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On

Septicaemia

during

The Puerperal Period

by

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In the following pages I have not given a full account of the different forms of Septicaemia which may follow Child-birth.
I have recorded as briefly as possible, a number of cases attended by me. Some in the epidemic, others in the sporadic form. Some undoubtedly contagious. others very little so, or absolutely non contagious.
After pointing out, what I consider as the interesting features of these cases, I will then give the opinions and conclusions I have arrived at; and finally, state what I consider to be the best plan of treatment of that epidemic form of Septicaemia. commonly called Puerperal Fever. when such a large percentage of cases end in death.
Soon after commencing practice, I had to attend several cases of Puerperal Fever. in its most malignant form. The severity of the symptoms. the failure of the treatment adopted and the fearful mortality. all convinced me that I was dealing with one of the most formidable, fatal maladies, we are called upon to attend, and treat.
The anxiety that these cases gave rise to was great, not only on account of the severity of the symptoms.

followed by fatal results. but also because I had been the carrier of some peculiar poison which had produced a disease in several patients I had attended during their labours
The mischief was done, before I was aware that I was spreading a fatal contagious disease.
As soon as I knew that this was the case, I ceased attending midwifery patients. Still the idea that I had carried a poison which had produced fatal results was not pleasant and made a deep, lasting impression on my mind.
From that time on to the present I have attended several other cases of Septicaemia following child-birth.
After I describe these cases it will be seen that several differed very much from each other both in symptoms. contagious properties, and results.
I will describe in the first place the cases I have attended which occurred in the epidemic form and in the second place will describe several interesting sporadic cases.
In the Summer of 1874. I attended a primipara

under the following circumstances.
She had engaged a medical man to attend her.
and not long after her labour commenced she
called him in.
He made a Vaginal examination & concluded
that her labour would be very tedious.
He had a full list of patients at the time, and had
quite enough to do, & attend properly to them.
Such being the case. he advised the patient, and
her friends to call in another medical man.
within two hours after he left; I was called in
and as he had predicted, the patient had a
tedious, & difficult labour. I went back & forward
to the case for twenty four hours. and at last
delivered her with the forceps. on account of
rigid perineum, & narrow outlet.
It took some considerable time to deliver her, as
the outlet was very narrow. The soft parts
very undilatable
as far as I could judge the perineum was
very little injured.
The placenta & its membranes were expelled by
natural efforts, & appeared to be entire. the

uterus contracted firmly, and there was no post partum haemorrhage -
The patient was very exhausted, but not more than might have expected after such a long and difficult labour. So that taking everything into consideration I was well satisfied as to her condition when I left her, an hour after the termination of labour -
I drove at once from this case, and attended a multipara who had a quick, natural labour -
From this second case I went off to a third.
This patient who was a primipara - was delivered shortly after my arrival.
I waited a considerable time for the placenta but as it remained high up in the uterus, I carefully introduced my hand. found it adhering, and had to remove it.
The time consumed in the attendance of these three cases. And by this I mean. from the birth in the first to that of the third - was not more than three hours.
On the third day after this I attended a multipara who had a quick natural labour -

On the fourth day, early in the morning I attended a multipara who had a quick, or it might even be called a precipitate labour. and during the afternoon of the same day, I attended a primipara, who had a fairly quick, natural labour.
On the fifth day I attended a primipara who had a very tedious, but otherwise natural labour.
It will be observed that altogether I attended seven cases at this time. viz. three on the first: one on the third, two on the fourth. & one on the fifth days. After this I attended no more cases for a considerable period.
In order to get at the source of the contagion I must state what occurred in the practice of the medical gentleman, who had been engaged to attend. I actually did make a vaginal examination in the first case of the series I have mentioned
at the time he made this Vaginal examination several of his confinements must have been ill with Puerperal Fever. because, within two days from this, two or more of his patients.

died - how many patients he lost during the week that followed I cannot now say but I know that the mortality was dreadful - All my previous confinements were doing well, and I was not aware of having been exposed to any possible contagion prior to this.
My first patient did well till the morning of the third day after delivery, when I visited her, then. I found that she had been seized with severe rigors during the night, followed by acute abdominal pain. She was extremely ill. The pulse was very rapid - & it is in puerperal cases that the pulse seems to beat its fastest. The temperature was high. There was constant vomiting, and the bowels were constipated. She could hardly bear the slightest touch on the abdominal walls, especially in the pelvic region over the uterus - the lochial discharge had ceased. The patient was greatly prostrated, and had an anxious careworn looking countenance. which is very often present in acute febrile attacks occurring during the puerperal period. The lochial discharge returned in a few days.

it was scanty. purulent. and offensive.
otherwise the symptoms continued very much
as they had appeared on the first day of the
illness.
The patient never rallied. prostration was
becoming greater every succeeding day. and
finally she died in a state of collapse. on the
eight day after delivery. having presented
the symptoms of that form of malignant
puerperal fever. where peritonitis is a prominent
feature.
This short account is I think sufficient to show
the nature of the case. and the history of the
other six cases is briefly as follows:-
The second. & third cases attended on the same
day as the first both made good & perfect
recoveries. The first of these two was a
multipara. The second a primipara. this
last had an adherent placenta.
Neither one nor the other presented a single
bad symptom from the first to the last of my
attendance. This goes to prove that. at that time
I was quite free from contagious germs

If there had been any poison on my clothes or fingers, I would most likely have communicated it.
The patient from whose uterus I had to remove an adherent placenta was very favorably situated for receiving a poison - as my hand had come freely into contact with the raw placental surface of her uterus.
The fourth case, it will be remembered, was a multipara attended on the third day. She had a quick, natural labour, & did well for the first two days. On the morning of the third day I found her very ill. She had had rigors through the night followed by acute abdominal pain. Her other symptoms were nearly similar to those present in the first case, and after running a very similar course, was followed by death on the ninth day of the confinement.
The fifth case attended early in the morning of the fourth day was a multipara. She was roused from sleep by violent labour pains and sent at once for assistance

When I arrived shortly afterwards, I found the membranes protruding through the ostium vaginae, I ruptured these and the child was born directly, followed in a few minutes time by the expulsion of the placenta by the unaided efforts of the uterus.
This patient recovered without presenting any bad symptoms, and said herself that it was one of the quickest best recoveries she had ever experienced.
The sixth case attended on the afternoon of this same day as the last was a primipara.
She had a fairly quick natural labour. Did well for two days, when she was seized with rigors, followed by peritonitis, cessation of the lochia, & altogether an exactly similar train of symptoms, as were present in the first and fourth cases, followed by death, on the ninth or tenth day of her confinement.
The seventh and last case was a primipara who had a tedious, but natural labour.
After doing well for the first two days, she was seized with rigors, followed by peritonitis

and the other symptoms, which were present in the cases already described.
They were perhaps hardly so severe as in the other cases, at any rate they proved more amenable to treatment, & the patient eventually recovered after a long and dangerous illness.
This extended over 9 months and left her weak and anaemic, with an offensive discharge from the uterus, purulent in character which continued for a very long time afterwards.
In these cases thus briefly described there are several points of interest.
It is I think beyond doubt that I was dealing with a disease, of a highly Contagious nature.
The germs of contagion in my opinion were carried to the first case of the series, by the medical man who was engaged to attend her. & who had made a Vaginal examination, at an early period of her labour. At that time, he was attending several patients with puerperal fever, and he had deaths in his practice, before any of my cases presented symptoms. So that, at the time he made the Vaginal examination in my first

case, he was most likely infected with contagious germs
The second, and third cases did well, showing that, at that time, I was quite free from poisonous material, on my fingers, or clothes.
In the meantime the contagious poison which was very likely communicated to the first case was taking effect. and on the third day as already stated serious symptoms were present.
From this patient, I believe I carried a contagious poison to all the cases I attended afterwards, with the exception of the multipara delivered on the morning of the fourth day.
In this case it will be remembered, only a single vaginal examination was made.
I ruptured the membranes on my first only examination. The baby was born directly. and in a few minutes time, the placenta & its membranes were expelled.
There must be some reason to explain, why this patient escaped.
During the examination, I only touched her momentarily, thus in my opinion minimizing

the risk of contagion.
Frequent and long Vaginal examinations, made by a medical man whose clothes, and hands are impelled with some contagious poison, are more likely to be followed by disease in those examined, than in those cases where only a simple Vaginal examination is made.
This patient was in splendid health; might have resisted the action of the poison in any case, but I am inclined to believe that either I communicated no poison when - on account of the incomplete Vaginal examination - or if any was introduced into the Vagina, it was washed away, at the time of examination, by the flow of liquor Amnii.
Peritonitis was a prominent, & disheartening feature in this epidemic
The pain commenced in all the cases over the uterus, & quickly spread all over the abdomen -
I think there was a true Metritis in the first place, followed by peritonitis
The uterus in each case seemed at the time of death, to be more enlarged than after the termination of Labour -

No post mortem examinations were made.
So I could only judge this by feeling through
the abdominal walls.
In the patient who recovered. the uterus remained
large than it should have been, for a considerable
time afterwards.
In connection with the subject of metritis, and
peritonitis, I think that in a large Number of
the cases I have attended. a certain amount
of metritis has been present, but it has only
been in the fatal cases, that peritonitis has
appeared. So that in connection with prognosis.
I would be inclined to say, that it is in
those cases of septic poisoning following child-
birth, in which peritonitis is well marked, that
we may expect fatal results.
If peritonitis is absent even when the symptoms,
which are present are very severe. My experience
has been that such cases mostly recover.
Various remedies, & methods of treatment were
tried, but in the three fatal cases. they all seemed
useless. the abdominal pain was relieved to
a certain extent in all the cases by the continuous

application of hot fomentations
Persistent nausea & vomiting prevented the nourishments, and stimulants ordered from being retained by the stomach, all the remedies tried, seemed to be alike powerless over this symptom. The prostration which was present on the first day of the illness, after a few days was so great; that recovery became nearly an impossibility. all the patients had a common haggard expression of countenance,
Though seriously, & dangerously ill, not one seemed to realize it. Even when so weak, that they could hardly move, they all declared that they would recover.
The seventh case though attacked with this disease, recovered. Her symptoms though severe were not so bad as in the others. Vomiting was not present to such an extent, nor was there such great prostration. Her recovery was very slow & imperfect, and one year after labour when I last saw her she was suffering greatly in health from the effects of her severe illness.

The next epidemic I will describe occured in the year 1848.

Here I met with a contagious disease following Child birth, with very severe symptoms whilst they lasted, but from which all the patients recovered.

In a healthy country district I acted as locum Tenens for a medical man.

As soon as I arrived at his home, he departed leaving me on his visiting list for recent confinements.

Three of those four cases were attacked with severe and serious symptoms, a few days after the termination of labour.

The first case attended was a middle aged primipara. She had experienced a long, difficult labour. The second, third, fourth cases all had quick Natural labours. My medical friend had attended those cases in the two days preceding his departure, and when he left for his holiday no symptoms had appeared.

Three of those cases were attacked with symptoms very much alike in each. The variations were

unimportant so that one description will suffice for all.
On the third or fourth day of the confinement the patients had rigors followed by the symptoms of fever - the skin hot & dry. pulse very quick temperature very high - in one case 105° Fah. delirium, cessation of the lochial discharges - or if present scanty, and offensive. but there was neither Peritonitis, nor vomiting.
The symptoms were so severe that I gave a grave prognosis in each case
This febrile affection continued for three or four days when a distinct crisis seemed to take places. Profuse perspiration followed by the disappearance of the febrile symptoms & the return of the natural lochial discharge showed that the patients had recovered
They were weak & debilitated for some little time, but in the end made perfect recoveries
The above history applies to the first, second and fourth cases.
The third case was a multipara, a weak strumous, anaemic female. her age was 32.

This was her eleventh pregnancy, & She was suffering very much from the effects of too rapid child-bearing.

This patient I was informed, had a very quick labour, Notwithstanding her debilitated Condition, the fact that she had been exposed to some poisonous influence, she made a rapid and perfect recovery. There was not the slightest sign of fever during her confinement. (I learned recently that she died in the following confinement of some complication, & believe septic in character).

Ignorant of the whereabouts of the medical man for whom I was acting, I had not been able to communicate with him, to inform him of the febrile affection which had attacked his puerperal patients.

He returned late one night after I had retired to rest, and before I had seen him, he was called up the country that same night, to attend a Multipara

This patient had a long labour, but was delivered by natural Efforts.

She progressed favorably for three days, when she was seized with similar symptoms to those which were present in the other three cases. Only that they were more severe. This patient was so ill, that at one part of her illness, I concluded she would die. Foureen after lying in bed for weeks she made a slow, but perfect recovery. and two years afterwards when I last saw her. She was still suffering from the effects of this severe disease -

Now this group of cases differs very much from that first described

They resembled each other in one important point viz:- that they both appeared to be very contagious.

This last series from the first to the last case all showed that the medical man had carried some peculiar poison to them.

He could make no suggestion, or give any explanation as to the probable cause of the epidemic. all his previous confinements had done well. he was attending no surgical cases

nor had he made any post mortem for a long time previous -

The cases of the first group were of an asthenic type, where peritonitis, severe gastric disturbances were prominent features. The mortality was large -

The cases in the last group were distinctly sthenic in character, there was no peritonitis. and very little gastric disturbance, and all the patients recovered.

The third patient attended in this last series was as already stated weak, strumous, anaemic, and appeared to be the most likely to suffer from the effects of septic poison. Yet she recovered without presenting one bad Symptom.

In this Case the medical attendant arrived only in time to be present at the birth of the baby. and as a result there was less digital contact with the vagina, than in the other cases.

Why she escaped? I do not know - unless the quick birth of the baby necessitated little interference on the part of the doctor, & therefore less chance of communicating those contagious

germs, he was carrying on his clothes or hands.

The fifth case was attended by him, after an absence of ten days from his practice and yet this patient developed symptoms, similar to, but more severe than in the others, showing, I think beyond doubt - that he had some poison on his hands, or clothes. and that this poison was still as powerful, as before his departure.

The question now arises:- Do these two epidemics I have been dealing with are the same disease?

The patients nearly all died in the one epidemic and they all recovered in the other - This is an important difference. But notwithstanding this rather difference, they may both have been produced by a similar poison, acting differently at different times.

We know that this happens in many better known Zymotic diseases, e.g. in Scarlatina we have a Zymotic disease presenting very different symptoms, results in different Epidemics

In Scarlatina maligna, the mortality is fearful
Some patients dying after a few hours' illness
In Scarlatina simplex, the mortality is nil, all
the patients recovering, if proper precautions are
used to prevent complications.
These two forms of the same disease differ
very much from each other, and I am sure,
if the distinctive symptoms of Scarlatina were
not present in each, no one, judging from the
other symptoms as a whole, would class them
as the same disease. I suppose every one is
ready to admit that the causation in both is
the same. Only we cannot tell the causes which
produce the differences in the symptoms, and
results at different times.
In the epidemics I have described, we have two
different diseases, if we judge from symptoms
and results. But we must remember that
many contagious diseases vary very much in
different epidemics. We may then reason,
that as Puerperal Fever belongs to the Zymotic
class of diseases, it may behave as many others
of the same class. by appearing as a mild

non fatal affection in one epidemic, and in another, as a most severe & fatal disease. I am inclined to believe that in both epidemics the same causation was at work, or in other words they had a similar origin. such that the differences in symptoms, and results were produced, by the unknown causes which influence zymotic diseases in General.
Both were contagious. the symptoms appeared in each about the third day of the confinement. and in the first epidemic death occurred about the ninth day of the Confinement. whilst in the second epidemic, recovery took place in about the same number of days.
Leaving these two epidemics for the present I will now pass on to the consideration of a third, & attended at a more recent date. This epidemic is very interesting as bearing on treatment, and the results obtained. Each case at its commencement had all the appearances of malignant Puerperal Fever. & yet the percentage of recoveries was good.
I will now give a short account of this

epidemic, only pointing out the chief features of the cases

On the 19th July 182. Mrs A. a multipara was delivered of a living child. She had a quick labour. The baby being born. The placenta expelled, before I arrived. I found the uterus contracted firmly. The placenta appeared to be entire. & everything as I considered was quite satisfactory.

Her husband only earned a small wage, and as they appeared to be improvident. They occupied one apartment. which was in a dirty condition. and served both as bed room. and kitchen. This room was below the street level, being in what is called the sunk flat. It was badly lighted. The ventilation was very imperfect. The weather was very hot at the time, and a fire was kept burning for culinary purposes. The two causes combined rendered the atmosphere of the room very hot. and the insufficient light. The bad ventilation made it a most undesirable unpleasant place to live in

The drainage appeared to be bad. and altogether the room was in a most unsanitary state and certainly not a proper place for a puerperal case. Mrs P. progressed favorably till the 22d July when rigors commenced. followed by several severe symptoms. There was acute abdominal pain most severe in the pelvic region over the uterus. rapid pulse. high temperature, cessation of the lochial discharge. frequent vomiting. The bowels were constipated. the countenance was anxious. haggard. There was great prostration.

The peritonitis seemed to yield to treatment. at least the pain in the abdomen was not so bad, but the febrile condition continued without one hours remission. the prostration present from the first became daily more marked, till at last the patient died in a state of collapse on the 28th July. or ten days after the termination of labour.

This case presented all the symptoms of Puerperal Fever, Peritonitis was a prominent feature. altogether the symptoms were very

much the same as those present in the cases of the first epidemic
The actual cause in this case has been a matter of conjecture.
The disease may have been autogenetic.
The bad sanitary condition, & the heat of the room may have been sufficient to produce decomposition of the foetal discharges, and blood poisoning as a sequence -
I made no vaginal examination, and all my cases attended prior to this made good recoveries, so that presumably I had no hand in the causation of the disease in this particular case.
There were six cases attended in rapid succession in the week following Mrs P.'s delivery. I attended four of these cases, & then my suspicions being roused, on account of Mrs P.'s illness. I asked a medical friend to attend the fifth. and got an intelligent nurse to deliver the sixth. Though not present at the birth of the babies in these last two cases. I made the after attendance -

The four cases attended by me, consisted of two multipara - and two primipara - Three of these cases had natural, and easy deliveries, but on the third day in each cases set in, followed by peritonitis, & other symptoms very similar to those present in the first case - The description I have already given of this case will suffice for these three. with this important difference, viz: that they all recovered. And this, in my opinion, was probably due to the method of treatment adopted. This will be considered later on -
The fourth case was rather peculiar, and demands a separate description -
Mrs S. a primipara aet 20. had been under the care of a firm of medical men. in one of the London suburbs,
They told the friends of Mrs S. that she was suffering from Renal dropsy. and that very probably she would die at an early date.
Mrs S. was removed to her mothers house. and I was called in. I found that the menses had ceased for about eleven months.

and this fact probably misled her former medical attendants. She was confined to bed, and vomited the greater portion of her food. Her legs were oedematous - the arms, & upper portion of the body were greatly emaciated - albumen was present in small quantities in the urine - there was a large abdominal swelling which had been mistaken for ascites. but which was really produced by a gravid uterus. I satisfied myself at the first examination that she was far advanced in pregnancy.

The persistent vomiting - emaciation - weak heart - cold extremities - and the fearful debility present; all led me to believe that unless premature labour was induced, death would occur before she reached the full period of gestation.

I therefore proceeded at once. and induced premature labour. by introducing a gum elastic catheter one or seven inches between the membranes & the uterine wall.

Labour commenced on the following day. and after twenty four hours. very much to my surprise was concluded by natural efforts. the child was still born. and appeared as if it had arrived at full time. the placenta. & membranes were expelled naturally. & appeared to be entire. after delivery the patient was extremely prostrated. all nourishments and stimulants were instantly rejected by the stomach. She passed a restless night and on the morning was lying on her back. in a semi conscious state. the pulse very rapid, so weak as to be hardly perceptible. the temperature was 103° Fah. the lochial discharge was scanty. the stomach still rejected all nourishments

This low febrile condition continued till the end of the third day. when the patient died in a state of coma.

There was no sign of peritonitis at any time during her illness

The patient seemed never to recover, or

rally from the exhaustion which was produced by the labour.
I have often wondered once whether I really carried some septic poison in this patient - which in the debilitated, and broken down state of her constitution - acted with the great quickness & quietness - or that she simply died from the exhaustion of labour, in the then low condition of her vital powers. I am inclined to believe that septic poisoning was at work.
The fact that all the other cases attended at the same time presented symptoms, and also the febrile symptoms which appeared in this case would indicate that some septic agent was at work. If the symptoms were caused by septic poisoning, they were of a most asthenic type producing death before Peritonitis, and symptoms present in the other cases had time to appear.
The fifth & sixth cases both made good recoveries. I was not present when the babies were born but I made the after attendances in both the cases.

I have three groups of cases, comprising my experience of Epidemic Septicaemia following child birth. In all the occurrence spread the disease. The first and third epidemic resembled each other in every thing but results. The second presented very different symptoms from both, & yet from reasons already stated. they may have all been produced by a similar cause.

I have often met with a disease undistinguishable from Puerperal Fever in symptoms. except that it appeared to be non contagious. Whilst attending such a case, I could go on delivering other patients and no evil results follow.

This brings me to the sporadic cases of Septicaemia, I have met with in practice. One of the most interesting cases of this class was that of Mrs H., attended by me on the 14th Sept 81. She had a quick & natural labour.

The same day, and in the same house another female was delivered by another medical man. This patient as I was informed had adherent placenta, and post partum haemorrhage.

followed in a few days by offensive lochial discharge, for which Vaginal injections were ordered by the Medical man in attendance. The nurse in this case was timid, inexperienced, and called in Mrs H's nurse, who was less timid, but quite as inexperienced, to administer those injections. This was done without my knowledge or consent. I learned that the injections were administered three, or four times daily, and I dont suppose that the nurse took much pains to cleanse, and disinfect her hands afterwards. Mrs F. progressed favorably for six days. When she was seized with rigors, followed by peritonitis, high temperature, exceedingly rapid pulse, persistent vomiting, lochial discharge diminished, & very offensive, and great prostration was present. These symptoms continued. minus the abdominal pain till the ninth, or tenth day of the illness. When death seemed imminent, the pulse was barely perceptible, the hands and feet were cold, but under the free use of sulphuric Ether, and other

stimulants she recovered after a long and severe illness.
Judging from the symptoms, I would have called this a severe case of puerperal fever. It was probably caused by some poison conveyed to her by the nurse.
The nurse was washing out decomposing foetal discharges from the uterus of another puerperal case, three or four times daily. So that very probably she carried some septic poison to my patient.
The symptoms did not appear till the sixth day of the confinement, this is rather later than usual, but in itself was rather favorable for my patient. as my experience has been that the longer the interval between the birth of the baby. & the appearance of the symptoms, the greater is the chance of recovery.
Now here we have a case presumably caused by contagion, but all the time of her illness, I was attending confinements in rapid succession and did not carry a poison to one, as they all made good, rapid recoveries.

This looks as if the case was non contagious. It had all the symptoms of Puerperal Fever, & yet differed from it, in this important point. The symptoms were most likely produced by septic poison derived from the decomposing lochial discharges of the other puerperal case, & carried through the nurse to my patient.

The next cases I will mention are interesting in as much as they occurred at different times in the same room. pointing to the belief that there was some hidden cause existing in the room itself.

Mrs W. was attended by me on the 2nd January 183. She had a good labour. did well after it. and recovered sufficiently to leave her bed. About the tenth day of the confinement febrile symptoms appeared. accompanied by diphtheritic patches on the fauces & tonsils. After a long & serious illness she made a slow and imperfect recovery.

At that time I casually learned that a female had been delivered in the same room about one year previous to this

This patient had. What my informant. called "Inflammation of the bowels" during the puerperal period. She was dangerously ill, but recovered after a long illness.
I never saw the Medical Man who had attended this case, but from what I was told I considered that some septic Cause was at work in producing the symptoms.
On the 15th March 84. I attended another patient in the same room. Mrs B. a primipara aet. 26. had a quick Natural labour. The perineum yielded easily, There was no apparent breach of tissue, the Placenta was expelled by uterine action aided by gentle pressure on the fundus of the uterus, through the abdominal walls.
The patient was well. Doing afterwards, and continued so till the evening of the 18th March. When she was seized with rigors. followed by peritonitis, high temperature. very rapid pulse Partial Cessation of the Lochial discharge. Besides the above Symptoms. there was one I never witnessed before
This Symptom was nearly Complete Blindness

She could distinguish light from darkness but she could not tell one person from another, except by the voice.
The breasts were very much distended, and painful. The bowels were very costive, and the urine was free from albumen.
I ordered a hot-water enema for the constipation, hot applications to the abdomen, & Tinct. Morphia internally.
The following morning I found the abdominal pain gone, but when pressure was made on the uterus great tenderness was felt. all the other symptoms were as severe as on the previous night. The lochial discharge was completely absent. and in addition vomiting had commenced Vaginal injections of hot-water with Carbolic acid were now ordered, and the Tinct. of the Morphia prescribed in the form of an effervescing mixture on account of the vomiting. Stimulants were given freely as there were signs of prostration.
The bowels had not acted freely with the enema. So I gave her five grains of Calomel.
In the evening I found that the lochial

discharge had returned but it was still scanty and offensive. The vomiting had ceased. The temperature was 104° Fah. The pulse was counted 140 beats per minute. She had passed a large and offensive motion. The signs of prostration were not so great. There had been well marked insomnia from the first day of the confinement. So I gave her 30 grains of Hydrate of Chloral - which produced deep & continuous sleep for many hours. Without going further into the history of this case from day to day, it will be sufficient to state that the febrile symptoms continued, sometimes better. Sometimes worse but that the prostration was gradually becoming greater till the 23rd of the month, when acute abdominal pains again commenced accompanied with low muttering delirium, picking of the bed clothes, and death on the 24th the tenth day of her confinement. The treatment all through was purely stimulating, and three or four days before death. Uterine injections were substituted

for the Vaginal ones. These uterine injections were administered twice daily.
This was a case of Septicaemia, sufficiently severe as to cause death.
It very much resembled in Symptoms, and result, those Cases of Epidemic Puerperal Fever I have already described. And yet all the other confinements attended by me at the same time, and afterwards made good recoveries.
The source of the septic poison in this case is a mystery.
I noted the two previous confinements attended in the same room as having developed symptoms probably due to septic poison.
So that in the same room three different females had been confined, and in each Symptoms of Septicaemia had appeared after labour.
Between each confinement the room had been papered, and painted, it was situated up stairs & was not close to either water closet or drains. And as far as I could see the room and house were in a good sanitary Condition

Those three cases of a similar nature following each other may have been purely accidental. but I am inclined to believe that some hidden cause was at work either in the house, or in the room.

The interesting symptom in this case was the blindness. this lasted for two days then got better but it returned two days prior to. and continued up to death.

The patient was so ill as to prevent the use of the Opthalmoscope, but I believe it would not have told very much.

Very likely the symptom was due to the optic portion acting more strongly on that part of the brain which supplies the optic nerves

In such cases. I have several times seen the sense of hearing very much diminished. but never before have I seen blindness.

I now come to the consideration of four cases which I will notice as briefly as possible.

The two first have been the only two cases of Scarlatina following confinement I have ever seen.

The third was a premature labour at the

seventh month whilst the patient had smallpox.

The fourth was one of Typhoid Fever following confinement.

Mrs S. a primipara had a natural labour. and after doing well for eight or nine days. had shivering. vomiting. and sore throat. and on the second day presented a well marked scarlatinal rash - followed by pertonitis. alteration in the character of the lochial discharge. suppression of the lacteal secretion. and all the other symptoms of a bad case of Septicaemia, and but for the distinctive symptoms of Scarlatina, I could not have distinguished it from Puerperal Fever.

This patient made a slow imperfect recovery marked debility. anaemia. and purulent uterine discharges were present for months afterwards.

Mrs M. a primipara showed symptoms of Scarlatina five or six days after delivery There was a well marked rash - With the condition of the throat tongue showed the

was suffering from Scarlatina
The other symptoms which were present were those of Septicaemia fever, and simple There was Pertonitis, alteration in the character of the Lochial discharge, and all the other symptoms we are accustomed with in Puerperal fever. This patient was dangerously ill, but recovered, Her recovery was spread over a very long period. It is now three years since that confinement, and when I saw her lately she was still suffering from the effects of her serious illness
In both these cases the symptoms were those of Puerperal fever plus the distinctive features of Scarlatina.
Whilst I was attending these cases, I went on delivering other females, and no evil results followed.
So that here we have two cases of Septicaemia following child birth, presenting the Symptoms of Puerperal fever and yet caused by the poison or germs of Scarlatina.
This shows that Septicaemia following

child birth may be produced by more than one poison, and that whatever the cause the action on the puerperal patient is very much the same.
It is just possible that many sporadic cases, are caused by the poison of Scarlatina. The distinctive features of Scarlatina might be absent. or very evanescent. This escape detection.
The third case was one of premature labour in a primipara
This patient had reached the seventh month of pregnancy. when she was attacked with small-pox. It was not a very bad case, and it showed the ordinary symptoms for the first three or four days.
Labour now commenced was terminated quickly. Two or three days after delivery Peritonitis, exacerbation of the febrile Symptoms. and all the other signs of Septicaemia appeared, followed by death on the sixth or seventh day of the confinement.
The small pox here had presented the

usual symptoms till two days after labour, when they gave place to the symptoms of Septicaemia, and assumed a secondary position. It was a well marked case of Septicaemia of the worst type, and yet whilst attending it, I carried no contagion to other patients delivered at the time
The fourth case of this class. I will mention is that of Mrs. S. a primipara aet 35 years. I delivered this patient with the forceps. The baby's head was very large. and the pelvis was slightly deformed. and the soft parts were very undilatable
It was a most difficult case, and it required a considerable amount of force to accomplish the delivery. with this result, that the perineum was injured to a considerable extent.
There was a fairly large external uterine fibroid tumour in this case, but I do not think this had any influence either on the labour, or on her progress afterwards.
She did remarkably well, for such a case. for seven. or eight days.

About this time febrile symptoms of a severe character appeared
The course of the temperature, the appearance of the typhoid stools, and other symptoms present, indicated Enteric Fever
Then, as in the other three cases. Symptoms of Septicaemia came to the front. Masked to a certain extent those of the Enteric Fever rendering it rather a difficult matter to tell. What the disease really was.
This patient had pelvic cellulitis, and after some time an abscess pointed above the groin. This was aspirated, and by degrees the patient recovered.
From the consideration of these and other cases. I am of opinion that many different causes may produce symptoms of Septicaemia following child birth
There is the large contagious class. of which I have noted three epidemics.
All three may have been produced by the same poison acting differently at different times according as the prevailing epidemic

constitution of the period
They were all very contagious, & carried the septic poison in the first and third epidemics. and my medical friend was the carrying agent in the second epidemic,
The first and third were identical as to symptoms, but not as to "results".
The second was quite different, chiefly distinguished from the others, by the absence of peritonitis, and the non fatal results, but the contagious properties here seemed to be quite as strong as in the other two more severe epidemics as a proof of this, it will be remembered that the accoucheur in attendance carried the contagious germs, on his clothes, hands, & communicated them to the last patient attacked, after he had been away for a holiday for ten days or so.
The causes of septicaemia are very obscure. but at the same time are very important.
In my first epidemic, I think it was clearly shown, that another medical man communicated the poison to the first

patient attended, How it arose in his practice I cannot say?-
In the second epidemic the medical man could not give a cause. all the four cases were attended within two days. So that there was hardly time for him, Whom received the poison from the first case attended. The fact was, that the three cases, of the four, that were attacked, presented symptoms within twenty four hours of each other. So that most probably he got infected from some outside source, and communicated the poison to all the patients.
In the two epidemics I attended personally from first to last. I think there was an interval between the first case. and the second in each epidemic. during which I was free from poisonous germs. but that I became a carrier of germs, which were produced by those first cases, to all the patients attended afterwards who were attacked,
In the third epidemic, the origin of the first case was only a matter of conjecture.

The patient had a quick, Natural delivery.
The baby was born, and the placenta was expelled before I arrived on the scene.
I made no Vaginal examination, all my previous confinements were doing well, so that most likely I had nothing to do with the production of the disease in this patient.
The bad sanitary condition of the room may have been the cause of the disease. But this brings forward the questions.
Is this contagious form of Septicaemia ever auto genetic? Or must the germs of contagion always be communicated to the patient from some outside source?
I am not prepared to answer these questions but I am inclined to believe that an affirmative answer to the latter question is correct.
I am free to admit that the first case of this third series, looked very much as if it were autogenetic.
Whatever the cause in this case there can be no doubt that I carried a poison to all

the other cases attended afterwards, and that this poison was most~~ly~~ probably produced in the first case.
Very many isolated cases of Septicaemia present the worst features of puerperal Fever even to the termination death. And yet there seems to be no contagious elements produced. At any rate if such cases possess contagious properties, they are so weak that other patients may be attended in their confinements without risk.
One of the cases I have described very likely was infected through the nurse.
The nurse in that case was getting her hands covered three or four times daily with decomposing lochial discharge - & without making great efforts to cleanse them afterwards, went up stairs, handed napkins to her patients, and performed all the duties of a nurse, and thus was very favorably situated for carrying contagion, even if it were weak.
At any rate I carried no poison from this case to other patients, so that either there

was no contagion at all, or it was so weak that ordinary cleansing preventings were quite sufficient to destroy it.
In those cases where contagion is carried to them by the accoucheur, I think it is nearly requisite that a Vaginal examination should have been made. My own experience in the last epidemic I attended, was that whilst I carried some powerful mysterious poison to all the patients when I made Vaginal examinations. Yet the two cases delivered without me, but when I made the after attendance. Seemed well - I must at this time have been carrying some poison on my clothes, and hands. and yet I did not hurt those two females.
As already stated there are even cases when Vaginal examinations are made by medical men who are carrying poison, and yet no evil result follow.
In the first, and second epidemics I described there was a patient in each escaped contagion altogether
In an ordinary zymotic disease such as

Scarlatina it is customary to see it attacking some and leaving others, even when they all are equally exposed to the contagion
This disease does not appear to possess such powerful contagious properties, as septicaemia following Child-birth.
Septicaemia appears to be so contagious that it is a wonder to me that any patient exposed to the influence of the contagion, should escape at all.
The patient in the first epidemic who escaped was a strong robust female. On the other hand, the one who escaped in the second epidemic was a weak, anaemic, thin woman individual, and actually died of septic poisoning in the following confinement.
The labours in these two cases were very similar in character. They both had quick labours necessitating not more than a single vaginal examination. And in the patient I attended the examination was very brief, the finger was not introduced far within the vulva, as the head was lying on the perineum.

with a great bag of waters protruding.
Whether there was no person introduced, or if introduced, the incomplete examination, followed by the immediate gush of the Liquor Amnii washed away any germs. I am not prepared to say.
Of Semels Theory that frequent Vaginal Examinations made by a Medical man, whose clothes, and hands are infected with some Contagious properties, are more likely to be followed by Septic poisoning, than when only a single Vaginal examination is made.
This may be one of the reasons why Primiparae are more susceptible to the influence of Septic poisons, and Zymotic diseases in general. When Septicaemia does occur in Primiparae I believe the symptoms are generally more severe. and followed by death in a larger percentage of cases.
Of course there are other reasons why Primiparae should be more easily affected by Septic poisons. and when affected why they should be worse The exhausting nature of a first Labour renders the System more liable to the action of

Zymotic diseases in general.

When there is the most frequent wounding of the soft parts in this case. Every breach of surface seems to open a door for the introduction of septic poison, if any is about. A large number of sporadic cases of Septicaemia seem to be produced by some retained portion of placenta. Shreds of membrane or blood clot decomposing in the interior of the uterus. I have again, & again seen cases where acute febrile symptoms were relieved as soon as some decomposing material had either been expelled or been taken away from the uterus. This decomposing tissue in many cases looked very much like placenta.

One well marked and interesting case of this class was that of a multipara who had an abortion at the fourth month.

The foetus was expelled, but the whole placenta was retained, I waited in thinking it would get expelled in the course of time, but peritonitis, and acute febrile symptoms forced me into action.

I chloroformed the patient, and after great difficulty removed a decomposing placenta. The following day all the symptoms of Septicaemia had disappeared. The patient the one day was in a precarious condition, and on the day following was free from all bad symptoms.

Another case of a similar kind occurred last year. Mrs L miscarried about the fifth month of pregnancy, and as in the last case the foetus was born, but the whole placenta retained. I waited, thinking that the placenta would be expelled, but severe symptoms appeared. There were shiverings, quick pulse, high temperature, and all the other symptoms of Septicaemia. They were so severe that I thought it very probable that she would die if they continued. The os uteri was so contracted that only one finger could be introduced. I dilated this by means of Barnes' bags and succeeded after much trouble in removing a large decomposing placenta. The following morning the patient

was better, all the symptoms of Septicaemia having vanished. I must have taken about one hour to remove the placenta, and during this time my hands were coming freely into contact with decomposing tissue. Yet shortly afterwards, in point of fact within two hours - I delivered a primipara with the forceps, and communicated no poison to her as she made a splendid recovery.

My experience has been, that in the majority of these cases of Septicaemia produced by decomposing material in the cavity of the uterus, the accoucheur runs little or no risk of carrying contagion from these, to other patients attended afterwards.

These are in my opinion cases of pure Septicaemia, and when the cause is removed early enough, the disease is likewise removed.

In puerperal fever when the accoucheur carries some powerful mysterious poison and communicates this to nearly all the

patients he attends, we have a form of Septicaemia undoubtedly very Contagious, and totally different in this respect from the above class of cases. I have been Considering.

In Puerperal Fever it is not necessary that there should be retained portions of placenta - Shreds of membrane - or blood clot in the interior of the uterus

The uterus may be emptied as thoroughly as possible, and yet that poison which the medical man carries produces severe Septic Symptoms, & decomposition of some of the urine proper of the uterus, as shown by the offensive lochial discharge passed in many of these Cases.

I have long that in the Contagious form of Septicaemia, there is a specific poison - which is wanting in the non Contagious forms.

There could hardly be a worse Case than that of the lady attended by me this year where the symptoms of Septicaemia were most marked, and quite as severe, as in

any case even attended by me
The cause here was obscure - Three
successive patients who had been confined
in the same room, were attacked with
symptoms of septicaemia. This may have
been purely accidental. And the cause in
the last case of the three may have been
portions of placenta - blood clot. or membrane -
at any rate in this seven cases, there appeared
to be no germs produced. Capable of being
communicated to other patients, attended
afterwards
This looks very much like, as if there were
contagious, and non contagious particles.
working with new decomposing placenta
as has already been shown, need not
produce septicaemia in patients attended
afterwards, but if a female is suffering
from Septicaemia of the contagious variety -
then the medical man in attendance is
quite unfit to attend other cases for weeks
afterwards, if he does attend, he will produce
puerperal fever in all or nearly all the

patients he attends.
The behavior of puerperal cases under the influence of ~~the~~ the poisons of such Zymotic diseases as Scarlatina. Small pox. and Typhoid Fever. is very remarkable. Why these poisons should produce Symptoms in puerperal cases different from those we are accustomed to see produced in other patients is an interesting, and important question
Each of these poisons in a non puerperal Case produces a distinct train of symptoms. but in a puerperal Case they all produce the Symptoms of Septicaemia.
They act very much the same way on the patient as portions of decomposing placenta in the Cavity of the uterus. The Symptoms are very much the same. yet the causes are quite different.
I suppose these remarkable changes which take place in the few weeks following delivery have something to do with the action of these poisons.

How they should interfere with the powers of Involution I cannot say. Unless this powers cannot be satisfactorily accomplished except when a patient is in good health
This class of poisons seriously derange the health, and have an effect on the majority of the organs of the body. And they appear best up specific changes in the uterus than in any other organ. The uterus is in a transition state at the time, & with its raw placental surface is rendered more liable to the action of Septic poisons, than other organs. The symptoms which are produced, are quite different from those we are accustomed to see when the ovarians attack non puerperal patients. The symptoms of the ovarians are masked, and placed in a quite secondary position, so that in a case of Scarlatina following child birth, it is not the scarlatina we are anxious about, but the fearful symptoms of Septicaemia which appear.
In the four cases of Zymotic diseases I have mentioned, as having occurred during the

puerperal period, the symptoms were very severe, but they all recovered, except the small pox patient: and whilst attending them I went on attending other patients in their confinements, and carried no contagion.

I have practised amongst the working classes for many years, during which I have seen more times than I can remember females confined in rooms where scarlet fever patients were lying, and in some cases even in the same beds. Those females seemed to be unaffected by the poison of the scarlet fever, as they made good recoveries. I am inclined to think that puerperal cases do not take scarlet fever more readily than other people, but when they do take it, they are more seriously affected.

The only two cases of undoubted scarlatina I have seen following child birth, occurred in houses where there had not been cases of scarlatina for years, and I never could trace the source of the contagion.

The subject of contagion is very important in many ways.
In a case of septicaemia following child-birth the medical man in attendance is not only alarmed about it. but is kept in a state of fright at the idea of his probably carrying the disease to patients attended afterwards!
He may go on attending other cases, as has been shown, no evil results follow.
On the other hand before he is aware of it, he has spread & produced the disease in nearly all the confinements he has attended with the awful results which we are accustomed ~~to see~~ seeing in those cases
I suppose the correct plan would be to cease attending all confinements, as soon as suspicious symptoms appeared in a puerperal case
This plan undoubtedly would be the best to follow, but it would be difficult to carry out. And in some cases would be quite unnecessary. and it would seriously interfere with the working of a general practice

I do not know of any symptoms which would distinguish a contagious, from a non contagious case of Septicaemia
If we are certain that decomposition of retained placenta is acting as the cause - as is frequently met with in premature labours - then my experience has been, that other cases may be attended at that time with perfect safety.
In city populations. the working classes marry very young, and rapid child-bearing is the rule for some years afterwards.
Thus, with the impure atmosphere, improper diet, and bad or insufficient home accomodation. all help to deteriorate the health of the female.
In such patients, and I am writing of cases I have seen in London practice - when the baby is born before the arrival of the medical attendant, it is no uncommon thing to find the uterus enlarged full of blood clot - The placenta very often lies in the vagina acting as a plug thus preventing the escape of the blood which usually flows.

This I believe accumulates behind, and in the atonic condition of the muscular tissue of the uterus, easily distends it, by doing so increases the accumulation.

In such cases, as a rule it is an easy matter to expel the greater portion of this blood clot, by means of compression of the uterus, through the abdominal walls, and the administration of a dose of Ergot.

Many of these cases do well, but occasionally febrile symptoms appear with offensive vaginal discharge and other symptoms of Septicaemia due in my opinion to decomposing blood clot. Some of these cases are very serious. and I remember well, one case which was followed by pelvic cellulitis, and very nearly had a fatal termination.

Rupture of the perineum to a certain extent is not of very uncommon occurrence in primiparae, even in cases born by the unaided efforts of the female. I have repeatedly seen tears in the perineum

This may be one of the reasons why

primiparae are more subjects to
Complications following delivery.
An open wound of recent origin over which
flows lochial discharge is favorably situated
for absorbing poison. especially if the discharge.
lies & decomposes in the wound.
I have often attended cases where the perineum
to my certain knowledge was injured, where
symptoms of septicaemia appeared due in
my opinion to absorption through the wound.
The permanent effects of septicaemia on the
uterus, when recovery takes place, are sometimes
very great.
It was a common thing to find that the
uterus had been left in an enlarged state,
I suppose that in such cases the process of
involution had been stopped, and muco
purulent-uterine discharge followed on for
months, or years
This condition of uterus in a proportion of
cases seems to prevent future pregnancies.
I have met with numerous females, who
have dated all their troubles to a bad

confinement. They had been taken from that time, and were troubled with leucorrhoea — In some of these cases I have formed enlargement of the uterus, as measured by the uterine sound.

Septicaemia following child-birth is then a very serious disease!

The life of the patient is in great danger during the acute period, and when she recovers. she does so slowly and imperfectly and may suffer permanent damage.

She may die years afterwards from some disease brought on by the condition she has been reduced to by the septic poisoning.

To sum up my experience of Septicaemia. I would divide the disease into the two classes. viz the contagious, and the non-contagious, That there are varieties of the contagious class — It may be met with a very slight disease when all the patients recover. and also as a disease producing more serious symptoms up to that form from which nearly all the patients die

all these contagious forms may be produced by the same poison, acting differently at different times, as is the case with many zymotic diseases. I am inclined to believe that some specific poison produces these cases. and that this poison is very powerful and contagious. and when once on the clothes, and hands of a medical man it will remain very powerful for weeks. months,

That the majority of sporadic cases are either non contagious, or very slightly so, and that the chief causes in these cases are decomposing placenta - membranes, or blood clot - in the interior of the uterus. and that when these are removed early enough - the disease is also removed.

That septic poison may be introduced through tears in the perineum - the vaginal walls, or the os or cervix uteri.

That many well known zymotic diseases when they occur in puerperal cases, produce symptoms of septicaemia - which mask, and place the usual symptoms of such diseases

in quite a secondary position,
With this hurried, and incomplete sketch
of the diseases in question, I will now pass
on to the very important part Engl:- that of
Treatment.
The Treatment of this disease necessarily must
be a varied one.
It can be very well divided into the two
branches. Viz Preventative, and Curative
Treatment.
One of the most important duties of an
accoucheur is to prevent this disease from
appearing at all, and if it should appear
to do everything in his power to prevent its
its spread.
The raw uterine placental surface present
in every case. the tears in the perineum, Vaginal
walls, or the os or cervix uteri which may be
present in others all render a recently delivered
female peculiarly liable to the action of Septic
agents, I pointed out how decomposing
material in the interior of the uterus gives rise
to serious symptoms -

as a routine of practice, it is therefore of
great importance to use every known method.
So that the uterus shall be emptied as
thoroughly as possible of all portions of placenta.
Shreds of membrane. & blood clot.
To accomplish this, the best method to pursue
and make a practice of is to follow the uterus
down when the baby is being born. And see
that it is properly contracted before the
umbilical cord is tied, as soon as the baby
is separated, to return to the uterus, & keep up
gentle grasping compression, till, and a few
minutes after the placenta is expelled.
This mode of procedure will insure - in the
majority of cases - that the uterus is thoroughly
emptied, and at the same time will prevent
post-partum haemorrhage
In all cases I consider the birth of the
placenta, the method in which it is
accomplished as very important. And in
weak, debilitated anaemic females. So
commonly met with in large towns. it is still
of greater importance.

As a rule if there is no haemorrhage, the placenta should not be interfered with till it is well down towards the Vulva Vaginae, then if gentle pressure is kept up on the uterus with one hand, very little traction on the presenting edge of the placenta will effect its delivery.

In cases of retained placenta where there is no haemorrhage - as e.g. in hour glass contraction, by keeping up pressure on the uterus, and waiting for some time, the placenta will in many be expelled.

In adherent placenta, when haemorrhage is not an urgent symptom, and it very rarely is in such cases, except those in which endeavours have been made to accomplish its delivery by pulling on the cord. I am of opinion that hours should pass before any attempt is made to remove it.

In many such cases. firm & continuous pressure kept up on the uterus, & the internal administration of Ergot will effect its expulsion

If it fails to come, then the hand must be introduced into the interior of the uterus. and the placenta removed. This procedure if performed in a hasty. and imperfect fashion may produce serious after effects In such cases I strongly advocate the use of Chloroform.
I know its disadvantages, but I dont think they can be compared with the advantages arising from its use.
If portions of adherent placenta really prove dangerous to the female, then it is a most important duty. not to leave such.
In a case when no Chloroform is given. the introduction of the hand, through the already burried Vagina, into the interior of the uterus. puts her to great pain. The struggles, and Cries of the patient are sometimes very distressing. These together with the great loss of blood which sometimes takes place. act as strong incentives, to nervous medical men. to grasp at. and tear away the placenta in a hurried & Imperfect manner. Leaving

portions of placenta adhering, which may produce serious symptoms, and even death.

If chloroform is used. the patient lies quiet There is no need for hurry, the placenta can be stripped away in the most leisurely manner. and the accoucheur can in most cases be perfectly certain that he has removed the whole of it.

The working class of large towns are not so robust as country people.

Town life has a bad effect on the process of labour.

It means a life spent more indoors. and this remark applies more to the female sex. The result is that they become debilitated, and are in a condition very far removed from a natural one.

Such females require far greater care during their confinements than robust healthy ones

The muscular tissue of the uterus, seems to have lost tone, and in these cases it is a good plan to stimulate uterine action by the

administration of Ergot; if there is no contra indication to its use
My nearly invariable practice of late has been as following:-
If the labour is progressing favorably. I do not interfere, as soon as the baby is born I give a dose of Ergot and by so doing, the uterus is made to contract on & expel the placenta in a more thorough manner. It prevents relaxation of the muscular fibres afterwards, constant contraction is kept up. and the danger of either external or internal haemorrhage minimized, and Septicaemia is not so likely to follow.
If there should be any laceration of the perineum it should be carefully washed several times daily with warm antiseptic lotions.
In cases where we suspect that injuries to the os and cervix uteri have occurred as in instrumental & forceps cases. I think it a good plan to recommend a simple Vaginal injection for a few days.

In all suspicious cases I suppose it is proper to carefully wash the hands with some antiseptic lotion - this may do good in preventing the spread of the disease in some cases. But in the fatal, and contagious form of the disease I have met with. antiseptic hand washes seemed to do no good

The hand supplied to anoint the fingers should always be examined - I have found it in a state of decomposition on many occasions, and therefore quite unfit for such a purpose, In this state it might produce septicaemia.

Carbolic oil seems to suit this purpose well, but then we dont carry this about with us - and the majority of patients dont possess it. I have been told by one medical man of great experience that Carbolic oil spread freely over the perineum - and inside the vagina, seems to render the last stage of labour less painful, how I cannot say.

In all cases which appear to be contagious then, it is the bounden duty of the accoucheur to desist from attending all other confinements till such time as he is free from the contagious germs
By adopting such methods as I have stated and looking after the patients well. I think that in many cases, septicaemia is prevented from appearing. The practitioner who delivers his patients in a careless manner will most probably have complications more common, than the one who bestows great pains in the treatment of his labours.
This brings me now to the curative methods of treatment of Septicaemia.
As the disease presents itself in many forms, and the cause is not always the same. So the treatment must vary considerably.
In the mildest forms of Septicaemia, where the symptoms are not urgent, not much treatment is required, we must be wholly guided by the symptoms and treat them as they arise. This form of Septicaemia

as a rule ends in good recovery.
In the remaining pages. I will treat especially on that form of Septicaemia which is epidemic, and Contagious, but the treatment of one will as a rule be the best to follow in Severe Sporadic Cases.
One thing I am sure of, is this. Viz - It is of the utmost importance to commence active treatment very early in the course of the disease, the loss of one or two days at the first onset may make all the difference between recovery and death. These Cases if left to themselves often run rapidly on to death. Before we are properly aware of the serious nature of the illness, the patient is at deaths door. In all those cases which are produced by decomposing material in the cavity of the uterus. the plan of treatment is very evident.
This decomposing tissue must be removed to treat the disease successfully.
To do this is not always an easy matter.
I have always experienced great difficulty after labours at the full time - the interior

of the uterus is large, and it is really difficult to tell if the hand is introduced portions of placenta from the tissue of the uterus. In these cases warm antiseptic uterine injections will generally accomplish the desired result by the separation of and the expulsion of a piece of decomposing tissue. In premature labours, and abortions the placenta is more often a source of trouble, and if retained may produce serious symptoms and death. In such cases the union between the placenta and the uterus is more complete. Nature has made no preparation for its expulsion at this period of gestation. Uterine injections will often fail here. In such we must if necessary dilate the uterus with tents, or Barnes' bags. Search for the placenta with the fingers, and remove it, if the fingers can just reach it, but no more, then a pair of long narrow forceps are of great use, small portions of placenta can be thus got away. When the fingers have failed

In cases of abortion I am of opinion that when the placenta is retained, not expelled, after waiting a reasonable time, that before Septicaemic symptoms have had time to appear the placenta should be removed by the fingers, and if they fail, such a pair of forceps as I have mentioned will nearly in all cases be successful in removing the placenta even when it is adherent.
I am confident that the longer it remains in the uterus, it becomes a greater source of danger to the patient.
In cases where peritonitis has been present I have several times tried leeches to the abdominal walls, but never convinced myself that they did any good, but in a case with severe peritonitis, in a plethoric female and the symptoms as a whole sthenic in character I think the abstraction of blood might be used with benefit.
In similar cases I have used blistering agents, but as a rule found them of little or no use

The effects of both these remedies are lasting. and very depressing and it should be remembered that, however Asthenic in character. the Symptoms may be at the Commencement of the disease, as a rule in a few days they become asthenic, and require not depressing remedies, but free stimulation, as an outward application to the abdomen when peritonitis is present. I prefer linseed meal poultices in flannel repeated very often, or a decoction of poppy heads as a Constant fomentation - Soothing & bland applications such as these are I think more to be preferred than stronger Counter irritants & Rescents.

at a very early stage of the disease a large dose of calomel in many cases undoubtedly does good.

If the Symptoms are inclined to be Asthenic in character. Small frequent doses of calomel may be given, combined with the free use of Quinia, & Morphia.

I put my faith more in Quinia & Morphia

in a severe case of Septicaemia, than in any other remedy or combination of remedies -
Five grains of Quinia with twenty minims of the Liquor Morph: Hydrochlor: of the B.P. administered every three or four hours appear to do good by relieving pain, relieving the temperature, and giving tone to the system.
In such cases the great drawback to this method of treatment is the gastric irritation so frequently present. All the nourishment and remedies employed being rejected soon after they have been given -
I have tried when Vomiting has been a severe symptom - Morphia, Quinia & Citric Acid. and Potass: Bicarb, combined so as to form an effervescing mixture, and have got good results; the Vomiting diminishing, or disappearing under this treatment.
But in many cases we may try remedy after remedy, and Vomiting continues.
In British Cholera Vomiting is a dangerous and distressing symptom.
In several Cases of such I tried Morphia in

the form of hypodermic injection with this result viz:- that the vomiting was checked completely in nearly all the cases.

In puerperal septicaemia morphia as a rule is clearly required, so that in those cases, in which the stomach rejected all nourishments and medicines, I have used hypodermic injections of morphia, with great benefit to the patients.

When nausea vomiting are bad and the other symptoms in proportion, the patient has not much chance of recovery, unless we check the vomiting.

The symptoms are so severe that the patient must soon die especially if food and remedies are persistently rejected. So that if the vomiting is checked we place our patient in a better position for recovery, and besides the mere act of vomiting in a patient seriously ill, distresses her very much and wears out the remaining strength.

In the case of Mrs H I have described as having most probably been infected through

her nurse, I checked vomiting most effectually after other remedies had failed by administering hypodermic injections of Morphia - I have injected more than 1/4 of a grain at one time. as soon as the effect of this dose disappeared, the vomiting as surely returned to be again checked by another dose of morphia - I sat up with this patient during the worst night of her illness, keeping the vomiting under by hypodermic injections of morphia - and administering Sulphuric Ether and other stimulants; And by doing so, I believe I tided the patient over the worst period of her disease.

In the case of Mrs B. attended this year I could always check vomiting by giving her hypodermic injections of morphia - but as this case - from the severity of the symptoms appeared a hopeless one from the first onset of the disease - in spite of all treatment she died.

In cases of Septicaemia where persistent

vomiting is present. and which resists the action of internal remedies, I would strongly recommend the hypodermic injection of morphia. It should be given in 1/4 grain doses from four to six times in the twenty four hours according as the severity of the disease. It will relieve pain, prevent sleep. Calm down the patient. and more important still, will allow of stimulants. Nourishments, and other remedies being retained by the patient, and thus give her a better chance of recovery.
Nourishments in the shape of egg beat-up with milk. beef tea. Nourishing soups should be administered very often
Stimulants as a rule should be commenced very early. the disease kills by prostration. and we should guard against this from the very onset of the symptoms.
Brandy in free doses should be given. and in cases where death seems imminent small doses, often repeated of Sulphuric Ether or some such diffusible stimulant

may tide the patient over a dangerous portion of her illness. and thus lead to her recovery. If we can keep our patients alive sufficiently long. the disease seems to wear itself out. and they recover.
The symptoms are so severe. & the duration of the illness so short in fatal cases, that unless we act quickly we can do no good.
But important as the treatment I have now been considering may be, I believe that the good results obtained in my last epidemic were due to the injection of solution of Carbolic acid into the cavity of the uterus.
In Septicaemia ~~the~~ following Child birth, the uterus of all organs in the body. seems to be most affected. It is through the raw surface to which the placenta has been attached. that the septic poison enters the system in a proportion of cases.
It does not much matter how the poison enters the body, as its action on the uterus in all severe cases is very much the same.
Even in very slight cases we have

uterine symptoms any of them present.
The suppression of the lochial discharge.
~~in some~~ or if present scanty and offensive
would lead us to believe that the uterus
is very much affected by septic poison.
In cases that terminate quickly in death
one of the first suppression of the lochial
discharge all through the illness. But in all
the patients who recover even if the lochial
secretion has been ~~at~~ stopped during some
part of the illness - it returns, & always is
offensive, and purulent in character.
The interior of the uterus in such cases must
be in a filthy condition, at least one would
judge so from the character of the discharges
which flow forth.
Injections composed of hot antiseptic solutions
would then seem from a rational point
of view, to be most likely of great use.
In the first case of the last epidemic, I
had Dr Aveling as a consultant.
He recommended a solution of Sodaic as
an uterine injection

I used it only in this case and did not satisfy myself that it was any better than Condys fluid, or Carbolic acid.
In the patients who recovered I used a solution of Carbolic acid.
All these patients were attacked with symptoms of the most severe order.
The first case might have recovered if uterine injections had been commenced early enough. But the difficulty was that these injections must be administered by the medical man himself. he should trust no nurse with this duty. however well trained she may be. To the busy practitioner this is an unpleasant addition to his duties. and in my case, at that time I was very busy. I thought it just possible that the injections would not be required.
In the other cases I was on my guard. and on the first day of the illness used uterine injections
If they are carefully. and slowly thrown into the uterus, they are a power for good

and seldom for evil.
The contact of a warm antiseptic solution with the interior of the uterus, must do good in this class of cases.
The os uteri as a rule is relaxed and very patent. The nozzle of the syringe can be inserted with great ease up to the fundus and pints of fluid injected slowly without much force. The fluid runs back directly and can be felt or seen - if anything should prevent its backward flow. The injection can be stopped till that portion which has already been injected has flowed back.
The fluid in many cases returns full of broken down and decomposing tissue, and patients as a rule express themselves as deriving great comfort & benefit from the use of these injections.
The dangers of uterine injections are small when compared with the advantages to be derived from their use.
I have never found dangerous symptoms produced, nor evil results follow from

them use. and would strongly advocate them as an efficient method of treatment in Puerperal Septicaemia

They must be commenced very early. administered two or three times daily - and from a pint to two pints should be injected on each occasion

It is a troublesome form of treatment for the busy medical practitioner. as he must give the injections himself. but if it really possesses the advantages I believe it does. then I think the results he obtains will repay him for all the trouble he has been put to.

The death of a puerperal patient is always a serious matter. but when the patient belongs to the poorer working classes. it means in many cases the breaking up of a home. and the death of the baby often some time from improper diet. and general neglect on the part of the nurse hired to attend it for a very small sum of money as recompense -

The medical attendant in such a case has a heavy responsibility. In the treatment & management of his patient he must leave nothing undone. He thinks would conduce to their recovery, and if he has really done everything he could do, then he has the satisfaction of having performed his duty; even when the case terminates in death.

When recovery takes place - the after treatment is important. No general rule can be laid down, each case requiring its own special treatment.

In many cases Quinine and Iron are necessary with wine & good nourishment. Removal to the sea side as soon as possible does good in many cases.

In very many such cases we may treat as well as we can, but the results are not encouraging.

Anaemia with grave disturbances of the uterine function continue sometimes for years, and certainly none of the zymotic

diseases I have met with, leave such lasting, permanent effects on the patients attacked, as does septicaemia when it occurs during the puerperal period.