GRADUATION THESIS

FOR THE

DEGREE OF M.D.

BY

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An analytical review of 350 consecutive cases of labour, with observations on the treatment of special cases

In treating and reviewing such a number of cases, I do not propose to treat of the normal and ordinary cases, which would be tedious and uninteresting, but in the first division I must take them into account, as we may derive some information from them as to frequency or otherwise of the various presentations of the foetal head, sex, mortality, &c

In division I I shall deal only with the statistical part, In division II with what I may term Special particulars, in abnormal cases or those calling for remark, with the mode of treatment adopted and the result In division III something must be said on some cases which could not fairly be considered under division II

Division I

1 General Statistics

Total number of cases attended 350

Number of children born	354	
Single births		346
Twin births		4
		350

Number of

1st	confinements attended	58	
2nd	"	"	62
3rd	"	"	47
4th	"	"	41
5th	"	"	39
6th	"	"	23
7th	"	"	21
8th	"	"	13
9th	"	"	14
10th	"	"	15
			333

333

11th confinements attended		4
12th "	"	5
13th "	"	4
14th "	"	2
15th "	"	2

17

350

The various presentations

Head cases	
1st Postion	335
2nd Position	1
3rd "	6
4th "	none
Face "	1
Breech	7
Feet	2
Arm	1
Head Arm & Funis	1

354

Sex of the infants

Males	188
Females	166

354

In the four twin births

Both males	2	
Both females	1	
One male and female	1	4

Mortality of children

Live born	333	
Dead born	21	354

Causes of Death in dead born

Craniotomy (pelvic deformity)	2
Breech presentation	2
do do (placenta praevia)	2
Feet do	2
Arm do	1
Head, Arm & Funis presentatim	1
Premature labour	4
Dead in Utero	3
Puncture of Sac in Spina Bifida	1
Ruptibre of Uterus	1
Accidental Hoem[illegible]hage	2

21

Mortality of Mothers 2

Causes of death

Rupture of Uterus - 1

Puerperal Septicæmia 1

2

The character of the labours may be classified as follows

1 Normal or natural

2 Præternatural

The latter are again divided into

Præternatural { 1 Difficult
2 Complicated
3 Difficult & Complicated

Natural cases	318
Præternatural cases	32
	350

Then we take the præternatural cases and tabulate them in detail

1 Difficult		
Deformed Pelvis	3	
Contraction of pelvic brim	4	
Inertia Uteri	7	
Rigidity of Perinaeum	2	
Ossified Head	1	
Arm Presentation	1	18
2 Complicated		
Accidental Haemorrhage	3	
Prolapse of Funis	2	
Retained Placenta	1	
Ruptured Perinaeum	2	
Puerperal Mania	1	9
3 Complicated & Difficult		
Deformed Pelvis	3	
Placenta Praevia	2	5
		32

Division II

Here I propose to deal only with reference to those cases enumerated under heading B or 2 viz praeternatural cases, as although among the natural cases, there were some which had some points of interest, and some instructive as to the value of external manipulation as urged by Dr. Braxton Hicks, it will be better to consider any of those natural cases under the third division. The cases under the heading praeternatural will be enough for the present purpose.

I will take the cases in the order as in the last table - Thus —

Deformed Pelvis - 3

1 E. S at 32 in her 7th confinement here there was great deformity of the pelvis, chiefly in left oblique diameter (patient was of marked scrofulous diathesis) After waiting for some hours, and the

Os Uteri remaining fully dilated, and head on the brim of pelvis, and no progress resulting and patient becoming exhausted, and the pulse showing signs of collapse. I gave her Brandy, and then applied the long forceps They were fixed with great difficulty, & only after I got one of the female attendants into the proper manner of fixing the head of child from the abdomen. I had to use considerable traction to bring the head through the pelvic cavity, but by slightly turning the head towards the right oblique diameter, I succeeded in getting the head born, after which the shoulders and trunk quickly followed.
The head of the child was much elongated and misshapen, but by inducing respiration by slapping and Sylvester's method as for drowning
The child eventually began to cry lustily

Placenta soon followed the trunk.
There was no undue hæmorrhage. as the
Uterus contracted firmly
Both mother and child did well

2.

E. P æt 19. in her 2nd confinement,
Os Uteri had been dilated six hours
the pains were very short and at long
intervals, and on my returning to
the case, and finding the head had not
progressed any for about four hours,
I carefully examined the pelvis, and
found some slight deformity -
a narrowing from side to side -
I then introduced the long forceps, and
by steady traction, the child was born in
about 20 minutes. the child fortunately
was slightly under the average size,
There was a rather severe post partum
hæmorrhage, with some difficulty owing

to hour glass contraction, I introduced my hand, and found the placenta adherent by posterior edge of the fundus, and to the right side, which I managed to detach, and bring away, then I kneaded the womb outside, at the same time giving a one drachm dose of Ergot, when the hæmorrhage soon ceased, and did not recur. Both mother & child did well

3

L F æt 34 in her 1st confinement
This patient had Spinal deformity or humpback. I examined her during pregnancy, and came to the conclusion that owing to deformity, it would be at least a safe precaution to induce premature labour. When she had gone nearly eight months in pregnancy, I proceeded to induce labour by passing a bougie into the womb, to the extent of five or

Six inches, and leaving it there. Labour pains came on in 17 hours after. I found labour to proceed quite naturally, but as the Os Uteri became fully dilated, I found the head becoming wedged, but in this case I did not wait until exhaustion set in, but applied the long forceps at once, and by traction well back to the perinæum I got her delivered quite safely.

In this case although there was considerable deformity in the spine, there was only a slight twisting to the right, of the pelvis which caused a narrowing of the left oblique diameter

Mother and Child did well.

In both "no" 1 and 2 it would have been better not to have waited quite so long as the women, had not the same help to give to the medical attendant, which they otherwise, would have had

The next four cases are put under a separate heading from the last three, as these are cases where the deformity is greater than in the three preceding cases, and more referable to the brim alone.

Contraction of Pelvic brim – 4

1

F. S aet 37 in her 1st confinement, had been in labour 26 hours. The Os Uteri was fully dilated. Head above brim for some hours, without any progress made Conjugate diameter narrow relatively, but the whole brim was smaller than usual. Had to apply pressure outside to Uterus in order to fix the head. applied long forceps. Child large. Placenta found to be adherent to fundus and had to be detached, and external manipulations kept up to induce Uterus to contract firmly. Patient eventually did well, child also recovered from tedious birth

she had been delivered 6 times before by the forceps, and three times delivery had been premature

2

C F aet 24 in first confinement. Os Uteri had been dilated three hours. Head wedged in the brim, notwithstanding strong labour pains there was no progress. It was only with great difficulty that the forceps could be passed at all as the head was so wedged The promontory of the Sacrum projecting unduly forwards. The labour pains were strong and frequent. After I got the forceps locked, I made steady traction for over forty minutes, when I succeeded in delivering. The child was dead. Mother recovered rapidly

3

C W aet 23 in her third confinement Here there was only slight diminution of the antero-posterior diameter by tilting

forwards of sacral promontory, Os Uteri had been dilated four hours, head above brim, not much progress being made, notwithstanding frequent and strong pains Applied long forceps to engage head in the brim, kept up steady traction for a long time, the head became moulded and became long and pointed "sugar loaf moulding" drawn out as it were. Head of child large Mother and child did well

4

M J aet 31 in her 5th confinement. Had allowed herself to go the full time on this pregnancy. Been in labour with strong pains for 13 hours. Liquor Amnii had all escaped, parts hot and dry; been no progress for three or four hours. Pains began to get weaker, and signs of exhaustion set in as quickened pulse, skin hot & dry and hiccup, and some slight delirium

found head in second position, brim contracted in the conjugate diameter. Put on a tight body binder, and applied the forceps, and effected delivery.

Previous labours had been instrumental Mother and child well, though at first had to combat exhaustion of the mother by stimulants In this case also the forceps had been delayed too long, but patient had a fear of them and begged for delay, which I foolishly complied with.

Inertia Uteri.

1 S.S. æt 18 in her first confinement, had been in labour over 24 hours, Os Uteri dilated for over an hour, there were no forcing pains sufficient to expel the foetus. I determined to apply the forceps, and gave at the time of applying them a drachm of Ergot with some Spirits of Ammonia, and then delivered her

as soon as I had separated the child, I grasped the Uterine wall through the abdomen, and pressed and squeezed until I felt the Uterus contracting and becoming firm under my hands. By this time the Ergot began to act, and as the pulse became slow and regular, I took away the placenta and bound her up, There was no flooding

2 M. B aet 25 in her fourth confinement been in labour three days, with only weak but frequent pains. After Os Uteri was widely dilated and quite relaxed, there seemed to be no progress made by the head. The vertex presented in the 3rd position, and was engaged in the pelvic brim. The patient whose three previous labours had all been difficult, was much exhausted, and at her urgent request I sent for my forceps and applied them, and a large child

was extracted. Shortly afterwards, violent hæmorrhage came on, and as the cord was very thin, and placenta did not yield to traction; I introduced my hand into the Uterus and removed the placenta, (which was normally situated), when the Uterus contracted satisfactorily and the hæmorrhage entirely ceased. Mother & child did well

3 E W æt 38 in her fifth confinement Os Uteri had been dilated several hours, and head on perinæum; frequent and ineffectual pains, patient getting exhausted parts dry. applied forceps and child easily extracted. Uterus contracted well under the influence of Ergot.
Child was still born

4 M. S æt 26 in her second confinement In labour three days. Os Uteri dilated

several hours, little progress. Applied forceps delivered and found funis twice round child's neck, and had evidently been dragging, as there was quite a depression round neck under the cord. There was no undue hæmorrhage. Child was still born

5 ' P. R. æt 29 in her fourth confinement In labour 22 hours, ~~patient~~ patient suffering from Phthisis, and as Os Uteri had been dilated one hour, I delivered her by forceps to save patient any further exhaustion. Mother and child did well, Mother died of the organic disease some few months after

6 L. G. æt 37 in her seventh confinement In labour 28 hours. Os Uteri dilated some two hours, and as there was too much hæmorrhage, I delivered at once by forceps. Mother and child did well

1 C. J æt 27 in her second confinement patient was in a state of nervous fear. In labour a day and a half, Os Uteri dilated about one hour, I introduced the forceps without the knowledge of the patient, until I began to make traction, when I delivered quickly and easily, as external parts were favourable to quick delivery

In uterine inertia one must in this as in any other case, first find out the cause whether it is in regard to size of fœtus or malposition, or whether it may be from uterine fibres being overstretched by too much amniotic fluid, or somethings inherent in the Uterus itself, as thin muscular walls, weakness of Uterus, as in Phthisical Mother exhausting diseases in the woman.
What the accoucheur has to do is to effect delivery, and get contraction of the Uterus

when inertia is clearly diagnosed, I should advocate slow delivery by forceps, at the same time in majority of cases giving an oxytoxic as Ergot, and combining with these the external manipulation of the Uterus by well regulated pressure and kneading. Of course in these cases, as much rest as possible afterwards is a necessity for a good convalescence

Rigidity of Perinæum - 2

1 In B oct 28 in her first confinement. Head remained on Perinæum without much progress for nearly five hours, although the pains were moderate in character.

As there were some objections by friends of patient to instruments being used, I rubbed in Vaseline and warm water alternately, but as I expected to very little purpose, but it satisfied the friends. I then applied forceps and made

~~and made~~ steady traction, and as soon as I got part of head through I unlocked the forceps to allow of head stretching gradually the perineal body, so as to reduce rupture of perineum to a minimum, It was soon born with a little tearing of perineum but only to a small extent
Mother and child did well

2 A E M aet 20 in her first confinement Head well down on perineum for two hours there was considerable moulding of fœtal head (sugar loaf moulding). In this case instead of waiting long as in last case. I incised by an > incision thus, and as pains were frequent the head pushed through easily and merely made the incisions gape widely, but did little harm besides, as the two incisions were at an obtuse angle, from before backwards, to the straight line

or raphe of perineum.
The next day the incisions could scarcely be detected. This proceeding obviated use of forceps, and the liability thereby of ruptured perineum

In rigidity of perineum, I am quite sure there is no good but harm done by the so-called "supporting the perineum" and in many cases the use of forceps induces rupture, but less so if used & traction made in the axis of outlet. I think the oblique incisions in most cases would be the best method of effecting delivery, and in my experience after the labour is over there is little of the two incisions to be seen, and the Sphincter Ani is kept free from harm all the after treatment which may be needed on account of the incisions, is to keep the legs as close together as may be comfortable

Ossified Head 1

M a H æt 26 in her first confinement She had perceived labour coming on for four days. She had acute pain in hypogastrium most of that period. Had occasional forcing pains for eleven hours. The membranes been spontaneously ruptured three hours. Os Uteri of the size of a florin, soft and cushiony. Vertex presenting in right oblique diameter of pelvis: bones of head hard & firmly ossified. The patients sufferings appeared so great as almost to amount to frenzy, I gave her 15 grains of Chloral Hydrate every 20 minutes until she had had three doses pain became greatly moderated, and labour terminated naturally in another hour. Child and placenta large. The bones of the head were firm, and sutures & fontanelles not near so patent as usual. Mother did well and child got on well also as long they remained under observation They moved away some few months after & were lost sight of

Arm Presentation - 1

E. O æt 28 in her first confinement When sent for she told me she was only eight months pregnant. Had been in labour about 12 hours, and membranes had spontaneously ruptured 2½ hours ago. I found the right arm presenting (palm towards Sacrum) very flaccid, and evidently belonging to a dead child, and the head apparently lying in the left iliac fossa. There was no difficulty in replacing the arm across the thorax, as the Os Uteri was fully dilated, but the arm as frequently prolapsed. after several ineffectual efforts in consequence of violent contraction of the Uterus, and cramping of my fingers, I at length was successful in singing one knee, and bringing it partially down, but from the violent contraction of Uterus, and partly from flaccidity of child was unable to effect complete

version. The water has I said before had also been coming away for 2½ hours. After a little time however to my astonishment, version occurred apparently spontaneously, both feet presented, the breech and body soon followed and I hooked down the arms with my finger, I was able without much difficulty to extract the head

The child appeared to be an eighth month's foetus, and had probably been dead several days. The placenta was expelled almost immediately after birth of child, placenta was small, pale, and bloodless.

The patient had had frequent abdominal pains for the previous fortnight, and had not during that time felt any movement of the child.

She had subsequently severe febrile disturbance and abdominal tenderness but as soon as I detected feverishness

I began with injections to vagina & Uterus of Permanganate of Potash (4grains to the ounce at first, then making a pinkish solution of it) and continued them until feverishness had gone which it soon did. It is now my invariable custom to syringe out Uterus & vagina in all cases where temperature rises above 100°. Mother did well

2 Complicated cases

Accidental Hæmorrhage 3

1. H. K. æt 24 in her fourth confinement She suffered from hæmorrhage before labour I was sent for and finding she was quite to the anticipated time, I examined for cause, and found just within the Os Uteri a small thin edge of detached placenta. I tried dilatation by the fingers, and whether through the hæmorrhage

or not, the Os dilated quickly so as to permit of my rupturing the membranes, then keeping my forefinger in vagina I lifted up anterior lip of Os until head got well down into cavity of pelvis, when hæmorrhage ceased and I allowed the labour to terminate naturally. The funis was four times round neck of child, which was still born.
Mother did well.

2 E F æt 21 in her third confinement She had repeated though not very profuse gushes of blood in the early part of labour The lower border of placenta could be felt separable from Uterus. Ruptured the membranes at once and gave a dose of Ergot, when the hæmorrhage soon ceased, and the labour terminated quickly and naturally
The placenta followed almost immediately
Child still born. Mother did well

3 H. O aet 37 on her thirteenth confinement
She was eight months pregnant. She had
been in labour upwards of twelve hours, pains
having commenced suddenly with profuse
flooding, after violent exertion in punishing
one of her children. Hæmorrhage continued
during the intervals & ceasing during the pains.
On my arrival I found the Os Uteri dilated
to the size of a shilling, membranes entire,
and vertex presenting. No portion of the
placenta could be felt. As the pains became
more frequent and forcing, the hæmorrhage
diminished, and in three hours time, the
Os having fairly dilated, I ruptured the
membranes, and the hæmorrhage entirely
ceased, and the birth of a dead child
speedily followed, followed by the placenta
The mother recovered well

Prolapse of Funis 2.

1. E L æt 29 in her seventh confinement Having gone her full time, was in the second stage of labour when I was called in and examined her. I found the vertex presenting along with a long loop of funis. I could not effect its reposition as head was well down, so I did my best to put it as much out of the way as possible Strong pains were causing labour to be much quickened and expulsion followed quickly The child was almost asphixiated, but at length restoration was effected by inducing artificial respiration

2 A. W æt 36 in her eighth confinement She had been in labour six hours, I found the head, arm and funis presenting The hand and forearm were external to vulva, and a coil of funis in vagina, and pains were

frequent and forcing, and turning was out of the question. The outlet of the pelvis being very capacious, I endeavoured to push the hand and forearm into vagina so as to allow the vertex to come into view. After some twenty minutes perseverance I was enabled to do this, when down came a coil of funis, and head came into position. I placed the loop of funis near the soft perineum, as least in danger. After a short time the head was born, the child was still born, though I persevered with artificial respiration for a long time.

The mother did well

Retained Placenta

E B oct 24 in her third confinement she had gone her full time, and the child was born quite naturally. The placenta remained in Utero, notwithstanding frequent bearing down pains, blowing into

her hands kneading of the abdominal parietes and the womb through them, and traction cautiously applied to the cord. Hæmorrhage at length became so profuse, and the patient so exhausted, that I delayed no longer, and introducing my hand, I found the placenta normally situated, and a portion of it firmly adherent to the anterior part of the fundus uteri. This portion having been gradually peeled away. I was able to grasp and extract the placenta at the same time pressing the wall of Uterus between my two hands one being on the abdomen.
The Uterus contracted firmly. The patient stated the she had had a fall two months before her confinement

Ruptured Perineum 2

J. J. æt 22 in her first confinement She was at her full time. Perineum was very rigid, outlet of pelvis small,

elasticity of soft parts seemed wanting and on introducing even three fingers, there was a feeling of tightness. Expulsive pains sharp and frequent, told patient to give over bearing down, and not to help the pains, but to cry out, to do all in her power to loosen effect of pains. In spite of all this, the head was forced through, causing a slight rupture, extending nearly to the sphincter ani. Two hours after delivery I introduced a silk worm gut ligature to approximate the torn edges, Union soon took place The catheter had to be used three times a day for three days, and the bowels kept quiet. Mother and child did well She felt no bad effects from the rupture as the perineal body was quite healed

2 M A aet 23, in her second confinement She had gone the full time, on making

an examination I found the Os fully dilated and head coming well down, but to my great astonishment and what added much to my anxiety and responsibility I found only the external sphincter ani patent and that only by about half its number of fibres while the rest ~~of the~~ of anterior wall of rectum ~~or~~ posterior part of vagina was wanting for about $\frac{3}{4}$ of an inch forming a large recto-vaginal fistula, this did not tend to allay my fears. I got a history of instrumental labour in first confinement, and the medical attendant had introduced his hand immediately to bring away placenta. She complained of his roughness: She felt something give way at the time he introduced his hand which was very large. Between the two confinements, she had had a deal of trouble, in not being able to retain

her motions except when she was very costive
When I found them matters in this condition,
I at once proceeded to put her under chloroform
and delivered her with some rupturing even
of ~~the~~ a few of the remaining fibres.
Mother and child did well

I operated on this woman subsequently
treating it as a bad case of ruptured
perineum, it will be found described
in the third division of this Thesis

Puerperal Mania

H. B aet 42 in her ninth confinement
She had a tedious labour, Ten minutes
after removal of placenta, she became
unconscious ~~without~~ without any warning at all
She began starting up, eyes fixed & staring
and calling out some incoherent sentences
but unable to answer questions rationally

She remained in this state about two hours. Pulse slow and full, skin perspiring freely. Got her to swallow Tinct Opii and Spt Amm Arom aa 3ss in a little water. This was followed by a quiet sleep of two hours duration when she awoke I followed by giving her a mixture containing Bromide of Potash and Belladonna. After which there were intervals of consciousness, which soon became more frequent, she rapidly improved. In thirty hours the delirium had ceased, and she complained only of headache
There was no relapse.

3 Difficult & Complicated

Deformed Pelvis 3

1 E. P Aet 24 in her second confinement Unfortunately she had been allowed to go her full time. She had been in labour

30 hours, when I was sent for to consult with the practitioner who was in attendance I found the Os Uteri fully dilated, head in first position above pelvic brim, which was much contracted, owing to great projection of sacral promontory, as near as I could measure the antero-posterior diameter was about three inches or perhaps a trifle over.
The membranes having been ruptured and the bladder emptied, and seen that the rectum was clear I applied the long forceps but only slight progress was made by moderate and steady traction. I then put her slightly under the influence of chloroform & tried again but to no purpose. I then left the house directing the medical man to keep up some little traction, while I went home. I returned shortly with my bag and finding no progress, we decided upon performing Craniotomy. After perforating

and breaking up the brain substance, and causing the cranial bones to collapse, the foetus being steadied by pressure through the abdomen, and taking care to perforate in several directions, and endeavouring as well as I was able to break or stir up the base of the brain. Then passed in craniotomy forceps and broke up the bones and by traction brought away most of parietal bones guiding them with my fingers. Then applying them again we removed some of frontal bones, reapplying them. I pushed up the frontal part of the head, and by traction managed to get base of skull through brim. Keeping the frontal part of head pushed up with chin on of foetus on sternum, and making traction I managed to get the head born, as outlet was capacious. The cord was around the neck of child. This having been severed, the shoulders were born by firm

traction with a towel around the neck of child. Placenta came naturally in about 20 minutes after. The Uterus contracted firmly. The mother had a rather long convalescence, but ultimately did well

2. M. W aet 24 in her seventh confinement When first seen she had been in labour with strong sharp pains for about three hours, and had had occasional pains during the previous day. About five hours after my first going the Os Uteri was dilated to the size of a crown piece, the anterior lip thickened, the posterior lip was thickened, indurated, irregular and somewhat nodulated. The Sacral promontory projected far into pelvis and there was some flattening of bones about pubes. The head presented above brim, membranes unruptured. Nine hours after this the membranes ruptured spontaneously

six hours after this again, no progress had been made by the head, nor had the Os Uteri dilated any more. Pains were occurring every fifteen minutes, but becoming weaker than before. Four hours after this I then determined to wait no longer, I gave her chloroform, and got her deeply under, and tried the long forceps, but with little result. I ought to mention that on measuring the brim of pelvis, the antero-posterior diameter was barely three inches and as the parts were very dry all the amniotic fluid having escaped, I judged that by turning, there would be danger of injury to Uterus, even if I could have effected turning, which I much doubted I then decided on Craniotomy, and proceeded as in last recorded case, and effected delivery. After the birth of the child, haemorrhage came on

rather profusely, and as the placenta was not expelled in twenty minutes, I introduced my hand, but found great difficulty to get knuckles passed, but was not able to draw down the placenta, as I could not pass my fingers high enough owing to the deformity of pelvis, I withdrew my hand and gave patient a dose of bygot, and then syringed out Uterus with two pints of watery solution of Condy's Fluid to check haemorrhage, while an assistant was kneading and pressing the Uterus externally. On again making traction by the cord with two fingers introduced to act as a pulley, I was successful in extracting it. Haemorrhage then ceased, and did not recur, the womb contracting firmly.

The patient was convalescent in ten days

3 M. J. R æt 28 in her third confinement
The patient came and saw me when she was
about five months pregnant. She gave me a
history of two previous labours being exstremely
difficult, and turning having been resorted to.
Her family doctor had told her there was some
bony formation in the pelvis, an osseous
tumour. From the general history which she
gave me, I recommended her to have
labour induced after the seven months period.
When she judged herself at the period resolved
upon she called upon me when I arranged
with her the time &c. I proceeded to induce
by passing the sound very cautiously and
after passing it up for some distance. I withdrew
it, and passed up a bougie, and left it in
next day labour pains came on.
I took with me on my visits all the
appliances which I thought might be
required. When Dr was sufficiently

dilated, I introduced my hand as well as I was able and explored the whole cavity of pelvis, and certainly found a marked projection of sacral promontory, but no osseous tumour as I could detect, and as the antero-posterior diameter seemed a little over three inches I decided on turning, with some difficulty I contrived to turn the foetus, by the combined external and internal manipulation method and when the foot came within reach, I brought it down, and held it until another pain came on, when I allowed labour to proceed of itself for a short time, until head got engaged in the brim, I kept up steady traction for over an hour, I tried to get on the forceps over the shoulders, but could not do so, however in a little time longer by pulling at the shoulders and getting the arms down, I succeeded in getting the head into

the cavity of the pelvis, whence delivery was soon effected. The child lived a little time, and as heart seemed getting weaker, I severed the cord, to allow blood to flow to relieve the heart by that means, but as it did not seem to do so, I tied it & separated the child and tried every means of resuscitation but all to no purpose, it was practically still born. The mother did well

In all these cases where turning is out of the question, and simple perforation is not sufficient, though I should say in most cases perforation followed by collapse of cranial bones will be found sufficient to allow of passage of foetal head, the question arises in one's mind Craniotomy or Cephalotripsy which shall it be? much has been written on these two points and their relative advantages and although the weight of evidence, seems

to be in favour of Cephalotripsy and although knowing this, I used the Blaniotomy forceps as I was more familiar with them, having seen my old master use them, and being instructed by him as to their use, when a pupil under him In any other cases I may have meant to try for myself the advantages of both methods

Placenta Prævia 2

1 C. S æt 23 in her second confinement She was in the eighth month of pregnancy. She stated that while straining at stool a gush of blood came from the womb without pain or warning, and oozing had continued for about three hours. On examination the Os Uteri would just admit the tips of two fingers. Within the Os, the placenta could be felt extending in all directions, as the pains and dilatation increased, hæmorrhage became more profuse. I drew off the urine

and passed my hand into the vagina, and swept my forefinger as far round the inside of the Os as I could reach, thus separating the placenta by that extent, by doing this I found a thin edge of placenta not far from anterior lip of Os Uteri, It had extensive adhesion to posterior and lateral parts of lower segment of Uterus & cervix, As the hæmorrhage was now very great, I bared my arm I passed hand in again, in direction of placental edge and finding I pushed fingers through the membranes, I found the breech presenting As the waters could not escape owing to my arm, I felt further until I reached one knee it was now an easy matter to hook the foot belonging to it, and on withdrawing my hand I brought foot along also, and kept up traction, until the child pelvis began to press against Os Uteri, when the hæmorrhage was checked somewhat. I now gave full

cervical zone

dose of Ergot, and keeping up traction, delivery was soon effected. The placenta followed almost immediately, but the Uterus contracted only temporarily, and shortly showed signs of filling, the body becoming large and soft, and outline of Uterus gone, and patient showing signs of exhaustion. I passed my hand again into vagina and found and removed a number of clots, and continuing my fingers into the Uterus I removed a quantity of clots I swept my hand round Uterus and used pressure with my left hand outside, and at last I felt the Uterus to respond to this stimulation, but as my invariable rule is in such cases I syringed out the Uterus with solution of Condy's Fluid, and gave the patient again two drachms of Ergot in water and applying cold cloths to vulva, and keeping her head low, I applied a firm binder around abdomen, using abdominal

pads, I felt now the Uterus firmly contracting and haemorrhage ceased Patient was so low that I found it advisable to give Brandy.
The child had apparently been dead only a short time before birth, probably through placental circulation being interfered with both by the separation and also by the pressure
The mother was convalescent in three weeks after delivery.

2 Mrs M aet 37 in her seventh confinement She was being attended to by a neighbouring practitioner, who sent for me very urgently I went, and found blood coming through the bedroom floor, and dropping freely into the sitting room below. I went upstairs and examined at once, and found placenta was presenting, and profuse flooding. I could not feel the edge of placenta on sweeping my fingers round the dilating Os Uteri and

cervical zone of Uterus. The Os was about the size of half a crown, I sent off at once for my midwifery bag, keeping my hand inserted in the meantime to act as a plug, and directed the practitioner practitioner to give her Ergot and Brandy in full doses, as soons as I could when I got them I inserted the middle size of Barnes' bags and this seemed to control the hæmorrhage a little In ten minutes I inserted the smallest bag alongside of the other, and got forceps Ke in readiness. Soon I got the smallest bag out, and put the largest size in along the side of the middle sizedone, and inflated it by warm water, after waiting some little time perhaps 15 to 20 minutes, during all this time of using the bags, hæmorrhage appeared checked. On withdrawing the bags, I found the Os Uteri well dilated but flooding very profuse again, and on passing my hand within the Os, I now found the

edge of placenta to the anterior and right side of Uterus, and made out a breech presentation, I passed my hand further and rupturing the membranes I seized hold of a foot, and brought it down, and by making steady and constant traction I soon got her delivered of all but head, which I easily delivered by the forceps.
Placenta followed in about seven minutes but flooding commenced again, which was overcome by passing in the Uterine stem belonging to Barnes bags, and injecting a great quantity of cold water into cavity of Uterus, my colleague had to continue kneading the abdomen with both hands for about half an hour, at last to our great gratification we perceived the Uterus to be contracting, and when it got hard, we put on extra pads and used great pressure by a body bandage, and keeping head low

giving her cold drinks and stimulants,
hoemorrhage did not recur,
Child of course was dead although she had
felt its movements during the same day
probably the cause of death, was the same as
in the last case.
Mother was not able to get about for
four weeks from this date.

Division III

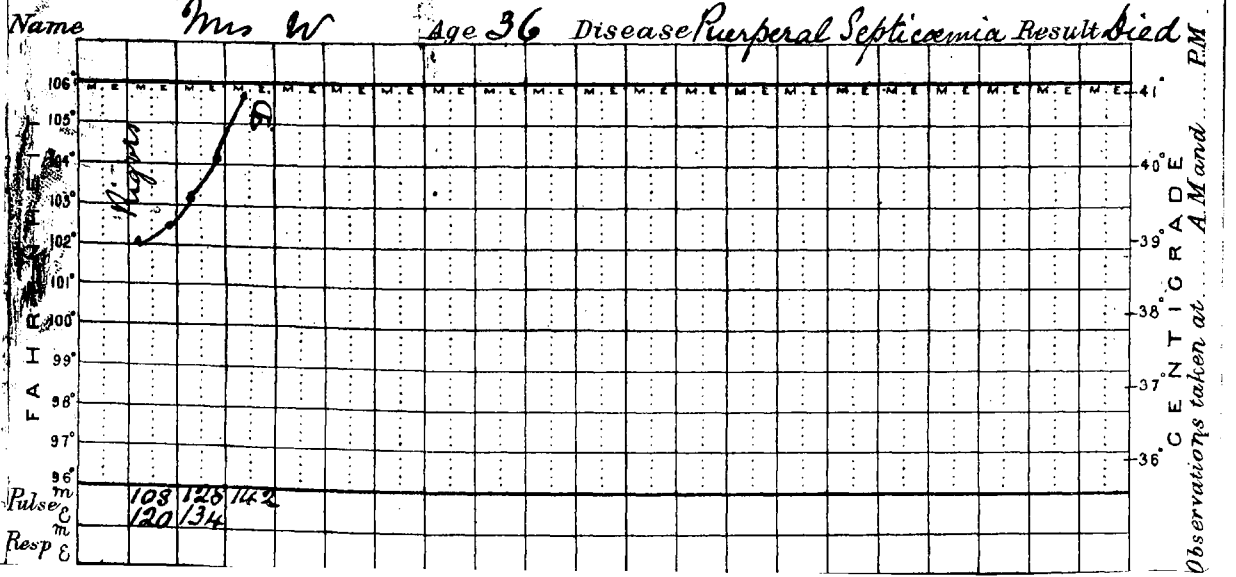
In this division I propose to deal with what I may call the puerperal state, and also obviating any untoward result which has come on through the labour, and also to make a few generalisations on what may be deduced from the experience gained in midwifery practice

Firstly I will give a history of two cases of Septicaemia following two cases of labour

1. Mrs W. æt 33 in her sixth pregnancy. This woman was weak and anæmic, and had a small family & I fear half starved herself to let children have enough, she was broken down in health, and had a care worn expression. When about Six months gone in Pregnancy, she was greatly upset in her mind, owing to a tramp having attempted rape on her daughter 9 years old, I was sent for to examine the girl, but

while in the house, I noticed Mrs W having labour pains, and had as show of blood I ordered her to bed at once, and to be kept quiet, and gave Opiates and sedatives as Potassæ Bromide &c. Yet the discharge continued, but not in any great quantity on the third day she was delivered of a six months foetus, and placenta and membranes came away quite right, some hours after on my next visit, I noticed the lochial discharge was of a dirty greenish hue, though patient herself said she felt nicely. I saw her again in two hours, when she told me she had had "rigors" and I saw she was feverish, pulse was quick, small but compressable, the temperature was 102° She complained of acute pains in her abdomen which was tender on palpation over Uterus I at once syringed out the Uterus with a solution of Condy's Fluid, this seemed to

give relief, could rest better, not quite so hot, and took fairly well of beef tea & milk, this improvement only lasted about three hours, and in the evening the temperature was 102·5° and pulse 120. I was at this time giving Salicylate of Soda with Aconite, Next morning the temperature was 103° & pulse 128 in the evening it was 104° and pulse 134 I syringed out Uterus night & morning with strong solution of Permanganate of Potash but did not now to seem to have any effect, except bringing away foetid discharge Next morning temp was 106° and pulse 142



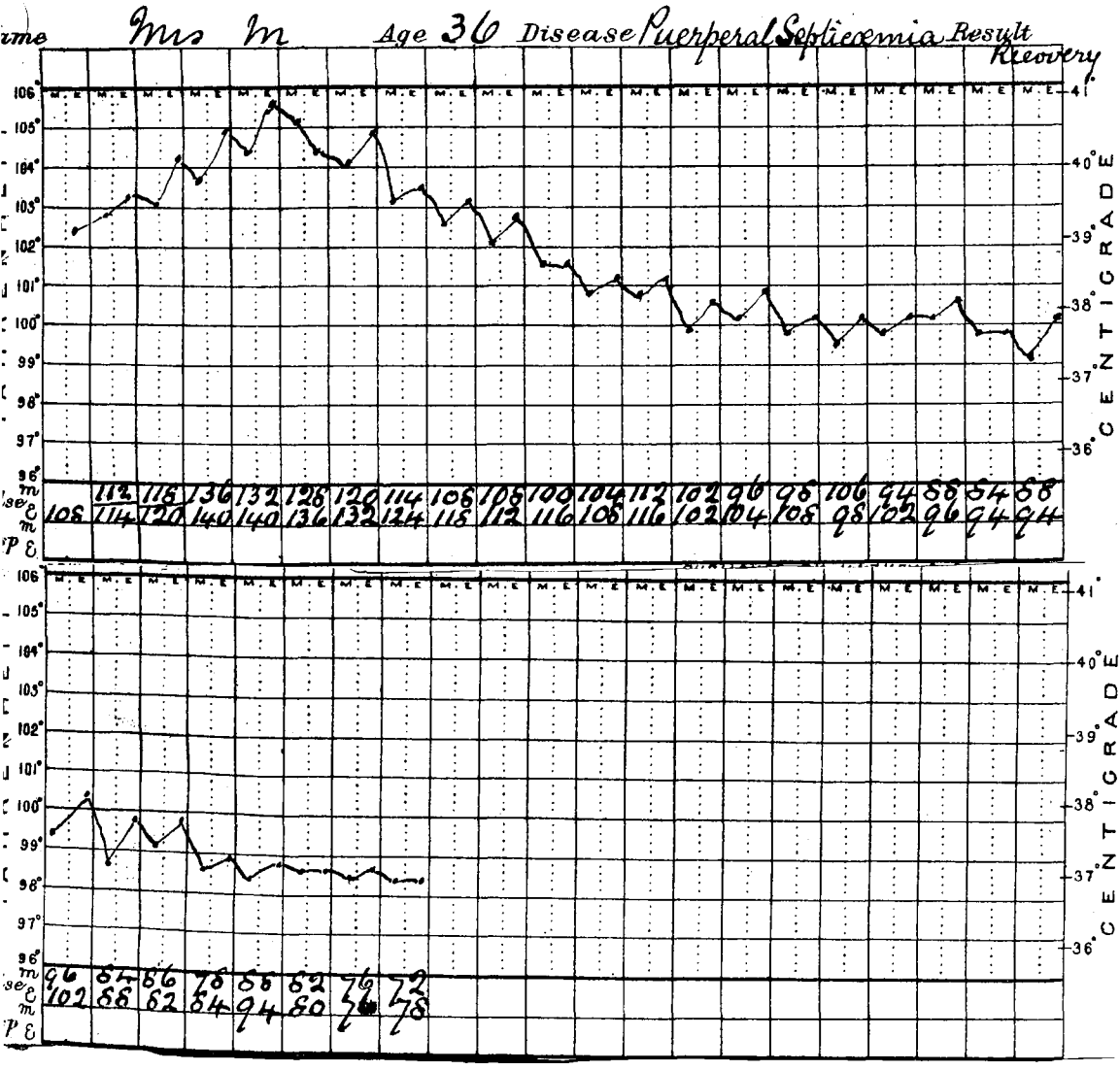
In this case, we had considerable hæmorrhage for three days, in a woman in broken health, before the fœtus was discharged, and as I could not ascertain that there was any probability of infection to account for the Septicæmia. I came to the conclusion, that it was probably auto-genetic in its origin. I account for it that in all probability the cervix Uteri was torn, and the lochial discharge, was some of it, absorbed by the blood vessels and lymphatics, and diffused through the system.

The case was remarkable that rigors should come on so soon after delivery, but considering she had been flooding a little some three days, and there being some solution of continuity of the generative track during that time. I thought that in all probability there was some endo-metritis even before delivery, but unfortunately I

had neglected to take the temperature or notes of the symptoms, being thrown off my guard in endeavouring to get the miscarriage over Drugs, and injections had little or no effect on the Septicæmia, though the first injection seemed to ameliorate the symptoms for a few hours, but unfavourable symptoms soon set in again

2 Mrs M aet 36 in her ninth confinement In this case the labour was only noteworthy for its rapidity, she was in labour only two hours altogether, and it was quite natural and patient seemed to be doing very well until 42 hours after birth of child She then had severe rigors, and complained of feeling cold, but soon complained of being feverish, I found her pulse quickened and temperature over 102°, and could not bear pressure over abdomen, and the lochial

discharge was much diminished and offensive tympanites also became a prominent Symptom and persistent sickness and hiccup. The temp still continued to rise and pulse quicker,



As soon as I saw her after the rigors, I made a careful examination of the Uterus to see if there were was any clots, or retained placenta or membranes and satisfied myself that the Uterus was emptied. I Syringed out the Uterus twice daily by a strong solution of Permanganate of Potash, sending up one pint and a half each time. This seemed to give her considerable relief, still the temperature steadily rose for a day or two until I almost despaired. During this time she was being fed exclusively on milk and lime water. I gave her also large doses of Salicylate of Soda with small doses of Aconite, but soon had to discontinue their use as it made her sick, and a twenty grain dose of Quinine affected her head greatly, so gave her simple Potass. Bicarb & adjuvants, made to effervesce with Citric Acid. This she found most grateful to her parched tongue and throat

Tympanites became early a prominent and distressing symptom, for which I ordered her Assafœtidæ pills, one every three hours, she only found partial benefit from these, I then tried an injection per rectum of Spirit of Turpentine one ounce, Tincture of Assafœtidæ one ounce and water a pint, which reduced the tympanitic distension very much, and whenever flatus was distressing, this injection was repeated and invariably with a good result.
She had unlimited quantities of ice to suck and ice bags on her head.
For the delirium at nights I found Dover's powders made into a five grain pill, one or two at night to have a very sedative effect and the above injections obviated any constipation. These brought on the disease for about a fortnight after this period the patient complained of a severe pain over the region of the ileo-cæcal valve, which was painful on pressure

On examination, much thickening and something solid could be detected, and as there were symptoms of localised peritonitis present, I came to the conclusion, that I had to do with secondary inflammation of the peritoneum, with exudation, and covering the ileo-caecal valve and immediate neighbourhood The temperature at this time was 102° but some improvement had taken place in her general condition, She could take light solid food and could sleep a little longer,
I fomented the part affected, and applied linseed poultices, but not getting as much relief as I could have liked, I applied a good sized blister 5×4 inches over the part, which gave great relief, I dressed part with Vaseline, and after two applications of Mercurial Ointment on poultices, I had simply hot poultices applied which gradually had the effect of relieving pain and causing

absorption of the effused lymph, and pain seemed to die away, At this time two the Assafetida pills seemed to be able to keep down the flatulence and tympanites, and the temperature as seen by the chart was getting lower each day. The tongue became more and more moist and clean.
Vaginal injections were continued for some fourteen days after temperature had become normal. She made a good recovery.
On inquiry into the suspected history of the case I learnt that two of her children had been in a neighbours house, in which Scarlet fever broke out directly after my patient began with rigors, but her children were not attacked at all, so that I was driven to the conclusion, that either the disease had arisen, by her children being the vehicle for the infection, or that the disease had arisen auto-genetically, but I think the former the more probable cause

The points of remark in this case as regards treatment are 1 The importance of carefully and regularly syringing out the Uterus by some antiseptic solution, 2 Great cleanliness 3 Use of injections per rectum for the relief of excessive tympanites & Some antipyretic medicine as Salicylates of Soda, Quinine, Aconite & Ice, Though in this particular case I tried the two former but had to discontinue them for reasons I have stated while the Aconite after first few days caused some slight failure in the hearts action so I had to rely as I said before on a simple saline made to effervesce with Citric Acid and which the patient found the most grateful of anything, she had had.

In the case of Ruptured Perinæum, which I mentioned in the second division, where there was a large recto-vaginal fistula, and only a few fibres of the Sphincter Ani remaining and forming a rectocele.

I wished to do the immediate operation, but the patient and her over anxious friends were greatly averse to it, and would wait and see. but after she began to get about and fulfil her household duties, she found the rectocele, and the constant bearing down very irksome & she had not much power of retaining the feces, except when she was rather constipated, and her womb falling & dragging, she found life very intolerable, as she could not go into Society or leave home except for a very short time, - She was now easily persuaded to undergo the operation, this was seven weeks after her confinement.

I had her bowels thoroughly emptied both by -

dose of Castor oil and by enema previous to operation.

After getting her well under chloroform, I put her into the Lithotomy position, my assistant looked to the chloroform part, & instructed the two women as to holding legs apart and holding speculum which latter is a modification of my own, which consists of two silvered blades joined together by a hinge so that they can be shut or open at right angles to each other and fenestrated, like the new tongue depressors one blade is a little smaller than the other so adapted for young girls or women.

I proceeded first and cut the few remaining fibres of the Sphincter Ani, and then separated the mucous membrane from the Vaginal edge for some distance, and likewise did the same with the rectum, in a word made a raw surface of the whole of the perineal body with the scalpel, and after revivifying the two sides

including the fistula, I closed the fistula
first by three sutures, and then passed in
four deep sutures, until I came down to the
Sphincter then relaxing legs a little, I introduced
four superficial sutures, I did it all under the
influence of the Spray, then dressed the part
with pads of antiseptic lint, tied up the
knees, together and got her back into bed
The needles used were the ordinary curved
surgical needles, and the sutures were strong
silkworm gut steeped in Carbolic oil 1 in 40
The haemorrhage was very slight throughout
In six hours after I called again, and drew off
her urine, there was only slight rise in temperature
I gave her half grain morphia pills to rest her &
to keep the bowels confined for four days.
I syringed out the vagina twice daily with a
solution of Permanganate of Potash, and dressed
with antiseptic lint & Iodoform.
There was only a trace of pus from beginning to end

On the fourth day I gave her by the mouth a
misture very common in this part, which
consists of Sulphur, Cream of Tartar & Treacle
and which certainly causes the faeces to become
very soft, so as not to stretch the newly healed
parts, though it has the disadvantage of
causing a noxious smell, and tarnishing any
metal worn by the patient, a little after I
ordered this misture I told an attendant to
give a soapy water enema to wash out rectum,
and the sulphur brought away soft motions
so that the parts were not put on the stretch
much, and healing process went on
On the seventh day I removed the fistula sutures
and next day I removed all the remainder
when I found union had occurred throughout
and there was not the least sign of irritation
or soreness. As a matter of precaution I still
kept her knees slightly tied and was careful both
in having vagina syringed out every day and even

second day the sulphur mixture, on the 13th day she was up and came downstairs, and on the 15th day was able to walk out.
Three months afterwards I found there was no fistula, no bearing down, and of course no recto-cele, and as she expressed herself, she never felt better in her life than she was then

The next case I should like to mention is the one of Puncture of Sac in Spina Bifida -
The mother had had a very bad time during the whole of her pregnancy, with sickness darting pains, haemorrhoids &c,
The labour proceeded easily and normally until after the head was born, when I found there was some impediment to delivery, on examining to see what it was I detected a bladder like substance pressing on the pubes, on further examination I found it continuous with the line of the

spine, and as the cervical part was somewhat deficient, though not open, it then occurred to me that it was a case of Spina Bifida, though I had never had such a case before.
As no progress was being made I decided to puncture the Sac, and let out the fluid, which I did by a sharp pointed probe, when I should think about six ounces of fluid came away. I now had no difficulty in completing delivery. The Sac was protruding through a deficiency in the spinous processes of the 2nd and 3rd lumbar vertebræ, it was almost as large as the infants head, and was extremely thin, and deeply purple, so that I felt some justification for having punctured, and thus lost all chance of saving its life, as even if I could have completed labour without puncturing,

which I did not think possible, I do not think there would have been much probability of child surviving birth
The sac had a broad base.

Ruptured Uterus

E. J. aet 28 in her third confinement I was sent for urgently one night to attend this woman as labour pains were severe when I arrived she told me pains were quick, strong and violent, and there was great heat in lower part of abdomen & in vagina, and that the waters felt to scald her.
I requested her to lay down on the bed and had just made a digital examination and found Os Uteri fully dilated, extremely tender, and the vagina and amniotic fluid felt to almost scald my fingers and was just remarking upon it to my

patient, when she gave a loud piercing shriek, and gasped two or three times and died. As I had been in the house barely five minutes, I did not feel justified in giving a death certificate, so I got to make a "post mortem" for the coroner, some thirty hours after death,. The Uterus had torn asunder for over five inches anteriorly from the cervix upwards -and to the left of middle line.
There was a great quantity of extravasated blood in the pelvis and peritoneal cavity The head of foetus was wedged in the cavity of pelvis and was in the 1st position The Uterus showed extensive signs of inflammation, great redness, mucous membranes very thick, vascular & spongy the whole substance of the wall of the Uterus was very soft, and tore easily on handling the parts. The placenta

was still adherent in part to the fundus Uteri, but torn in other parts along with the rupture of Uterine wall, the placenta was also very soft.
Under the microscope, the tissues appeared to be undergoing "fatty degeneration" as there were fine granules of fat in cells, which had great refraction, and the number of them was very great in the field of the microscope I came to the conclusion that it was a case of endo-metritis, with extension of inflammation to the muscular wall, & along with this, a tendency to anticipation of the natural process of involution of the Uterus, causing a softening of tissues these acting as predisposing causes, the exciting cause of rupture being the violence and severity of the pains.
There had been no ergot given to her.
I did not deliver the foetus for the

following reasons. The suddenness of the death, five minutes after my arrival. The head being low down into the cavity of the pelvis, and being sent for in a hurry, I had gone without my forceps or any other instruments, and by the time I could have got them, the child would have been dead, and head being low down "turning" was out of the question. I had attended the woman before on three separate occasions for miscarriage in the twelve months preceding her becoming this last time pregnant, and this of itself would cause much hypertrophy and probable weakening of the muscular walls and although it did not admit of proof it was well known the husband of the woman was in the habit of using violence to her, and there may have been blows or falls to account for the setting up of the

endo-metritis

This case was of so uncommon a nature, and one to cause a severe shock in a medical attendant's mind, as it did in mine that I deem it worthy of record, and having had the good fortune to make a post-mortem, I was able to follow up the case pathologically.

In theory we are given various signs and symptoms of threatened Rupture of Uterus, and it's treatment when it does occur, but it seems to me, there are no reliable signs of themselves, and are at best very indefinite, and the appalling catastrophe comes upon one suddenly, when it is then a case of what resources a man has got in him, combined with some amount of experience in midwifery in general, and each case must be treated according to it's individual characteristics

Conclusion

The great lessons which may be gathered from the foregoing cases are, That while in ordinary cases of labour, where no difficulties present themselves, it is best to interfere as little as possible, except by putting woman in a good position, and cheering her, and perhaps rectifying as I often do any retroflexion. Yet in all cases of difficulty whether it may be owing to pelvic deformity, Uterine inertia, or any cause in soft parts of pelvis in fact in all abnormal cases, there is nothing to be gained by waiting & trusting to the so called "natural forces" or as old nurses say "let nature have it's time" but that is true conservation, which helps, and guides the natural forces and interferes or rather supplements nature by the aid of manual & mechanical efforts whether it be by turning, incising perineum

rupturing tough membrances, or abviating any impediment in soft parts, or by the help of any of the varied instruments, which may be called into requisition, as each case may seem to warrant, as the most important point to aim at in my opinion is to save the mother first, and the child after, though in majority of cases, by judicious help, we give both mother and child the best chance of survival

I have been called in consultation to many cases, where a medical man has been a disciple of the "expectant" or "trusting to nature" doctrine, and have found the woman in almost the last stage of exhaustion, and in a majority of cases the foetus dead or nearly so, when by an earlier resort to operative or accelerative measures, the child might have been saved, and the mother's

strength and energy preserved, instead of having a helpless, exhausted patient to deal with, and a long and tedious convalescence, with a train of troubles to follow, in the shape of Uterine diseases as leucorrhœa, and "bearing down pains" and frequently mal-positions of the Uterus Thus I repeat again that it is best from the patients point of view, not to wait too long in any difficult case of labour, but to give what help may be needed or required sufficiently early, while the woman has her strength and energy, when she can best second the efforts made by the Accoucheur in her behalf