A Series of 280 Obstetric Cases.

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Table I

Number of Cases		280
Children Born		284
A Male 160	B Female	124
Primiparous Births		94
Second or subsequent Births		186
Twin Births		4
Mothers Recovered		277
Mothers Died		3
Children Born alive		276
Children Born dead		8
Preternatural presentations		10
Cranial presentations		274
Children born naturally		248
Delivery effected by forceps in		34
Delivery effected by turning in		2
Ante-partum Haemorrhage		2
Post-partum Haemorrhage		3
Puerperal Convulsions		1
Phlegmasia Dolens		1

Table II Presentations

Total No of Childn	Cranial	Breech or Foot L.	Sup Cy.r	Twins
284	274	5	1	4

Table III Cranial Presentations

Total No.	First Pos.	Second Pos.	Third Po.	Fourth Pos.
274	224	10	38	2

During the period in which the following series of cases occurred I attended 280 labours. These produced 284 children. There were thus 4 cases of Twins. 160 were male, 124 were female. 8 Children were born dead, or 1 in 35. There were 10 preternatural presentations. (1-28). The head presented in 274.

The Arm presented in one of the cases of twins, the first presentation having been a footling, and the second the left arm. My notes of the case are as follows;- At 1 P.M. on the 28th June 1874 I was called to see Mrs Parry in her 6th confinement. I was informed that a child had been born that morning at 6 A.M. the feet coming first; that her pains had then left her, and had not since returned. The after-birth had not come away. On examining per vaginam I found a cord protruding, and an arm the left- presenting. The bowels and bladder having been evacuated, I proceeded to turn, and in a short time succeeded in bringing both feet down. Labour pains then appeared and the patient was speedily delivered of a living male child.

The Breech presented in 5 cases, and proved fatal to one of the children. These labours required no interference, and were all completed naturally. Respiration generally required to be established by Sylvester's method of artificial respiration.

A Coop of the umbilical cord presented in 4 cases, and proved fatal in 2. In my first case I only

arrived in time to diagnose the presentation, and see the termination of labour unaided. The child was speedily brought round by artificial respiration and did well. In my next case I arrived after the full dilatation of the os uteri but whilst the head was still high in the pelvis. There was a very considerable loop of cord protruding beyond the head. All efforts to return it wholly by the fingers in the usual midwifery position having failed, I placed the patient on her hands and knees, and was then more successful in replacing the cord, and in keeping it beyond the head until the pains brought the head sufficiently low down to retain it in position. The child was born alive and did well. In my 3rd & 4th cases the cord was pulseless on my arrival, and the labours terminated naturally with the loss of both children.

The Head presented in 244 cases. Of these - 224 were in the first position - 10 in the second - 38 in the third - and 2 in the fourth. Of those in the third position, 2 did not perform the usual rotation and become presentations of the second position, but were delivered with the forehead passing under the pubis. Both cases occurring in the fourth position were converted by rotation into presentations of the first position.

Labour was completed by the natural powers in 248 cases. The forceps were used in 34, and in 2 the

presentation was altered by turning. Of the 34 forceps cases, 24 occurred in primiparae. 33 were completed without injury to mother or child. In one the mother died 4 days after delivery from exhaustion and shock. In this case No 198 in the series the patient, Mrs L. aged 35; had been married 7 years, but had never been pregnant previously. She sent for me when about 2 months advanced in pregnancy, as she then thought herself consumptive (to and which she had some tendencies) and was quite unsuspicious of her state. On being informed that I suspected her illness was due to Pregnancy, she said "it had come for her end". To this opinion she firmly adhered during her whole remaining period, and frequently assured her relatives that she would never get over it. On the 13th Sept. '75 Labour commenced, dilatation of the os proceeding very slowly. About 9 P.M. the first stage of labour was completed. The second stage was likewise very tedious and painful - the head making very slow progress, whilst the pains were very sharp and frequent, but of short duration. The patient becoming much exhausted I applied the forceps, and easily completed labour at 3 A.M. of the 14th. She never rallied after delivery, despite of treatment she sank, and died on the fourth day.

The maternal mortality is very large. 3 in 280 cases.

The deaths may be divided into 2 classes 1st direct and 2nd indirect. Of the direct class, there was one the history of which we have given in the last paragraph. Of the 2 remaining cases death was only indirectly the result of labour. In one instance death was principally due to Pleuro-pneumonia and in the other to long standing Bronchitis with Emphysema.

Turning was performed twice. In my first case for a presentation of the arm already noted, and in the second (No 176 in the series) I turned on account of a very prolonged labour in which the head was presenting. The patient, aged 34, was in her first confinement, and had a most rigid Os Internum. The labour pains were strong and powerful, but after lasting many hours failed to effect dilatation of the Os beyond more than half the extent necessary. Antimony was given but without avail. The patient becoming exhausted, I proceeded to turn in the usual manner, and succeeded in bringing down the feet. Labour was soon completed, but although every effort was made to restore animation, the child was lost. The mother made a good recovery.

Twins occurred in four cases (1 in 70). Of the 8 children 4 were female and 4 were male. In one case both were female, in one both were male, and in two a Boy and a girl. In 2 of the cases it

happened to primipara and in 2 to pluripara. In all the cases there were two placentas attached at their margins with a cord arising from the centre of each.

The hemorrhage before delivery occurred in 2 cases. In one it began (an instance of accidental hemorrhage) about the 3rd month, and the patient continued during the whole remainder of her pregnancy to have a weekly discharge of blood, considerable in quantity, and lasting for a day. Notwithstanding the patient went to her full time, had very little discharge during or after her confinement of a living healthy child, and made a good recovery. My second case was an example of unavoidable hemorrhage - the placenta being partial previa. The patient aged 34 only came under my care in the last week of her first pregnancy. During the previous months she had had occasional attacks of hemorrhage, but not to any extent. On examining per vaginam the edge of the placenta could be felt on the anterior edge of the os. There was no hemorrhage at the time, but the patient was very anemic in appearance. I at once confined her to bed enjoining perfect quiet, and warned them of the danger to be apprehended from the hemorrhage, and directed them to plug the vagina with pieces of lint should it occur to any extent

before my arrival. During the first few days nothing occurred except a slight "show". On the 5th day the hemorrhage became more alarming, and the vagina was plugged, there being then no pains. On the night of the sixth day the labour pains commenced. After a short time I withdrew the plugs, and finding the os dilating and the head low in the vagina, I ruptured the membranes and again plugged as before. In a few hours the pains increasing much in strength I withdrew the plug and found the os freely dilated and the head in the vagina. Soon afterwards I had the satisfaction of completing the delivery of a dead female child with comparatively little hemorrhage. The patient's convalescence was very protracted, and it was a long time ere she lost her anæmic appearance.

The hemorrhage post-partum occurred in only 3 cases beyond the extent safely left to Nature. In two of the cases there was not much difficulty experienced in controlling it. In both the sudden application of cold by means of napkins soaked in cold water to the abdomen with friction by means of the hand over the uterus succeeded in controlling it. In my third case these means were of no avail, and it assumed a very threatening aspect. Mrs L. a primipara, was

safely delivered of a living healthy child by natural efforts after a very good labour. The child was soon followed by the placenta and almost directly afterwards blood commenced to flow in a constant stream from the vagina. On placing the hand on the abdomen the uterus could be felt flabby and uncontracted. I gave her at once a full dose of Ergot. Friction over the uterus, and the sudden application of cold wet napkins to the abdomen were successively made use of, but without producing the slightest contraction of the uterus. I then passed my hand into the uterus, turned out all the clots and felt the uterus contracting on my hand. This however was little more than momentary, and the uterus was soon as flabby as ever, and the stream of blood continued as free as ever. The long pipe of a Higginson's Syringe was then passed into the uterus, and cold water freely injected, at the same time grasping the uterus firmly & applying circular friction over it. The uterus instantly contracted and remained so for 2 or 3 minutes. On the contraction passing away, more water was injected and again the uterus contracted & the stream ceased to flow. The patient was now pale & ghastly (my first experience of Puerperal

pallor), the lips seemed to have lost every drop of blood - the patient was only partially conscious, and on being roused complained of much giddyness and faintness. The pulse could scarcely be felt. The flow of blood had ceased and hopes were entertained that the uterus would remain rigid. Soon however these were disappointed, and the hand which grasped the uterus could feel that organ again relax, and become flabby. Again the blood streamed from the vagina, and again the cold water was freely injected into the uterus. Contraction rapidly took the place of relaxation, and the hand again grasped a hard firm organ. A large quantity of Brandy was now administered, and with a most wonderful effect. The bloodless lips soon assumed a pinkish hue, the pulse became perceptible, and rapidly became fuller and fuller, and the patient expressed herself as feeling better. The tide had now turned. The uterus remained firmly contracted, the haemorrhage had completely ceased, and the general symptoms continued to improve. After allowing a short time to elapse, I cautiously and firmly applied the abdominal bandage,

placing a firm pincushion over the uterus. Perfect rest and quiet were now enjoined, and an hour having passed without any appearance of the uterus relaxing I had the baby put to the breast and kept there for some minutes. My patient now made steady improvement and rapidly regained her strength and former colour without any bad symptom. The effect of the injection of cold water was very marked, the uterus very speedily reacting to the stimulus of the application of cold, although it required to be repeated several times before we obtained permanent contraction. I had some Perchloride of Iron with me, which I should have used had the relaxation appeared again. Fortunately its use was not required, and so the danger of its use did not need to be incurred.

Puerperal Eclampsia. Of this alarming complication it has only been my lot to see one case, which occurred amongst the last cases of my series. The patient Mrs S-, aged 18, was safely delivered by a midwife of a living male child about 11 P.M. on the 14th Jany. 76. Up to the time of her confinement she was apparently in perfect health. Her labour was said to have

been perfectly natural. Shortly afterwards she fell into a sound sleep lasting until about 5 A.M. Her nurse about this time left the room on some errand, and had not been long gone when she heard a curious noise coming from the bedroom. On returning she found the patient in a fit. It was said to have lasted about 3 minutes. On recovering she said she felt all right and did not remember anything about the attack. About 7 A.M. she had another fit lasting a similar time to the last. I was then sent for, and on seeing her soon after 8, I found her perfectly conscious with a pulse of 120. There was no oedema, nor could I from my examination discover any cause for the attacks. Whilst I was talking to her she rapidly passed into her third fit. The first thing I observed was a vacant expression of the eyes & I found that she did not reply to my queries. This was soon followed by twitchings of the face - the eyeballs were turned up, and the head thrown backwards - the hands clenched - the respiration suspended - and the whole body rigid. The face now became of a deep livid hue. Soon the rigidity gave way, and spasm alternating with relaxation of all or nearly all

the muscles in the body took its place. The fit lasted about 4 minutes, and was soon followed by a return of consciousness. Chloral Hydrate in large and frequent doses was prescribed. During the day the fits continued to recur and as they advanced they became more frequent and of greater severity. The chloral did not seem to produce the slightest effect upon the attacks. At 7-15 P.M., as the convulsions were now almost continuous with scarcely an interval & no return to consciousness, I commenced the inhalation of chloroform. At this time the patient's condition was almost hopeless, the symptoms all tended towards a fatal termination. The pulse was small and rapid. The insensibility was complete, the convulsions were almost constant - lasting a long time with only a very short interval and of a very severe character. The following are abreviated notes of the night's proceedings. The inhalation of the chloroform produced an almost instantaneous effect. There was an immediate interval of 10 minutes (7-25 P.M) before the first fit which was noted as being much modified, only lasting a minute, & possessing scarcely any tonic Spasm. At this time the temperature was noted as 102·4 pulse 140. At 7-48 P.M. another fit similar

to the last. At 10 P.M. the temperature was noted as 104·4. My mode of procedure was first having placed the patient completely under the influence of the chloroform I simply directed my efforts to keeping her in that condition, the slightest approach of consciousness or motion being taken as a signal for its renewed application. From 7-48 P.M to 12-45 A.M. there was a period of complete repose from Convulsions. At that time I desisted from pressing the chloroform so closely and in consequence I had to note at 12-45 A.M. another fit (the third) more severe and intense than the last, lasting 3 minutes. At 2 A.M. the temperature had come down to 102°, at 8-30 A.M to 101°6, at 10 A.M. to 100°2 at 10-30 A.M. the pulse was noted at 98 and at this time we stopped the administration of chloroform. That agent was thus given for 15 hours and a quarter, and there were only 3 convulsions after its administration. During the rest of the day the patient was narrowly watched, but no appearance of convulsion or any spasmodic action was observed. She did not recover consciousness until late in the following night, and then only for a short time, soon falling into a heavy sleep from which she woke much refreshed though complaining greatly of stiffness, and pain in her limbs. Showing the severity of the

symptoms there was found over the sacrum a large black patch, which sloughed and left a deep wound. She made a good recovery without any further bad symptom, and was able to suckle her child. Unfortunately I had not the opportunity of examining her urine until after the fits had ceased, but there was then no albumen. The history of the patient was perfectly satisfactory, coming of a healthy family, up to the appearance of the convulsions believed to be perfectly healthy herself, the cause of their occurrence is doubtful. In this case the prognosis was very bad, the convulsions rapidly increased in violence and the intervals as rapidly became shorter, whilst the coma towards the evening became profound. There can be no doubt that the successful issue of the case was due entirely to the exhibition of the chloroform. Chloral seemed to have no effect in diminishing either the severity of the fits or prolong the interval. In future cases I will certainly be much inclined to give chloroform an extended trial, beginning its exhibition earlier, and if one may judge from the result in one case with every prospect of a good result.

Phlegmasia Dolens. Of this complication of the puerperal state I have only seen one case.

Mrs C. a very pale flabby woman on the 6th day after her confinement of her 5th child was attacked with a violent shivering, soon followed by pain in her left groin. The limb rapidly swelled and assumed the characteristic appearance generally met with in this affection. She had lost a considerable amount of blood after her delivery, and was very weak and anæmic. The pulse was 130 and the temperature 102°. The treatment adopted was to bathe the whole leg with fomentations of a boiling infusion of Poppy capsules. The leg was kept in an elevated position and when not fomented was kept enveloped in cotton wool. She took a mixture of Quinine and Iron and made a very slow recovery, convalescence being very protracted.

Having now shortly described the different presentations, operations, and complications of the puerperal state met with, I now come to the third part of my Thesis. I propose to glance back over the past cases, and review the work done. This will give me the opportunity of stating what conclusions I have drawn from my past cases and how they will modify my future practice.

The first thing that strikes one in looking over Table 1 is the large number of mothers who have died. Compared with the statistics which appeared about a year ago in the Lancet, where some practitioners gave their death ratio as 1 in 1000 and some much less than this, my ratio of 1 in 100 is certainly very large. But on enquiring into the causes of these deaths we will find that only one death was due directly to the act of parturition, whilst in the other two cases death occurred after delivery, but from affections of the lungs. In one case Labour was secondary to a most acute attack of Pleuro-pneumonia. The patient in this case was believed to be about 3 weeks short of her full period of gestation, when she was attacked with Pleuro-pneumonia. The violence of the attack brought on Labour, and an easier or less exhausting Labour I never attended. I do not think she had more than four Labour pains altogether, and there was but little haemorrhage. She suffered a good deal from after pains and sank on the fourth day after suffering most acutely from her Pleurisy, and with the greatest difficulty in breathing. In this case Labour can scarcely be said to have anything to do with her death. In a

second case the patient had suffered from Bronchitis and Emphysema for about 10 years, and had had her children very fast. I attended her in her two last confinements, there being an interval of little more than a year between. During the whole of her last pregnancy she was confined to bed and could not lie in the recumbent position. Her condition was critical for a long time, and the wonder was not that she died four days after her confinement, but that she had not died undelivered. In this case the labour probably had some determining influence in causing her death, but it was like the last straw that weighed the balance down on the fatal side. My third case which I have classed as directly due to the labour I have referred to already as having died from Shock & Exhaustion. The question in this case at once presents itself, how far did the use of the forceps influence the fatal result? Let us see what are the facts. The patient was aged 35, had been married for seven years, and had never previously been pregnant. From the first she took a very

grave view of her position, was depressed in spirits, and frequently said "she would never get over it." The labour was a very slow tedious one, dilatation of the os during the first stage of labour being very slow and exhausting to the patient. The same remark applies to the second stage of labour. The pains were powerful but infrequent, and causing but little progress. The application of the forceps was delayed for 6 hours after complete dilatation of the os, and delivery was easily and speedily effected, little or no rupture of the perineum occurred, and only a trifling quantity of haemorrhage. One point in reference to the use of the forceps in this case is that they were applied unknown to the patient herself, so that they cannot have had any prejudicial effect, so far as I can see either upon the mind or the body. And I believe the fatal result would have occurred if the forceps had never been used. She never rallied, and died from shock and the exhaustion on the fourth day. It is still a want which every one must feel in his early mid-

wifery practice, that there should be no definite authoritative time, when we would be justified in applying the forceps. Amongst the limited number of Statistics to which I have access bearing on the subject of the frequency of the application of the forceps the very greatest divergence is found, and none state at what time the forceps were applied. Some seem to use them only in extreme cases, whilst others use them very frequently, indeed, some even maintaining the absolute necessity for their use to reduce the mortality of children at birth. This subject appears to me to be one of great importance, as the use of the forceps seems to be becoming both more general and more frequent. I trust the time will soon come when one or more of the great authorities on this subject will speak more definitely, as to the time when the forceps may and should be applied. The use of the forceps is a most important one, both from the amount of pain and suffering which they save the mother from, as well as from their effect in lessening the number of still-born children. In my series they

have been used in 30 cases and of these 21 were primiparae. With the single exception mentioned above my results have been highly satisfactory, and such as give me every confidence in considering their use as not only safe but highly desirable in every case where any of the indications for their use are present, and in future I should be inclined to use them at a much earlier period than I have done. What are the indications for their use? The first and most common is "uterine inertia", where the pains are slight or altogether absent. In cases where there is obstruction to the advance of the head - the obstruction being either rigidity of the os externum or internum, or some form of malformation of the pelvic bones. I would place next cases where the presenting part is either the face or the occipito-posterior position of the head. Further in cases of Hæmorrhage, Convulsions, Funis presentations. Of these indications my cases have generally been those where the os was fully dilated and the head making but slow or no progress from absence of, or deficiency in the expulsive

efforts. I have often been surprised in cases of this kind how easily the head advances with the aid of the forceps even when the pains appeared to be strong, but with no corresponding advance of the head. I have never applied the forceps until the Os was fully dilated, not having yet met with a case where the anterior lip did not slip back with the assistance of the finger. It might of course happen that the forceps were immediately required, and then I should not hesitate to apply the forceps even if the anterior lip had not gone back. In one case where the Os was extremely rigid and where the expulsive efforts were powerful, the Os after many hours of severe labour did not dilate more than a half despite of antiphlogistic remedies. The patient becoming exhausted I turned and effected delivery though the child was still-born. In only one other case have I turned, but that is not because I do not view the operation favourably, but because I have not had cases where I considered it advisable to perform it. It appears to me to be an operation inferior to the delivery by forceps in most of the cases

where they come into competition, on account of the increased risk to the child. It was in my opinion the only operation applicable to the two cases in which I turned. In performing this operation I do not think it necessary to do more than reverse the position of the child, leaving its expulsion to the natural efforts.

Hemorrhage after delivery is one of the most alarming accidents met with in midwifery practice, because it comes entirely unforeseen, and it may find us unprovided with the requisites necessary for its control. Of the extreme cases where the hemorrhage is so great as to result in the almost instantaneous death of the patient, I am fortunate in not having seen a case. Indeed, as has been already seen, it has but once occurred to me to see a case where the hemorrhage was to a dangerous extent. As a rule the milder remedies suffice, such as grasping the uterus externally, and applying circular friction with the hand, cold applied to the vulva by means of wet napkins, the cold douche

to the abdominal wall, or the presence of the hand inside the uterus. In my case these were successively used without producing more than a merely transitory effect. The injection of cold water into the uterus by means of a Higginson's syringe acted more powerfully, but at first the contraction was intermittent. The injection of a solution of the Liquor Ferri Perchloridi into the uterus has been much advocated by some authorities, and if the injections of water had failed in my case I was prepared to have tried its effect. Although it has been used most successfully, I can scarcely look upon it as a remedy that should be used until every other has been tried and failed. Its use seems to me to promise too many risks to sanction its adoption except in extreme cases. Ergot is of much use in mild cases, but its effect is too uncertain, and too long delayed to allow of much dependence being placed upon its use.

In Twin presentations I have attained an average success, there being two deaths in four. The result so far as the two deaths are concerned could scarcely have been

otherwise, as the cord ~~could not~~ was pulseless in both on my arrival, and therefore I had no opportunity of taking any of the usual steps to remedy the complication. That it is possible in favourable cases for labour to terminate naturally and with a living child is proved by my first case, but here the labour was very rapid from the time when the membranes ruptured to the delivery of the head. From the good result I obtained in the case in which I adopted the postural method I would be strongly inclined to give it a further trial, though I can easily foresee many circumstances that would either prevent its use, or tend to keep it from being successful. Wherever it is possible reposition of the cord should be effected either by the fingers alone, or by the fingers or a repositorium with the postural method. When this fails we should guide the cord into the part where it will be least likely to be pressed on, and, if the other conditions are favourable, the forceps applied at the earliest possible moment. Under some circumstances it may be justifiable to perform Turning, but this operation has the great objection that there

is still great danger to the child.

The management of labour, though in most cases a simple process, yet from the numberless accidents which may occur, always requires skilled attendance. These accidents have seemed to me to occur more frequently in some patients, indeed a small number never seem to have a thoroughly natural labour, now they have an abnormal presentation probably resulting in the loss of the child, at another time they have a loop of the cord down, at another they have a retained placenta, whilst many patients pass through the whole childbearing period without meeting the slightest departure from what is natural. I have adopted the usual midwifery position in this country, the patient lying on her left side. In the district in which I am practising, it has always been the custom for patients to be delivered whilst they are dressed, lying on the mattress with the bed turned up, from which position they have to be moved into bed and undressed after labour. The inconvenience of this position can only be fully understood by those who have been obliged to conform to the custom, whilst its dangers from haemorrhage ~~x~~ in the after-removing is at once apparent. I have insisted in all cases, where I have seen the patient early enough

that they should be fully uncovered with the night dress rolled up over the waist, and when they are approaching the termination of labour that they should lie on the top of their bed protected with some waterproof material. I have sometimes had some difficulty in inducing patients to follow these directions but after they have done so, I think I would have more difficulty in inducing them to revert to their old method. The difficulty of giving a prognosis as to the duration of labour is a very apparent one, in my experience the only safe rule is never to give one During the second stage of labour I have found much assistance given by bringing in the abdominal muscles to assist the propulsion of the child. When the os has become fully dilated or nearly so, and the membranes remain unruptured, I puncture them whilst a pain is advancing. If the puncture is performed at this time, it has often seemed to me to advance matters considerably, whilst if delayed until the pain is receding or during the interval of a pain, it has seemed to protract the labour. I have found it very convenient, on all occasions when I rupture the membranes, to catch the liquor amnii in a vessel as they come gushing away, thereby adding much to the comfort of the patient. Regarding the support of the perinæum, I have never seen the slightest necessity for adop-

thing such an expedient, and as I have never seen a case of rupture of the perineum beyond the most moderate extent I cannot be said to have injured my patients by failing to do so. I have in some cases seen some assistance given by gently pushing back the distended perineum during the pain, but beyond this I leave the perineum to nature. After the birth of the head the cord will frequently be found twisted round the child's neck. These are almost always cases where the second stage has been very prolonged and it has often seemed to me the only apparent cause for the delay in the birth of the child if animation is suspended I have found nothing better for inducing respiration than by performing artificial respiration by gently raising the arms above the shoulders slowly, repeating the movement at intervals, and alternating it occasionally with turning the child over on its face, so as to permit any mucus which may be lodged in the mouth or throat to run away. Having ligatured the cord with two strong threads and divided it, the delivery of the placenta is our next care. This has seemed to me to be best effected by keeping the cord on the stretch, but avoiding any dragging or pulling, and by grasping the uterus externally. Should these means fail in a short time, I then pass my hand into the uterus, and examine for any

adhesions between the placenta and the uterine wall. If these are present I seperate them and then the placenta is withdrawn. The presence of hour glass contraction is also discovered. The longer we wait before inserting the hand, the greater suffering will be caused, in many cases where the vagina is capacious the hand may be passed just after delivery without any suffering. In every case I then apply a bandage tightly round the abdomen from which patients rarely fail to express themselves as receiving much welcome support. In one district in the South East of England where some of the cases included in the series were attended, it had been the custom from time immemorial for every patient to receive from her accoucheur's hands and made by himself a mixture of a switched egg, brandy sugar & hot water, as soon as she was made comfortable. I saw no bad result from the plan myself, nor could I learn that any harm had ever resulted, but I can scarcely look upon it as a plan to be followed in every case. Beyond any cases of Phlegmasia Dolens, and Pulmonal Embolism I am glad I have no other complications to record as having been met with after the first few hours after delivery. My plan has been to enforce perfect rest, and quiet for the first week after parturition and to this and to early and constant attention to the state of the bowels, I attribute this successful result.