"Notes on Midwifery cases with observations."

Synopsis of Thesis

A. Cranial cases. Some cases requiring forceps. &c.

B. General observations on

a. deaths from overlaying.
b. ruptured perineums.
c. adherent placenta.
d. abdominal palpation as a method of diagnosis.
e. attention to the uterus at the end of the second and during the third stage of labour.

C. Cases other than cranial.

a. Footlings.
b. Breech.
c. Head and Hand.
d. Head, hand, and cord.
e. placenta previa.
f. facials.

D. Several accidents and Interesting "Index" Cases

a. post partum haemorrhage.
b. precipitate labour.
c. opening up old perineal cicatrix.

a. 3 craniotomy cases.
b. Complete placenta previa.
c. Septic case.
d. Caesarian Sections.
e. Puerperal Eclampsia, cases of.

By James Stevenson MB. CM.
Kilmalcolm.

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

"Notes on Midwifery cases with observations".

The compass of this thesis includes only a few notes and observations on the nature and variety of the cases which came for the most part under my notice while acting as outdoor house surgeon to the Clayton Maternity Hospital from February till May 1890.

The outdoor house surgeon attends with all students in their first three cases, and besides visits every outdoor case whether it has been attended by a student or nurse to see that the case has proper attention.

He also attends in cases of emergency, or having sent to him an emergency card from the student or nurse in charge. The experience gained in this way was invaluable. By it, I have conquered my previous dread and aversion to a branch of general medical practice, in which operative interference is often so unexpectedly and urgently demanded, without time being

allow for a much wider for consolation. Leaving aside for the present over 100 cases which occurred in my general practice, (except some few cases which shall be referred to afterwards), and noting only such as occurred midden from February till May, the accompanying table gives a fair idea of the amount and kind of work dealt with.

MOTHERS.	CHILDREN												
		MALES.		FEMALES									
Proportion of	NUMBER	alive	stillborn	alive	stillborn	CRANIAL	OTHER	twins	abortions	premature	forceps	version
Married, widows, single 92·7%: 1·6%: 5·7%	433	202	15	203	13	414	16	13	14	18	21	6.
DEATHS. I.													

In addition to the outdoor cases, it was my happy fortune to be present at most of the deliveries of the indoor cases occurring then. Certainly at every case requiring operative measures. In all, these cases numbered about 100. To some of which occasional reference will be made. As such cases offered the best advantages for personal observation, their reports are more full and particular.

In attempting then to indicate the nature of the work two ways of doing so occurred to me. Should I introduce a case or series of similar cases which might form the subject of a thesis, or should I endeavour to classify the work generally - and present a more or less complete summary of cases treated during my interim appointment. Either course would have perhaps been

worthy of special attention, but I have concluded that an attempt to present a more general description of the cases would be advisable - and shall endeavour to group my cases, and amplify here and there any special case, or class of cases, that appears to deserve special notice.

General classification of Cases.

I Cranial

II other than cranial, i.e.

Forehead
Breech
Head & hand
Head, hand & cord
Placenta previa
Facials

Forceps at

I Brim. for contracted conjug. diam

II Cavity for a. uterine inertia
b. moderate deformity of
c. pendant pelvic tum
d. 4th cranial presentat

III outlet.

I Cranial presentations.

These cases in all numbered 417, or 96·3% of all the cases treated.
In these 417 cases a. 308 were 1st Cranial
b. 44 " 3rd "
c. 23 " 2nd "
d. 9 " 4th "

or in percentages :—

1st position	2nd position	3rd position	4th position
73·8%	5·5%	18·4%	2·3%

The long axis traction forceps (Simpson's) which I always use were required on 21 occasions to complete delivery, several times in cases where the head was arrested at the brim on account of slight contraction of the conjugate diameter (once after turning for mal-presentation) but most commonly for cases in which the head was arrested in the cavity or on the perineum, from uterine inertia, slight degree of disproportion of the pelvic bones

Require brief, & Method of Application of Forceps.

dry, tense, resistant passages - and in several cases for delayed labours in 4th cranial presentations.

The danger and difficulty in the first class of cases, from obvious reasons were much greater than in the latter.

In each case we waited until the os was sufficiently dilated. Then emptied the bladder and rectum, & punctured the membranes if these had not already ruptured. In the application of the long forceps, to the head at the brim, or high up in the cavity, chloroform was administered in each case - and also occasionally in less dangerous cases, where the occasion seemed to demand its exhibition. The blades were washed with a warm antiseptic lotion - and well oiled before introduction. As a rule the lower blade was introduced first, the woman

Forceps for moderate contraction at brim :-

Mrs McCue

Conj. diam = 3½".

Sacral promontory easily felt.

as a rule lying on her left side. The following are notes on several cases which required forceps to end labour. —

For moderate contraction of conjugate diameter: —

Mrs McCue 30 Clyde St (Branch case). The attendant surgeon being absent I was called to find an os well dilated. Promontory of sacrum could be distinctly felt and the conjugate diameter at brim = 3½". The membranes had ruptured some hours before and pains slight though regular and good, had failed to further the progress of the case. The head presented the long diameter lying almost transversely. After the patient had been catheterised and enemasised chloroform was administered by the two students attending. Forceps were applied in the direction of most room and after a stiff pull the child was born. A history in previous cases of instrumental delivery was obtained and on this occasion the

Mrs McWade.

Conj. drain @ brim. 3 3/4".
Ineffective pairs and
resistant passages.

Mrs Waddell

Conj. drain = 3 3/4".
Strong pairs.
Formation of large caput succedaneum,
large child.

Child's head was much elongated in the occipito frontal diameter, and narrowed in the biparietal. — Mother & child both did well. ——

Mrs McWade 8 Swan St. multipara aet. 38. Third child. The first was delivered with forceps. The second was born by the natural powers after a prolonged labour, and for the third the present labour. On account of a conjugate diameter of 3 3/4", together with ineffective pains and resistant passages. The forceps were applied at the brim and delivery completed. The lower blade grasped the face with the nose exactly in the jugulum. The upper the occiput in the middline. Both did well. ——

Mrs Waddell 64 Charles St. Bridgeton. Multipara. 4th child. 1st puritum. Head arrested at brim for 4 hours after the membranes ruptured. Antero posterior diameter was 3 3/4". The strong and regular

Mrs Hamilton :-

Os worth a crown piece.
membranes ruptured.
Prolonged labour.
Complete uterine inertia
Head at brim -
Catheterization required after birth of ch

pains which were occurring when I arrived were quite ineffectual in moving the head. The only effect on the head being the formation of a very large caput Succedaneum. After the patient had been prepared in the usual way, the axis traction forceps were applied, and, after the exercise of considerable tractile force during the pains, the head was released with a distinctly audible snap. The child was very large, and had a big head (apparently normal). Left instructions to have it weighed which were not carried out. Both did well.

Mrs Hamilton 62 Cowcaddens. 5th child

She "B" on arrival was with 5/- No progress - was being made, although the membranes had ruptured some hours previously. The woman had been in labour for several days, and by this time was thoroughly exhausted

Forceps — in Cavity.

Mrs Boyle. 1. Transversely ruptured membranes

2. Effect of 15 gr. doses of Chlor[al] hydrat[e] repeated every 1/2 hour

The presenting head could with difficulty be felt arrested at the brim. After chloroforming the os carefully with the fingers. Her bladder & rectum were emptied, and forceps applied. The child was born after a stiff pull. Both did well.

This was the only case in the outside department, during my three months' term of office in which Catheterisation during the first few days of the puerperium was required. Evidently from prolonged pressure the bladder-wall had been paralysed and until it regained "tone" the urine had to be drawn off twice daily.

Forceps in cavity.

Mrs Boyle 39 Muse Lane. Primipara aet. 26. 1st cranial. The forceps were required high up in the cavity, for prematurely ruptured

Maggie Sweeney — primipara — head of hand presentation.

membranes - the os previous to the application of the forceps, having become softened and dilated under the influence of 15 gr. doses of chloral hydrate every 1/2 hour. continued for 3 hours.

Again and again this method of dealing with a hard rigid but otherwise normal os, has been attended with remarkable benefit. Next to Chloroform it is the best agent for this purpose that I know, and probably it owes part of its power in this direction, to the fact, that in the blood it is converted partly into Chloroform. — Besides producing the result desired, it often brings about a much needed rest - and after a few hours refreshing sleep, in not a few cases the patient awakes, sufficiently recovered, to complete labour without assistance. —

Maggie Sweeney 21 Gorsedubbs. 1st cranial.

In this "first case" the child's left hand

Jane Smith.

uterine inertia –

4th Cranial presentation. –

acted as a temporary wedge between the advancing head and the pelvic wall. The nurse attending sent for me to assist at a "head and hand" presentation. On arriving only an incomplete "1st cranial" was diagnosed: the head being well advanced into the cavity — but arrested from uterine inertia. On delivering with forceps however the left hand came down with the head, and applied to its left temporal region. Apparently the head & hand had entered the pelvis together — and the obstruction had been caused in this way. As labour progressed, the head had been driven in advance, so that when I examined the hand could not be felt as it was above the presenting vault.

Both did well.

Jane Smith, 27 Lockwell St., Second child, presentation 4th cranial. The membranes

Mary Ann Irvine — Elderly woman. Second cranial [illegible] uterine uterus

Mrs E Thist — narrowed [illegible] approximately [illegible] prim. procedure [illegible]

had been ruptured for some hrs. and on my arrival pains were nil. The os was fairly well dilated. after preparation chloroform was given and forceps applied. After the head had advanced from the upper to the lower part of the cavity. the forceps blades slipped over the occiput. They were reapplied and the occiput was in a short time delivered over the perineum. when the forehead soon followed from behind the Symphesis pubes. The perineum was lacerated slightly. Both did well.

Mary Ann Irvine 66 Rose St. SS. a widow for 4 years. multipara. Last child born about 4 years ago. Chloroform and forceps required for a second cranial presentation. Head arrested high in cavity.

Mrs Elliot 12 Claybrae multipara. 1st cranial presentation. Delayed second stage necessitating the use of forceps in cavity for narrowed sub-pubic angle, with

approximate ischial tuberosities – in addition to a firm resistant coccyx.
Mother & child progressed favourably.

Subs for observation.

Death from Overlaying.

I propose at this stage to introduce some facts for observation, in connection with obstetric practice which have not that attention in general practice paid to them which they deserve - and in this connection a few remarks on death from overlaying may not be out of place.

"Death from Overlaying"

The subject of death from overlaying may not as a general rule be considered as falling properly under this category - except in those cases of general practice amongst the very poorest and lowest classes. Several deaths occurred in Glasgow at the time of which I write, in connection with the outdoor department of the Glasgow Maternity Hospital. The homes visited were inhabited for the most part by members of the lowest - and unhappily too often the most degraded & vicious classes.

and in several instances the child's death was certainly due to the cause ascribed. Any excuse for a debauch is welcomed - and considering the habits of these people - and often their utter regardlessness of order concerning the "lying in" period, the results obtained were remarkable.

Probably after having a case, whisky would be procured in some way, and after carousing as long as the stimulant lasted the husband would tumble or be lifted into bed beside the patient and her babe - and next morning the baby would be found dead.

In Germany, I believe within these last 6 months a law has been passed making it absolutely criminal in such cases, for any person to sleep with a newly born babe - and certainly such a law is urgently needed for

Ruptured Perineum.

Britain. Probably some practitioners have themselves to blame sometimes in this matter, for preventing proper legislation in allowing such cases to be certified in the death certificates, as deaths from weakness, the effects of cold & Low. The matter is a difficult one to tackle with in large towns. In some cases any remedy offered would not be accepted by some, for reasons best known to themselves. To prevent such an accident, the remedy to be effective, must be compulsory.

Ruptured Perineum.

Ruptured perineums of the first degree, are very liable to be missed, and were very often undetected by students and nurses alike. The head at the final stage of expulsion, causes occasionally, especially in primiparae, a very slight laceration of the parchment-like perineum

-which would often never have been noticed, unless labour had been very carefully observed - or the eyes of the woman had been separated after delivery. In this way, the smaller (false) percentage of ruptured perineums "outdoor" as compared with indoor maternity hospital practice is explained. This small tear made by the head, is very liable to be further increased in extent by the passage of the shoulders, and in breech presentations especially this increased danger of further laceration was observed, fortunately, without serious consequences as a rule. Often in the eagerness to effect delivery, attention was detracted from this accident - and fixed on the child. Cases of ruptured perineums in moderately clean houses and with obedient patients, outdoor, could always be managed successfully by strict antisepsis - after

Uterine pain, induced by profuse action
tearing &c a ruptured perineum.

stitching if necessary, and tying the sutures; with strict injunctions that absolute rest had to be maintained. In several cases of moderate laceration, attention to strict cleanliness, and tying sutures, was often followed by the best results. Strict regard to the maintainence of antiseptisism is the key to the solution of many puerperal difficulties.

In one case, (Mrs Adams 42 Thistle St. multipara. Second child) in which the forceps were required at the outlet, for absolute inertia. The mere application of the blades, by reflex action, induced such a powerful pain, that the head & forceps were shot out, and the perineum badly ruptured. No time was allowed to hold back, and so save the perineum. Both mother and child did well.

Adherent Placentae

Incr in 600 cases.

Adherent placentae.

From general impressions, one would be led to regard this accident as one, by no means infrequent, but in about 600 cases (outdoor, indoor, & general practice) it has only been met with by me on two occasions. I am convinced, that in many cases where the hand is introduced into the uterus to remove a so called adherent placenta - the action is perfectly unwarrantable - and deserving gravest censure. Very often Students and nurses have desired assistance in such cases, but in every case without exception, Simple "Credeing" caused the expulsion of the placenta, which was merely retained by a contracted os. In one case, to which I was called, the operator after waiting ½ an hour from the birth - attempted to express the placenta. But failed.

Two cases of adherent placenta :—

1. Mrs Stevenson (outdoor)

Indeed his manipulations in the attempt to grasp the placenta at the os only the more effectually caused Spasmodic closure of the internal os.

After administering a full dose of opium, and allowing a sufficient interval to elapse, the spasm wore away & the placenta was easily "Credéd" out.

The only two true cases reserved to are given below. One occurred "outdoor" and one "indoor".

outdoor case. Mrs Stevenson 25 St. Andrews Square. A history of retained placenta in a birth 2 removed from this one was elicited. A history of metritic pain at that time, & several months ago also, was given. Child, on my arrival, had been born two hours previously. "Crédéing" only emptied the womb of a large blood clot. On introducing the right hand (after it had been thoroughly cleansed) into the uterus,

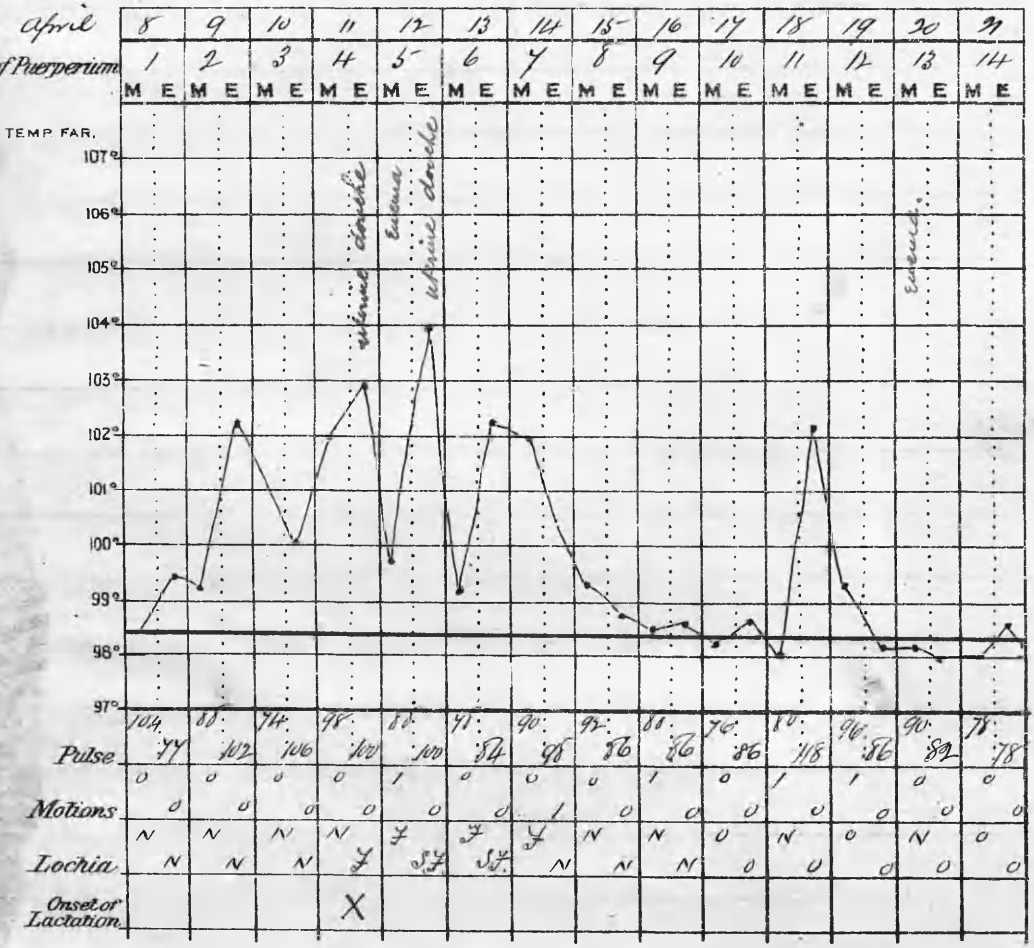
2. Sarah Jones (widow)

without the administration of chloroform. The placenta was discovered to be adherent over about ½ its area, at the fundus, and towards the left side posteriorly. Careful peeling, by the edge of the right thumb was adopted. Coaptation being employed by the left hand manipulating the uterus externally. A few fragments remained in spite of my best endeavours. But these I diminished in size and broke up, as best I could. ——

3 days afterwards to my surprise and horror, the woman was doing her own house-work and considered herself perfectly well. Mother and child did well. —

Indoor case. Sarah Jones æt. 24 primipara. delivered 8/4/90. Child female, alive, mature. The perineum was split to the second degree. Placenta and membranes were entirely adherent, and had to be skimmed off with the edge of the

Sarah Jawes (adherent placenta and membranes)



hand — Chloroform was administered.

April 9th. Slept well. No pain in abdomen, slight headache, Temp 102·4°. Crying about the baby (wh. was illegitimate.)

" 10th. Put on salicylic acid and Quinine.

" 11th. Slept well. Slight pain over uterus in the morning, which increased greatly as the day went on. Headache. Lochia very foetid — uterus douched with creolin solution —

" 12th. On a very nervous excited State. Marked hyperaesthesia all over lower part of abdomen, even when the skin is lightly touched. No distension. 5 P.M. Morphia Suppos. Gr ½. Op. fomentations — uterus douched out under Chloroform

" 13th Slept 3 hrs. after paraldehyde 3ij. Pain then returned very severe. 7 A.M. Morphia Suppos. Gr ¼. Pain still severe. very restless crying. Morphia Suppos. Gr ½. ℞ Liq ammon acetat. Spt-eth. Nitr. Vin Ipecac. was ordered by Dr Cameron. Pain easier during afternoon —

" 23rd. — Uninterrupted recovery since 13th. Both well.

Abdominal Palpation :—

If, soon after the birth, the cord ceases to beat, we may be certain that there is no true placental adhesion — but the observation made by an eminent obstetrician, of a depression in the uterus, felt abdominally during a pain — at the placental site has not been observed by me, probably from want of opportunity.

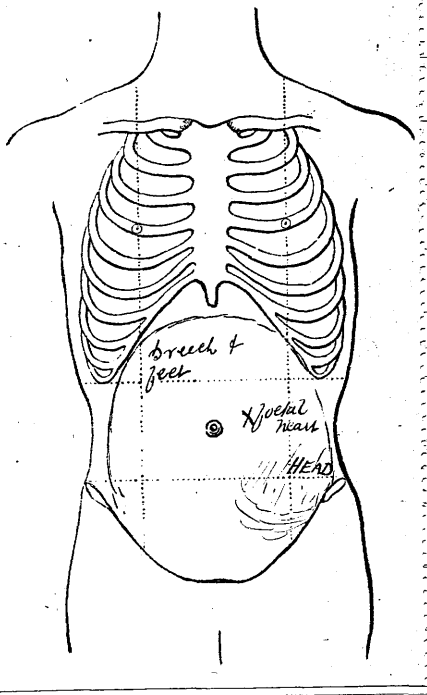
Abdominal Palpation as a means of diagnosis, in many cases yields most valuable information when, perhaps, a vaginal examination leaves one perfectly unaware of what to expect, in regard to the nature of the presentation — Though by no means an exact method of diagnosis, I maintain that its value and practicability are unquestionable — especially when auscultation is combined with it.

Given a pregnant woman with abdom-

abdominal parietes not unduly thickened by adipose tissue, or subjected to an extreme degree of tension by the presence of an excess of amniotic fluid, we by abdominal palpation, can arrive at a very fair estimate of the nature of the presentation, and in no branch of medical practice does tactile impression aid one more or can it be perfected more by application, than in this method of abdominal palpation — As a rule, there is little difficulty in diagnosing the direction in which the long pole of the foetus is lying, (especially if the membranes have ruptured) when the hard cranium is felt for, and the ? of a breech or cranial presentation settled, the position of the point of greatest intensity of the foetal heart, assisting here. In some cases, the knees or elbows, or even hand or foot, can also be felt.

For my own benefit before making a vaginal examination. I employ this method often with considerable advantage and in a general practice in which I am at present engaged, a case occurred, only a few days ago, exemplifying the advantage of this method.

Case. Mrs Taylor. X para. 10th Child Membranes unruptured. Head was felt in left iliac region. Heart (foetal) heard 2" above & to left of umbilicus. Breech & foot felt in right upper segment of uterus. By vaginal examination no part of the child could be reached by the examining finger.



I pushed the head with the right hand, down towards the pubes, at the same time pushing up the breech with the left hand. Case ended as 1st Cranial

Proper management of the uterus during and
after the birth of the child.

As a means of diagnosis therefore, & firmly believe that abdominal palpation in some cases, yields information which cannot possibly be derived from a vaginal examination, — and in most cases, it is admissable as corroborative proof. although as the most generally useful method that of vaginal examination has the preference. —

The only other and most important point which I would like to lay special emphasis on, is the most careful and proper management of the uterus during the latter part of the second and the whole of the third stage of labour. Very often have I seen the uterus partly or completely neglected at this time — sometimes with dire results. —

Mrs Sergison the patient who died from phthisis pulmonalis &c. several days after puerperal labour, was not considered as part of the proper mortality — in connection with the Maternity Hospital returns.

Mrs X —. Kirricanni (during a brief tenancy) died from postpartum Haemorrhage. (Case detailed elsewhere)

Maternal mortality :-

The patient who died "outside" was confined on 8th March 1890. On the 11th the T rose to 103.5°. P 90. Lochia offensive. Under antipyretics and antiseptics the T gradually fell, and on the 15th March attendance was discontinued by the students in charge. Patient doing well.

On 17th March, the husband came to us, and said that the patient had had 2 "fits" - one at 3 A.M and one at 3 P.M. - and during the latter she died. Beyond having to hold the woman in bed he could not describe the nature of these seizures.

The maternity officials were not apprised of these attacks having occurred, till several hours after the fatal issue. No note was taken of the character of the urine

Cases "other than Cranial"

1 "Jostling and Breech"

Points of importance :-

a. Pressure on Cord.
b. Pulling on limbs or trunk causing
c. Attention to position of arms
d. " " jerkiness -
e. Final danger from asphyxia

The cases "Other than Cranial" numbered in all 16, and comprised :-

2 Footlings
5 Breech.
2 Head & hand.
3 Head hand & cord
1 marginal placenta previa
3 facials and (1 complete placenta previa "undone.")

Footling and breech presentations. 7 in number all children being born alive. Pressure on the cord was always prevented by drawing & retaining the cord at the Spot of least pressure - which the "evil practice" condemned by Dr Leishman - of pulling on the trunk or limbs was carefully avoided. According to the position of the arms after the trunk had been born, often demanded much care - and sometimes gave considerable trouble to release them. In this class of cases that danger to perineum from passage of shoulders, specially risen - and subsequently the head remains to be

dealt with. By the usual manipulation at this stage, I was fortunate enough to get all the children born alive without employing the forceps, or having had to resort to that more objectionable operation perforation.
Animation in several cases was suspended, but was restored by employing Sylvester's method — or that other, in which the child is grasped by the shoulders behind & revolved round three spots as on a pivot — through an arc of a circle — to produce inflation & forced expiration about 20 times per minute. Douching, & rubbing with stimulants, were additional helps to resuscitation.

a practical point which I found useful in several cases where one foot only could be easily grasped to pull on — so as to assist delivery, consists in pushing upwards with the uterus the opposite hip to allow the more readily

Head and Hand Presentations

1 (Shoulder). Left dorso anterior

Membranes ruptured 14 hrs. prior
Turning
Child Asphyxiated.
Resuscitated.

of Cotyledon occurring at the top of the leg pulled on, thereby minimising the risk of injury to that thigh.

2 Head & Hand cases. (Dorso anterior).

1 Mrs McLachlan 318 Canning Rd. Under the care of a nurse who sent for assistance, with a "footling". On arrival, after vaginal examination I diagnosed the right hand presenting - while the occiput presented also - being fitted well towards the left iliac above the brim. The membranes had ruptured 14 hours previously - and pains were 'nil'. The patient was catheterised & evacuated then put deeply under the influence of Chloroform. An attempt was then made to return the presenting hand within the uterus with the object of getting the head to present & engage at the brim, but feeling a knee I drew it down cautiously, at the same time helping the head into the uterus, with a couple of fingers of the same hand.

2 Major Sweeney.

Heav & left hand.
Left hand acting as a weapon.
Forceps in cavity.

Turning was effected without very much difficulty — child asphyxiated. Resuscitated by artificial respiration &c. Both mother and child made good recoveries.

2 Mary Sweeney of Gorsedubbs. Head & left hand presenting. This case was under the care of a nurse who sent for assistance owing to a protracted second stage. I could only make out a 1st position on making an examination. The Cranium occupying the cavity of the pelvis. On delivering with forceps however the left hand came down with the head, and applied to the left temporal region — Apparently the head & hand had entered the pelvis together, and the obstruction had been caused in this way. As labour progressed, the head had been driven in advance, so that when I examined, the hand could not be felt. Both did well.

Head. Hand. & Cord presentations

1 Mrs Robertson (Conjug. vera. 2½" - 2¾")

Primipara
turning
perforation
delivery with crotchet. —
Recovery.

3 Cases of "Head hand & cord" presentation – notes of 2 cases given.

1/ Mrs Roberton 43 Greendale St. Primipara. aet. 26.
The student in charge of the case sent to the hospital for assistance – Dr Malcolm Black accompanied me. After examining the woman, turning was determined on & successfully performed, after considerable difficulty in releasing the arms. Forceps to the after coming head proving unsuccessful, perforation of the occiput was performed, and delivery effected by use of crochet. comparatively easily –
Conjugate vera at Brim. 2½" – 2¾" –
Chloroform, of course, was administered before operating.
After recovery patient was advised when next she became pregnant to have premature labour induced at 7th month. During the puerperium – on the second day the temperature began to rise. but fell after a uterine douche. (1-2000 bichloride) from 104·5°. till it reached normal –

Extract from maternity Journal :—

"Cyst of child ganged out by Sacral promontory."

2 Mrs Caslow

(Left dorso anterior).

On admission pains of 3 fingers.
Turning by bimanual method.
(membranes had been ruptured for 30 hours)
Cord pulseless.
Delivery by traction : slowly.
Forceps to after coming head.—
Child 7½ months.

There was a deep indentation of the child's left temporo-parietal region, caused by the projection of the sacral promontory. (In the Maternity Journal some yrs. ago, a case is noted - where the eye of the child was forced out by the sacral promontory during labour. The child died.) —

2 Mrs Caslaw 20 Lwr St. Gardenbe Rd. Dr Boyd, the indoor house surgeon, assisted me & gave chloroform. On vaginal examination a ♀ hand, & cord were easily felt. Cord pulseless while with the hand in the vagina the occiput was felt in the left iliac region. position? Diagnosed as left dorso anterior — The "O" was about the size of a 5/- piece - only admitting the finger of three fingers, hard and undilatable. The membranes had been ruptured for 30 hours. I returned the hand and cord, then decided to turn, employing the bi-manual method, with two fingers of

Remarks.

the left hand in the vagina. A foot was at last seized and the legs and trunk slowly extracted. The head was caught by the os. Manipulations with the view of pulling mouth down into sacral hollow. & pushing up the occiput proved ineffectual. & forceps were used to end the labour. Only a small laceration in left lip of the os, was caused. The woman made a good recovery. Child premature. 7½ months. Stillborn.

Now I consider that forceps applied before turning, if that had been practicable, and traction made to dilate the os carefully, but not to deliver, would have been the better treatment. If, when the forceps were applied, delivery had been effected it probably would have been at the expense of a split os and cervix. But after dilating with the forceps & then turning, the "os" would have been

Placenta Previa.

1 Mrs Mac Donald

Partial placenta previa
on work 2/-
turning (bimanual)
Hair got to present.
Membranes then ruptured.
Pressure on fundus caused the
hair to engage.
Chloral Hydrate.
Sleep.
Delivery easy. in 12 hours.
Recovery.

less liable to injury as it would have been more dilated, and further, the head then would have been smaller in regard that it was being delivered base first.

Partial Placenta Previa.

Mrs Macdonald Xpara. act 40. 1st Cranial presentation OA with R. and very hard. Bleeding had continued for 6 hours before arrival. and on vaginal examination the edge of a placenta was diagnosed encroaching on the OS. As bleeding was taking place. Turning was determined on. Having no Barnes' dilators at hand, the bipolar method was employed two fingers of the right hand within the vagina, and the left hand for Coaptation of abdomen. By the exercise of some skill & patience a knee was got to present at the OS. But owing to the small size and rigidity of the OS, the presenting part could not be got through. The membranes were then ruptured

2 Mrs Forrest complete placenta praevia

and pressure being brought to bear on the fundus - caused the knee to engage. Bleeding was now arrested, and chloral hydrate was given in two 15 gr. doses after an interval of 1/2 an hour. Patient fell asleep - and the os not dilating satisfactorily, she was left in charge of a nurse at 12 PM. Next day at 12 A.M. the woman was easily delivered of a full grown male child. Both did well. There was slight post-partum haemorrhage, wh. I easily arrested by an intrauterine douche of hot water (.). → R Tr Iodi ℨi
Aquae ad Oi.

The following case occurred "indoor" at the Maternity Hospital - at which I was present and assisted. :-

Complete placenta previa :-

Mrs Forrest 307 Balti St., aet. 38. 10th child. Child male, dead, mature. Mother made a good recovery. Patient was admitted

Mrs Forrest. — (Complete placenta previa, retained membranes, version.)

Date. March	6	7	8	9	10	11	12	13	14	15	16	17		
Day of Puerperium	1	2	3	4	5	6	7	8	9	10	11	12.		
	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E
Pulse	120 114	116 90	100 100	100 102	78 102	86 100	86 88	86 96	84 80	88 80	76 80	80		
Motions	0 0	0 0	0 1	3 1	0 0	2 2	0 0	3 0	0 0	1 0	1 0	1		
Lochia	N N	N N	N N	N N	N N	N N	N N	N N	N N	N N	N N	N		
Onset of Lactation					X									

TEMP. FAR.

107° 106° 105° 104° 103° 102° 101° 100° 99° 98° 97°

Enema

Enema

Pm. Colon et Hyog.

Enema +

pregnant. having been confined in the hospital on 9 previous occasions. She was at her "full time". A history of haemorrhage 10 days ago was obtained. On the day of admission, she was walking down a stair when the bleeding restarted. On admission, she was found to have been plugged ante-Side. Pulse weak. 130 per minute. Stimulants were exhibited, and Dr Cameron sent for. The plug came away in a few minutes, & a Barnes' Bag (largest size) was inserted, after the placenta, which was completely on the os, had been detached as much as possible by sweeping two fingers round and within the os. Chloroform was administered, and as Dr Cameron did not arrive the Barnes' Bag was removed in 1/2 an hour. pains at that time being very severe. Dr Boyd - indoor Surgeon - passed his left hand up posterior wall of uterus - separating the placenta in its progress.

Facial Precautions.

Two 4th facials.

The membranes were reached, and ruptured. A foot was seized and version completed. There was some difficulty in removing the head which was large, but with Dr Black's assistance it came away. Ergotin was injected Subcutaneously. The membranes were retained & had to be removed by hand. The womb was washed out with a warm antiseptic douche. The woman made an uninterrupted recovery. Child male dead mature.

3 Facial Presentations

Two of these three, ended as 4th facials. Beginning as first facials. (By a movement of extension probably mostly of flexion) the chin lay close to right Sacro iliac Synchondrosis. and forehead in Right oblique diameter: pointed to left iliac pectineal eminence. Each ended as a 4th facial. The

Tronk- Cotyloid —

Chin came forward under the pubic arch - and the head was born by a movement of flexion, whereby the chin, nose, & forehead in succession swept over the perineum. -
The children - in each case survived - and the mothers made good recoveries -

The third case was a Face-Cephalic. The case had evidently started as a cephalic, but on vaginal examination the orbits & nose were felt behind the symphysis pubes. Happily it occurred in a healthy multipara. The case was tardy - but under the influence of strong pains the head descended, and the perineum was markedly bulged - and ultimately was slightly torn.

The part wh presented moved up and to the left - until the occiput passed - and subsequently by a movement of extension with the

nape of the neck at anterior part of the perineum as a centre, the head was born. — The shoulders slightly increased the laceration in the perineum, during their passage. but it did not require stitching. Animation in the child was suspended but with proper measures it recovered. and the mother made also a good recovery. —

Several accidents :-

1. Post Partum Haemorrhage.
2. Precipitate Labour.
3. Reopening old perineal cicatrix

Post partum Haemorrhage.

1. Mrs Walker.

a. primipara
b. very faint and collapsed from bleeding.
c. placenta retained by contraction for 3 hours -
d. Recovery.

Several accidents which occurred in my practice.

Leaving aside such cases as abortions premature births and cases requiring forceps turning or special operations a few notes on postpartum haemorrhage either from retained placenta, or relaxation of uterus subsequent to the birth of an anencephalic monster with hydramnios — precipitate labours and rupturing of old cicatrix (perineal) are detailed below.

Postpartum Haemorrhage.

Mrs Walker, 4 Carpin St. S.S. was delivered of her 1st child by Mr Smyth, who however had failed to express the placenta. On arriving, I found that the patient was blanched. pulse weak, 140 per minute, soft, and easily compressible. No regular pains was inclined to faint, and vision

In this case Mr S— in attempting to Credé out the placenta before my arrival, had been pressing simply with the flat of his hand against the abdominal lower segment, instead of digging the ulnar border of his left hand well down into the abdomen then grasping the fundus with outspread fingers and expressing, firmly and steadily, in the axis of the brim. Very few students & nurses attain this proper practice until after much attention to details.

was defective. It was evident that for 3 hours, the patient had been losing a large amount of blood. The hips at once were elevated, the head lowered, and ℥ss of Brandy with 30 m. of Liq. opii Sedativus given. I "credéd" out a large blood clot but no placenta, and deeming the necessity of the case extremely urgent proceeded at once to dilate the contracted internal os carefully with the fingers, and insinuated the whole hand into the uterus. (after thoroughly disinfecting the whole arm and hand by scrubbing with hot water, Soap & Brush, then washing with a solution of 1. 1000 Bichloride). The palm of the hand unfolded the detached placenta, and in a very short time, a pain expelled the hand, with the placenta and a large clot. During the operation, the left hand externally, was

2 Kirriemuir case. Fatal.

Cardy taken
Hyoramine.
~~[illegible]~~ecphalic morule –
Next morning – delirious
radial pulse imperceptible –
Death.

employed in supporting the womb. External pressure was continued for an hour. At the end of which time the uterus was well contracted. ℥ss of Brandy was again given. and a hypodermic injection of 15 m. Tannen's Sol. of Ergotine. — after hot douching the interior of the uterus the patient was left under the care of Mrs Smyth. 4 days afterwards the patient was much better. Both she and the child did well. —

A second case of post partum haemorrhage occurred while I was acting as Locum tenens in Kirriemuir. The patient after a tardy labour was delivered of an anencephalic monster. About 30 pints of liquor amnii escaped when the membranes ruptured. The womb was, after the usual measures, got to contract and the woman left. Next morning

Precipitate Labour

Mrs Sergison.

Incurable Phthisis pulmonalis.
Severe paroxysms of coughing.
precipitate Labour.
Both died.

When I saw her, the radial pulse was quite imperceptible and she was slightly delirious. The bed was soaked with blood, as also was the mattress on which she lay. In spite of stimulation the woman died in about an hour. The question of transfusion arose but before the solutions were ready it was too late.

Precipitate Labour.

Mrs Jervis 14 Parker St. multipara a poor woman, who a few days previously had been discharged as incurable from the Royal Infirmary, in the last stages of phthisis pulmonalis with heart complication. Coughing paroxysms were intensely severe. 1st cranial presentation was diagnosed by the students, who had kept the case for a few hours on account of the cessation of pains.

Opening up old cicatrix

Mrs Connelly

In their absence the woman got out of bed and while walking about slowly to relieve the chest symptoms a severe attack of coughing occurred and the child and placenta were born precipitately on to the floor before my arrival. The womb contracted fairly well under friction and ergot. The child lived for two days and the mother's chest symptoms improved slightly after delivery but she succumbed a fortnight later. (I did not consider this as part of the mortality in connection with the Maternity returns)

Opening up the old cicatrix.

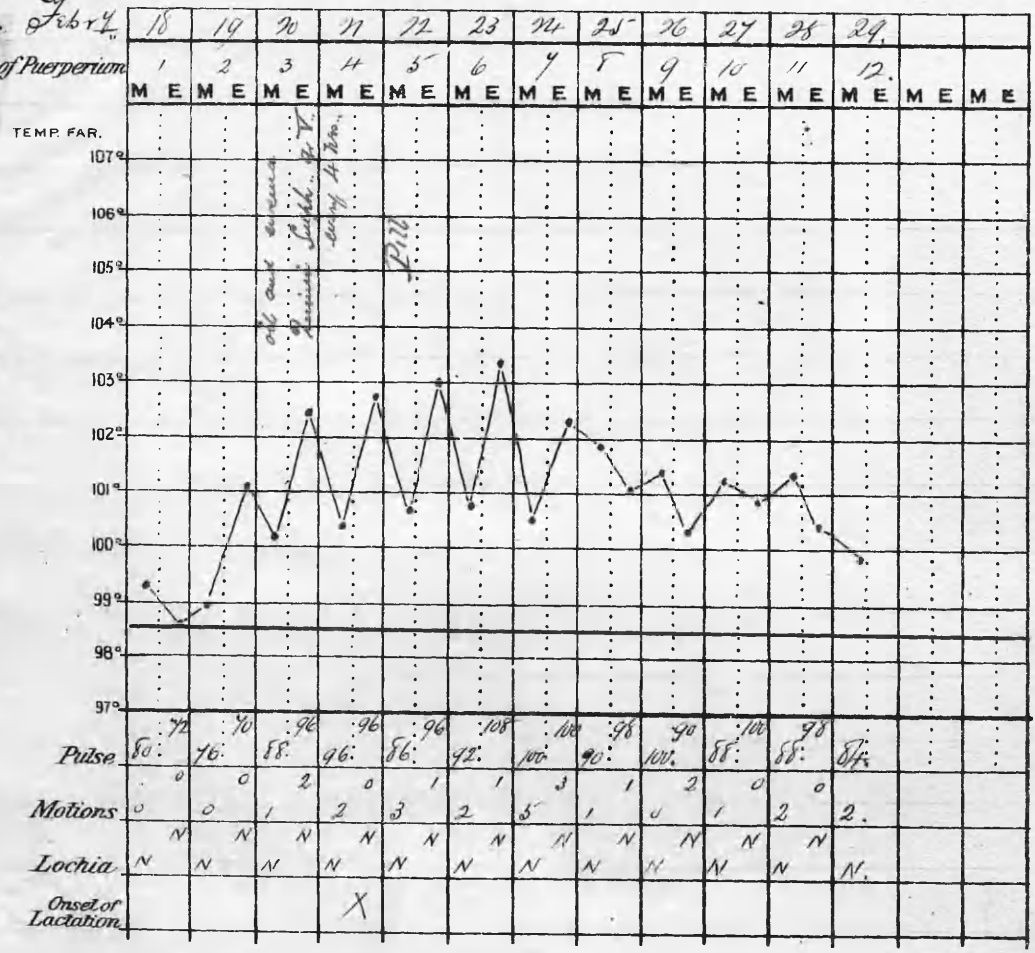
Mrs Conelly 8th Salmarket 2nd child.

History of perineal rupture at last confinement with resulting cicatrix extending the whole length of the perineum, through leaving the rectum intact.

The presentation at this labour was 1st cranial

after a fairly easy labour the head reached the perineum, but all attempts to preserve it were ineffectual. The small lateral incisions which were made, opened up a little, but the head of her child, and subsequently a shoulder opened up the cicatrix in its whole length. A deep silver Suture, and four superficial silk Sutures were used, but as the attendant did not carefully wash away the discharge, healing was tardy and was effected by Suppuration.

Catherine Kirkwood. (Cranioclasm. conjugate- 2½". recovery.)



Notes on Some Interesting Index cases which I attended.

Under "Puerperal Eclampsia" will be found a record of the case of Tessie Short aet. 18. primipara. who had 5 "fits" before delivery was effected. after dilating the os with Barnes' dilators. and applying forceps. —

Craniotomy. Conjugate diameter of 2½"

Catherine Kirkwood. 90 Nelson St.. aet. 22. primipara. Admitted February 18th at 1:10 A.M. Delivered at 2.50 A.M.

Presentation first cranial. Child. female dead. mature. Duration of Stages 1st 2 = 2 hrs 20 min. " " Stage 3 = 15 min.

Weight of child 5½ lbs. Length 21".

Placenta weighed 18 ounces. and the cord was 16" long.

The conjugate diameter at the brim was 2½". Dr Reid performed craniotomy and extracted with the craniclast. Patient went out while there was still some pelvic cellulitis

Complete placenta prævia and breech presentation.

Mrs Forrest 304 Bathie St.. This case was detailed under that section headed cases "other than cranial".

Craniotomy. Conjugate vera 3". Fatal.

Mrs Thompson aet. 22. Delivered 11/4/90.

Presentation. 4th Cranial Duration of 1st Stage = 12 1/2 hrs.

" " 2nd " = 4 1/3 hrs.

" " 3rd " = 8 min.

Child female. dead. mature.

Result. Patient died of pyæmia.

Patient was admitted at 8.15 P.M. on the 10th April 1890. with the history that she had had one child previously delivered at the 8th month with forceps. On examination. the abdomen was found to be very large and the tumour so tense that palpation gave no result. The foetal heart was heard loudly in the left loin. The "os" was the size of a crown piece. Membranes un-ruptured and very tense. Presenting part

above the brim. At 1.30 A.M. the pains were nearly fully abated and as there appeared to be a very large amount of amniotic fluid, the membranes were ruptured. An hour afterwards, as the head was still above the brim - lying almost transversely with the occiput to the left and slightly posterior - forceps were applied several times, but always slipped. Patient under chloroform. The hospital surgeon was sent for. He applied forceps but they slipped - The second time they held, but he failed to bring the head through the brim. The foetal heart could no longer be heard. The cranium was then perforated and the brain substance broken up with the crotchet. The cephalotribe was applied & the skull crushed. The cephalotribe was then removed, and after very great difficulty - and with the exercise of a very great amount of force, which nothing but the circumstances would warrant, the head was

delivering with the crotchet, guarded by the operator's left hand — a good deal of cranium having first been removed with the cranioclast. The shoulders stuck above the brim. The head was pulled on with crotchet, towel piece of cord &c. but without effect. A sharp hook was then fixed into the thorax and traction made — and at last the posterior shoulder came down. The anterior shoulder was then released with great difficulty, and the trunk delivered after a stiff pull. Temperature after operation 99.4°. P 80. Slept till 7 A.M. No complaint or wandering. The operation lasted between 2 and 3 hours. I gave chloroform — and Dr Black and Boyd assisted —

Puerperium :-

April 11th. Delivered at 5.57 A.M.

" 12th. Slept well. complains of after pains.

" 13th. Has slight frontal headache and pain over

Mrs Thompson (craniotomy. Conjugate vera 3". Fatal.)

Date April	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	
Day of Puerperium	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	
	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E
Pulse	80 90	90 90	80 82	82 86	100 84	92 86	80 84	76 82	78 90	84 96	90 120	110 98	106 110	106 124	100 106	100			
Motions	0 0	0 0	1 2	1 0	1 0	0 0	1 2	0 0	1 2	0 1	1 4	0 0	2 0	3 0	0 0	0			
Lochia	N N	N N	N N	N N	N N	N N	N N	N N	N N	N N	N N	N N	N 0	0 N	N N	N			
Onset of Lactation					X														

TEMP. FAR.

107°
106°
105°
104°
103°
102°
101°
100°
99°
98°
97°

Enema 210
Enema
R12
Enema
210 Enema

uterus. Gr ¼ morphia suppository, and Lt douche ev. 4 hrs.

April 14th. Slept well. Pain gone.

" 15th Slept well. Feels sick. Breasts forged.

" 16th. Has felt perfectly well for the last few days, but T at 10 A.M. = 104°. Cat 11 A.M. Felt cold but no rigor. T 104·4°. P 100.

" 17th. Slight diarrhoea in the evening. T still up.

" 23rd. Slept well. Vomited this morning. No pain T at 11 A.M. 104·8°. Per vaginam. There is slight pain on right side of pelvis but nothing abnormal to be felt. Pulse antipyr gr X ev. 4 hrs. Tongue thickly coated with yellowish white fur. Eyes red and devoid of epithelium.

" 24th. Seems slightly better this morning. Sick once. Given a mixture of Bismuth, Cerii Oxal, Hydro-cyanic acid.

" 25th. Not nearly so well today. Face pale, dull weary expression. P 146. T 104·6°. Breath with distinct odour of new mown hay. Eyes sunken. Pulse 146 & empty between the bounding beats. Tongue dry. Sick fur persistently

Lips show sordes. There is apparently a peritonitic swelling on the middle of the subcutaneous portion of the left ulna and right great trochanter. Lead lotions applied. Put on brandy 3ft ev. 4 hrs. & Strophanthus mT. ev. 4 hrs. Evening:— Pulse weaker 140 per min. Resp. 38. & laboured. Pain in the joints. No effusion. Only partially conscious. T. 104·6°.

April 27th. P 140. weaker. Effusion into left knee joint. Pain in elbows. Very dull and difficult to rouse. R. 60. Very laboured. Not taking food. Conjunctivæ very injected. Ice to head. cold pack &c. During the day became quite unconscious.

8 P.M. T 106·8° Sinking fast. Pulse weak & small

9 P.M. T 106·8°

10 P.M. T 108. Slight Cheyne Stokes respiration

11 P.M. T 108·8°. Death.

Inquest:—

No peritonitis. Upper portion of vagina and lower segment of uterus is black & gangrenous.

placental site and immediate uterine area in a similar condition. Small pyaemic abscesses in uterine muscle or back of left arm. Considerable amount of pus in left knee joint. Lungs congested. Brain. In front of ascending frontal convolution on the right side is a superficial area of suppuration, about ¾ inch in diameter. Brain surface congested - excessive serous effusion under the pia mater. No basal effusion. Kidneys & spleen show infarctions of a later date i.e. not very recent. But no abscesses. Liver fairly healthy -

Remarks. The question of Caesarian section which cropped up when the attempt to deliver with forceps failed. Fell to the ground when the foetal head was inserted. The amount of force employed to extract the head & shoulders no doubt occasioned very severe bruising of the maternal structures, ending in gangrene as shewn by post-mortem examination. But a curious point

—ii the case, is that until the 10th day no alarming symptoms manifested themselves — probably because the morbid process was slow — and absorption therefore retarded. Indeed until the 10th day, the woman had been doing well — and the lochia was normal. After crushing the head, the cephalotribe was removed and not used to extract the cranium, as such a proceeding is considered an additional element of danger from bruising. — In my opinion, I am inclined to the belief that there would have been less danger of lung fever — and inflammatory pressure on the maternal structures, had one or both shoulders been amputated — as a fair trial at craniotomy had been made & proved unsuccessful. For even with the bruising caused by the delivery of the head, there would have been a great[er] chance of the tissues recovering tone without sloughing, had no more protracted bruising by the shoulders taken place.

Mrs Spiers (Craniotomy – Conjugate-vera 3¼")

Date Afwie	17	18	19	20	21	22	23	24	
Day of Puerperium	1	2	3	4	5	6	7	8	
	M E	M E	M E	M E	M E	M E	M E	M E	M E
TEMP. FAR. 107°									
106°									
105°									
104°			Ob Edema					Edema.	
103°									
102°									
101°									
100°									
99°									
98°									
97°									
Pulse	100 88	82 88	92 84	76 88	88 78	82 84	78 80	74	
Motions	0 0	0 0	1 2	0 0	0 0	0 0	0 0	1	
Lochia	N N	N N	N N	N N	N N	N N	N N	N N	
Onset of Lactation				X					

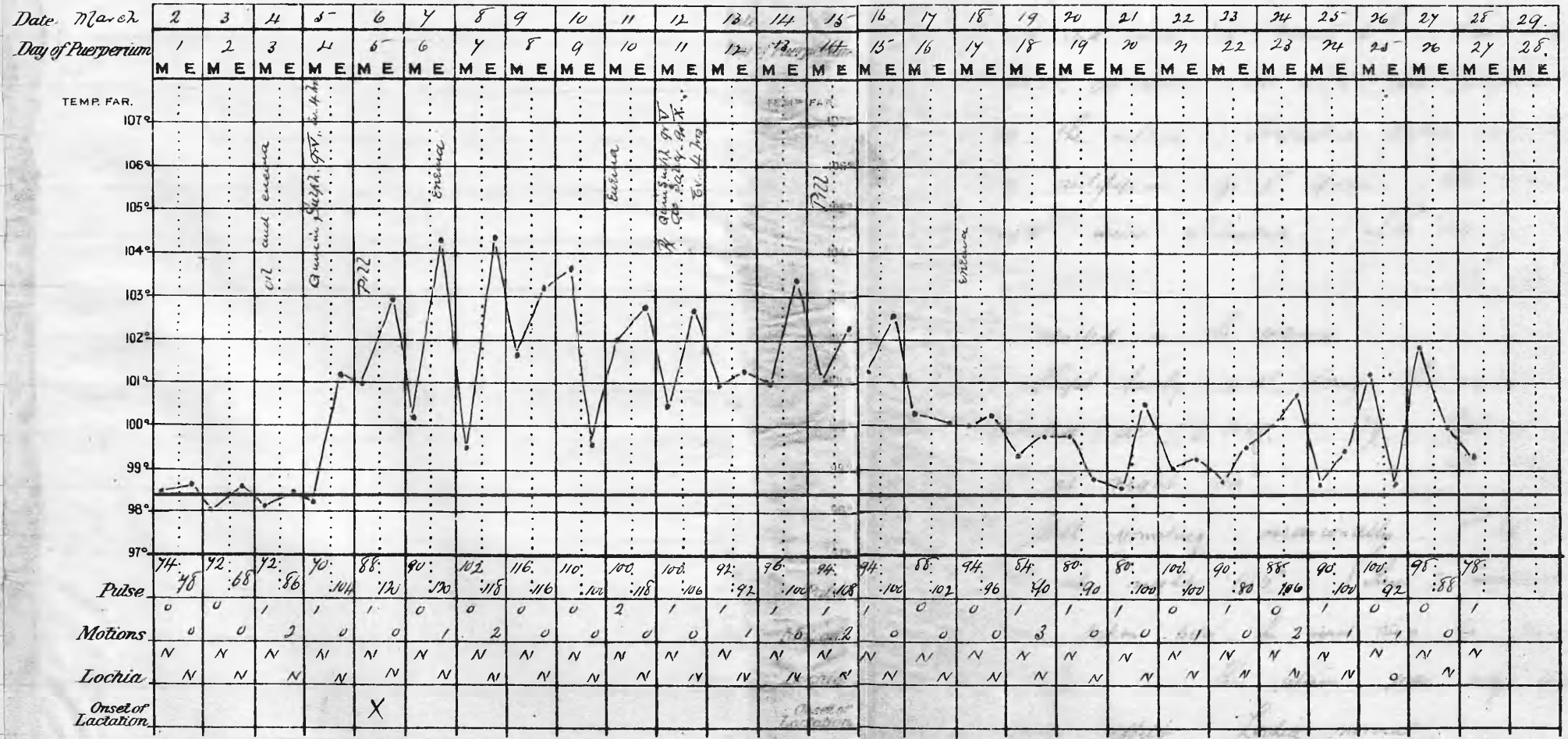
Craniotomy. Conjugate vera 3¼".

Mrs Spiers 19. Preston St. primipara. Adt. 25.
Presentation 1st Cranial. Mother discharged
well.

On admission the os was nearly fully
dilated. The membranes had ruptured
and the head was above the brim.
Large caput succedaneum. No foetal
heart sounds heard – or movements felt.
Conjugate vera 3¼". Pains strong and
regular. Dr Black applied forceps but
failed to extract, and Dr Cameron who
had been sent for, also failed to
deliver with forceps.
The cranium was perforated – and the
crotchet employed to disintegrate the
brain substance – and ultimately to
deliver.

The woman made an uninterrupted
recovery.

Christina Taylor (Syphilis Case. result fair.)



Septic Case. Admitted 1st March '90. Discharged 27th March

Christine Taylor 220 Hope St. act 22. Primipara. Presentation 1st Cran.
Duration of labour, Stage I. 39 hrs. II 1/2 hr. III 20 minutes.
Child female alive mature. Result fair.

Mar. 5th Patient did well till March 5th, when she had a rigor.
T. 101·2° at noon. At 2 P.M. she complained of severe pain
over the uterus. Turpentine stupes and laudanum applied
and antipyrin gr X given. The breasts which were
gorged were rubbed. In the evening she was put on

℞. Quinini Sulph gr X. 2nd Hrly.

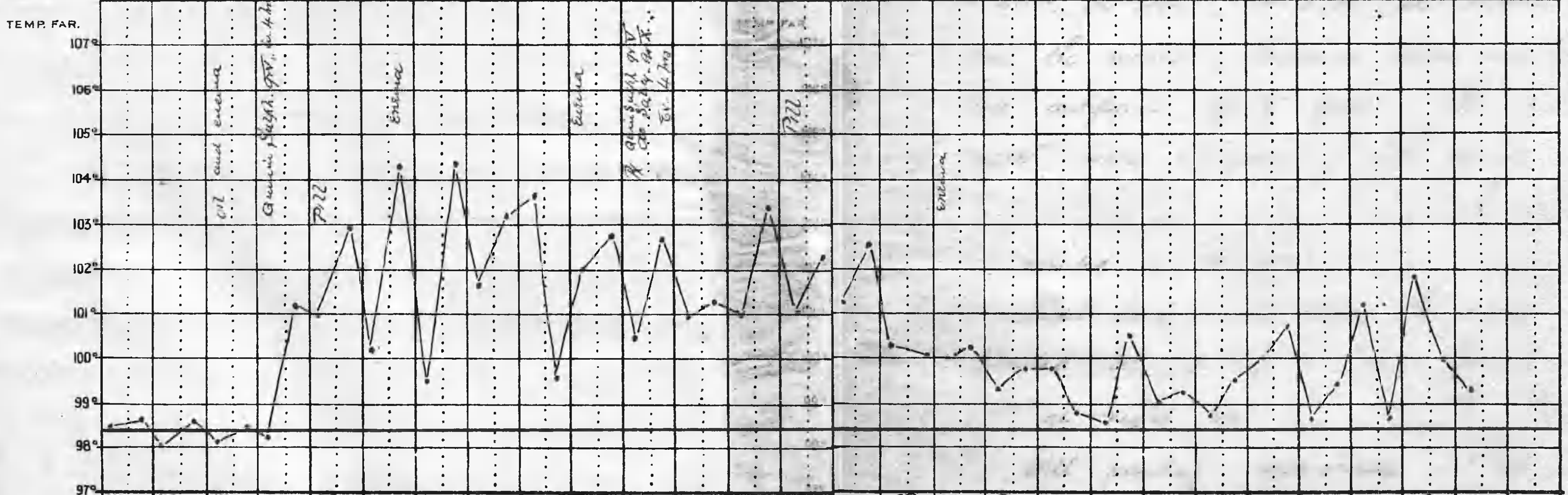
She vomited in the evening.

Mar. 6th. Slept fairly well during the night. No pain over uterus.
Vomited at 3 P.M. ℞. Calomel gr IV
T at night 106°. Op. (pulv.) gr I.

Mar. 7th. Still vomiting occasionally. P 132 per min. & weak.
T at night 106°. (There 2 temperatures on 6th & 7th Mar.
were taken betw. the usual times for registering the T on the
chart.) The uterus was only douched once, without
much effect. Lochia normal.

Mar. 8th. Headache severe. Occasional vomiting. Slightly delirious
in the evening. Abdomen distended, and painful.
Given an Enema. Followed by Supper. Morphia. gr 1/4. —

Christina Taylor (Septic case. result fair.) —



Date March	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Day of Puerperium	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Pulse M	74	72	72	70	88	90	102	116	110	100	100	92	96	94	94	88	94	84	80	80	100	90	88	90	100	98	78	
Pulse E	78	68	86	104	120	130	118	116	100	118	106	92	100	108	100	102	96	90	90	100	100	80	106	100	92	88		
Motions M	0	0	1	1	1	0	0	0	0	2	1	1	1	1	1	0	0	1	1	1	0	1	0	1	0	0	1	
Motions E	0	0	2	0	0	1	2	0	0	0	0	1	[illegible]	2	0	0	0	3	0	0	1	0	2	1	1	0		
Lochia M	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	
Lochia E	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0	N		
Onset of Lactation					X																							

Calsarian Sections

Mar. 12th. Has not been sleeping well at night requires opiates. T still down in the mornings & -up at night. Put on Rx. Quin Sulph gr v
ac. Salicylat. gr x
Ex. 4 hrs.

Nothing to be made out per vaginam, except slight pain at left lateral part of cervix. No ulcers. Lochia normal.

Mar. 18th. Sleeps now without opiates. T down to 100°. and without much variation. Has developed lumpigibs (which she says frequently troubles her.) and slight bronchitis. On the whole however she is improving.

Mar. 23rd. T below 100°. Taking food well. Allowed up.

March 28th. "Went out", of her own will, to be nursed at home.

Caesarean Sections.

I attended two cases performed by Dr Cameron, one on 10th April 1888. and a second in June 1890. (while I was acting as Nurse Surgeon in the Victoria Hospital SS.) A case was performed in the Maternity Hospital a week before my term

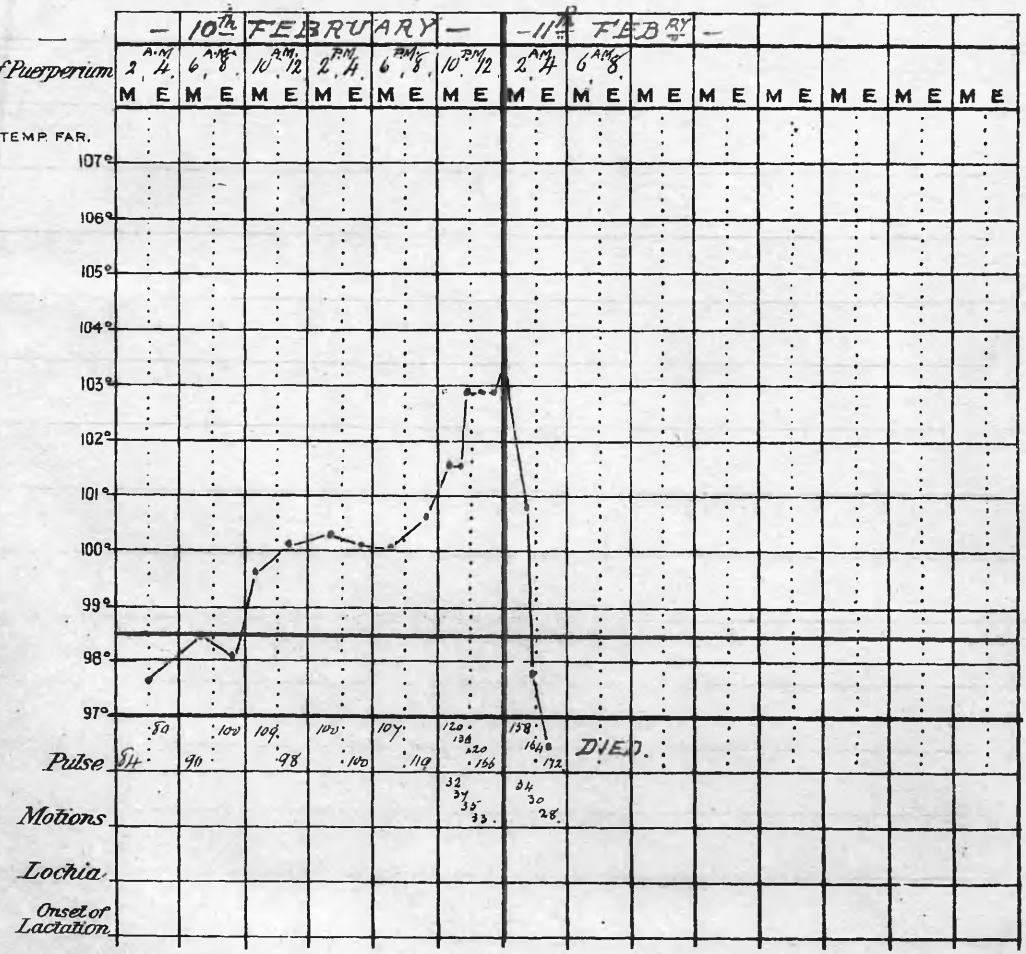
began as outdoor surgeon — by Dr Reid — and as it affords valuable instruction — and room for a few observations — especially when compared with Dr Cameron's cases — notes of it are detailed below. (extracted from the journal of the Glasgow maternity hospital).

Maggie Black, 72 Millroad St. primipara aet. 23.

Admd. 9th Febry. @ 10.45 P.M. Caesarian Section.
Delivered 10th " " @ — 1 A.M.
Died 11th " " @ — 3.53 A.M.

Presentation 4th Cranial. Total duration of labour 12 hrs. Child. female alive. mature. weight 5 lbs 12 ounces. Length 21". Placenta weighed 1lb ounces — and the cord was 21" long. On adm. the "os" was dilated to the size of a crown piece. membranes unruptured. Conjugate diameter less than 2". Patient was a very ricketty little woman, but appeared well nourished. She considered that she was just time. Dr Reid was sent for, and others of the staff were called for a consultation. There attended were Prof. Leishman and Drs Cameron, Swan, Black, and Oliphant. The opinion was almost unanimous in favour of Caesarian Section. Dr Reid alone inclining to Craniotomy. Chloroform was administered

Maggie Black. (Caesarian Section. Conj. diam 2". DEATH.)



by Dr Brown and Dr Reid performed the operation assisted by Dr Cameron. Dr Oliphant attending to the instruments. A mesial incision was made from the umbilicus to a point a little above the pubes. Bleeding was arrested and the uterus carefully opened into in front, by small incisions (to preserve the membranes). The child & placenta were removed by Dr Cameron. The uterine wound was then stitched by Dr Reid with about 13 silk sutures. The abdominal wound was also closed by silk sutures. The operation was begun at 12.45 a.m. and the child born at 1 a.m. and the operation ended at 2 a.m.

3 grains of Ergotin were subcutaneously injected.

3 A.M. Patient slept well till 3.45 A.M. when she complained of severe pain in the abdomen, and great thirst. Little discharge.

3.45 A.M. Feeling sick but did not vomit. Sleeping soundly below the pains. Pulse more regular. Passed 3ij urine

4. A.M. Morph. Sulphas. 1/4 gr. given. Longer interval between pains which are much less severe.

5 A.M. Slept an hour. Pulse strong and irregular. Quite sensible but wished to rise.

6.45 A.M. Pains again severe. Great thirst. Feeling sick — No vomiting — administered Morph. Suppos. gr 1/4.

8 A.M. Sleeping quietly. very little pain.

9.20 A.M. Slept 1 hr. 45 min. Passed $\frac{3}{iij}$ urine naturally.

10.10 A.M. Sleeping mostly — only waking for a drink. Slight cough.

1.30 P.M. Not nearly so thirsty. Apart Water fluid for fear of Coughing.

5.25 P.M. $\frac{3}{viij}$ urine passed naturally. Refuses to swallow.

7.30 P.M. Great headache complained of.

8.30 P.M. Well marked Symptoms. breathing very laborious. Morph.

3 A.M. — Gradually becoming weaker, restless. pulse very feeble & irregular.

3.55 A.M. Died.

Inquest. Length of body 4 ft 11". Intestines distended with flatus. No peritoneal effusion or lymphy exudation. Abdominal and uterine wounds healthy. No clots in utero. Uterine wall 1/8" thick at upper part. No clots in abdominal cavity. Bladder small — empty. Healthy. Spleen and Kidneys normal. Right lung adherent all over from top to bottom. Left lung free from adhesions

No tubercle. Both lungs very adhesions. — Emphysema in lower front of left lung. Both kidneys throughout. Heart normal & Liver healthy. —

Previous History. The patient has not lived with her father for 6 years — and appears to have led a very loose life. Before her confinement she was a very heavy beer drinker. —

Two cases of Caesarian Section — operated on by Dr Cameron, at which I was present. One case only will be detailed, the notes of which are taken from a printed pamphlet of the case, which Dr Cameron kindly presented to me — and as the method of operating — and subsequent treatment so closely resembled those adopted in the second case (which was operated on in the early part of the summer of 1890.) no detailed notes of the latter are considered necessary. —

(over)

Conjugate vera at brim = 1½".

C. C. ; aet. 24. Primipara. admitted into the Glasgow Maternity Hospital on April 10th '88.

She was a little woman, somewhat delicate & very pickelly. She states that she was at the "full time" — and has lately enjoyed good health. Foetal movements felt. —

On examination the sacral promontory was easily reached with the fingers — The conjugate diameter only permitted the insertion of the point of two fingers — a little more space existing towards the right side, but not sufficient to be of any practical value — A consultation was called — and all agreed that the conjugate diameter at the brim did not exceed 1½". and recommended Section. —

She was chloroformed at 4.30 P.M. Ether being afterwards substituted. She bore the anaesthetic well and without sickness. The pubes having been shaved and the abdomen washed, an incision was made in the middle line from the umbilicus nearly to the pubes. The parietes were thin, and the few vessels cut

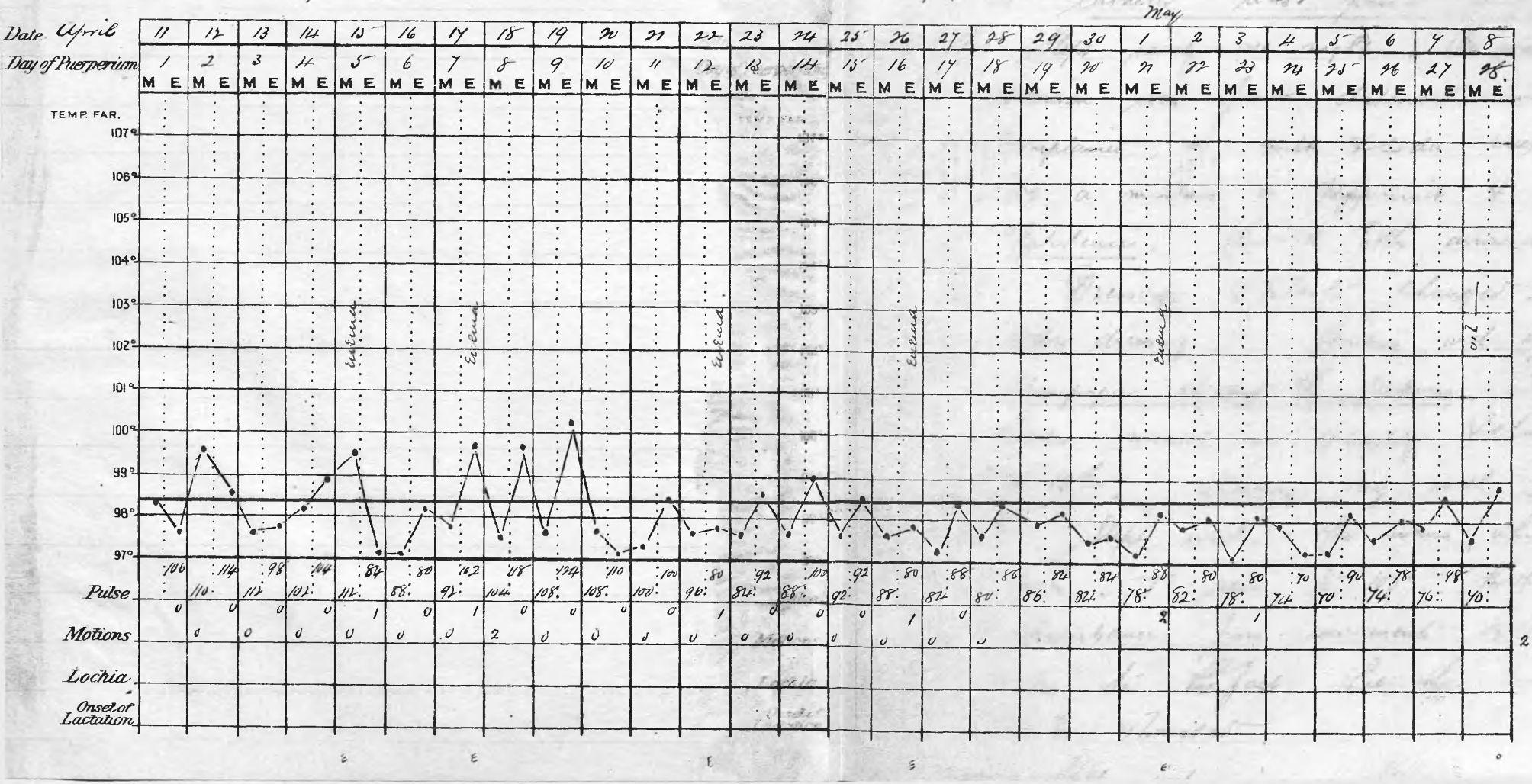
were easily controlled. The incision into the uterus extended from below the fundus on the anterior aspect, straight down for about 3" inches. The membranes were hooked up and an opening made, after which the living child was immediately extracted by the presenting head. He weighed 6 lbs Danes. The placenta was detached & removed in a few minutes, the membranes being complete. There was free haemorrhage from the Sinuses. A finger passed from the vagina through the os uteri met another finger passed through the uterine incision. Showing that there was a free channel for the lochia.

Seven silk antiseptic sutures were passed through the outer two thirds of the uterine wall, and fricture was applied to the fundus to ensure thorough contraction. The stitches on being tightened, immediately checked the bleeding. No difficulty was experienced in getting complete apposition of

the peritoneal surfaces. 15 minims of Tanners solution of Corrosive were injected into the thigh. The abdominal cavity having been carefully sponged out and the external wound closed with 9 antiseptic silk stitches. Three long strips of adhesive plaster were applied at intervals, and the part dressed with Boracic cotton and Sublimated Gauzee over which the binder was applied. Everything about the patient was immediately changed; hot pans were placed round her & nurses appointed to take charge of the case. The time occupied was 50 minutes. At night after the operation the patient felt well and slept at intervals. She got iced milk and soda in 3i doses. amounting to 3i every hour.

April 11th. Slept a little last night after ½ gr Morphia suppository had been given. Did not sleep during the day but felt well. Milk increased to 3ij &c.

C. C. primipara. aet. 27. (Caesarian Section Conjugata vera 11½" Recovery)



Complained only of thirst and hunger, and wanted food. She voided urine but the catheter was passed every 6 or 8 hours.

April 12th. Slept nearly all night. On examination, the abdomen was found distended with flatus. Complained of milk & soda making her sick. Got a mixture of peppermint & morph. for flatulence. Had a little arrowroot. & vomited.

" 13th. Dressings & plaster changed. No stains on cotton dressing. Vomiting with expulsion of flatus. Champagne checks the sickness. Breasts & lochia normal in quantity & character.

" 14th & 15th. Keeping very well.

" 16th. Slept well. Had enema, which operated three times. T rose to 100°. probably due to disturbance from movements of bowels. Pyrexia also to the fact that the breasts had again to be drained.

" 19th. Still improving. Stitches were removed from the abdominal incision (which had healed by first intention). New dressings applied.

May 4th. allowed up. May 16th. discharged. Child 2lbs heavier

The remarkable success which has attended this operation as performed by Dr Cameron (who has within the last few years had 10 successful cases) and others, disproves the too General belief which happily is fast dying away, of the immense danger to the mother connected with it.

N.B. Indeed as compared with a difficult Craniotomy case, such as I have witnessed, the Caesarian Section is a much safer, and most assuredly, an easier operation to perform. Here I take the opportunity of expressing my indebtedness to Dr Cameron for many valuable and practical hints, connected with this operation and also with General obstetric work which he gave me during my term in the Glasgow Maternity Hospital as acting Surgeon.

Caesarian Sections owe in a great measure, their successful issues to the strictest attention to details, such as

as a proper temperature of the operating and nursing rooms — thorough antiseptic precautions &c — and success also depends much on the operation being a primary choice. Many fatal cases recorded are cases in which before section was performed — protracted & fruitless attempts — have been made to deliver with forceps &c. If possible have the patient under observation for several days previous to the ~~beginning~~ of labour. Have as few assistants as possible during the operation; one to administer the anaesthetic, 1 to attend to the instruments, and 1 to assist the operator. also a nurse to have Sponges &c. As Dr Cameron points out "Serious results may follow the unskilful removal of the adherent placenta in a normal labour — if the finger nails, in place of the edge of the hand, are used to detach it." Some operators advise that the

—uterus should be turned out through the abdominal wound — before the child & placenta are removed. But I have seen the uterus emptied most satisfactorily and safely — when in Situ. Dr Cameron by abdominal manipulation if necessary, gets the head of the child to present at the intended Site of the uterine wound — & subsequently delivers by the head. In this way any loss of time or increased danger from the escape of fluid into the peritoneal cavity — is prevented, which would be very apt to occur — in a case of breech delivery if the head being caught by the uterine wound, necessitated lengthening of the incision —

Dr — Cameron never employs a ligature to control bleeding, and he disapproves of the elastic band being employed prior to delivery. He contends that

with precautions short of these measures bleeding can be checked. The elastic band is probably dangerous to the child. (Dr Cameron) "In opening the uterus any bleeding that may occur is easily controlled, and should not be troublesome. After extraction of the child an elastic band could then be very easily applied".

To stitch the uterus. Straight needles & antiseptic silk sutures, varying in number according to the nature of the case, were used. The sutures grasped the outer 2/3 rds. of the uterine wall avoiding the endometrium. No difficulty was experienced in obtaining perfect opposition of the peritoneal surfaces. Special sutures for the peritoneum, besides lengthening the operation, have been proved unnecessary. For suturing the uterine wall "Silver wire if left in, is unsafe, and catgut is unreliable".

The Fallopian tubes were tied in both cases with antiseptic silk — without evil results — Some use kangaroo tendon as being more reliable.

Dr Edmunds has had successful cases — in which he left the uterine incision without sutures, but in our case he had an alarming gush of blood — with enlargement of the uterus and consequent gaping. Suturing the uterine wound still lessens this danger — and therefore ought to be adopted in each case. — although it has been proved that many cases do well without.

The evil of plugging the cervix with a drainage tube was avoided in each case cited. The fact of a small clot or piece of placenta plugging the cervical canal and acting as a foreign body leading to post partum haemorrhage and distension of the uterus is well known to —

very practitioner.

In a multipara we need not wait for labour to begin, but Dr Galabin advises that as a preliminary the membranes should be ruptured.

Recognizing the probability of many operators for the operation of which each is most expert — the absolute decision as to when craniotomy or Caesarian Section is the better operation, is a difficult question to decide.

Some authorities state that "Caesarian Section can never supplant craniotomy", but the decision as to which operation will be performed turns on the consideration of the special circumstances of each case.

Certainly we can infer from the history of the results before us, that "the time is speedily approaching when this operation will take the place of craniotomy where the child is alive", and as in the

Treat Symptoms, cough - flatulence &c.
wh. tend to lead to
disturbance of abdominal
and uterine women.

cases cited "let us decide beforehand if Cæsarian Section is to be performed avoid unnecessary manipulations or attempts at delivery by other means, and secure the strictest antisepsis before, during, and after the operation, which should be performed at an early stage". (Dr Cameron).

The opinions which Dr Cameron would like to hear expressed on the following questions I leave for other and more experienced obstetricians

1 When is the operation justifiable?

2 Whether Section or Porro's operation is preferable?

3 The treatment of the Stump in Porro's Operation?

4 Whether the Cæsarian operation might not be accompanied or followed by the removal of the ovaries?

5 Any other points of importance

Puerperal Eclampsia

with special reference to treatment – when the convulsive seizures accompany labour

Puerperal Eclampsia

This condition occurring in connection with a case of labour, is one of the most alarming complications in obstetric practice, and as several cases have come under my observation directly - and as my interest in such cases was fostered by Dr Malcolm Black. I would like to detail a few notes on the subject with special reference to the line of treatment I would be inclined to follow in an Eclamptic case during labour.

The first case occurred in a primipara aetat 38. She was confined in a small farm house, in a most remote part of Orkney - 4 miles from the nearest medical man and 10 miles from the nearest town. After a long and tedious labour she was delivered of a 7½ months child (which only lived for a few days).

During the labour she complained of an intense and persistent

temporal head ache "as if a red hot wire had been passed through her head" A history of puffing of eyelids in mornings was elicited - and a sample of urine by rude tests, (heating a specimen in a metallic spoon over a candle - and adding vinegar) was found to contain albumen - in considerable quantity. Labour ended satisfactorily - but 8 hours after the child was born convulsive seizures - epileptic in nature, began and had continued for 4 hours before I got to her. By that time she was in immediate danger of choking, from the blood which continued to trickle from her lacerated tongue into her larynx. In appearance she was livid - and bloated. Tongue swollen and protruded - and face sprinkled with blood & foam. Her dishevelled hair and disordered clothing made her a horrible spectacle -
after some trouble, we succeeded in

clearing her throat of blood & foam and no chloroform being at hand, hypodermic injections of morphia at intervals of 1 hour were given – with the assurance, that the only hope for the woman lay in getting her fully under the action of the drug. – (1½ grs in all were given.)

At last she was left dozing – and next morning when the consultant called with me, we found the woman drowsy, but capable of being roused to consciousness. With attention to general state of her health she ultimately recovered. –

One year later I was informed that she also suffered from eclampsia during her second confinement – but recovered –

An experience of this kind, occurring as it did in such an outlying district – impelled me to enquire more fully into the treatment of such cases, more

especially of those cases in which the convulsive seizures accompanied labour.

The facts noted refer to cases, some of which occurred some years ago in connection with the Glasgow Maternity Hospital practice - others occurred in Dr Malcolm Black's private practice - and three cases were seen by me in connection with Glasgow Maternity Hospital work.

The treatment recommended by those obstetric authorities I am in the habit of consulting in difficulties appears practically to consist in rupturing the membranes whenever the os is fairly soft and dilatable - and then leaving the case severely alone. We may get the forceps ready and only when the head begins to press on the perineum should we proceed to use them, without

much hesitation, if the labour begins to flag or the urgency be deemed imminent. Dr Leishman advises "that in the majority of cases we had better devote our attention entirely to the medical treatment".

These authorities appreciate the fact, that delivery is of the utmost importance and state their belief, that in the majority of cases delivery will mitigate the severity of, or put an end entirely to the convulsions, while we are cautioned to expect no lasting improvement until delivery is over.

On the other hand any attempt at operative interference, even digital examination may so intensify the spasms as to render matters distinctly worse. Especially do they deprecate forceps and turning and according to Prof Leishman "forcible dilatation of the

as a method of procedure which can scarcely be admitted as warrantable under any circumstances, and the operation of turning should never be entertained unless in the presence of malpresentation." While Dr. Playfair says "forcible dilatation of the os and especially turning are strongly contra-indicated."

When delivery can be safely and easily performed there is no doubt as to the proper course to pursue, but when the convulsions begin with the onset of labour, or when the os is but slightly dilated - what is the best course of treatment?

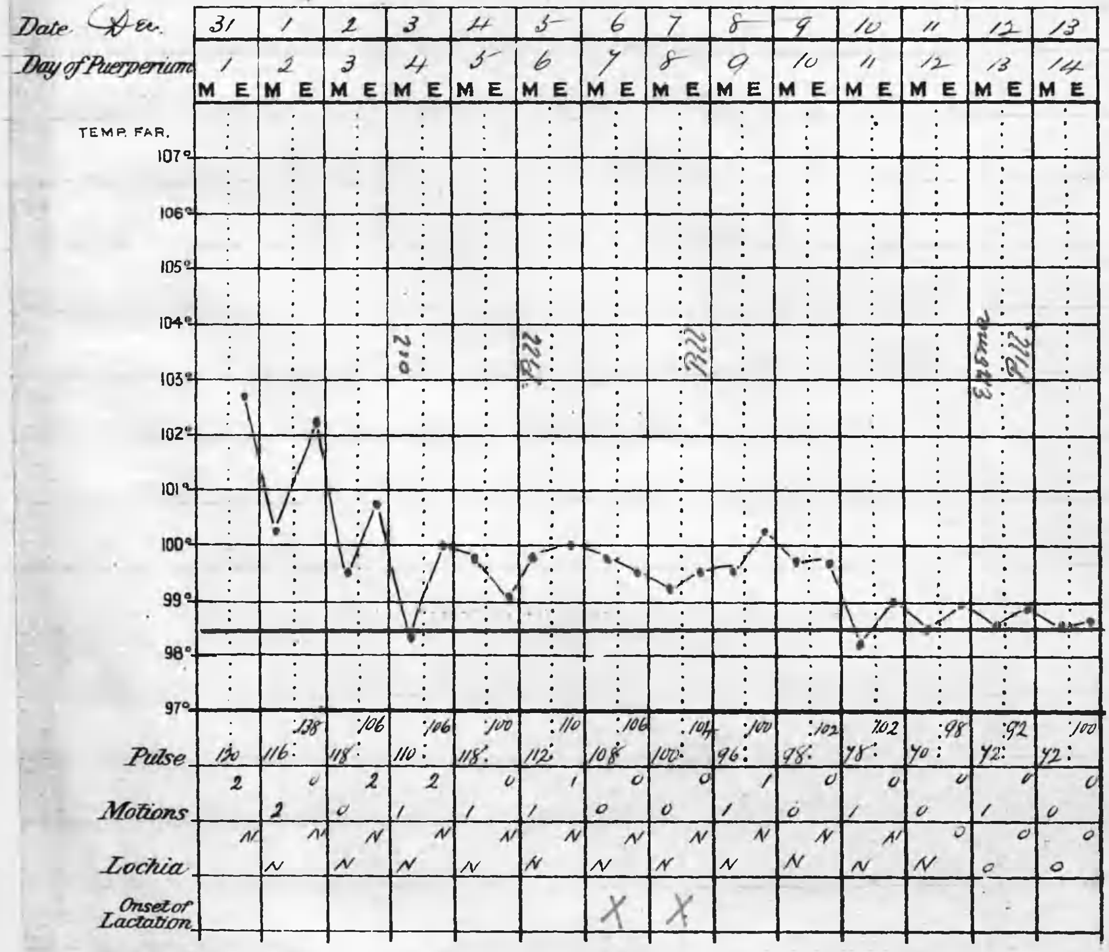
These convulsions most frequently develop during the last months of pregnancy or early in labour - and least frequently after delivery.

In those cases in which the convulsions develop at the onset of labour,

Labour is by no means rapid even after the membranes are ruptured while if we wait until the head begins to press on the perineum or even until the os is sufficiently dilated, the opportunity of saving the patient may have passed - or short of that, the danger may be greatly aggravated.

If we regard the foetus as the source of the nervous disturbance, the indication distinctly is to get it removed - and supposing that the patient is already crippled by disease kidneys - the argument is all the more powerful why a foetus, which constantly augments the waste products already existing in the blood of the mother, should be got rid of as soon as the operation can be performed safely. Dr Leishman asserts that with rare exception puerperal

Jessie Short. (Puerperal Eclampsia, Recovery)



eclampsia is essentially connected with uraemia and albuminuria. Even apart from this the mere presence of the foetus in utero appears to act as an excitant of the spasm centres — and clearly it is of paramount importance that it should be got rid of at the very earliest practicable opportunity.

The following case seen by me illustrates that class in wh. the spasms develop at beginning of labour:—

Jessie Short aetat 18. primipara adm 31st Dec. 1888 at 4 P.M. delivered at 7.30 P.M. — Presentation 1st cranial. Duration of labour Stages I & II 10 hours? III 17 minutes. Child female dead mature. Wt 5 lbs 14 oz. Length 20". Wt of placenta 1 lb 2 oz. Length of cord 17½".

The patient was first seen between 2 and 3 P.M. She was unconscious, and had been since 8 A.M. having had 9 fits. The tongue had been bitten, and a quantity of

bloody froth was collected about the lips. She was sent into the Maternity Hospital in an Ambulance wagon. On the way there she had other 3 fits & had another when being carried upstairs and 2 more shortly after being put to bed. She was then quite unconscious - with corneal reflex insensible. Per Vaginum. She admits the point of one finger. Presentation 1st cranial - Foetal heart sounds were heard distinctly - 2 minims of Ol. Crotonis were put on the back of her tongue and an Enema given. Chloroform was then administered and Dr Reid sent for. In his absence, Dr Oliphant came, who, along with Dr Black decided to deliver as soon as possible. She as was forcibly dilated by Barnes' bags - and the child delivered with forceps. The child was stillborn. The placenta was removed by the hand as it could not be

expressed. Chloroform was then stopped. Delivery was over at 7.30 P.M. At 8.30 had another fit. Chloroform repeated. At 10.30 had another. All night she was very restless, requiring chloroform at intervals. Enemata of Chloral Hydrate were tried, but could not be retained. During the night she was also dry cupped over the loins, and a hot poultice applied.

1st Jany. Still unconscious. Remained "in Statu quo" all day albumen 1/4th. No motions given.

2nd Jany. Still unconscious, although like yesterday, very irritable. Took some milk for the first time.

3rd Jany. Conscious. complains of headache. Took milk and said she was very hungry. Got dose of oil. Makes plenty of water, as she has done from the beginning. Albumen a trace.

4th " Quite conscious.

5th " No albumen detected.

6th " After making a complete recovery was discharged today. No albumen.

In this case, and others to be noted, the method of treatment employed, was in direct opposition to that advised by the best authorities and followed by good results. Under chloroform Dr Black dilated the os either by the fingers or Barnes bag and delivered by turning in 4 cases - 6 making good recoveries. The 4th for many hours was in convulsions before coming under his care - and died. but certainly not from the delivery which was very easily accomplished. In other two cases, the os was mechanically dilated under chloroform, and delivery effected with the forceps - both making fairly good recoveries. From the journals of the Maternity Hospital, extracts from two cases show that under chloroform the os was forcibly dilated, and delivery with forceps effected. both making good recovers. In a third hospital

case - under chloroform the cervix was dilated with the fingers - and further dilatation made by tractors on head with forceps - delivery ultimately being accomplished by version - and child extracted by the feet.

From Dr. Blacks experience I got the following - information.

Of 4 cases managed in a similar way by mechanical dilatation & extraction by the feet (in one case the feet presented) all proved fatal to the mother.

In 3 of these (one of which had been in Convulsions for 12 hrs.) no convulsions occurred during the operative procedure, therefore we may conclude that delivery did not aggravate their danger. In the 4th case, the woman had been in Convulsions for 14 hrs. before delivery was attempted.

In 3 cases seen by me - good recoveries followed the deliveries under

chloroform — after the os had been forcibly dilated — two women being delivered by turning — and one by forceps — the symptoms in each case disappearing after administration of the anæsthetic — Certainly the danger to the patient was not increased by such a course — and in such cases any exacerbation of the convulsive seizures likely to arise from irritation by mechanical dilatation of the os, is very trivial compared with the immense advantage of speedy delivery. In one case of puerperal eclampsia during labour, occurring in connection with the outdoor department of the maternity hospital, the fatal issue was in great measure most likely due to the injudicious efforts of the student in attendance to hurry the labour by repeated digital examination. After this examination was succeeded

by spasms of ever increasing severity, but believing that the woman's only chance of safety lay in speedy delivery, he persisted in his efforts — and at last got the child away. The child survived but the mother succumbed. ——

When there is unusual rigidity of the os all we can do is to wait, at the same time keeping the woman fairly well under the influence of Chloroform. wh. is in the highest degree a relaxer & softener of the os.

Turning should only be performed (when not required for malpresentation) when it can be easily accomplished i.e. membranes unruptured. liquor amnii abundant. Child small &c. —

In an eclamptic case during labour, I would say. Put the patient deeply under the influence of Chloroform — & keep her under it, or under the influence of Chloral hydrate — Clear out bowels — &

empty the bladder, then as soon as possible proceed cautiously to dilate the os, either by the fingers or Barnes' dilators, then proceed to deliver by forceps or turning. After delivery do not, as a routine practice give ergot or inject ergotine, as even a slight post partum haemorrhage may, in the light of Statistics, regarding bleeding, be to the benefit of the patient ——

During pregnancy, if Symptoms of kidney disease manifest themselves, proper measures should be taken — and the possibility of an epileptic outbreak during labour, prevented by proper medicinal treatment continued during the latter term of pregnancy.

When labour comes on in such cases, give a full dose of Chloral Hydrate — and have the chloroform bottle at hand in case of an emergency. —