

THESIS

Submitted For The  
Degree Of Doctor Of Medicine  
University Of Edinburgh.  
- - - - -

A Year's Obstetric Work at Plaistow Maternity  
Institute, London. Statistics and Notes on  
Fifteen Hundred and Fifty Cases, with  
Observations on Cases of Chorea Gravidarum,  
Extra Uterine Gestation, Rupture of the Uterus,  
and Inversion of the Uterus.

By

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I N T R O D U C T I O N.

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The choice of a subject for an M.D. Thesis is a somewhat difficult matter. It is rendered still more difficult if the writer is limited to a selection of something of purely Clinical interest. A Thesis which comprises an original investigation on a particular subject, or even on some single point of importance in relation to it, is of much greater interest and satisfaction than one limited to the Clinical side, - that is, - if such investigation has added even a little to the sum of human knowledge of that subject. However in this, as in other matters, one has to be guided by circumstances, and, as I was fortunate enough to hold the post of Medical Officer to the Plaistow Maternity Charity in East London for a year, and as that post turned out a perfect mine of wealth in things Obstetrical, I have decided to collect some of these Obstetric fragments into a more or less concise and coherent whole.

The choice of two courses was open to one, viz., either to select from the material at disposal, one or two subjects, and elaborate them fully from one's own experience, and still more fully from the

the experience of others as culled from the Bibliography; or, to take the material as a whole, and confine oneself to one's personal experience regarding the subjects treated of, at the same time adding any reflections which occur to one regarding them. I have finally decided on the latter course, and for two reasons. In the first place, as the amount of the material was large, and the records reliable, any statistics that may be made, are useful for comparison. And secondly, a Bibliographical research is of greater interest and necessity to the original investigator than to me.

In the following pages, therefore, I have given a record of Statistics and Notes on the Fifteen hundred and fifty cases under the care of the Charity in my term of office, adding some observations on some of the specially interesting and instructive cases.

For purposes of convenience I have written in the following order:-

I. A few words regarding the Charity, and the manner in which the work is carried on.

II. A Table of the Maternity cases, with Notes on:-

- a The Presentations.
- b The operative interference found necessary.
- c The Complications of Labour.

III. Complications of Pregnancy.

- IV.
- a Extra Uterine Gestation.
  - b Rupture of the Uterus,
  - c Inversion of the Uterus.

V. Complications of the Puerperium.

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## INTRODUCTORY.

The following is a short note of the Maternity work, with illustrations of the routine method of its performance. The area comprised under the Plaistow Maternity Charity is a large one of nine square miles, in the East End of London. The houses are built on the Plaistow marshes, the foundations being the town sweepings. In many of the back yards, dark, foul-smelling water lies to the depth of two or three inches, this being due to the back wash from the Thames.

As regards the general health of the district, Diphtheria and Typhoid are both very prevalent and might almost be said to be endemic. Both of them, but very specially the former, provided abundant opportunities for testing the efficacy of the Anti-toxin treatment.

Considering the conditions of the people and their surroundings, the Statistics, especially as regards the Mortality and febrile conditions, read all the more remarkably, and speak volumes for the very excellent work carried on by the seventy Nurses of the Charity, under the care of Sister Catherine, and the Staff of very efficient fully qualified Nurses, who hold the Certificate of the London

London Obstetrical Society.

A few words may be said regarding the method of working.

Each Woman is expected to pay at least 5/- for the midwife's attendance during the confinement. At the onset of labour, two pupil nurses are sent out and they subsequently send in a report of the particulars of the confinement. (vide infra).

Name Mrs Wilson

Address 66 Salween R<sup>d</sup>

Age 25 Married or Single Married

No. of previous Pregnancies 0

No. of previous labours at term 0

Dates at which last Catemeri appeared and ceased } March 2<sup>nd</sup> - 5<sup>th</sup>

Date of Faetal Movements —

Labour began. Month November

Day 29<sup>th</sup> Hour of day 12 a.m.

Delivery took place. Day of Month 30<sup>th</sup> Hour 7.5 p.m.

Presentation Vertex 4<sup>th</sup>

How delivered Forceps Chloroform

Complications Gt. oedema of legs, Slight torticollis in the face

Sex of Child Female

Remarks No albuminuria (A.M.C.G.).

Present. D: Geddes  
Sister Katherine  
Nurses Quennell & Jones.

Each pupil has previously been made thoroughly conversant with the rules (q.v.) and if any abnormality arises, sends for assistance. The pupils are always followed by a qualified midwife, who sees that everything is as reported.

## RULES.

### WHEN TO SEND BACK.

1. If you can find no os, or cannot distinguish presentation.
2. Any hæmorrhage occurring before, during, or after delivery.
3. For placenta retained over half hour.
4. For the following presentations :
  - Face.
  - Breech.
  - Prolapsed Funis.
  - Placenta previa.
  - Anterior fontanelle rotating under pubes.
5. If 1st stage lasts over two hours, and os, is not dilated beyond half a crown.
6. If 2nd stage lasts over one hour.
7. Fits of any kind.
8. Take pulse between pains, if over 100 send back.
9. If perinæum is lacerated within  $\frac{3}{4}$  inch of anus.
10. If baby is malformed, or feeble, or premature, or apparently still-born.
11. If any suspicion of twins.
12. In any case if life of mother or child is in danger.

N.B.—Infant must not be washed before placenta is expressed and all danger of hæmorrhage over. Baby to be washed before the mother. Placenta not to be burnt until last thing.

N.B.—In sending back a report the following points are to be noticed.

- Size of os.
- Presentation.
- Frequency and strength of pains.
- Size and shape of bag of membranes and if ruptured or not.
- Pulse.
- Anything special about previous labours.
- When labour began.

Junior pupil always to write the report and sign her name and the name of the senior if she agree. If the senior finds anything left out, or differs in her diagnoses, she must write her own report below and sign her name.

Always mention the time in sending back report.

Name W<sup>rs</sup> Jennings Age 39 P.P. 11

Address 27 Crowdon Rd<sup>2</sup>

Date of Confinement March 23<sup>rd</sup> 1897

Sex of Infant Female 5.25 lb Position Vertex II

Nurses Present Lucas, Brooks, Grant.

Remarks.

Day 1<sup>st</sup>  
Day 2<sup>nd</sup>  
Sept 27<sup>th</sup>  
Sept 27<sup>th</sup>

DAY	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th
Lochia	N	N	N	N	N	N	N	N	N	
Breasts	R	R	R	R	R	R	R	R	R	
Uterus, position	B <sub>4</sub>	B <sub>4</sub>	B <sub>4</sub>	B <sub>4</sub>	B <sub>4</sub>	AP	AP	AP	-	-
„ feel	H	H	H	H	H	H	H	H		
Temp.	98	97	98	98 <sup>2</sup>	98	98	97 <sup>6</sup>	97 <sup>6</sup>	98	
Pulse	72	80	82	80	80	72	74	74	80	
Tongue	R	R	R	R	R	R	R	R	R	
Bowels	0	1	1	1	1	0	1	0	1	
Bladder	R	R	R	R	R	R	R	R	R	
Sleep	2 hrs.	w.	w	w	w	w	w	w	w	
Food	w	w	w	w	w	w	w	w	w	
After pains	Bad	few	few							
Infant	w	w	w	w	w	w	w	w	w	
Navel	R	R	R	cap off	R	R	R	R	R	
Eyes	R	R	R	R	R	R	R	R	R	
Bowels	R	R	R	R	R	under	R	R	R	
Bladder	R	R	R	R	R	R	R	R	R	
Sleep	w	w	w	w	w	w	w	w	w	
Chafing										
Nurse	Forbes	Forbes	Julia Forbes	Forbes	Forbes	Forbes	Forbes	Forbes	Forbes	Richard Forbes.

ABBREVIATIONS.—P.P.—previous pregnancies. N.—normal. R.—right. T.—tender.  
 B,U.—below umbilicus. E.U.—even with umbilicus. Tr.—tremulous.  
 A.P.—above pubis. H.—hard. W.—well.

Whenever temperature is over 100 respirations are to be taken.

Forbes  
Julia Forbes

During the Puerperium, a daily visit is paid to multiparae, and a morning and evening visit to a primipara for the first 5 days. After each visit the nurse fills in the daily record, and reports at once if anything is wrong. The rules to be observed in this daily visit are here indicated.

The record on opposite page is an illustration of an ordinary puerperium in a multipara.

## RULES.

### TO BE OBSERVED DURING THE DAILY VISITS.

1. To take temperature and pulse directly you go into the room and if either are above 100, send back word to the Home.
2. Always wash your patient and make her bed before you wash the baby.
3. To tell your patient to take oil on the evening of the 2nd. day, if the bowels have not acted by the 3rd morning give an enema.
4. If the baby is still-born don't give oil, as it increases the milk; give  $\frac{1}{2}$  oz. of ~~Maggi~~ *Maggi* or an enema. Don't give ~~Maggi~~ *Maggi* if patient is anemic or has had hæmorrhage.
5. If your patient cannot pass water on your 1st visit after delivery, send back to the Home for someone to pass the catheter.
6. Give 1 drachm of ergot if patients is passing clots.
7. *Maggi-Sulphur*. Give  $\frac{1}{2}$  oz. of ~~Maggi~~ *Maggi* if breasts are hard.
8. Give 1 drachm of ergot if uterus is E.U. *(even with Umbilicus)*
9. If infant's eyes are swollen or have pus in them, wrap in a warm blanket and bring it to the Home.
10. Send to the Home at once if anything is wrong with either mother or child.
11. Temp. of waters always to be taken with the bath thermometer.
 

Temp.	Baby's	bath	<del>105°</del> 110
"	Douche		110°.
"	Enema		<del>100°</del> 110
"	Sponging		<del>110°</del> 120
12. Patient's room must always be left clean and tidy. Patient's hair, nails, etc., to be looked at daily.



On opposite page is an illustrative chart of a primipara.

As will be seen, this is a little more elaborate - involution of Uterus progressing more slowly than usual.

Reg. No. ....

Name W. L. Jones S. Pres: Page 8.  
 Address 46 Avenue R. Plainfield  
 Disease Confinement  
 Doctor D. Sedder

Age 35

Date.	Orders.	Time.	Temp.	Pulse.	Resp.	Urine.	Bowels.	Sleep.	Stim.	Food.	Remarks.	Nurse.
Feb 2 <sup>nd</sup>	Inch. Cocaine Subst 1 in 3000. Lumina gr. III	11 a.m. + 6 p.m.									Pouches, Vagina + Perineum dusted with iodoforn.	
Feb. 4	Stop Douches. bath with Creoline Dovers Powder gr. given at 10 a.m. Belladonna 6 + 10 p.m. - 6 liquid motions were passed.									Rice + Barley Water.	Pt. had incessant diarrhoea, during night - very weak + depressed.	Breathwick Pitcheard
Feb. 4 1/2	hull report	2 a.m.	108				4 liquid motions			Milk - Barley W.	Slept quietly - only complained of pain when bowels acted, hiccoughing.	D. Jones
Feb. 5	Lumina powder every 4 hrs. Chlorid: 1/4 gr given 8 a.m. 11 p.m. 5 p.m.	10 a.m. 2 p.m. 6 p.m.	98.2 99.6 98.4	108 112 112		R.	0			Milk - arrowroot Lumina Water.	Pt much better - lips dry + coughs. Breem very quiet uterus still slightly tender.	Breathwick
Feb 6 <sup>th</sup>	Right nurse not necessary	10 a.m. 6 p.m.	98.6 99.2	110			1. loose				patient seems so much better. Taking nourishment well + is improving. uterus is still slightly tender on left side	Breathwick

Reg. No. ....

Name W. L. Jones  
 Address .....  
 Disease .....  
 Doctor .....

Chart No. 4

Age .....

Date.	Orders.	Time.	Temp.	Pulse.	Resp.	Urine.	Bowels.	Sleep.	Stim.	Food.	Remarks.	Nurse.
Feb. 7 <sup>th</sup>		6 p.m.	99.2	96							Complains of more pain in left side of abdomen. Feels better otherwise	Breathwick
Feb. 8 <sup>th</sup>	Lumina gr. III 10 a.m. 6 p.m.	6 p.m.	99	92							Pain nearly gone. Taking food well.	
Feb 9 <sup>th</sup>	Chlorid 10gr at 6 p.m.	5.30	98.5	92							Tenderness gone. Tongue clean Lochia scanty.	Breathwick
Feb 12 <sup>th</sup>											Pt. much better up + dressed.	Breathwick

The following is an illustration of a case with a slight complication during the puerperium, (severe diarrhoea). (vide opposite)

It also however illustrates the short notes made of a case which required simple operative interference, viz., Chloroform and Instruments.

CHOLZ.  
Forceps.

Name M<sup>r</sup> Moss Age 35 P.P. 8  
 Address 46 Avenue Tr<sup>o</sup> Plaintrou  
 Date of Confinement Febry 2<sup>o</sup> 6.15 a.m.  
 Sex of Infant Male Position 3<sup>o</sup> Face under Puber.  
~~Name~~ Present J<sup>o</sup> Gadder h. Hunt. Sliptrow Pritchard.

Remarks.

Pt. always had had confinement, been confined since previous by the husband & she had pyrexia on the 3<sup>o</sup> day which was reduced with the following. Pt. pregnant every year. Last year was attended by a gump midwife & from all accounts seems to have had septicaemia, premature confinement, transient labour was very tedious. Uterine inertia in 1<sup>st</sup> stage & no advance for 5 or 6 hours. Forceps applied with difficulty owing to adhesion of Ovary to Cervix. Pt. very much nervous. Prolia succinea & telangiectasis, 10 slight beyond examination.

DAY	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th
Lochia	prof	h.	h.	h.	h.	h.	h.	h.	scanty	scanty
Breasts	.	.	soft	soft	soft	2	2	2	2	2.
Uterus, position	2u	2u	Bu	Bu	Bu	Bu	A.P.	A.P.	-	-
„ feel	soft H.	J	J	J	J	H	H	H	-	-
Temp.	98.6	99	98.4	98.2	98.6	99.2	98.8	98.4	98.2	98.4.
Pulse	104	108	112	105	110	104	92	92	85	80.
Tongue	C.	moist	moist coated	coated	coated	clean	clean	moist	C.	C.
Bowels	0	0	loose diarr. diarr. lerr.	1.	1.	0	0	2 loose	1.	1
Bladder	cat.	Cathet	-	-	-	0	Cathet	-	-	2
Sleep	little	little	none	slm.	better	w	little	0	w	w
Food	no appetite.	traces	traces	crisp	better	little	little	w	w	w
After pains	-	-	-	-	-	-	-	-	-	-
Infant	w.	w	w	w	w	w	w	w	w	w
Navel	-	2	2	2	cat. off.	2	2	2	2	2
Eyes	2	2	2	2	2	2	2	2	2	2
Bowels	1	2	1	1	1	1	0	1	1	2
Bladder	2	2	2	2	2	2	2	2	2	2
Sleep	w	w	little	w	w	w	w	w	w	w
Chafing	-	-	-	-	-	-	-	-	-	-
Nurse	C.S.P. Pritchard	C.S.P. Pritchard	C.S.P. Pritchard	C.S.P. Pritchard	C.S.P. Pritchard	C.S.P. Pritchard	C.S.P. Pritchard	C.S.P. Pritchard	C.S.P. Pritchard	C.S.P. Pritchard

ABBREVIATIONS.—P.P.—previous pregnancies. N.—normal. R.—right. T.—tender.  
 B.U.—below umbilicus. E.U.—even with umbilicus. Tr.—tremulous.  
 A.P.—above pubis. H.—hard. W.—well.

Whenever temperature is over 100 respirations are to be taken.

Reg. No. ....

Chart No. ....

Name... Mrs. Gally. ....

Age .....

Address... 32. First Avenue. ....

Disease... miscarriage 3<sup>rd</sup> month. ....

Doctor... Dr. Geddes. ....

Curetting . Injection of Anti streptococic serum.

Date.	Orders.	Time.	Temp.	Pulse.	Resp.	Urine.	Bowels.	Sleep.	Stim.	Food.	Remarks.	Nurse.
Sept 8 <sup>th</sup>	Flooding came on last night nothing came away										Touche - Pt Permany. Expol. 3 <sup>rd</sup>	Lucas.
		p.m.	98.6	90.							Slight haemorrhage. Touche + expol.	Lucas - Loch
Sept 9 <sup>th</sup>		11 a.m.	98.6								" " "	Lowell
		9 p.m.	98.4								" " "	"
Sept 10 <sup>th</sup>		1 p.m.	100.2	92				little.			hot feeling well. Headache -	Lowell
											Touche. Tongue dry.	
		5 p.m.	102.2	96.							Dr. Geddes. Dilated cervix with Hegars dilators. Curetted	
		8 p.m.	98.	80.							+ removed the miscarriage, which was smelling badly. CHCl <sub>3</sub>	
											given by Dr. Sales - Intra uterine Touche (Corrosive subl. 1 in 5000)	Sister K. Lowell.
											5 c.c. Anti streptococic serum injected into abdomen.	
		10.30	101.5	Regior.							Perchloride Touche. Lochia red.	William.
11 <sup>th</sup>	Intra Touche.	10 a.m.	98.4	80.							No lochia. Touche returned clear. Pt feels very much better.	Lucas
	Expol 3 <sup>rd</sup> hour + lo.										No lochia. - Pt very bright.	Lucas.
		5 p.m.	99.5	88.				4				
		8 p.m.	101.4	92.						Milk 5 <sup>th</sup> .	Complains of pain in abdomen	
	Hot fomentations with Tinct Opil									Beef Tea. 0.	put over the place where injection was made.	

Reg. No. ....

Chart No. ....

Name... Mrs. Gally. ....

Age .....

Address .....

Disease .....

Doctor .....

Date.	Orders.	Time.	Temp.	Pulse.	Resp.	Urine.	Bowels.	Sleep.	Stim.	Food.	Remarks.	Nurse.
Febr 11 <sup>th</sup>	night. Intra 2 1/2 p.m.		100	72						Brandy milk 3 <sup>rd</sup>	Patient feels much better.	
	wrong 4 hrs.									3 <sup>rd</sup> Beef Tea 3 <sup>rd</sup>	Touched twice - returned clear.	William
	Touche with Todrick.											
Febr. 12 <sup>th</sup>		10 a.m.	99.2	84						Eating food well.	Pain much less, not quite gone yet.	Lucas
		1 p.m.	97.	76		R	1	food.			Opium fomentations applied.	
		5 p.m.	98.4	88.				1 1/2 hrs.			" " Pain better.	
	light		98.4	76				food		Well.	Slight headache.	
Febr 13 <sup>th</sup>		9 a.m.	96.6	80.		R	1			well.	Feels much better. - Touche relieved	Lucas
		5.30 p.m.	97.6	76.		R						
14 <sup>th</sup>		9 a.m.	97.4	8.				good.			Headache - Had a very good night	William
	Liquorice Powder	6 p.m.	99	80.		R	1					
15 <sup>th</sup>		11 a.m.	98.4	80		R	1	w			Feels quite well.	
16 <sup>th</sup>		11 a.m.	97.4	72.		R	0	w		w.	" " " " no lochia.	
17 <sup>th</sup>		11.30	97.4	80		R.	1	w.		w.	Patient up + dressed	
											No lochia.	Lucas.

The chart on opposite page illustrates the notes made of such a case as a Miscarriage, with the supervention of septic symptoms.

- Treatment consisting in the curetting of the Uterus and injection of Anti-streptococcic Serum.

TABLE OF MATERNITY CASES

with notes on Presentations, Operative Interference,  
and Complications of Labour.

The accompanying is a note of the Labours at term  
for the whole year.

	Ja.	Fe.	Ma.	Ap.	Ma.	Ju.	Jul.	Au.	Se.	Oc.	No.	De.	Total
<u>TOTAL</u>	134	104	118	113	111	134	130	144	120	142	143	156	1549
Primip.	6	10	18	16	14	8	18	17	15	12	16	6	153
Multip.	128	94	100	97	97	126	112	127	105	130	127	150	1396
Miscarriages	1	6	5	3	4	4	3	7	4	6	4	1	48
Deaths							1		2	1			4

AS regards the above-mentioned proportion of miscarriages, it must be borne in mind that these figures merely represent the cases that presented features calculated to alarm the patients and their friends, e.g., severe haemorrhage - the actual number of miscarriages being very much greater. The treatment of these cases calls for no particular comment, except perhaps the large proportion of cases in which it was deemed advisable to use the dull wire curette. The two points which always guided one in this procedure, were the continuance

continuance of a red discharge, and the study of the temperature chart.

With regard to the deaths the mortality cannot be considered high, especially in view of the circumstances under which the work was carried on. The deaths were due to the following causes.

- a. Pulmonary Embolism, on 14th day.
- b. Pulmonary Embolism, on 10th day.
- c. Phthisis - formation of a Pneumothorax - death on the 4th day.
- d. Rupture of Uterus - Abdominal Section - death on the 7th day after operation.

(considered later).

#### A PRESENTATIONS.

Cephalic	-	1497	-	96.72%
Pelvic		49	-	3.1%
Transverse		3	-	.4%
Funis		1		

#### Cephalic.

- I. Occipito-Posterior. 27 cases ended with Face to Pubes, - 22 of these cases requiring interference to effect complete rotation.

rotation.

II. Face - 2 cases - both of which ended naturally.

III. Brow - one case - Delivery was effected by transforming into a vertex.

Pelvic.

These do not present any points of special interest.

Transverse.

- a. L.A.P. with prolapse of arm, in<sup>a</sup> patient with a flat pelvis - delivery by version.
- b. The second of twins - R.A.P. - small premature infant - delivery by version.
- c. In this case the ribs presented, but after posturing the patient and rupturing the membranes, the breech presented. This case was complicated with an intra-mural fibroid on the left side.

Funis.            1 Case.

Contracted Pelvis - head did not enter the brim - delivery accomplished by external and internal version.

Statistics showing frequency of Presentations.

	Hospital Records.		Out Patient.	
	Rotunda.	Winckels.	Spiegleberg.	Plaistow.
Total of Cases.			9,3871	1550
Vertex	96.4	95%	97.3%	96.7%
Face	.2	.6	.3	.1
Pelvic	3.1	3	1.59	3.1
Transverse	.2	.5	.78	.4
Brow	.1			.06

Statistics of Placenta Praevia.

Spiegleberg	1 in 1,000
Muller	1 in 1,000
New York (Emergency Hospital)	nil in 15,000
Plaistow	1 in 316.

With regard to the comparative frequency of Placenta Praevia at Plaistow, one must remember the marked existence of the predisposing causes. Thus we

we find rapidly recurring pregnancies, abortions frequent, subinvolution common, and often severe physical work at the commencement of Pregnancy. One case may be cited as an example of fertility - a woman aged 24 , confined of twins in March , a three month's miscarriage in July , and five months pregnant in December.

Several patients were attended with families ranging from 16 to 22 - in one instance numbering 28.

Eclampsia.

New York	1 in 500	Indoor
Spiegleberg	1 in 500	Out-door
Plaistow	1 in 770	Out-door

Inversion of the Uterus.

This occurred once at Plaistow during 1897, but is the first case recorded in the practice of the Charity.

Rotunda	1 in 190.000
Vienna	nil in 250.000
Malins	1 in 20.000

(System of Gynaecology)

Rupture of Uterus.

Rupture of Uterus.

Plaistow	1 in 10.000
Vienna	1 in 2137
Paris (Jolly)	1 in 3403
London Maternity	1 in 672.

B OPERATIVE MIDWIFERY.

I. Version.

The operation of Version was performed on ten occasions; the more important being:-

- a. Two cases of severe accidental haemorrhage.
- b. A Transverse Presentation.
- c. A Placenta Praevia Centralis.

As regards the remaining cases, the choice of operation lay between Version and the use of Axistraction Forceps.

II. Forceps. 45 cases.

In 8 cases the forceps were applied, as the head had not entered the brim, and the pelvis was flat. Of the remaining cases, Axistraction forceps were used 15 times, and ordinary long forceps in the remainder.

III. Induction of Labour. -

This was performed on three occasions, as follows:-

- A. For persistent Uterine haemorrhage at  $4\frac{1}{2}$  months, in a patient aged 28, affected with Rheumatoid Arthritis and Aortic regurgitation.

regurgitation.

- B. For Chorea at  $7\frac{1}{2}$  months in a patient aged 30. This case is discussed later.
- C. For Placenta Praevia Centralis at 8th month in a patient aged 36.

A few words regarding the respective operations and their results, may be here be given.

In Case I. -

The treatment consisted in the injection of  $1\frac{1}{2}$  oz. glycerine into the cervix and plugging the Vagina with a Champetier de Rebes bag. This was done at 10 a.m. At 2.30 a.m. patient had a few pains by which the bag was expelled. On examination the Os was the size of a shilling. She was then douched, and the Vagina was plugged with anti-septic gauze. At 8.30 p.m. the Fœtus and Placenta were lying in the Vagina. The Urine passed at 8.15 was dark, porter-coloured, containing blood, albumen, but no casts. The Urine drawn off at 3 a.m. on the following day was slightly smoky, containing blood and albumen. The Urine was passed naturally at 10 a.m.

10 a.m., the day following the labour, and was clear, and contained no abnormal constituent.

The occurrence of Hæmaturia is of interest in relation to other cases reported.

In Case II.-

Introduction of Catheter into Uterus, with hot Vaginal Douching- labour concluded at end of 36 hours.

In Case III.

Placenta Prævia- Rapid Digital Dilatation followed by Version and Delivery.

#### IV Abdominal Section.

a Hysterectomy for Ruptured Uterus.

b Extra Uterine Gestation- miniature labour in August- symptoms of peritonitis in December- operation- recovery.

These cases being of special interest, are discussed fully later.

#### V Craniotomy.

This operation was performed in a woman aged 38, the conjugate diameter being  $3\frac{1}{4}$  inches, - an attempt at Version having previously been unsuccessful.

#### VI Repair of Perinaeum.

VI. Repair of Perinaeum.

This was only called for in 22 cases in all. In this connection one must acknowledge their indebtedness to the most efficient training received from Miss McCall, M.D. at the Clapham Maternity Hospital. In this Institution, the patients being almost solely primiparae, a ruptured perinaeum is a thing of the greatest rarity, and it only occurred once in 60 cases under the writer's own charge, this case being that of an elderly primipara of 43 years.

C COMPLICATIONS OF LABOUR.

I. Twins - 22 Cases.

The only case that presented any special point of interest was one in which the first was a footling, and the second, a transverse presentation.

II Hæmorrhage.

A. Ante Partum. - 12 Cases

I. Unavoidable- 3 Cases.

I. Placenta Prævia Centralis.

II. Placenta Succenturiata, the succenturiate lobe was lying over the Os Internum, and when this was detached, the Hæmorrhage ceased.

III. Placenta attached to lower Uterine segment.

II. Accidental- 9 Cases.

None of these cases call for special note, except one in which the Hæmorrhage was very severe, the patient having lost about two pints.

On examining immediately after the Hæmorrhage, the Os was the size of a sixpence, no placenta was felt, or a presenting part, the lower segment of Uterus contained soft

soft blood clot.

The membranes were ruptured at once, when a vertex presented and pains set in. As the Hæmorrhage still continued with each pain, Version was performed, the placenta being found completely detached, and the Uterus was emptied in the following order:- breech, placenta, head. The child was still born.

B. Post Partum. 35 Cases.

Nine of these were serious and accompanied by severe shock and collapse. Four were cases of secondary Post Partum. None of the others presented any specially noteworthy points.

3 Contracted Pelvis. 9 Cases.

These were mainly Rickety pelves, the conjugate diameter varying from  $3\frac{1}{4}$  inches upwards. In one case the contraction was at the outlet, and due to an exostosis on the articulation between sacrum and coccyx. This latter was interesting from the difficulty in delivery, as the forceps were always pushed off by the projection. Delivery was effected with difficulty by Version, and the application of forceps to the after coming head.

4. Eclampsia.

4 Eclampsia.

There were two well marked cases, both, as is usual, occurring in ~~Puerperium~~<sup>7 months</sup>. Other two allied cases were specially interesting. In one, a Primipara aged 24, there was oedema of legs and vulva, twitching of the facial and arm muscles, but no albuminuria nor fits. In the other, also a Primipara aged 21, there was headache, slight sensory disturbances both general and ocular, with albuminuria, but no fits. All the cases did well under appropriate treatment.

5 Cystocele and Hydramnios.

There were two illustrations of each of these conditions. They were not, however, specially noteworthy.

6. Extra Uterine Gestation

Inversion of the Uterus

Rupture of the Uterus

} Considered  
later

## III.

## COMPLICATIONS OF PREGNANCY.

A. Diseases of Respiratory System.

Pleurisy	-	2 cases
Phthisis	-	4 cases

Phthisis:- The affected patients all seemed to get rapidly worse during pregnancy.

As regards subsequent history, one died on the 4th day after labour from a pneumothorax.

The second case became rapidly worse after delivery, and died at the end of the 3rd week.

The other two cases improved after delivery.

B. Diseases of Circulatory System.

## Cardiac Disease

I. Mitral Stenosis, with compensation good. Patient had one Hæmoptysis a week before delivery, and one during parturition. On each occasion the effect was beneficial and did not call for any treatment.

II. Mitral Regurgitation:- This patient had been getting progressively worse with each succeeding pregnancy. On this occasion patient was very

very seriously ill, and nearly died during labour, which came on at  $6\frac{1}{2}$  months. Her condition gradually improved after labour was over.

III. Double Mitral Lesion:- In this case labour came on at the 6th month, patient being exceedingly ill, and she died in 3 weeks after delivery.

IV. Aortic Stenosis and Incompetence:- This case has been previously referred to on page 14 .

V. Suppurative Phlebitis:- This occurred in a Multip. aet 40, the subject of extensive varicose veins and uncleanly habits. Very acute Phlebitis developed, followed by suppuration over the Internal Saphena Vein. Under appropriate treatment patient made an excellent and almost unlooked-for recovery.

C. Diseases of Haemopoietic System:-

Myxœdema:- Mrs T. IX Para, aet 38. Previous History. In childhood had Rheumatic Fever. For the last 11 years has been becoming weaker and more listless— Face becoming puffy, and much altered in

in form, speech becoming altered and markedly slow, hair and eyelids disappearing. In her last pregnancy patient was ill with Pneumonia at the 7th month and did not abort.

Present condition:- Patient presented all the typical features, physically and mentally, of a pronounced myxedema. Delivery took place at full term, and was in all respects normal. On getting about again, patient's mental and physical condition was worse than previously.

Treatment:- Thyroid Extract was begun on 1st April and continued till the middle of July, when patient was lost sight of. The treatment was carried out on the usual lines as regards doses, tonics, etc., and the result was in every way satisfactory, alike as to the improvement in physical and mental condition. The course of the case calls indeed for no further notes.

The most interesting points of the case are the facts- i., Since the onset of the Myxoedematous condition 11 years ago, she has had 4 full time children, all of whom are alive and healthy.

ii., During her previous pregnancy, she had a very severe attack of Pneumonia during the 7th month, from

from which she was hardly expected to recover, and yet did not have a premature labour.

... and evident disorganization. In the first part of the case the patient was ill with pneumonia of the lungs. ...

D Disease of Digestive System (vel nervous)

Uncontrollable Vomiting.

Case, Mrs B., II Para, aet 26.

Previous History: - During previous pregnancy four years ago , patient vomited incessantly from the second to the end of the 6th month.

Present History: - Patient was troubled with severe vomiting from the commencement of Pregnancy till the end of the second month, when seen by me. She presented a tired and worn appearance, with a dry skin, - Tongue raw and red, and offensive breath, and Constipation. She retched and vomited even after a drink of water , the vomit consisting of greenish or clear mucoid material. She had been under Medical treatment without benefit.

On Vaginal examination, Cervix was found to be hard and tightly contracted, and not like that of pregnancy. It would not admit the tip of the finger even on forced pressure. The Uterus was the size of a two month's pregnancy.

The interesting part of the subsequent history of the case was the permanent beneficial results

results obtained by forcibly dilating the cervix on two occasions by the forefinger, for a period of about five minutes.

Slight improvement followed the first dilatation, but the result was very marked on the second occasion, as the sickness entirely ceased.

In conditions like this where very many remedies are tried, it is frequently difficult to know to which remedy a cure should be attributed, if such takes place. In this case, however, the ordinary medical remedies had been tried previously both outside the Home and by myself without any benefit, and the dilatation was accompanied by immediate and pronounced relief.

E. Diseases of Nervous System.

- I Epilepsy
- II Chorea
- III Eclampsia
- IV Case of Multiple Tumour of Spinal Cord.

I Epilepsy:- There were 4 pronounced illustrations of this condition. The details of the cases would occupy too much space, but the following points may be noted for comparison with other cases.

Effect of Pregnancy:- In 2 cases the Epilepsy seemed to be unaffected by the Pregnancy. In one case the manifestations became decidedly less frequent, and in the fourth case they became decidedly more pronounced.

Effect of Labour:- They all had an epileptic fit during labour.

Associated features:- In one of the cases (that in which the Epilepsy improved during pregnancy), Pruritus of an aggravated character was a prominent feature. In the fourth case mentioned above, the patient complained much of the severity of the foetal movements. These movements were not apparently increased by palpation of the Abdomen.

II Chorea.

Case I. Mrs G., aged 30, III Para.

Severe Chorea each previous Pregnancy.

Induction of Labour.

Partial Recovery.

Previous History. Family- Father aet 72, alive, subject to Rheumatism. Mother alive, strong and active, but of a very nervous temperament.

Personal:- History good up to date of marriage; menstruation commenced at 16 and always regular.

First Pregnancy, aet 26.

Chorea began at the 4z months and was very severe, being treated for it in hospital for several weeks. Towards the end of Pregnancy the condition improved, and disappeared entirely after the birth of the child who is now alive, 2½ years old, and quite strong. Patient did not nurse the child.

Second Pregnancy:- aet 28.

Chorea started on this occasion during the first month, and became very severe about the 5th and 6th months. As in the previous case the condition improved during the latter months. After labour, there was very marked improvement for the first few days, during which

which time patient was very quiet, only shewing slight choreic movements. Patient then began to nurse the child, and immediately the movements became very violent, being always exaggerated when child was put to the breast. The nursing was then abandoned. Patient was admitted to Hospital where the condition improved, but did not entirely disappear. The infant was weakly and only lived a short time.

History of Present Illness. April 97. Third Pregnancy. Patient is now six months pregnant. The Chorea has been gradually increasing since conception. Patient is thin, in manifest ill-health, showing irregular jerking involuntary movements in most of the muscles of face, neck, arms and legs. She also exhibits marked jerking movements of head, bites her tongue, speaks in a typical choreic manner, laughs immoderately, and generally exhibits all the characteristic features of severe Chorea. Her walking was effected with so much difficulty that her mother always accompanied her to support her. The mother also reports that mentally the patient is much changed- her intelligence is dulled, her

her memory defective, and that lately she <sup>has</sup> taken violent likes and dislikes to people.

On objective Examination:- The mucous membranes pale and anæmic- condition of blood not examined. A well-marked systolic mitral murmur was present; the knee jerks were sometimes exaggerated, sometimes diminished.

Treatment:- Complete rest, Bowels to be kept relaxed, Internal administration of Bromides- gr.XV, repeated every few hours, and an Iron and Quinine Tonic.

May 14th. The remedies in use appeared to be of a little benefit for the first few days, but only slight, and thereafter the condition became more exaggerated. There was great difficulty in nourishing the patient; she began to lose flesh markedly. On consultation with the Consultant for the Institute, Dr Kennedy, it was agreed that labour should be induced. Preliminary treatment consisted in the use of a copious Iodine Douche (Tinct. Iodi  $\mathfrak{zj}$  to the pint) The os uteri was found on examination to be soft, and a No 8 Gum Elastic Catheter was introduced- (unfortunately the membranes were ruptured during the introduction) and

and about  $\frac{3}{4}$  of L. Amnii escaped. There was no change in the Chorea during the operation. A warm Corrosive Sublim. Douche, 1 in 5000 was ordered every 4 hours. On the evening of that day patient was much quieter, spent a quiet night, and took food without difficulty.

On the following day, just 24 hours after insertion of the catheter the instrument was removed; the os was dilating, just admitting 2 fingers; no pains had developed. The choreic movements were very slight. The temperature and pulse were satisfactory. At 6 p.m, Breech presenting, Chloroform was administered and feet brought down. Labour pains set in and child, a female of 7 months was born at 8.30. The Placenta was expressed,  $f$  There was slight Post partum Hæmorrhage. Child only lived half an hour.

Puerperium- normal. In the first 2 days the movements were rather more marked than during the induction of labour. Subsequently the patient underwent rapid improvement, gaining flesh and showing generally marked diminution in movements and other symptoms, which however continued in slight degree.

Case II. Mrs H. aet 26, ii Para- Chorea each pregnancy; partial recovery after dilatation of Cervix; Delivery at Term; Recovery.

Previous History. Family- unknown to patient.

Personal- Had always been subject to Muscular Rheumatism. First Pregnancy- Unilateral Chorea began at 4½ months. It continued up till the time of the confinement and she recovered completely afterwards. No further particulars could be definitely ascertained regarding this history.

During Pregnancy she was treated for the condition but without any success. The child only survived its birth a few hours.

History of Present Illness. Last menstruation in Oct. 1896. In March -97 she noticed slight movements beginning on the left side, these being aggravated on the slightest effort to make any definite movement. On March 11th, when I first saw the patient, the movements were very slight, unilateral, consisting in twitching in the hand and slightly jerky movements in the head. At the same time she complained of being very nervous. A fortnight later her condition became distinctly marked, unilateral


unilateral choreic movements all down the left side, face, arm, hand and leg; and otherwise highly nervous. She was markedly anæmic; a systolic mitral murmur was present.

Treatment- Pot. Brom. grX  
 Liq. Arsenic <sup>7</sup> iii  
 Aq. Ad *3℥* t.d.s.

Further Reports. April 20th. Been taking medicine regularly- condition much the same, certainly not worse. Patient thinking the medicine was not curing her stopped all treatment for six weeks. June 16th;- The movements had now become general and were so intense as to alarm the patient's friends. She had not slept for many nights and was generally in a lamentable condition, being quite unable to dress herself, her hair torn and matted, her tongue bitten, arms and back bruised and in some places raw from the blows. Always in constant motion, unable to lie, sit or walk, and could not eat. She presented at times the appearance closely resembling that of a case of acute mania. At once the necessity of inducing labour suggested itself, but the patient was most anxious to have a full time living child.

Treatment and Progress. Patient was put under a

a day and night nurse, having absolute quiet, the bowels being regulated, and being fed with suitable nourishment every few hours.

Given 1	{	Pot. Bromide gr. XV
2		Chloral Hydras gr. XV every 6 hours
	{	Ferri et Quin. Citrat gr. V.
		Liq. Arsenicii Hyd.  iii t. d. s.

June 20th:- Patient's condition in statu quo; has been taking some nourishment. Buttocks and arms severely chafed from the bruising. On Vaginal examination cervix was felt to be hard and firm to the touch; the external Os slightly patulous.

Reasoning from Case I. I tried the effect of dilatation of the cervix. This was done by inserting the first finger of the Right Hand into the Os Intern, and keeping it there for about five minutes.

Night Report. "Had a good night and slept well; movements did not stop during sleep."

June 21st:- Able to sit up; twitching of face and arms a little less. June 25th:- Up, dressed and downstairs; so much improved that the night nurse was not thought necessary. June 26th:- Found patient not so well; more movements in the arms, and had not slept much. The previous operation of dilatation of cervix was repeated, the right

right forefinger and also the top of the 2nd finger being used for the purpose. The same result followed; patient remained much quieter, and was able to get up, dress herself, go about the house, and also eat better and sleep quietly.

July 12th:- Patient still suffering from bilateral choreic movements, but so slight now that it is unnecessary to send the nurses. Still to continue the bromide and chloral and the tonic mixtures. Patient not seen again until August 12th:- slight bilateral choreic movements, which do not interfere with her household duties.

Labour commenced Aug 13th, 11 p.m.

Labour over Aug 15th, 11.10 a.m.

Vertex iii., Male, strong and healthy.

The choreic movements very slight during labour.

Puerperium- normal. Began nursing the child, but as this seemed to exaggerate the movements, child was weaned. The movements now are chiefly in one hand and are only occasional.

Case III. P.L., a gipsy, aet 20- single- Primipara-

Primipara- Chorea during Pregnancy- recovery.

This case was not seen before the onset of labour.

No satisfactory history was obtainable.

The patient is reported by the gipsies to have been so bad with Chorea for the last three months that they do not care to attend the confinement themselves as is their custom.

Report at 10 a.m. Os size of 1/, pains short and occurring every 20 minutes; slight twitchings of the muscles of the face are the only trace of choreic movements now visible.

Subsequent History:- Labour was natural and over at 9.30 p.m. There were no further manifestations of Chorea. Patient nursed the child.

OBSERVATIONS ON CHOREA CASES.

From an obstetrical point of view, the main points of interest lie in the beneficial effects following on the forcible dilatation of the cervix. What is the rationale of the treatment?

Is there any special virtue in dilatation per se? Would the more usual local treatment of counter irritation of the cervix, (e.g. Tinct. Iodi) have been equally beneficial? These are interesting points which could only be answered by more extended and fuller experience of the various methods. In Dr Buist's Tables on Chorea (Obstet. Trans: Vol. XX) the effect of labour is not noted. Out of the 273 reported cases, 90 recovered post partum, at varying intervals from a few days to months. Sixty cases are noted to have recovered before delivery and of these in 27 cases the movements terminated during the latter half of pregnancy, while only 8 recoveries are reported during the first  $4\frac{1}{2}$  months. Is there any connection with Morning Sickness, which is a reflex neurosis and is known to be much benefitted in some severe cases by dilatation of the cervix?

cervix?

From a medical point of view the case possesses some points of great interest. The relationship to Rheumatism is well brought out and is a well known fact. AS to other points, if we analyse Case I. we find the following interesting data.

1st Pregnancy: - Chorea began at  $4\frac{1}{2}$  months, improved towards end of Pregnancy, and disappeared entirely after delivery. - Child was healthy and strong and was not nursed by Patient.

2nd Pregnancy: - Chorea began in first month, also improved towards end of Pregnancy, did not disappear entirely after delivery - infant was weakly and only lived a short time. The Chorea was made worse by attempts to nurse the child.

3rd Pregnancy: - Chorea began with conception - became extremely serious, producing great Physical and Mental deterioration and emaciation. Knee jerks sometimes increased and sometimes diminished. Induction of labour necessary - Chorea persisted, though improved after labour.

The fact noted regarding the knee jerks is

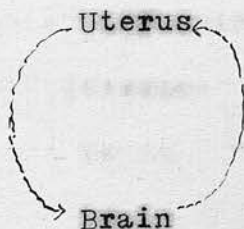
is extremely interesting in view of the various theories held regarding the relationship of different parts of the brain cortex to one another.

The knee jerk is referred to in one of the cases reported by Dr Buist , in his case being diminished.

It is known from experimental and clinical observations that the cerebellum plays an important part in the physiology of the knee jerk. Again we have the ingenious theories put forward that there is a mutual antagonism (if one may so speak) between the cells in the motor cortex and those in the cerebellum, whereby the cells and fibres of the latter are constantly exercising a restraining influence on the action of the cells and fibres of the former, and when their restraining influence is removed the action of the motor cells and associated projection system gets full swing and the result is shewn as an apparent increase in the activity of the cell.

A study of the case further well repays one from a psychological point of view. In it we find

find an ideal representation of cell physiology and pathology. It also illustrates well the propagation of disease from Mother to offspring. What is Chorea? It is doubtless a condition depending on defective inhibition, which in turn depends on faulty chemical processes in the cell. - Here then we find a patient aged 26 of a rheumatic temperament; - (A rheumatic temperament probably means; - the natural possession of cells, the chemical processes in which are readily disturbed, this disturbance occurring along certain more or less definite lines -), who becomes pregnant and in  $4\frac{1}{2}$  months Chorea develops, improves towards the end of Pregnancy and disappears entirely after delivery; the offspring being healthy. In other words a vicious cycle is begun which might be diagrammatically represented as follows:-

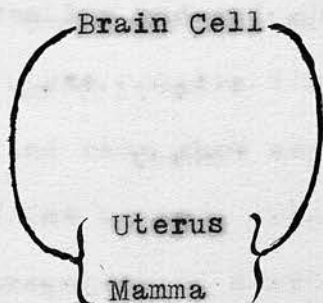


As the cycle did not exist at conception, the child was a healthy one. (This raises the very interesting physiological question of the physical

physical and chemical changes which take place in the ovum during fertilization; a question which probably has a great future before it).

Then again we find the patient aged 28, again pregnant, when Chorea develops at the end of the 1st Month, also improves towards the end of Pregnancy, aggravated by nursing, and not entirely disappearing, the offspring being sickly and only living a short time. What is the interpretation? The cycle existed at conception, with the result that the chemical processes at and after fertilization were defective, the subsequent anabolic changes in the ovum were abnormal, the child had not vital force necessary for life and so died.

The cycle might now be shewn:-



The darker shading indicates the greater establishment of the cycle, e.g., the Chorea did not entirely disappear.

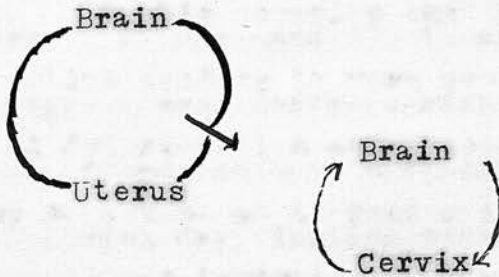
disappear.

Then we find the patient aged 30 again pregnant; On this occasion the Chorea beginning with conception leading to very severe physical and mental deterioration and emaciation, these symptoms being so severe as to render induction of premature labour imperative. The case is now a perfect picture showing the profound relationship that exists between the Brain cell on the one hand and general anabolic tissue changes on the other, and further indicates that such a cycle as the one above, once established, is not only incompatible with healthy child-bearing, but is highly dangerous to self-existence.

These remarks, while largely speculative, may serve as an interesting and valuable hypothesis for purposes of future observation.

Does the second case shew any points of interest bearing on the above? The Chorea was unilateral in each pregnancy to start with, This being probably dependant on some natural inequality of the two half brains. The subsequent history, and especially the operative interference, illustrates how the cycle may be interfered with,

with, and the natural course of the disease in measure arrested.



The arrow indicates the interference with the cycle as carried out by the forcible dilatation of the cervix. This may be diagrammatically represented as in the above figure as the establishment of a lesser and temporary cycle.

From our knowledge of the physiology of other organs there is little room to doubt that the pelvic viscera, one and all, have a distinct representation in the Brain, such representation probably involving directly or indirectly a considerable area of Brain Substance. In this case we may infer that the counter irritation of that part of the brain relating to the cervix, so altered the activity of the general centre or centres, as to lead to the cessation of the outward manifestation (Choreic movements) of the disturbed metabolism.

PARAPLEGIA (partial) - Labour -

Mrs L. a Pole aged 37- X Para.

History: - A week before confinement patient was out of bed and got thoroughly chilled. On the following day tingling sensations commenced in the legs, and at the same time she lost the power of standing *f* her grasp especially on the left side became weak . This was followed by slight flattening of left side of face and violent itching in the cheeks, *f* also the involuntary passage of urine and faeces. A daughter stated she had taken nothing but brandy and whisky for some weeks.

Labour commenced 15: XI: 97 at 8 p.m.

Labour over 16: XI: 97 at 5.35 p.m.

Presentation - Vertex - Face to Pubes.

Delivery Natural.

Child was an eight month's one.

The diagnosis was difficult, *My* first impressions led me to regard it as one of Acute Alcoholic Neuritis , but, as in that the condition the organic reflexes are almost never involved that made the case very doubtful.

doubtful.

Subsequent History (resume). On the 10th day patient had an attack of general twitchings, the daughter thinking she was going to have convulsions.

A careful examination (carried out with much difficulty, as the patient could not speak English) revealed:-

- a Complete loss of power in R leg, and also to a great extent of R arm.
- b Marked loss of power in L leg, and less marked in L arm.
- c Increased knee jerks.
- d Loss of sensation (partial, over irregular areas in both arms). Sensation in legs apparently normal.
- e Slight flattening of L side of face, with feelings of formication.
- f Bladder and rectum normal.

30: 11: 97. Admitted to King's College Hospital under Dr Ferrier. After careful examination they would not commit themselves to a diagnosis, though their first impressions led them to regard the case as one of Alcoholic Neuritis.

Neuritis.

On the 2: 1 : 98 - patient became very noisy and talkative, and in a few days she died.

Post Mortem:- "Multiple Gliomatous Tumours in the cord." This is all the information lately received by letter from the Resident Physician in the Hospital, and while it is an incomplete report, it is sufficiently complete for practical purposes.

Remarks on the Case:- The case is of much greater interest from its Medical than from its Obstetrical bearings. At the same time it is one of great obstetric interest, as being a case of normal parturition in a case of partial Paraplegia. It is true that the labour was a little protracted for a multipara with an eight month's child, but it was otherwise normal in every particular. The case has interesting bearings in relation to the paper on the subject recently published by Amand Routh.

## DISEASES OF REPRODUCTIVE SYSTEM.

Of the affections of the canal met with complicating Pregnancy, two only call for remark.- Vaginitis and Leucorrhœa.

A. Vaginitis (Colpitis Mycotica)

Mrs O, æt 30, III Para- six months pregnant.

Nov. 26, 1897. Patient was first seen on account of intense burning and itching in the Vagina and Vulva, with slight Leucorrhœal discharge. She appeared very ill. Temperature 98.6. Pulse 76. Local examination revealed the Vaginal mucous membranes to be covered all over with a white membrane exactly like Thrush. The Vulva was swollen, œdematous and painful.

On enquiry it was found that the drains in the house were in a shocking condition, and Diphtheria was very prevalent in the neighbouring houses.

Treatment:- A copious douche of 1 in 3000 warm Corrosive Sublimate was given, and this brought away a considerable amount of membrane, leaving the Vaginal mucous membrane bright red, swollen, and very painful. Thereafter hot antiseptic douches were given thrice daily, with the internal administration

administration of Perchloride of Iron in m X doses -  
(The drains were not attended to.)

Nov. 27, Condition much improved. A considerable amount of flakes still come away in the douche.

Dec. 10, Patient is now well; the Vagina appears normal.

Subsequent History:- Patient was confined (in the same house) in the end of November and made an excellent recovery.

Remarks on the Case:- This case would have been a more instructive one if a careful Bacteriological examination had been made. In nearly all such cases a specimen was at once sent off to the British Institute of Preventive Medicine, for examination and report, but owing to stress of work at the time, this was not done in this case.

B. Leucorrhœa. In the Department of the work which was devoted to the Cases of Pregnancy amongst unmarried girls, Leucorrhœa was so prevalent that in many cases douching twice daily with warm boracic lotions was found necessary during the latter months of Pregnancy. In the Puerperium, all were douched twice daily as a matter of routine. Before this was made a rule, involution was retarded, and in some cases pelvic inflammation occurred. The regular douching was found to be most beneficial, and as the patients were all under observation for at least 6 months after the confinement, a definite opinion as to the immense value of the treatment can be asserted.

## IV

A EXTRA UTERINE GESTATION.

Mrs C. aged 31. History:- Patient has 3 children, all living, the youngest being 9 years old. She has always enjoyed good health, and the menstrual function was regular up to and in November 1896. It was further also painless.

December 14th 1896:- Illness commenced with a discharge of blood, accompanied by an attack of very acute Abdominal pain, originating in the left side, and so severe that patient could not move from the chair on which she was sitting. She was nursed by two neighbours who described her as looking "very ill and faint." No doctor however was called in. About this time also, morning sickness commenced.

January:- No menstruation, some Abdominal pain.

February:- No menstruation. The pain however still continued and was so severe, that she went to Soho Hospital and was admitted for 10 days. She was examined carefully and opinions differed as to whether she required operation or not. The patient however left the Hospital without any treatment.

treatment.

March 17th:- A Haemorrhagic Discharge occurred and persisted for two or three days. During this month the pain experienced was very severe, and about the middle of the month she first felt foetal movements.

Patient consulted a Doctor about this time on account of great oedema of lower extremities. The Doctor after examining her reported her pregnant, and was engaged to attend her in August.

April:- During this month the patient had a good deal of difficulty in Micturition, the bladder being emptied only after much straining. On one occasion a Doctor was called in on account of retention, and he emptied the bladder by use of a catheter.

May - June - July:- During these months patient complained much of general abdominal pain. There was no discharge of any kind.

August 5th:- Labour pains commenced, followed by a slight discharge of blood and mucus. A doctor and Nurse were sent for. The Doctor after examination sent for two other Doctors, and they were much puzzled over the case, and stayed all

all night with the patient.

The pains went off, and then there developed a lochial discharge which lasted for some days, the breasts at the same time filling with milk and spontaneously discharging. After this date, patient felt no movements, and the breasts diminished in size.

September:- Patient was in bed, all the time suffering great pain. Her Doctor now told her that she had a tumour, and was not pregnant.

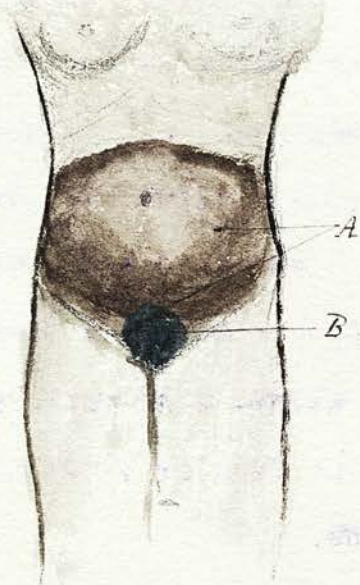
October:- During this month the abdomen diminished in size. The pain however was still severe, and kept the patient in bed almost continuously. Another Doctor was now consulted, and he also said she was suffering from a tumour, and recommended her to go to Hospital.

November:- The abdomen seemed to get smaller, and the pain diminished, allowing the patient to move about her room. Twice she had a haemorrhagic discharge lasting for two or three days.

December 1897:- During first 3 weeks the patient seemed much better and was able to get out, the abdomen at the same time still further diminishing in size.



## Extra Uterine Gestation



A-Tympanitic Area.  
 B-Dull Area. (Uterus?)



A Arm - presenting part.  
 B Placenta, very large + flat.

size.

29th:- Patient felt very ill; complaining of headache, sickness, ~~and~~ vomiting and feverishness.

30th 12.30 a.m.:- Patient was first seen by me at this time. She appeared extremely ill, and lay in an almost comatose condition. She complained of severe abdominal pains which became aggravated at regular intervals, resembling labour pains.

On examination the abdomen was much enlarged, presenting all the appearances of an abdomen at term.

On Palpation:- There was marked general tenderness, and parts resembling limbs could be palpated on the left side.

On Percussion:- The note was tympanitic over the whole abdomen area except two inches above symphysis. No dullness was detected in the flanks. *viz. Diagram.*

On Auscultation:- No foetal heart sounds could be detected. Fine crackling sounds were heard over the whole of the tympanitic area. A Uterine souffle was heard directly above the Symphysis.

On Vaginal Examination:- A large hard mass was

was felt in the posterior fornix. The cervix was displaced far forwards under the pubes, and the Os was patulous, and admitted the tip of the forefinger. The Uterus was anteverted, and a sound went in  $3\frac{1}{2}$  to 4 inches.

On Rectal Examination:- The large mass in the pouch of Douglas was now felt to resemble a foetal head. The Sutures could be made out and also, but doubtfully, a fontanelle.

The Temperature was  $101^{\circ}$ . The Pulse 120. In the course of the day the patient became much worse and passed into a comatose condition. Patient was seen several times in the course of the day and at night a Provisional Diagnosis was made of - An Extra-Uterine Gestation with miniature labour at full time in August, - Retention and decomposition of the foetus." Dr Kennedy the local Consultant saw the case in consultation, and concurred in the diagnosis.

Report at 7 p.m.; - Patient has been constantly retching and straining. In the afternoon there was a discharge of blood and mucus. Patient is in a comatose state; Temperature  $102.4$ . Pulse 128.

128.

Night Report:- Temperature gradually rose till  
5 a.m. Temp. 103<sup>o</sup>.6 - Pulse 144, 7 a.m. Temp.  
 103<sup>o</sup> - Pulse 130. Intermittent Pain very  
 severe and frequent till 1.30 a.m. Patient  
 much quieter since Tinct. Opii ~~in~~ XX given -  
 Has slept in short doses since 2.30 a.m. -  
 Slight retching. Bowels not opened.

December 31st:- Morning; - Temp. 103<sup>o</sup> - Pulse 140.  
 Patient looked much worse and was moved into  
 Cottage Hospital, and Dr John Phillips, the As-  
 sistant Consultant for the Institution, was  
 telegraphed for.

1.30 p.m.; - An anaesthetic was given. Dr Phillips  
 examined, but reserved his diagnosis, and de-  
 cided to perform Laparotomy.

Operation:- An incision 8 inches long was made, ex-  
 tending upwards from a point two inches above  
 the Symphysis. The Uterus and tubes first pre-  
 sented, and were seen to be rotated to the right.  
 The Uterus was about 4 inches long, and the tubes  
 appeared to be normal.

An enormous cyst next presented, and was  
 found to be adherent anteriorly to the Uterus

Uterus and posteriorly to the intestines, with fresh adhesions at the sides and posteriorly.

An attempt was made at this stage to stitch the cyst to the Abdominal Wall , but on pricking the sac, much gas escaped, <sup>f</sup>also a little fluid, so the attempt was abandoned, and the wound was packed all round carefully with sponges. An incision was then made into the sac, when more gas and a very foetid almost faecal looking fluid escaped. This appearance was so striking that Dr Phillips thought he had opened into a dilated colon.

The sac was then washed out with warm boracic lotion. At this stage the left arm of a child presented through the incision ; on further examination the foetus was found to be so large that it was necessary to sever the trunk from the head to facilitate extraction. Ultimately the whole body of a full time foetus was extracted, The head being removed from the Right Iliac region. The placenta and cord were then removed. The latter was shrivelled <sup>f</sup>-discoloured; the former, which in colour and shape resembled a large Abdominal sponge, was

was stripped off without much difficulty from the wall of the sac on the left side. There was no haemorrhage after this procedure. The sac was again washed out, and its edges stitched to the Abdominal wall.

The peritoneal cavity was closed above, and a glass drainage tube inserted. The sac was packed with antiseptic gauze, and the wound dressed with boracic powder and cyanide gauze.

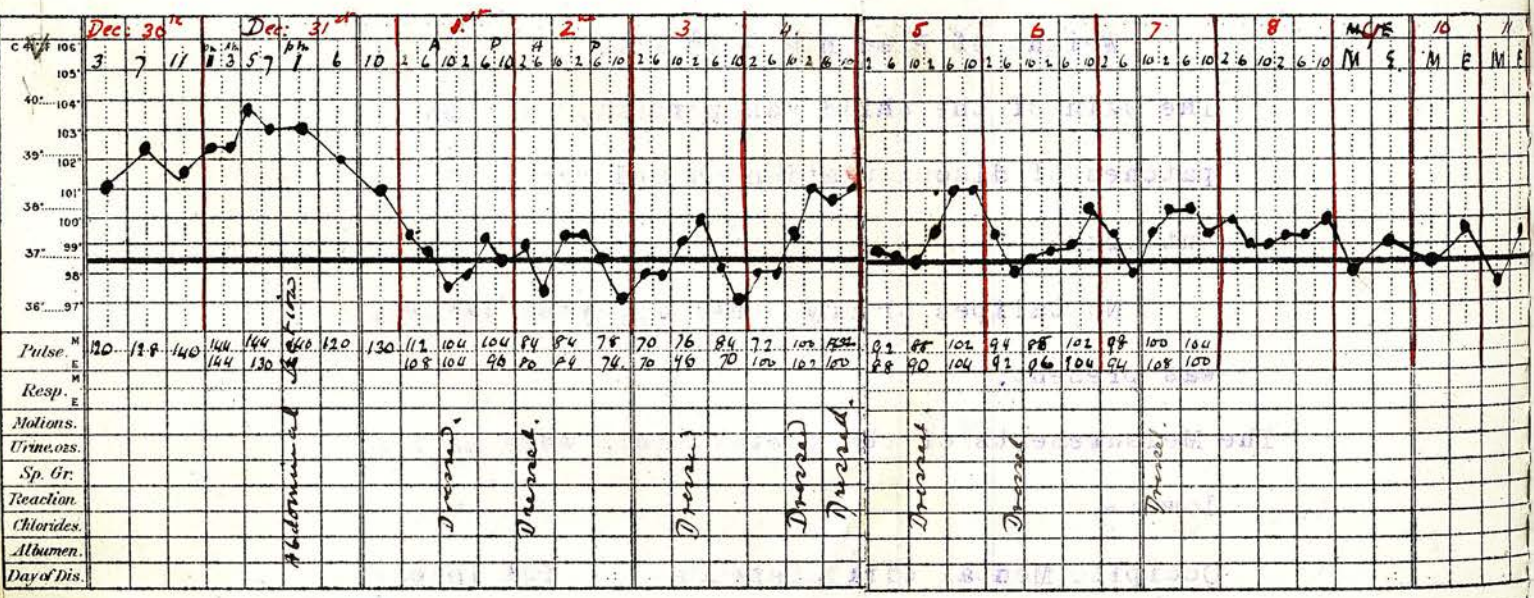
The patient took the anaesthetic well, the pulse improving from the time the gas was allowed to escape. Directly after the operation, some lochial discharge set in.

Subsequent report: - The lochial discharge lasted 7 days, at which time the Uterus was in its normal position. There was a decided feeling of fullness in Posterior fornix (collapsed sac<sup>v</sup>).

As regards the wound, there was slight discharge from it for 3 days, but after that, it was copious and foetid and full of tissue débris. The Cyst was irrigated thrice daily with large quantities of warm boracic lotion.

Jan. 17th: - Patient is well. The cyst now holds about 2 oz. of fluid, and a sinus of about two

was stopped at about 10:00 AM. The wall of the top of the left side was on average after this procedure. The wall again moved out and the edges of the abdominal wall. The pyloric cavity was closed above and a glass drainage tube inserted. The gas was passed with antiseptic gauze, and the wound



change from 12 for 3 days, but after that it was  
 Despite the fact that the patient was  
 copious and fairly and full of gastric contents.  
 The gas was investigated (pneumococcus) with large  
 quantities of very viscous mucus.  
 The temperature was 100.5. The eyes were  
 Jan. 1st - mucus as well. The eyes were  
 about 5 cc of fluid, and a sinus of about two

two inches exists (8 inches at time of operation). After this date patient made an uninterrupted recovery. - The temperature chart indicates clearly the favorable course of the case.

Foetus:- The foetus was a large full time child, and dreadfully foetid.

Length - 20 inches

Weight -  $7\frac{1}{2}$  lbs.

Weight of Placenta -  $1\frac{1}{2}$  lbs.

The skin of the child was perfect, only shewing patches of discolouration on abdomen and buttocks.

No talipes or any other apparent deformity was present.

The Measurements of the foetal skull were as follows:-

Occipito Mental circumference	$15\frac{1}{2}$ inches
" " diameter	$5\frac{3}{4}$ inches
Occipito Frontal circumference	$13\frac{1}{2}$ inches
Biparietal	4 inches
Shoulder girth	16 inches

The accompanying diagrams traced from the decapitated head are of interest as showing its size and shape.

(Vide over)

Remarks

A study of this tracing is of striking interest, as being that of a foetal head not moulded by labour.

The measurements of the foetal skull were as follows:-

Occipital frontal circumference	14 1/2 inches
" "	13 1/2 inches
Occipital parietal circumference	13 1/2 inches
Biparietal	4 inches
Suboccipital	10 inches

The accompanying diagrams traced from the cephalogram show the state of interest as showing the size and shape.

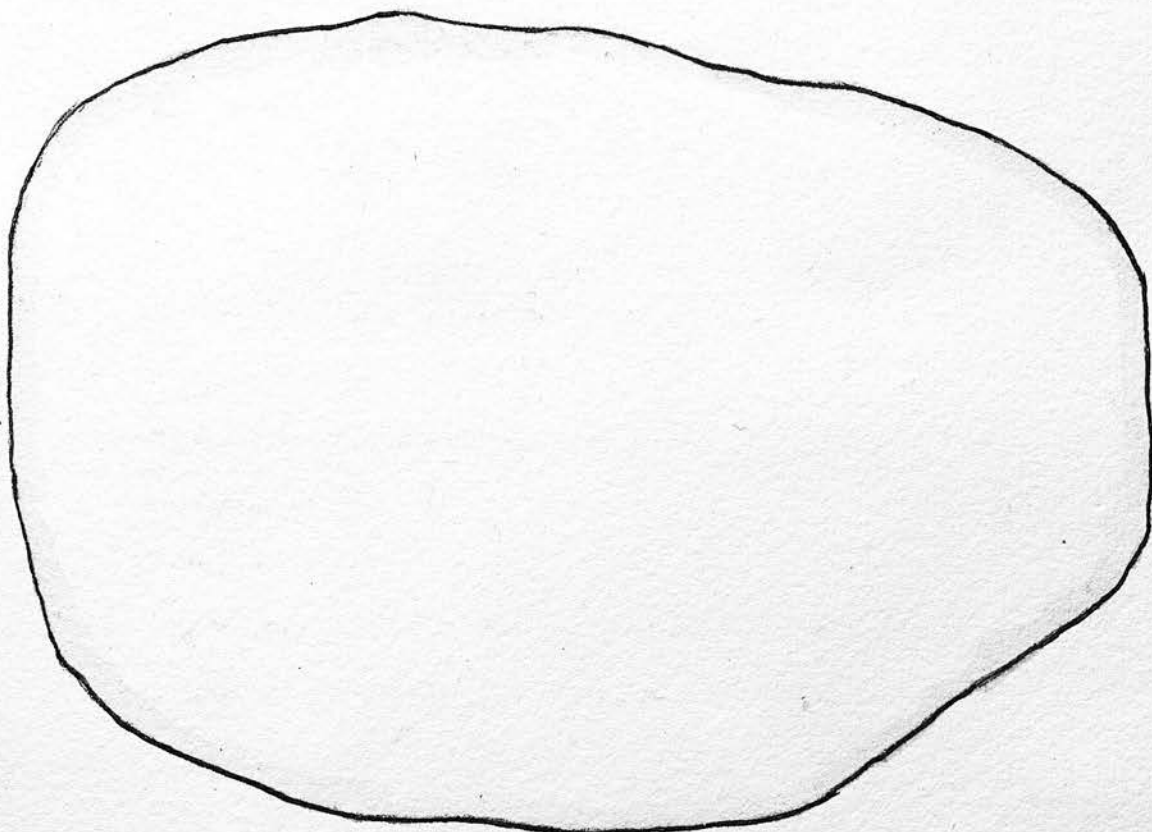
(Side view)

Tracing from Child's Head.  
(natural size)



occiput.

chin.



## OBSERVATIONS ON EXTRA UTERINE GESTATION.

The condition of Extra-uterine Gestation is at all times one of very great interest. It is so, alike from the standpoint of its aetiology and manner of development and treatment.

While it is comparatively frequently met with during the earlier months of pregnancy, and then usually presents points of difficulty alike in diagnosis and manner of treatment, the present case is one of even greater rarity, and exhibits many points worthy of notice. If we make a graphic resume of the case we find as follows:-

Conception in November

Hæmorrhage internal?  
& slight external  
Pain

Fœtal Movements  
4 months later

Miniature Labour at full Term  
death of fœtus

Labour Pains  
Lochial Discharge  
Milk Secretion

Abdomen diminished  
in size  
Decomposition of  
Placenta, etc.

Operation  
4½ months later

There are one or two minor noteworthy points in the case, e.g., the foetal movements were appreciated by the mother from 2 to 3 weeks earlier than usual, this possibly being due to the thinness of the sac. Again, the œdema of the lower extremities, and the trouble with micturition were probably pressure effects, and if so, the wonder is that these were not more pronounced, especially in view of the marked displacement of the cervix mentioned in the case. The account of the various opinions entertained by the different medical men at the varying periods of gestation is of interest, the case doubtless presenting at those times many anomalous features.

With regard to the History the following queries may be asked on points noted:-

- a Was the illness in December one of internal Hæmorrhage? The small amount of external discharge was evidently one of blood and not a menstrual one. Further, the Hæmorrhage had evidently been considerably less than is commonly met with in cases of Tubal Pregnancy.
  
- b At no time had there been any decidual cast passed.



c The entire absence of any symptom of pelvic disturbance in the 9 years previous to present pregnancy is worthy of note. It was noted in the case that menstruation had been regular and painless.

d As regards the abdomen itself the enlargement appeared quite median and not at all lateral.

With regard to the Miniature Labour:- This is an interesting Physiological Study and perhaps all the more so since we know little or nothing of the origin of those forces which institute normal parturition.

(vide diagram.)

With regard to the Operation and Conditions found there, the following points are noteworthy.

- I The apparently perfect state of the Tubes.
- II The fact that the walls of the sac could only be stitched to the abdominal wall at the close of the operation (vide case).
- III The amount of gases and decomposed fluid and the intensity of its fœtor.
- IV The entire absence of Hemorrhage at the operation

operation, and also the absence of any primary gestation sac.

V The wonderfully preserved state of the fœtus itself and especially its integument.

The foregoing points give rise to a few reflections. Firstly, with regard to aetiology. The case as a whole is strongly suggestive of its being an example of a Tubo-abdominal, or a Primary Abdominal Pregnancy. Some authorities deny the existence of the latter condition, and if we accept the former view, one must interpret the Hæmorrhage at the end of the first month, as indicating some disturbance in the fimbriated end of Tube, leading to extrusion of the ovum. In connection with the decomposition, it is probable that it began after the miniature labour. The labour initiated destructive changes in the placenta leading to its degeneration, and subsequently there followed chemical changes in the fluid of the sac.

This case does not support the view sometimes put forward, that the decomposition in this <sup>Condition</sup> ~~case~~ is due to the effects of ptomains derived from the intestines in proximity to the Gestation Sac.

It is unfortunate that the Placenta which was handed to Dr Eden for Pathological investigation and report, was too decomposed to be available for examination.

B CASE OF RUPTURED UTERUS.

Mrs D., aged 32. VIII Para. History.

A Family:- Mother has always been ill after her confinements from Hæmorrhage. Sister has had an adherent placenta after each of her confinements, and has been very ill at these times.

B Personal:- Patient has had 5 full time deliveries, and two premature labours, one at the 7th, and one at the 6th month.

At the 6th confinement the labour was complicated with adherent placenta and slight post partum Hæmorrhage.

At the 7th confinement labour itself was normal. The placenta however was adherent in parts, and was somewhat degenerated, and the membranes were rotten. There was slight post partum Hæmorrhage.

8th and Present Pregnancy:- Date of last menstruation April 1897. Patient has occasionally complained of abdominal pains, chiefly in the left side. Patient first seen by Midwife on October 3rd at 7.45 p.m. Membranes had ruptured the day before and she was having very strong pains.

The Midwife's Report was as follows:- "Abd. Exam.

"Exam:- Uterine Tumour extends to an inch above the umbilicus. Vagin.Exam:- A foot in the Vagina, on <sup>t</sup>bracing it up, the Os is the size of 2/, soft and dilatable. A hard ring is felt above contracting the child's leg below the knee. Patient states that she has been losing blood all day. There are now no traces of Hæmorrhage. The pains are severe and incessant!"

At 10 p.m. the pains were very severe but the Uterus was contracting badly. The writer was then sent for.

11.30 p.m. I found patient having frequent sharp pains and the Uterus contracting irregularly. Temperature 98.6. Pulse 100. The Os Uteri was size of 2/. The hard ring mentioned above was still present, and was contracting the leg above the knee. Chloroform was administered, and under its influence the tightened ring relaxed sufficiently for the other leg to be brought down, when nature expelled the trunk as far as the shoulders. The ring was again felt, this time clasping the neck of the child, but with a little manipulation the lower jaw was drawn down. The head, however, could not be extracted, and all efforts to do so

so were stopped for  $\frac{3}{4}$  hour, during which the patient had only a few severe pains.

At 1. a. m. CH Cl<sub>3</sub> was again administered. It was now observed that the constricting ring was not so tight on the left side as on the right. I then dilated the constricting ring with my fingers, and expressed the head. The child was not more than a 6 month's one.

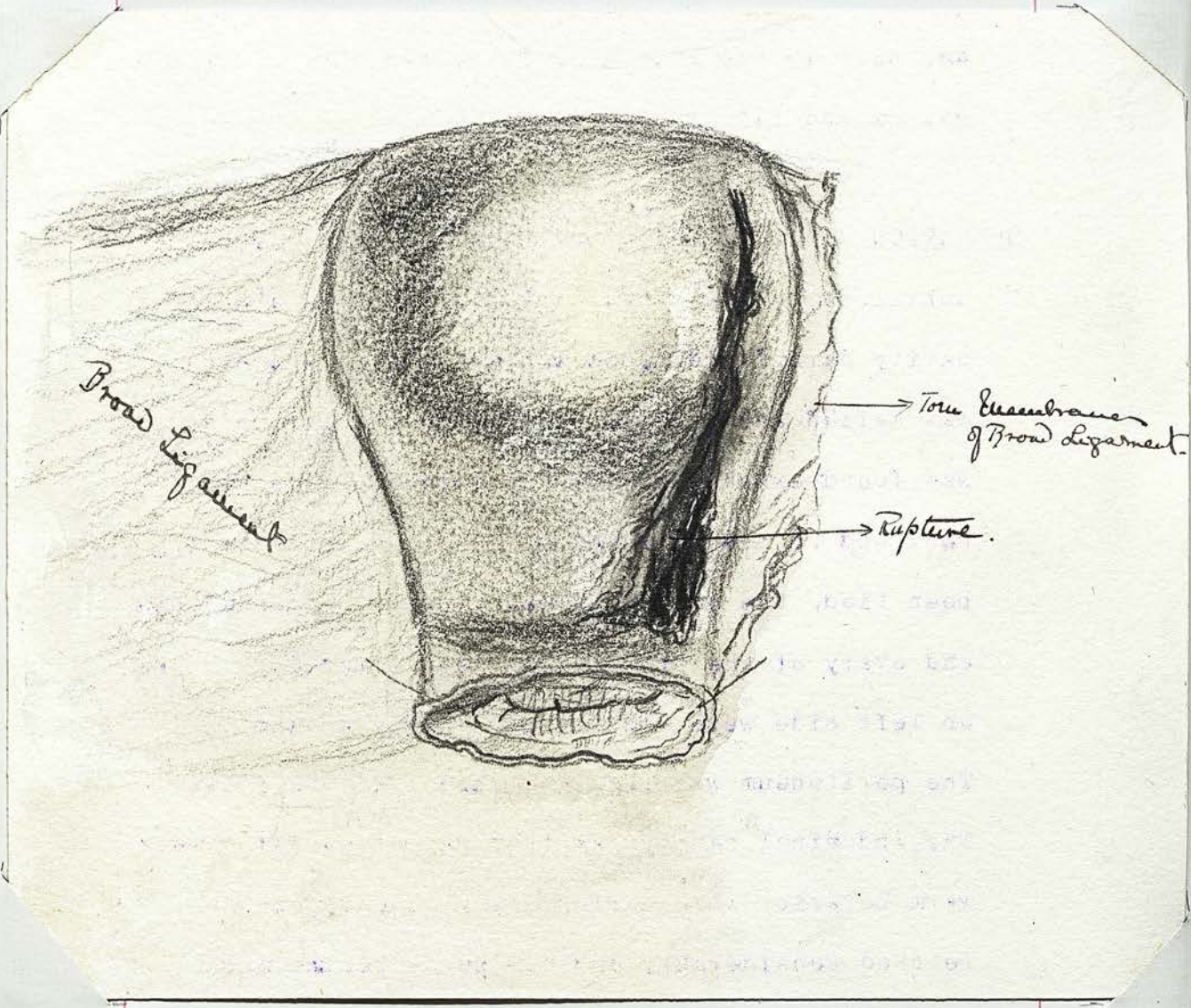
After delivery the Uterus did not contract properly, and in a few moments profuse post partum Hæmorrhage set in. As the Uterus was contracting badly, I did not deem it safe to use expression, especially with the previous history of adherent placenta. I accordingly passed in my hand to remove the placenta and found what appeared to be its thick edge roughened, and slightly detached from the maternal surface. Pushing gently past this, membranes were felt. These readily tore, and the hand passed over a smooth, slippery mass which felt like a placenta ready to be expelled. I then tried to bring the mass out in the usual way, but experienced some difficulty, so fixing my fingers into the membranes I tugged forcibly, and extracted some scraps of tissue which I thought looked

looked curiously thickened for fetal membranes. Then, with combined extraction and expression a large globular mass covered with membranes was expressed, the mass showing a deep rent from top to bottom. On realising that this must be Uterus, it was instantly returned and a second opinion sent for. I then examined "the membranes" and found I had extracted an ovary and fallopian tube and a piece of peritoneum!

The patient did not appear much collapsed, the pulse was 120, regular and steady, the feet and hands were slightly cold. Slight stimulants were administered.

At 2.30 a.m. the patient was seen in consultation with Dr Kennedy. At this time she seemed in a dying condition. Local examination revealed a coil of gut protruding into the Uterine cavity. Two nurses stayed all night with the patient keeping her warm and using stimulants judiciously.

Oct. 4th, 10 a.m. Patient had rallied considerably. Temperature was normal, pulse 120, no pain or abdominal distension. It was now thought advisable to give her a chance by performing Abdominal Section, and accordingly Dr John Phillips was



Broad Ligament

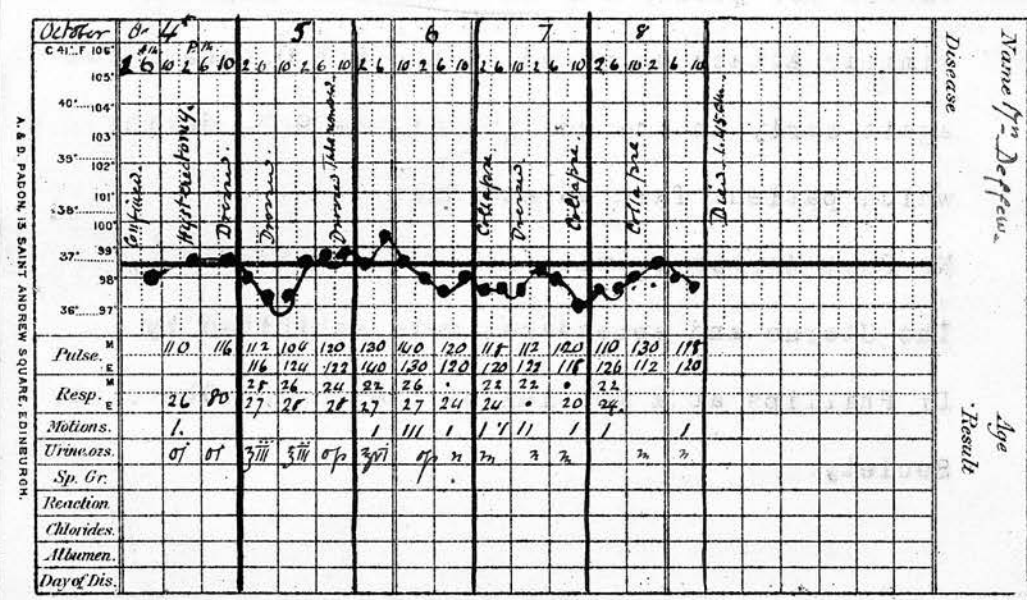
→ Torn Membrane  
of Broad Ligament.

→ Rupture.

was telegraphed for. On his arrival at 3 p.m. patient was then in fair condition. There was, however, slight abdominal distension, with a little dullness in the flanks. Pulse was 120, of regular rhythm, and fair volume.

OPERATION. An incision was made extending from the umbilicus to the pubes. On opening the abdominal cavity dark fluid blood welled up. The uterus was seized, and a large rupture on the left side was found extending from the fundus to the neighbourhood of the internal Os. The vessels having been tied, the Uterus, broad ligament and the tube and ovary of the right side, were removed. Those on left side were removed previously as above. The peritoneum was then stitched over the stump. The abdominal cavity was then washed out with weak warm boracic, ~~when~~ During the proceeding, patient retched considerably, and the pulse became much weaker. A drainage tube was inserted at the lower extremity of the wound, which was then stitched up. The operation was completed and patient back in bed well within the hour from the commencement of the operation. The pulse was good and the bodily heat

was telegraphed for. On his arrival at 5 p.m.  
 patient was then in fair condition. There was  
 however, slight abdominal distention with a little  
 salivary in the throat. Pulse was 120, of regular  
 rhythm and full volume.  
 OPERATION. An incision was made extending from the



Name Mrs. Deffen.  
 Age  
 Result

warm portac, was during the preceding relief  
 related considerably and the urine became much  
 water. A drainage tube was inserted at the lower  
 extremity of the wound which was then attached to  
 The operation was completed and patient back in bed  
 well within the hour from the commencement of the  
 operation. The urine was good and the bodily heat

heat was well maintained during the operation.

After History. Patient's progress was fairly satisfactory in every way (vide Chart) until the 7th Oct, the 4th day after the operation, when she had two attacks of Syncope, these necessitating the free use of stimulants. One of these attacks lasted for  $\frac{5}{4}$  hour, and was very alarming. A similar attack occurred on the 8th October, and again early in the morning of the 9th, during which patient fainted and died.

No Post Mortem examination was obtained.

The Uterus and appendages were exhibited by Dr Phillips at a Meeting of the London Obstetric Society.

OBSERVATIONS ON RUPTURE OF THE UTERUS.

In a case of this kind the first query that presents itself is • How far does the result of the case cast any reflections on its management?

Taking into consideration the patient's previous obstetric history, along with the hereditary obstetrical weakness (if one may so speak), and a full consideration of the sequence of the occurrences at the time, I do not think there is much to blame oneself for in connection with it.

The rupture took place I believe spontaneously before the delivery of the head, the mischief occurring before the second chloroform administration, at which time it was observed that the feeling of a constricting ring was much less marked on the left side.

The attempts at removal of the supposed adherent placenta doubtless were responsible for increasing the size of the rent.

The hereditary history in this case is interesting as indicating some defect in the uterine structures. This can be represented graphically as follows:-

follows:-

MOTHER

Each Delivery associated  
with Profuse haemorrhage.

One Daughter

Second Daughter (patient)

Adherent Placenta  
at each pregnancy.

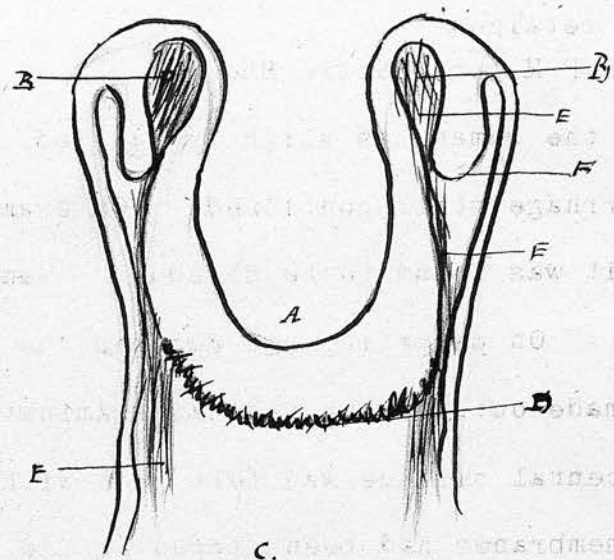
- a Pregnancies 1 to 5  
normal.
- b 6th and 7th compli-  
cated by Adherent  
Placenta and Post  
Partum Haemorrhage.
- c 8th complicated by  
rupture of Uterus, etc.

Another point of great instructive interest lay in the close resemblance (tactile) between the ruptured Uterine Wall and the thickened edge of the adherent placenta. (As I had previously had experience of over a dozen true adherent placentas I was quite familiar with the feelings imparted by it). Moreover, when my hand was (probably) between the layers of the broad ligaments, the tissues around felt just like foetal membranes, the Uterine Wall being simulated by the feeling obtained from pressure by the other hand above, on the thick abdominal wall.

wall.

The ultimate result of the case, and notwithstanding the favourable temperature chart, was very disappointing. The one thing which to my mind told unfavourably on the patient, was the fact of it being necessary to operate on her in her own small house, in which the absolute quiet necessary for a patient of her temperament could not readily be obtained. A further and even more serious drawback lay in the worry she experienced from her husband's attitude towards her. These things were, evidently, to my mind, the factors which led to the fatal termination.

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- A. Inverted Fundus.
- B. Uterine Cavity.
- C. Vagina.
- D. Placental Site.
- E. Membranes.
- F. Constricting Cervical Ring.

C INVERSION OF UTERUS.

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Mrs G., aet 28, IV Para.

Labour commenced	29,	12,	97-	9 p.m.
Labour over	30,	12,	97-	5.15 a.m.

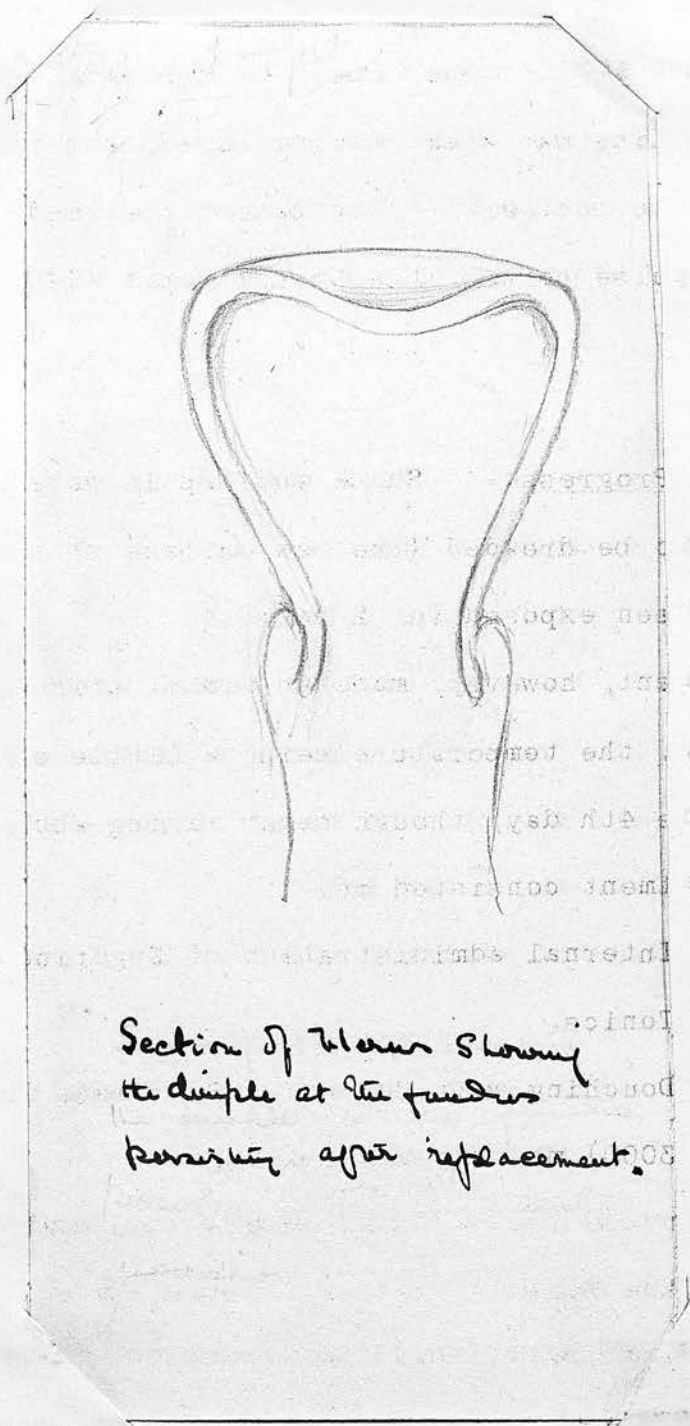
Report from Midwife:-

"Patient delivered 5.15 a.m.  
Placenta expressed 5.40 a.m.  
Membranes retained  
Alarming P.P.H. and Severe Shock."

On my arrival the woman had slightly rallied, though a slight Hæmorrhage still continued. On examining the Placenta it was found to be shreddy. Membranes were retained. On palpating the abdomen, the Uterus could not be made out, but on vaginal examination its roughened placental surface was felt just within the vulva. The membranes had been ~~r~~ipped at the cervix by the fundus in its descent.

The nurse in attendance had given 10 m Ergotine on account of the profuse Hæmorrhage.

When I tried to reduce the Uterus the patient complained of severe pain, and at the same time intense shock set in, the patient becoming pulseless and absolutely cold. After administration of suitable stimulants and the local application of heat, she rallied slightly, and an hour later another attempt was



Section of bladder showing  
the dimple at the fundus  
persisting after replacement.

was made to replace the Uterus. After some difficulty the Uterus was replaced, and ~~then~~ the hand was kept against it for some time. A hypodermic injection of Ergotine was again administered, and the Uterus then began to contract. The patient rallied considerably, the pulse perceptible though rapid (140) and very weak.

Subsequent Progress:- Shock and sepsis were the two things to be dreaded (the raw surface of the Uterus having been exposed for 2 hours.)

The patient, however, made an almost uninterrupted recovery, the temperature being a little elevated after the 4th day, though never rising above 100°

The treatment consisted in:-

- a Internal administration of Ergotine and Tonics.
- b Douching with Corrosive Sublimate (1 in 3000) morning and evening.

During involution, a slight dimple could always be felt at the fundus. Patient stayed in bed just a fortnight, and experienced no trouble or discomfort when allowed to move about again.

Remarks on the Inversion of the Uterus.

This condition, even in the puerperal variety, is far from common. Is this rarity due to want of recognition, or the want of publication, or partly both?

The Anatomy of the Condition in the above Case was, I believe, the Inversion of the body of the Uterus as far as the Os Internum, the Cervix remaining as a distinct fold or wedge around the neck of the Inversion, the membranes at the same time being nipped by the Uterus in its descent. Klob holds the opinion, that the cause of the condition lies in defective contraction of that part of the Uterine Wall which forms the Placental insertion, and he describes it as a sinking inwards of that portion into the uterine cavity, while the other parts of the organ remain tolerably well contracted. By this means the paralysed part is pushed down, and expelled through the Os Uteri and into the Vagina by the contracting parts. The Inversion in my case might have proceeded further, and led to complete obliteration of the Uterine cavity, but for the use of Ergotine. This probably aggravated the constriction induced by the

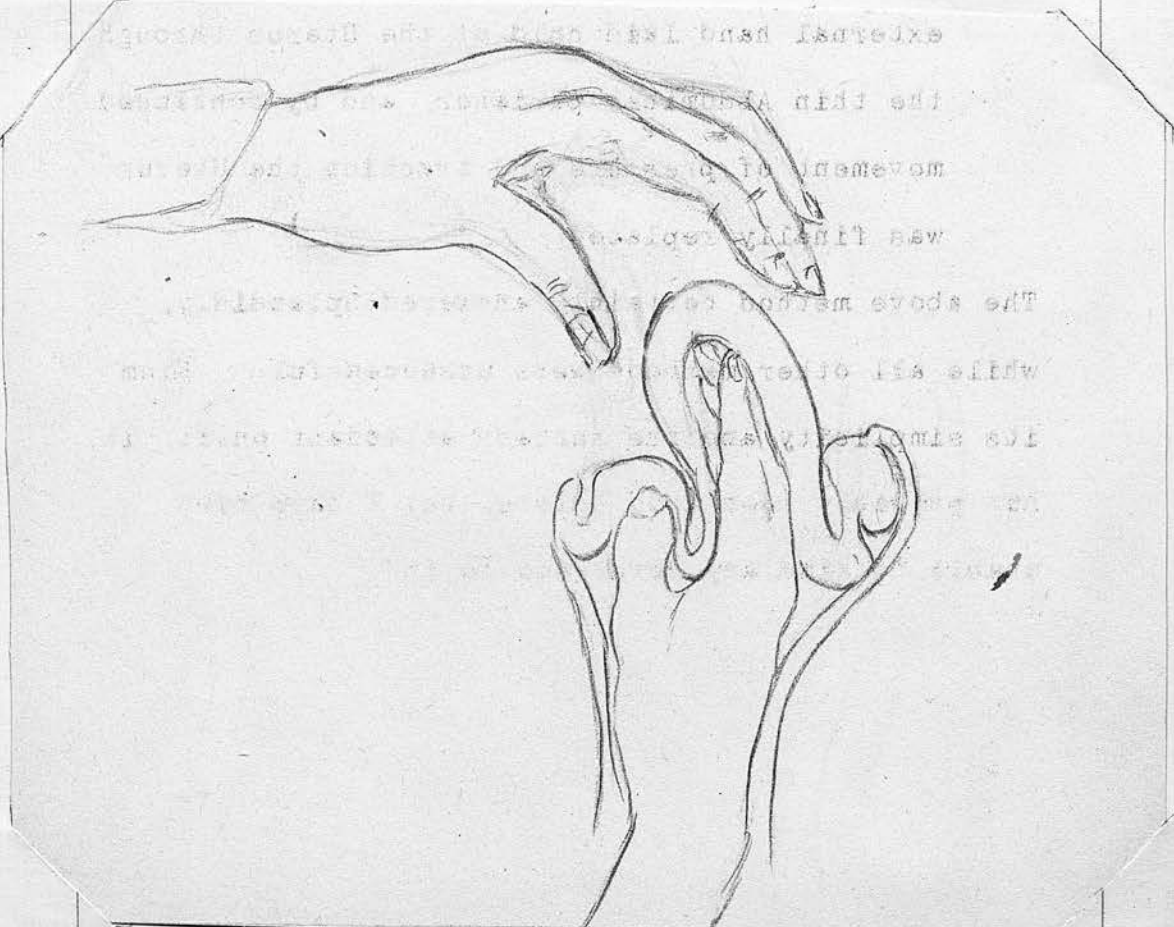
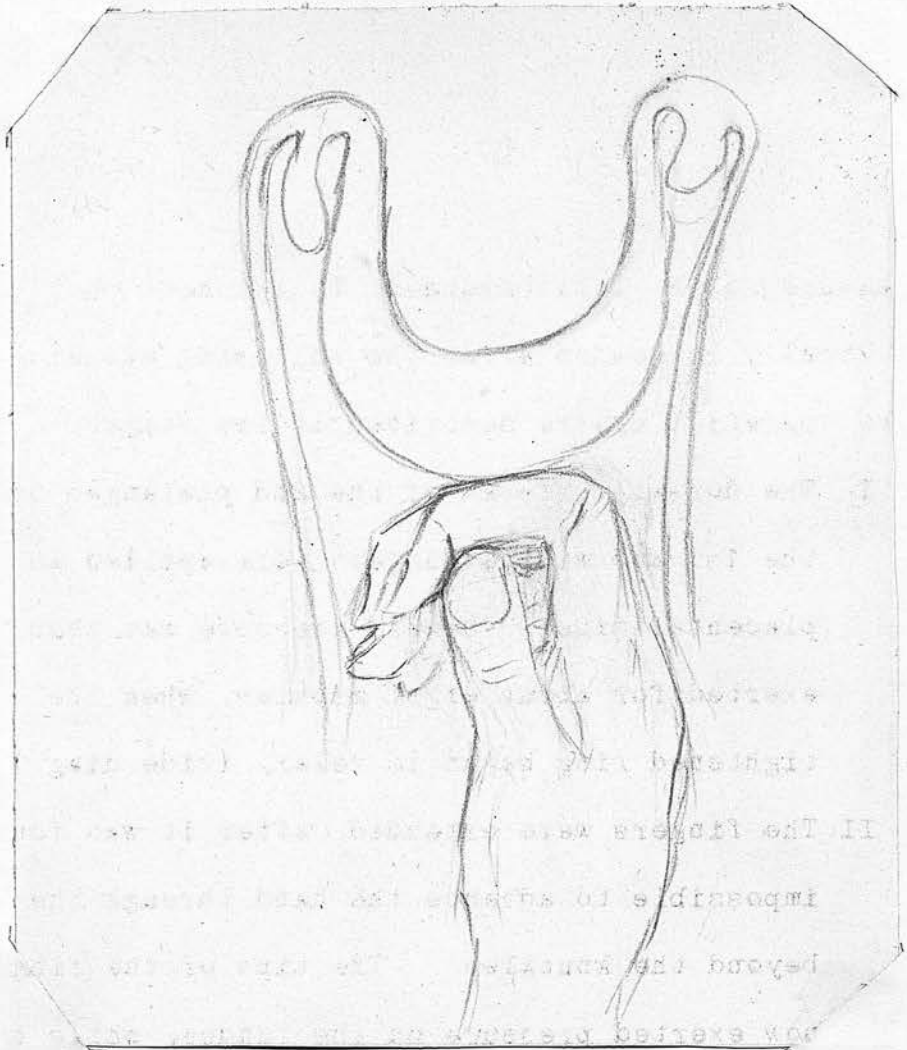
the cervical ring and so gave rise to the remains of the Uterine cavity and the conditions of the membranes seen in diagram.

The shock and collapse were profound, as is usual in these cases. One peculiarity in the case, however, lay in the entire absence of pain except when efforts were made to reduce the displacement. The attempt to do so ~~so~~ markedly increased the shock, the effect on the heart and circulation being almost instantaneous, and necessitating complete cessation of the attempt. The haemorrhage was only alarming to begin with. From the fact of its cessation after the injection of Ergot, it may be inferred that the Ergot was capable of producing contraction in the paralysed portion of the Uterus.

As regards the reduction, which was accomplished within  $2\frac{1}{2}$  hours of its occurrence, the great difficulty at first lay in the tonic contraction of the Constricting ring. When this became more lax, reduction was accomplished fairly easily.

Method of Reduction: - After trying the measures

08 p. 80



measures usually recommended, but without success.

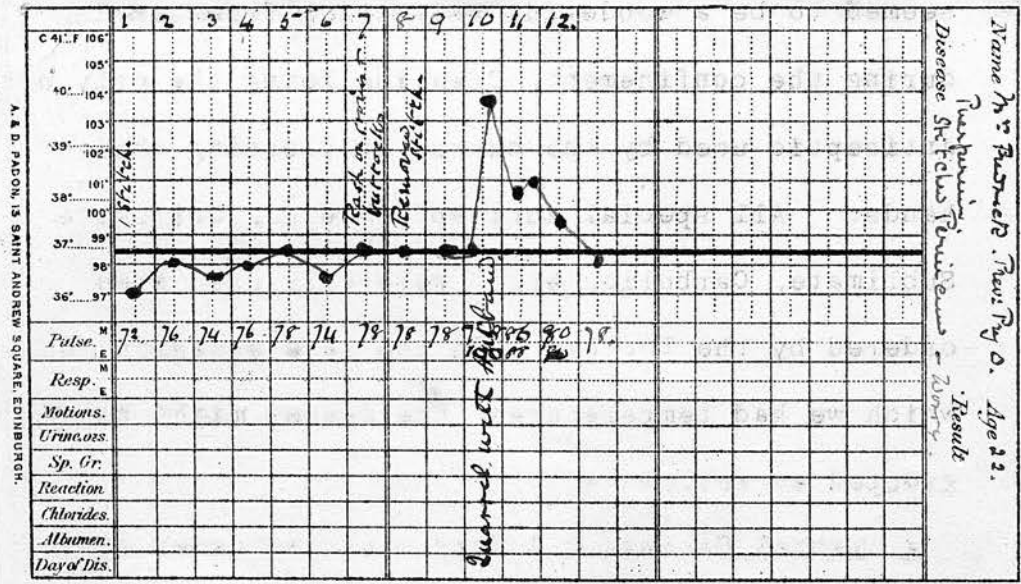
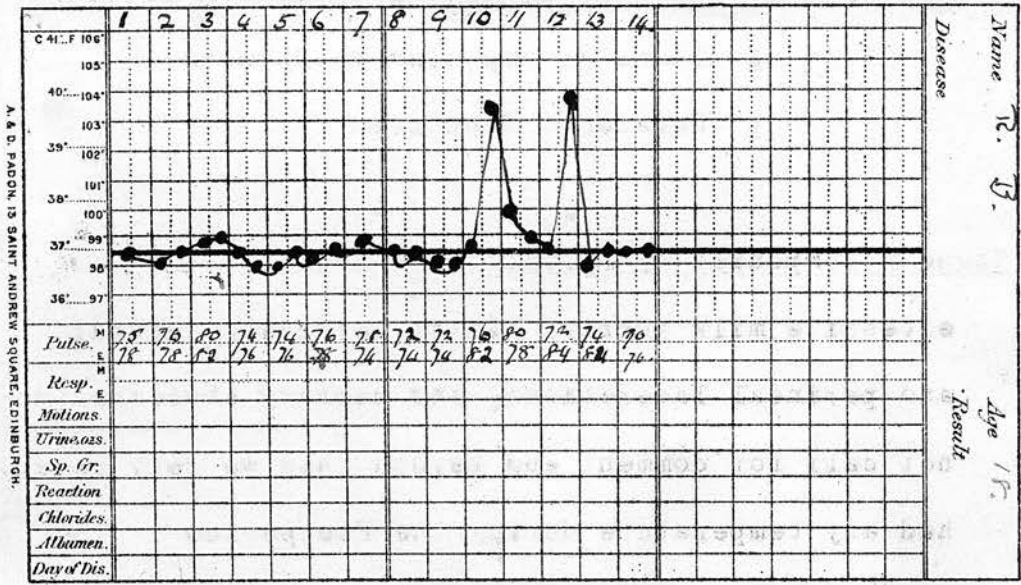
I finally succeeded after the following manner:-

The operation may be described in two stages,

- I. The dorsal surfaces of the 2nd phalanges of the 1st and middle fingers were applied to the placental site. Upward pressure was then exerted for about eight minutes, when the tightened ring began to relax, (vide diag.)
- II. The fingers were extended, after it was found impossible to advance the hand through the ring beyond the knuckles. The tips of the fingers now exerted pressure on the fundus, while the external hand laid hold of the Uterus through the thin Abdominal parietes, and by continued movement of pressure and traction the Uterus was finally replaced.

The above method certainly answered splendidly, while all other methods were unsuccessful. From its simplicity and the success attendant on it, it has probably been used before, but I have been unable to find any reference to it.

opposite p. 82



COMPLICATIONS OF PUERPERIUM.

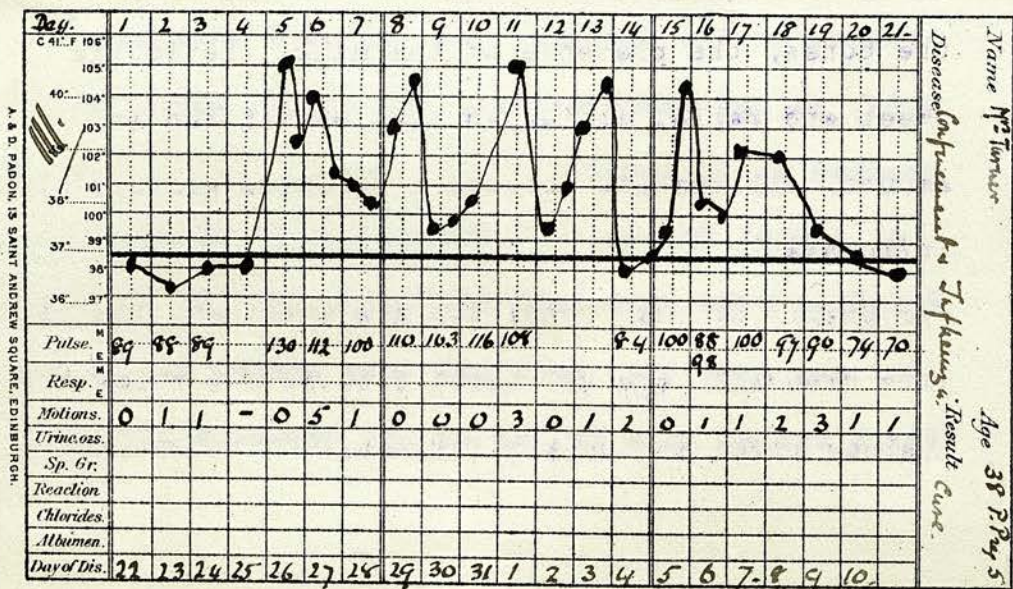
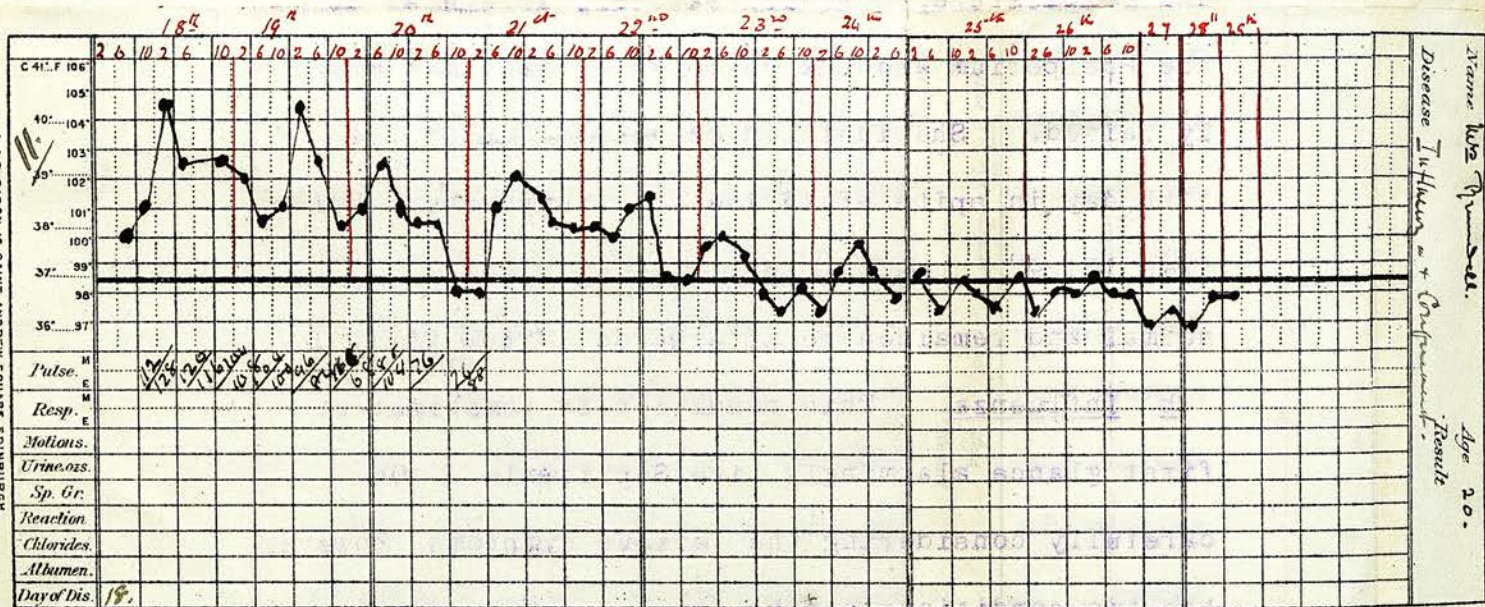
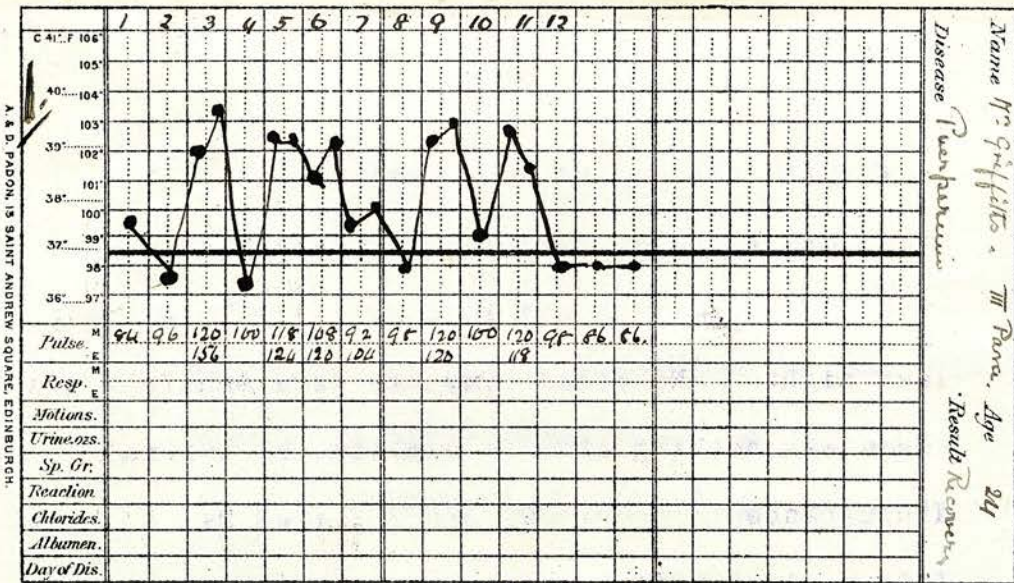
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These may be considered under the following headings:-

- a Those accompanied by Pyrexia
- b Cutaneous Eruptions

Those Accompanied by Pyrexia:- The usual ones, e.g., excessive milk supply, slight cervical, vaginal, and perineal lacerations, and mammary abscesses, do not call for comment, and beyond this we very rarely had any temperature during the Puerperium. The free use of Corrosive Sublimate Vaseline, 1 in 200, seemed to be a wonderful preventive from sepsis during the confinement, Creoline being the only other antiseptic used by the nurses in cleaning<sup>s</sup> their hands. All special antiseptics e.g., Corrosive Sublimate, Carbolic, etc., were only used when ordered by the Doctor. On the rare occasions on which we had temperatures, the causes might be grouped as follows:-

a Mental Causes. 1. Charts of two cases of Primiparæ who were both perfectly well until the 10th day, when they both had some mental worry, the first caused by a letter on two separate occasions



occasions, the second by a family quarrel.

The temperature<sup>s</sup><sub>A</sub> in both cases rose in the earlier part of the evening and were followed by a sleepless night. No other symptoms were manifest and there was nothing else to explain the thermal disturbance.

2. Mrs G., aged 24, IV Para.

This patient had a perfectly normal confinement.

The temperature, however, was very irregular during the Puerperium, and the Pulse Rate sometimes markedly raised. She insisted on getting up on the 11th day in spite of advice, her temperature being then 101.4° On the 12th day the temperature was normal and remained so afterwards. (vide Chart I opposite)

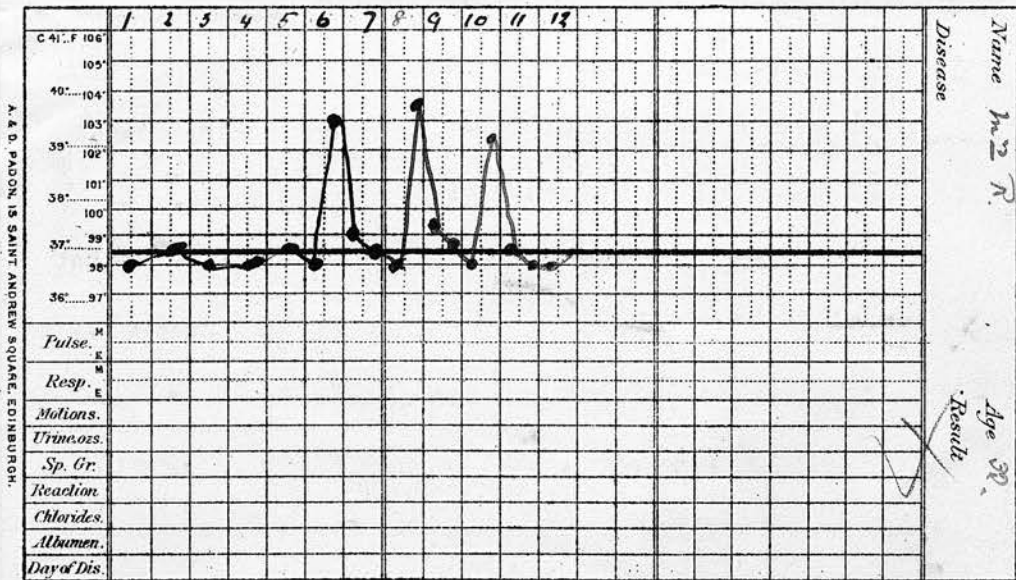
b Influenza. This condition is sometimes at first glance alarmingly like Septicæmia. On carefully considering the various symptoms, however, the two conditions can be fairly readily distinguished. The intense headache, sacralgia, pains in the bones, the presence of the milk, the lochia sweet, and rather increased than diminished in amount, all combine to form a definite picture of Influenza.

Two Charts of this condition are appended, the first (Mrs Brundell, age 20) being I believe a premature labour occurring during Influenza; the second

second case one of Influenza commencing during the Puerperium. (vide Charts II and III.)

c Malarial Type. Since the locality lies low and is very damp, temperature curves resembling quotidian and tertian aques are not uncommonly met with. These cases react very quickly to the internal administration of Quinine.

The accompanying is a Chart of a Puerperium complicated with a tertian type of temperature.



II. Rashes met with during Puerperium.

In quite a number of cases, and especially in Primiparae, a peculiar skin eruption manifested itself. In character it was mottled and papular, and situated mainly over the buttocks, thighs, and occasionally on the chest. It was noticed to be specially common in cases where the fourchette was torn, or where vaginal douches were not used regularly. There seemed to be no relation between the presence of cracked nipples and this chest eruption. These Rashes are not much referred to by writers, but they are of not a little interest.

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Such then is an all too brief and imperfect reproduction of some of the Obstetric wealth afore referred to.

I regret that the time at my disposal has not been such as to allow of a more full and perfect elaboration of it. I have indeed done little more than skim along its surface, with only here and there an occasional deeper participation, as indicated in the few reflections which presented themselves in connection with some of the subjects. Every part of it, however, outside facts and occurrences recorded, savour of incompleteness. Obstetrics, like every other branch of the wide domain of Medicine, is an incomplete Science. If it were not so, it would cease to be interesting.

The foregoing Thesis is my own work.

A. James C. Geddes.