act without convincing not only one's self, but mother and attendants of its absolute necessity. It is like tooth extraction; one gets no credit for a successful case and if anything goes wrong even a fortnight after the labour all the blame

blame is laid on the instruments, one requires to balance the risks of the two methods of procedure and to be sure that nature will not of herself bring the case to a successful termination before deciding to use them. I cannot pretend to speak on the relative advantages of the different kinds of forceps as I had to use the only means at my disposal, but it seems to me that Simpsons long forceps satisfy quite as many necessities as any others could and are quite as applicable at the outlet as at the brim. I quite admit that you cannot with them produce complete rotation in a 3d or 4th position, but you can at least initiate the movement by elevating the forehead.

Chloroform. As regards the use of chloroform in labour there is a great prejudice in this district against it. My principal at the same time shared this prejudice so that I have had few opportunities of forming an opinion as to its advantage. As in the case of forceps so also in that of chloroform the practitioner has to be prepared for any subsequent evil befalling the woman however remote, being ascribed to his artificial aid! However little this may affect the independent and conscientious practitioner in the discharge of his duty still in these times of competition it has always to be kept in view. It may seem paradoxical but education is not sufficiently wide-spread to produce

produce as yet the desired faith in a trained medical man. In puerperal convulsions however the case is different; there, chloroform is no mere artificial aid but an actual therapeutical agent.

The so-called midwife and her plans of operation. To my mind the presence of midwives at a labour whether alone or acting under the doctor's supervision is an unmitigated nuisance. In other parts of the country they may be perfect ladies and thoroughly qualified for their duties but it has never been my good fortune in this benighted place to meet with any such. They are all of the Sairey Gamp type generally drunk and always incapable. They often succeed in spreading

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the poor doctor in a hopeless difficulty
They often succeed in mutilating
the poor patient and rendering
subsequent child bearing impossible
and her future life a burden.
Those only who have some really
successful cases are the few who
have the common sense to let things
alone and trust to the labour coming
to a natural and unassisted
termination. I have seen them
at work and the ignorance they
display and the violence towards
the poor travailing woman, her
perinaeum her os and her vagina
all shamefully mauled is truly
disgusting. The callousness and
carelessness they display in
such difficulties as for instance
the occurrence of a septic case
(one usually to their own selves)
is

is simply inhuman. It is their own selfish gain which they have studied and not the practice of midwifery. It may be more deferent to the sensitive feelings of a woman to be attended by one of her own sex, but let it be by one who has really the feelings of her sex or till the day comes when properly trained ladies can assume the duty, let it be by a trained male practitioner and this even if a law be required to enforce it. As a matter of practice I invariably when I find a midwife there, order her out of the room and trust for such assistance as I may require to an untrained but sympathising friend. Even in these duties which lie more properly within a

mid-wife's

midwife's province, such, to choose a trivial example, as washing the baby, their deficiences are quite as apparent as when they ape the doctor. Most, nay all the cases of ophthalmia neonatorum are in my experience due to no specific cause except bad washing of the child at birth.

Peculiarities of Lancashire practice

Parturition has been much the same probably since the world began, so there are only one or two little things wherein Lancashire customs differ from those of other localities and these may perhaps be interesting. The chief one to which I would call attention is the custom the women have here, of being delivered in their every day attire. Dress, petticoats stays, everything is worn just as

as they were at the mill on the previous day. After the labour is over the woman is undressed by the attendants even to her chemise. The sheet, if dirty, is drawn out from below her, the binder and napkin are applied, the clean sheet replaced, and all is considered well. This custom has its advantages. The woman can walk about the room without fear of catching cold and so as is well known allow gravitation to expedite the labour. Secondly there is no doubt that this method gives a better chance of keeping the bed-clothes unsoiled, an end which do as you will is not always attainable under the usual method. Thirdly on the whole it is rather more in accordance with the modesty

modesty of the woman, But on the other hand the great argument is that it is not so safe. If anything such as post-partum haemorrhage or retained placenta occurs the comparative inaccessibility of the abdominal wall to the accoucheurs hand may put the woman in jeopardy. I have never actually found it so in my experience but I cannot shut my eyes to the undoubted risk. Moreover one has a feeling, selfish it may be, that when the child and afterbirth are both safely away that with the application of the binder one's labours ought to be over. It is a small matter perhaps but it is a bother to undress a helpless woman to whom the first essential is quiet, not to

to speak of the risks one's fingers run amid the countless pins which women will persist in substituting for buttons.
Another trifling detail in Lancashire practice is that the women will insist upon having the binder outside both night dress and chemise. I shall withdraw the word trifling as obviously when worn in this way it nearly fails of any little good it can do, and is much less comfortable to the patient herself. I have always therefore, unless where the time-immemorial argument was too strong for me, adopted what is laid down as the correct method, of putting it next the skin. Where the woman is spare in figure with the crests of the ilia

ilia projecting a pad over the uterus is a very useful adjunct. The Lancashire women are as a rule more provident than is usual elsewhere and there is never any difficulty in finding clean garments for either mother or child.

Abortion and Premature Labour

Abortion is very common in this district and is made light of. This I ascribe to the love of money on the part of the women, who on the one hand insist upon going to the factory all the time of their pregnancy and taking none of the care which their condition demands: and on the other hand when their recklessness has brought about an abortion they entrust themselves to some of the wise

women

women previously mentioned and only call in the doctor when in the direst straits. As to the causes they are of course the usual ones syphilis being an all too common factor. Menorrhagia previous to marriage or I should say its presumptive irritability of the ovaries often continues after marriage in the shape of tendency to abortion. One case of special interest to me was that of a woman whose previous and subsequent history had made me feel certain that I was the agent. She had been suffering from neuralgia and the large doses of quinine which I gave her seemed to bring on abortion. As to the treatment of impending abortion I have followed the routine as laid down

down. Opium seems the most effectual drug combined of course with rest and the usual dietetic arrangements. In one case of a woman who had aborted on several successive occasions and in whom no history of Syphilis could be made out, the liquid extract of Viburnum Prunifolium in 3ss doses proved effectual and she has had two children at the full time since. In cases where the labour was inevitable I have found it advantageous to give Ergot. As for placental forceps, perhaps I was lucky but at any rate I never required to use anything more violent than my fingers. In a few cases the placenta in whole or part was retained. In one note-worthy case

case of a woman miscarrying at the seventh month I did not succeed in removing it until after 36 hours, but Septicaemia set in and it was only after a lingering and alarming illness that under the influence of quinine and vaginal ablutions she recovered. But of the treatment of puerperal Septicaemia there will be more anon.

Transverse Presentations

I have had an unusually high percentage of transverse presentations viz 8 in 500. This is perhaps not very difficult to account for as a midwife if not too ignorant admits her inability to tackle such, and my percentage is also raised by this presentation having occurred 3 times in the successive pregnancies of

of the same woman. This latter fact was I think no mere coincidence but due to that anatomical peculiarity pointed out by Wigand viz:- the transposition of the long and short diameters of the uterus. The presence or absence of the liquor amnii makes of course all the difference between the ease and difficulty of the operation of turning. The question of the child being in the dorso-anterior or dorso-posterior position never stood much in the way. For even when dorso-anterior if the accoucheur be not too proud to get down on his knees, he will have no great difficulty in wriggling himself into some position in which the foot is attainable. In one case I was summoned to assist a brother practitioner, who,

who, as there was an arm and cord hanging in the vagina successfully diagnosed a presentation of the Superior extremity. Knowing that turning was the correct treatment of the difficulty he had risen to the occasion and brought down the other arm. The liquor amnii had long drained away and it was a matter of the utmost difficulty to me and pain to the woman, as no chloroform was used, to get my hand squeezed up as far as the fort. But with the aid of the fillet, which left the hand in the vagina free to push the shoulder upwards the case was brought to a successful termination. It was no fault of mine that the woman died a fortnight later of

acute pneumonia. If there is any greater difficulty it is in the dorso-posterior position and it only occurs towards the close of the labour, one must always see that the head is rotated into the reverse position and it is the delay in doing this which endangers the childs life or the failure to do it at all which endangers the mother's perinaeum. The bi-manual method of version is in many cases not specially reliable and in cases such as most of mine were where the liquor amnii had drained away it was quite inapplicable. But even where the amniotic sac was intact from want of skill perhaps, though I could move the child in the required direction I had not the power

power to retain it. I have never had an opportunity of trying it in head presentations.

Shock is the great bug-bear to the operation of turning though I have never found any really serious difficulty from it. With care, patience and no unnecessary violence and with a proper apprehension of what is desired, even without the aid of chloroform the operation of turning can be safely and easily performed. Still as to chloroform, had I been on my own responsibility I would certainly have used it to avoid the pain to the woman and the consequent struggles which in themselves are no slight impediment to the easiness of the task.

Placenta Praevia I have had 7 cases of placenta praevia. Of these two were distinctly complete or central and the rest more or less partial. Prompt and energetic measures are called for when we meet with such cases and turning was on all occasions the means adopted. In one case certainly the placenta was entirely detached mostly by my efforts and born before the child. So far all was well. But to my surprise and disappointment the pains at once died away although ergot was administered. Slight bleeding still went on seemingly from the mere flaccidity of the uterus and eventually turning had to be resorted to. Had we done so at first, probably the

child's life as well as the mother's would have been saved. From this and other cases I have for the present more confidence in the method of rapid and dexterous turning than any other as more conducive to the safety of all parties concerned. In a second case I was summoned one night to attend an Irish woman, on whom I learned by enquiry that a midwife was supposed to be attending. This midwife had been summoned two days previously when the labour began. She had made a thorough examination and given her authoritative opinion that everything was all right whereupon she had retired. She had left the woman to die. I found the

woman

room, bed clothes and woman deluged in blood, the woman herself very much exhausted, the pains slight and the os semi-dilated. The placenta was adherent all round its periphery. It was too late for plugging nor did the state of the os require it so after sending for assistance and diagnosing a cranial presentation I inserted my hand and by turning succeeded in delivering the woman. But for an unavoidable delay through requiring to rotate the childs head, and attending to the mother at the same time the child would have been born alive. There was some difficulty in getting the placenta away as the uterus seemed to be toneless, hence even after delivery

delivery there was no small haemorrhage. The mother went on perfectly well for a week but from want of careful nursing septicaemia set in with which she was too exhausted to combat. I mention this case not so much for any scientific lesson which it teaches as to illustrate the difficulty the general practitioner has to deal with. This death is the only blemish on my record of placenta praevia cases.

Post-Partum Haemorrhage.

Honesty compels me to admit a certain amount of ignorance of this dread calamity. Of haemorrhage after delivery I have seen many cases but in only one was there any resemblance to these ghastly accounts of rapidly

rapidly moribund women destroyed in this way. Had I been anxious to make up statistics easy were the task to enumerate cases where a profuse gush of blood before or after removal of the placenta might have seemed to justify one in relegating such to this class. There were only one or two cases however in which a rapid and continuous discharge of blood placed the woman's life in jeopardy and called for the administration of rapid and ready remedies.

The case on which I shall give special notes was that of a primipara aged 24 to whose confinement I was only called in by chance but providentially. She had suffered previously from an attack

attack of enteric fever, the recovery from which had left her weak and anaemic. By the merest accident I was called in to attend her in her labour which had already begun. On examination I found the head of the presenting in the third cranial position; and as a consequence the labour was slow but at last after rotation of the occiput the child was born and alive. To my horror the delivery of the child was followed not by the placenta and membranes in the normal way but by an abundant gush of blood. On making examination for the cause I found undoubted evidence viz the appearance presented by palpation of the abdominal walls that there was

contraction

contraction of the uterus and retention of the placenta had taken place. The haemorrhage was so profuse that in less time than it takes to relate, the woman was collapsed and unconscious. Prompt measures were called for. Taken unawares as I was I had none of the usual means with me for meeting such difficulties except liquid extract of ergot. Though quite aware of the slowness of its action at least when administered by the mouth as a matter of routine I had administered a half drachm dose of the drug coupled with brandy to counteract the collapse, while at the same time I set to work with both hands to stem the haemorrhage and withdraw the placenta. By dint of forcible manipulation

manipulation, while the deluge of blood went on incessantly the contraction of the lower segment of the uterus was overcome and the placenta removed. The uterus seemed now to be atonic and the bleeding did not cease. I therefore introduced one hand into the uterus and keeping the other upon the abdominal wall maintained a continuous pressure upon the whole organ and its bleeding sinuses. My efforts were only partially successful for though the profuse haemorrhage ceased it was succeeded by oozing which though slight and partially checked by the tardy action of the ergot was nearly incessant and wasted as the frequent fainting of the woman

woman showed, have resulted in her ultimate death. In desperation and though I was well aware of the opposition of the authorities, I resorted to plugging by means of a handkerchief steeped in vinegar combining it with pressure from the outside. This method in the end proved successful and I was able to leave the woman exhausted but safe. Certainly plugging seems borne to be contra-indicated in cases of very abundant haemorrhage from the uterus as it may, as is pointed out, convert an external into an internal haemorrhage and mask till past recovery the serious onset of the case. But when there is simply oozing, a serious enough

Symptom

symptom in itself it seems to me a very ready, applicable, and useful method of combating the danger. In one thing at least it leaves the accoucheur and his two hands free for external manipulation or for any other remedy which may seem suitable. In a country practice it must be remembered that such cases occur unexpectedly and it may be miles away from the surgery and that the physician has to fight the cases out single-handed with only a pair of hands and with such remedies and appliances as may suggest themselves to him on the spur of the moment. Any other cases that I have seen which might be

be styled post-partum haemorrhage have been comparatively trivial. I have repeatedly seen cases of not inconsiderable haemorrhage due to the stupidity of some women who insist on being delivered on their knees. Midwives who have been previously in attendance have not discouraged this pernicious practice sufficiently. Never, however did the haemorrhage fail to cease when the uterus was compressed from the outside by palpation of the abdominal wall. In one or two cases where there was a history in previous labours of haemorrhages from atony of the uterus I have found it useful to treat the woman for some little time previously with small doses of Liq Strychniae

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so as to give tone to the uterine muscle and to supplement this with a dose of ergot immediately before the head was born.

Craniotomy It has fallen to my lot to perform this operation in whole or part three separate times. The first occasion was in the case of a woman aged about 38 in her second confinement. Her first labour which had taken place several years before had only been brought to a termination by craniotomy. She had evidently suffered from rickets in her childhood as her general appearance and what was of more moment, the shape of her pelvis abundantly testified. On examination per vaginam marked projection forwards

forwards of the sacrum with its consequent lessening of the conjugate diameter of the brim was, the first point that attracted attention. The os could only be reached with great difficulty and although it admitted the tip of the forefinger no presentation could be made out, we decided therefore to wait. The dilatation progressed very slowly although the pains came on regularly and seemed of moderate severity. Having some other duties to perform I left her for some time and on my return was able to make out a cranial presentation and that the os was sufficiently dilated for using forceps if found practicable. My principal having been made acquainted with the

the case, now arrived and Simpsons long forceps were tried by both but without success. I have since thought that there would have been just a chance for the child's life if turning had been resorted to at this stage. The woman by this time was showing signs of exhaustion through her fruitless efforts and was suffering severely from cramps in the thighs. The question of turning was suggested but the small chance there was of saving the child considering the paucity of room in the pelvis, led us whether right or wrong to abandon it in favour of craniotomy. Chloroform was administered and perforation + decerebration carried out. As the head even

fell

yet did not advance the craniotomy forceps were applied but in this case the foetus invariably gave way. We then removed the vault of the cranium piecemeal breaking the bones with the craniotomy forceps and removing them partly with the forceps but chiefly with the fingers, care being taken in so doing not to injure the maternal soft parts. No very great difficulty was experienced with the base bearing in mind the plan recommended of bringing it edgewise into the brim and aiding its descent by the use of the crotchet. The woman progressed very well for 3 days and seemed in a fair way for making a good recovery, when she was seized with cerebral apoplexy due no

no doubt to embolism and died comatose two days later.
The other two were cases of undoubted impaction the head being immovable in both directions and had been under the care of women previous to my arrival. In both I tried the forceps before proceeding to the more formidable operation but without the desired result, There is nothing of special note in regard to the operation in these cases, after perforation and decerebration delivery was soon accomplished by the aid of the craniotomy forceps. In each case the mother made an uninterrupted recovery -

Puerperal Eclampsia My experience of this ever-dreaded malady

malady has been derived from the study of 5 cases. In all these cases there was more or less marked albuminuria with oedema of the lower extremities and sometimes of the face. Of the rarer forms of eclampsia as that from chloraemia etc I have not met with any example. Of these five cases only one had the advantage of any preliminary treatment as the other four did not come under my observation until after the first convulsive seizure had occurred. Judging from the success which attended my efforts in the case where I had the advantage of treating the patient for some time before the occurrence of labour I am inclined to attribute the high mortality attending the others to

to want of appropriate treatment beforehand- Of the 5 cases there were two recoveries and three deaths. In only one case was the child born alive. One woman a primipara in the 7th month of her pregnancy died undelivered. In this case such was the severity and frequency of the convulsions that the woman died a few hours after the first seizure — in spite of chloral and chloroform - without any appreciable dilatation of the os being observed. In this case a small quantity of urine drawn off by the catheter solidified on boiling. There is one point which the study of these cases has impressed on my mind viz:- that there is in

in some cases a close relation between the uterine pains and the convulsive seizures. In certainly three out of the five cases I have repeatedly noticed a seizure occur immediately after a pain and this took place so regularly that it not only attracted my attention but that of the women in attendance as well. It may perhaps be as well to mention that there was no other obvious source of reflex irritation as for instance marking an examination during the pain. In none of the cases did any tendency to post partum haemorrhage manifest itself. Perhaps a few words more in detail about these cases may not be out of place. My first instance was that of a primipara at the full time in

in whom the symptoms first showed themselves at the commencement of labour. As she lived about 3 miles from town a considerable time necessarily elapsed before I was able to see her. On arrival I ascertained that she had had several attacks and on examination found the os about the size of a shilling with the head presenting. I administered 30 grains of chloral with difficulty which had the effect of considerably lessening the severity of the attacks. After waiting about an hour I administered a second 30 dose of chloral. The labour progressed very rapidly and in a very short time I had the satisfaction of finding the child born alive, and the placenta

placenta followed almost immediately. The mother remained in a comatose state for several hours afterwards but had no further attacks and made an uninterrupted recovery. My next two cases were nearly identical in every respect. Both were primiparae and about the same age 23 or 24 - The convulsions had been occurring regularly for some time prior to my arrival and chloral in 3ß doses was first tried, as the convulsions still occurred regularly and severely chloroform was administered and as soon as the state of the os warranted the forceps were applied and the labour brought to a termination. The convulsions however still went on in spite of

of all our efforts and the woman
died a few hours after delivery.
Another case was that of a
woman who became pregnant
for the first time at the age
of 39 after being married 18
years. She had consulted me
some weeks before on account
of the swelling of her legs and
was treated with some mild
diuretic mixture with some
measure of success. She had been
bathing on the Thursday and
feeling a bit unwell had gone
to bed. Uterine pains and
headache thereupon attacked
her and an hour later she
was seized with a uraemic
convulsion lasting about two
minutes. I was sent for and
prescribed a mixture of 15 grains
of

chloral and 20 of Potass. Bromid every 2 hours. A digital examination revealed that the labour had made no appreciable progress. Fit followed fit at irregular intervals the next being at 5 am then at 9 am while the uterine contractions continued regularly every ¼ quarter of an hour. The presentation was a breech. The labour was consequently slow hence it was not till 10.30 pm on Friday that a foot could be brought down and the child delivered. This was done but the child was still-born. All the while the convulsions continued though moderated in severity by the steady administration of Potass Bromid & chloral and occasionally when a fit was impending by a whiff of chloroform. The delivery

delivery of the child did not check the fits and they continued at increasing intervals for 12 hours afterwards. The symptoms all the while remained most serious as besides an occasional convulsion there was twitching of the eyeballs and facial muscles while deep coma persisted in spite of all efforts to rally her. At last, her bowels and bladder were evacuated and this seemed to be the turning point. After remaining 30 hours in peril she regained her consciousness and appetite. The swelling of the legs rapidly disappeared and all went well. From the rapid disappearance of the oedema and the small amount of albumen in the urine, together

together with the subsequent excellent history, I am led to include this among those cases of puerperal convulsions due not to organic changes in the kidney but to mechanical pressure on the renal veins. As to treatment the first indication is by hook or by crook, by forceps or by turning to deliver at once. This is obviously of paramount importance in the interests of the child, while in those of the mother the gradual subsidence of the fits shows the same to hold good. To keep the convulsions in check no influence is so potent as chloroform.

Phlegmasia dolens I had only one really marked case of phlegmasia dolens. She was a

a multipara aged 45. The labour had been tedious and exhausting and to complete it the forceps had to be used. She seemed to be fairly well for 5 or 6 days when she had a rigor and became feverish and the usual signs of this affection showed themselves. There were no well marked prodromal symptoms but only a vague pain here & there with a feeling of great weakness until the characteristic swelling of the leg showed itself. It first appeared in her left leg and about a week later in the right. Her previous confinement had been much the same as described and followed by the same symptoms. The fever in this case did not

not rise to any great height and the lochia became only moderately offensive. The treatment adopted in this case was at first that of regulation of the bowels, an easily assimilated diet and the administration of Salines; the limbs were wrapped in hot fomentations. As the acute symptoms subsided tonics were administered and the limbs, first rubbed with stimulating liniments, were carefully bandaged. Under this treatment the woman made a gradual and perfect recovery. At no time were there any of the red streaks indicating implication of the lymphatics. Leeches were not used partly because there was no special call for them, partly because they

they could not have been got easily in this town had they been wanted. It is out of the question from one case to enter into a discussion on the pathology of phlegmasia dolens. The house was of the better class and the nursing very good. So I have no hesitation in ascribing the attack to the nature of the labour and the age and temperament of the woman. I have seen a case of undoubted phlegmasia dolens in a man whose life was being sapped by double pneumonia.

Puerperal Septicaemia & Fever

It is not easy in all cases to feel certain that a case which goes wrong after labour is puerperal fever in any of its varieties

varieties. For instance a woman may be seized with a rigor and her temperature go up to an alarming extent, the lochia may become fetid or cease and the milk also be suppressed. She may have pain in the abdomen, headache and all the other initial symptoms of an impending fever. Yet if her bowels be cleared out, a simple febrifuge mixture administered and perhaps the vaginal douche applied, the symptoms may subside as suddenly as they began and the woman make a good recovery all through. The subsequent history also of these cases shows that it cannot have been any of the puerperal inflammations of the uterus or its appendages. One does not call this Septicaemia yet what else can it be

be. were I to classify all doubtful cases as puerperal fever where the recovery took place just before a serious aspect seemed about to arise long were the list. on the other hand were I only to state the cases which ended fatally as having been puerperal fever I am happy to think I would have little to say. without therefore discussing the point, I shall proceed to give notes of a few cases, where the womans life was really in peril. A careless midwife had attended a woman in labour. A week subsequently while driving through the village I was asked to go in and see her victim who had, as the people in attendance said, gone wrong. I made an examination of her, almost two

carefully

carefully as it turned out and found her to be suffering from septicaemia. As I could get no details of the labour nor attendants I cannot state the cause but the foul scourge was there. She had pain in the abdomen which was swollen and hard, the lochia were foetid and the woman herself highly fevered and with that anxious expression which betokens a speedy end. Stimulants, quinine and the douche with Condy's fluid were all tried, but in vain, for in less than two days the woman sank. Unfortunately for my peace of mind I was called upon the day following to attend another labour in the town. The labour itself was one of the easiest I ever attended but to my

my horror a day or two later She was seized with a rigor and identical symptoms with the above set in. I treated her in the orthodox fashion trying everything that my wits could devise but all to no purpose. The conclusion to me was obvious that I and I alone had carried the infection to this unfortunate. It is curious however that on the day following my attendance on this case my duties led me to attend another labour which however had no evil sequelae. I certainly changed my dress but was unable to take any other special precautions. I mention these facts not that they teach anything specially new but only to show how unwittingly an accoucheur may be placed in

in difficulty, and secondly as suggesting the question as to how far nursing and predisposition enter into the calculation of the origin of puerperal fever. The second case of labour above referred to as attended by me was a woman in perfect health and perfectly nursed, She never had a bad symptom. My first was less equipped in health and nursing yet with an equal exposure she succumbed. While I do not dispute for a moment that scarlet fever infection is a frequent source of puerperal fever yet as I am here only to relate my experiences it may be worth my while to mention a case very much in point namely my own. While feeling rather out of sorts I

I had to be in attendance on a child suffering from undoubted scarlet fever. About a week later I attended a Labour. On returning from the Labour, that very night I was seized with a sickness and the following day was prostrated with a well-marked attack of Scarlatina. The woman whom I had attended however recovered in quite a normal way. In many cases of puerperal fever it is extremely difficult to trace accurately the origin and when the patient has had many friends coming in to see her and one is allowed the choice of scarlet fever, erysipelas, diphtheria and puerperal fever not to mention many less common infectious diseases as an origo mali it is not

not easy to say at what door the charge should be laid. I have attended many cases of the above diseases with labours taking place in the intervals, with only ordinary precautions yet without any bad effect. To my mind therefore the conclusion is, that though an infectious cause is necessary previous health and the nature of the nursing and the means taken to ensure cleanliness are very important factors.

It may be more useful to detail a case, out of several, where the onset of puerperal fever was successfully combated and to explain my treatment. She was a multipara aged 26 who was delivered without very much difficulty of a fine healthy child. She was slightly anaemic

anaemic but was in fair health during her period of gestation. She went on well for two days and even on the morning of the third although her pulse was a little quick, and she had a slight headache yet she seemed home to have nothing more ailing her than the so-called milk fever. On the same evening however a message came home to see her, I found that in the course of the day she had had a series of rigors and was now highly feverish her temperature being 104° F. The other symptoms now present were headache, pain over the uterus, rapid breathing inclined to be shallow and very rapid pulse. I administered 3i of Haust Mig and a simple febrifuge hoping that

that the attack would pass off,
Next morning however the temperature
was 105 F+ while the pain though
not particularly virulent had spread
over the whole abdomen. The pulse
was 180 the respirations very
rapid & shallow the decubitus
supine. The abdomen was tumid;
her countinance was flushed and
her expression anxious; the lochia
were fetid but milk was present
at that time in the breasts in
a considerable quantity. The
treatment I adopted was with
the exception of a good purge freely
stimulant from the beginning.
Constant poultices were kept
over the abdomen and a liberal
diet of beef tea milk and brandy
put in force. As to drugs I
continued the febrifuge as it
produced

produced at least a feeling of relief when administered and I applied the vaginal douche night and morning using a solution of Hydrarg Perchlor 1 in 2000. I also gave her large doses of quinine in powder during the day but as its bitterness upset the stomach and caused vomiting I was forced to desist. On the third morning after the onset I found her rather better as far as some of the symptoms went. She had been very delirious during the night however but in the morning her temperature had gone down to 102·8 F. I had given her full doses of antipyrin every 3 hours the evening before and to this I ascribe the fall in temperature; otherwise her condition

condition was still very alarming. She continued for 24 hours more in a somewhat similar state but still taking free doses of the stimulant diet. Her temperature however rose again the following day and finding antipyrin distasteful and, what is more important, ~~to~~ ineffectual to check it, I administered in addition to the febrifuge and vaginal douche 3 grain doses of quinine in pill form every 2 or 3 hours and continued with this owing as her temperature remained above the normal. The lochia for the last two days had been very slight and foetid and the flow of milk also had nearly ceased. The quinine however after it had taken hold

V

of her system seemed to produce the desired effect for the temperature crept down degree by degree morning and night till after a very exhausting struggle my patient safely recovered. Among the other note-worthy points of the case which have not been mentioned were, that at one period about the third day she had profuse diarrhoea even to the extent of passing her motions unconsciously and that after the temperature began to descend strange to say there was retention of urine. When recovery was assured I felt as if I had won a battle for in no other case of mine had so much personal supervision been exercised. I hold strongly to the

the opinion that a freely stimulant mode of treatment coupled with antiseptics and careful combating of every Symptom is likely to produce the most successful results in this disease. I am even doubtful but that the simple depletive measure of purging the bowels may produce the undesirable effect, as it did in this case, of profuse and almost unrestrainable diarrhoea. The other difficulties of Labour such as accidental Haemorrhage before Labour, funis presentations puerperal mania, and adherent placenta etc must be dealt with very Summarily, for the obvious reason that I have seen very little of them.

As to funis presentations I have seen

seen 3 cases but as in two of them the cord was pulseless before my arrival and in the third reposition was easily effected no further remarks need be made.

Of accidental haemorrhage before labour I have had one example but as the case was treated in the orthodox way by rupture of the membranes and ended in the ordinary fashion it also can be dismissed without comment.

Of adherent placenta I have had two cases. In both the placenta was easily stripped off without any consequent haemorrhage beyond trouble.

My thesis is unpretentious. I have no startling theories to propound

propound nor any startling cases to relate. All that it seeks to be, is a plain unvarnished account of ordinary every-day work in a busy Lancashire town. It points out the difficulties which are liable to occur. I have no ambition to teach how they should be met but only how I met them and with what success my results show. One thing they do indicate and that is, how different actual cases may be from the typical ones described in books and how a medical man when thrown on his own resources must keep all his wits about him when he is responsible for the life and health of a mother and child and how when the prescribed means are not to hand in a difficulty

difficulty he must use those which common sense and a ready hand suggest.

Robert Horn MB Hon

The thesis which this accompanies is entirely my own work and the facts mentioned came entirely within my own experience,

Robert Horn