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The Obstetric Experiences of a Young Physician

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"Obstetric experiences of a Young Physician"

It is said that the "more one has the more one want" and accordingly having received the M.B. & C.M. I set about preparing for the M.D. My first idea was to investigate the subject of "Compensation in Disease", but finding I would have to at once go into harness as an assistant I had to give up this subject from the difficulties in private practise of investigation and adapt myself to my surroundings, and finding I was to have more experience in obstetrics than anything else I chose that subject, not without misgivings however as to result. The first part of the essay is not of very much value, but still I think contains some points which every one will not think of till pointed out. It may be said that these simple cases do not make an important enough array for a Thesis for an M.D. but a workman must work with what tools he has, and seeing the great necessity for me acquiring the M.D. in my present uncomfortable position, I hope the important latter portion of the essay will make up for deficiencies in the former.

With these preliminaries I on the next page give a general outline of the way in which I have arranged the cases which I may say have all been entirely under my own care.

Outline Table -

I Cases with slight abnormal deviations

II Cases with important & graver deviations
most of these are characterised by being
too slow Labours -

I I Subdivide the slightly abnormal cases thus -

A. Those dependent on mother.	B. those dependent on child
1. Nervous	1. Hand + Head
2. Disappointment.	2. Twins *
3. Position	3. Short Cord ?!
4. Tough membranes	
5. Too weak abdominal pains	
6. Pendulous abdomen -	
7. Too early rupture of membranes	

II Severe cases are subdivided into

1. Small Pelvis ?
2. Hydatidiform mole
3. Forceps.
4. Placenta Praevia
5. Varices & Thrombus Vulvae -
6. Rupture of Perinaeum
7. Hour glass contracted uterus with retained placenta
8. Breech -
9. Pregnancy complicated with Heart Disease
10 Eclampsia -

Case. 1. (Nervous)

Mrs Bruce Fife Dispara.

In this case in the first child the waters had come away a week before delivery occurred, which had in the end to be terminated by Forceps. With this second child being born as it was (without help but merely by time and patience) some would say it was an easy and normal labour. To be accurate I say it was abnormal for these reasons. - The labour began at 9. a.m. and was over at 5. P.m. (8 hours) with ordinary exertions but the mere thought of her former bad labour put the woman into such a state of nervous excitement that she was with difficulty quieted. even between the pains in other words the thought that this labour might "go on a week" & need instruments at the end not only prevented the pains from coming on but actually stopped the pains when begun. the action of fear on the nerves taking the upper hand & inhibiting the uterine contractions.

Other examples of Nervous fear hindering good pains are constantly seen in primiparae.

Case. 2. Disappointment

Mrs Grass Balcaskie Fife. Primipara.

The message to attend this woman came at night & my principal being unable to attend, I went much to the woman's dismay, for on seeing me & not her own Dr arriving, she got into a great state, not so much taking as hysterical sobbing. She had had good steady pains for 3 or 4 hours, but they failed on my appearance (as they very often do for ¼ hour or more after Dr's arrival.) I waited quietly for ½ hour, & then asked to be allowed to examine her, but she refused saying she would have none other but her own doctor, and as I saw she would be persistently foolish I said I might as well go home but that the other Dr would not come (5 miles in snow). When she saw me putting on my top coat she came in & implored me to stay which of course I did. On examining her I found the head on perinaeum & in about 10 minutes after pains came on & the child was born easily & naturally. The disappointment here inhibited the pains reflexly, showing curiously how some of the acts of the body are controlled by the emotions, fear being the chief. Every one knows how nervous fear causes

causes frequent micturition & again sometimes spasm of the sphincter. A young friend, a minister has often told me that before entering his pulpit he was constantly micturating in the Vestry but that as he became accustomed to his position this ceased.

Case 3. (Position)

Mrs Hobson - Yeadon Leeds - Duipara aet. 30.

This woman in her first pregnancy 2 years ago had some mishap as she says the child had to be "extracted in pieces" at the 7th month. I can get no further explanation. In this pregnancy she feared the same would happen as at the 7th month she had pains & coloured discharge (This occurred about her would have been menstrual period) Opium & rest however prevented any miscarriage & she went on to full term of pregnancy. During the labour she was very frightened that the child was "fast" but on examining her & telling her she was "all right" her fears were quietened I was called at 3. a.m. She had had pains for 2 days previously but had good nights & slept without pains i.e. the pains only came on when she was standing or walking The

The pains were scarcely perceptible when she lay on the bed. She had pains if she sat. The pelvis was natural in configuration to a rough examination. The os was about size of half a crown. When she kneeled at bedside I found the head advanced with each pain & made good progress. In about ½ hour the pains seemed not so effective & I ruptured the membranes & waited. but the pains had not so much effect as I wanted. I tried her on the bed with a binder tightly round waist & in all positions for about 10 minutes at a time. I had her on back both sides & also on hands & knees. In this last position the pains were better but still would have taken hours to deliver. In the end I had to use forceps - & will refer to the case again under "Forceps". What I want to note is the fact that the pains were nil or almost so when recumbent & late on also very slight when erect. The head was rotated. & no obstruction but had the pelvis been extra roomy one might say that Gravity was the cause of pains being stronger when erect. but this cannot be as the pains ceased in time to be effective even in the erect posture. Could the abdominal muscles in this case be the chief

chief cause or initiators of the pains and that in the upright position these muscles were contracted (as is usual case) & acted on the uterus, & that they were relaxed & ineffective when recumbent?
Has the circulation anything to do with it?
I can understand that if in the upright position there was more blood about the uterus & therefore more bulk that the pressure on the nerves in & about the uterus would be greater & therefore more likely to set up reflex pains or contractions, but I fail to see how such a difference in the quantity of blood could be the cause.
The aeration of blood in erect position is certainly more complete
In the erect position the abdominal contents would by gravity help to press on & contract uterus & in erect position the heart & respirations would be quickened
Possibly the cause is to be found in a combination of the above.
Had the pains increased in the erect position I would have waited & delivered the woman standing or leaning on bed but the time was passing & I concluded Forceps would be easiest for all parties especially the woman who was tired.

Case 4

Case 4. Tough Membranes.

It is needless to mention ordinary cases where rupture of membranes has been ne=
=cessary to hasten or complete delivery
e.g. In one case I have had the child was born with the membranes unruptured (Caul) & in another the membranes were so strong that when os was fully dilated (24 hours) & the membranes protruding to 1 inch or so from Vulva (It was a Breech case unengaged vide post) I could introduce my hand in against them to make out presentation at Brim without rupturing membranes even during the pain In fact I could scarcely rupture the membranes when I wanted to do so as I will after explain
In another case of Placenta Praevia I had great difficulty in breaking the membranes.

Case 5. Too weak abdominal pains.

This is a fallacious expression as I am in=
=clined to think it is not the abdominal muscles which are at fault so much as that the prolonged resistance makes the muscles wearied out e.g. in the case of Primipara Mrs Lucy Yeadon - the woman got on all right till the Os was dilated & the membranes ruptured

ruptured and the head low down. Then the pains failed. How was this? The woman was natural in conditions though frightened a bit by foolish nurse saying "She would not manage without help. Ultimately I had to use Forceps but I want to note here that she was a primipara - a firm woman - a strong resistant perinaeum, & this last feature I believe to have tired the abdominal muscles so that they could not act efficiently. Whenever she tried to bear down at the "pain" she gave up very soon as if the efforts were useless

In some cases doubtless the "pains" are too weak throughout the whole labour. In the above it was not till later on -

Case 6. Pendulous abdomen -

Mrs. Marshall. Yeadon. Leeds - Triipara. 27.

This woman had a very prominent abdomen so much so that every one commented on her appearance & prophesied twins. Before examining her at all I thought it more like Hydramnios. There was no history of any forward displacement of womb. The labour was very protracted in first stage. I ruptured the membranes & soon a large child was born (male) which weighed about 8¼ lbs.

The

The Placenta was 11½ inches in its longest diameter The Liquor Amnii would be about a pint or a pint & a quarter. not very excessive at all events- The puerperium was good but she rose from bed with a prominent abdomen & has now (10 months since) as pendulous an appearance as when she first left her bed- She is a well nourished woman but not corpulent otherwise.

What can cause so called Pendulous abdomen?

1. Forward Displacement of uterus.
2. Leak says Proper Pendulous abdomen is seen in women with contracted pelves because the uterus as it grows, has to rise up more than usual-
3. In proof that a weak Lumbar spinal region would fall forward with corresponding back bending in dorsal region & prominent abdomen
4. Separation of Recti muscles in a wasted woman
5. Excessive Fatty deposits in abdominal walls in pregnancy-
6. Hydramnios
7. Twins.

The above is my own classification. Dr Rabagliati of Bradford tells me he has seen Ovarian and parovarian tumours simulating a pendulous abdomen. Of course both this and

and Ascites cause prominent abdomen but as they are commonest after the climateric period they cannot be classed under pendulous abdomen, which is a term generally I believe retained for "pregnant" women.

In the above case what "was" the cause?

1. A large child. 2. A large Placenta 3. A fair amount of Liquor Amnii. 4 Fatty deposits in abdominal walls. 5 & lastly ~~that~~ the fact that the woman went nearly a month by her own reckoning over her time. What is the cause of large abdomen now? A subinvoluted uterus would have shown some symptoms but there are none, nor are there signs as the woman is perfectly healthy. I think the cause now is simply a large amount of Fat in abdominal walls. As regards the causes I mentioned under 3. & 4. No: 3 would imply Spinal mischief & would most probably have pelvic mischief & therefore come under No: 2. Lusk. No: 4. Separation of Recti. This could scarcely occur to any such extent as to cause pendulosity. The muscles can be seen however very prominent sometimes with the Skin and Fascia between quite on the stretch. This is most apparent in spare women.

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Case 7. Too early rupture of membranes. & in this case partial prolapse of cord.

Mrs W. Fife aet 34. Pluripara.

I was sent for by the midwife. The first stage had been 24 hours, and when the os was about size of half a crown the midwife ruptured the membranes as she said to hasten matters. In ½ an hour after the pains ceased almost entirely & I was sent for. On Examination. I found the os about the size of a two shilling piece. the Head rotated but a piece of the umbilical Cord prolapsed down on one side of the head. It was pulseless. There were pains about every 10 minutes but very ineffective. Now this case if it had happened with the ancients they might have said that it was a natural case so far as mother was concerned, and supported their declaration by saying that at a certain time the child forced its "own" way into the world (constituting labour) & that in this case due to the prolapse of cord causing the childs death that the Child now was useless to act & therefore the pains ceased. & the child lay in the passages like a foreign body. Apart altogether from any such improbability in this case I have a proof that such was not the case because if the child could

could when alive force its "own" way then when dead it ought to be delivered easily by means of forceps, but such was not the case as it was not difficult to extract. What I want to note chiefly in this case is the fact that the nurse was wrong in rupturing the membranes. The labour was slow but going on all right as far as pod pains were concerned before & in all probability there was no prolapse of cord until by the early rupture of the membranes the gush of liquor amnii would carry the cord down with it.

As a rule I never rupture the membranes till the os is almost or quite "out of feel" & even then I do not do so unless the pains get weak or the membranes protruding at vulva. I have mentioned a "caul" I had lately. By so doing though it that case there was only about a wineglassful of liquor amnii & scarcely a drop in front of head. It was a premature child 7-8 months and was easily born.

B. Mrs R. Edinburgh Primipara.

In this case I want to note the danger of "accidental" rupture of membranes in first stage. This woman was standing on a stool doing

doing some house work. She had had some pains for 5 or 6 hours previously. When done with the work she foolishly jumped down on to the floor (about 1½ feet only) & the membranes broke. She sent off for me in great alarm. On arrival I found the os about the size of a shilling. With time and patience the child was born all right except a very prominent and hard caput succedaneum. This was one of my first cases in Midwifery and I was in great fear as to result. The child was not born till about 4 hours after rupture of membranes. I supplied the vagina copiously with lard & so kept the parts soft. There are two unnatural cases. In Burmah I believe they make labour very hard the patient lying on ground & the midwife sitting on the woman's abdomen, or a board placed across with a woman at each end. This way must surely rupture the membranes prematurely. I am unable to quote my authority for this but I certainly read it in an authentic paper or journal.

y. Mrs Smith Yeadon. 25. Primipara

In this case the waters came away when os was size of 2/- the 2nd stage being 14 hours. The cord was once round neck and was 39 inches long. the longest I have had.

D. Mrs Spyvie. Yeadon. In this case the liquor amnii came

came away 48 hours. before the child was born. I was not called till 40 hours after the membranes broke - & found os size of 5/- piece I gave Ergot in this case 10 minims twice in last 1½ hours.

E. Wm D. Yeadon - pluripara

In this case there was a pseudo rupture of membranes if I might so call it.

When I was first called she said that the night before when straining in bed the "waters broke". On examination I found the Os uteri closed & no waters escaped. It was certainly urine which she had voided in bed but she would not believe so. In a week after labour came on & all was over in about an hour and a half. the waters coming away just before head came over perinaeum -

All the above cases made excellent recoveries showing that the excessively long second stage did no harm, as far as I can make out. I don't say it is right & wait in all cases as long but certainly some practitioners would have used Forceps in some of the above cases whereas by time and patience all went well.

B. Cases depending on Child.

Case 8. Head plus hand.

a Mrs Taylor Guiseley Leeds - Multipara
The first two pregnancies were miscarriages
The second two were all right. For this the 5th
I was called and found the head presenting
but very high up in pelvis. The membranes
were pouched like the thumb of a glove
The os between 1/- & 2/- pieces in size -
The pains were strong but the advance of head
did not correspond. In two hours the os was
size of 5/- piece and now was dilating rapidly
The head jerked back suddenly after each pain.
Soon the pains died down to almost nil for
about an hour. the head still being high
The liquor amnii in front of head was large
I ruptured the membranes & waited ½ hour
& then I found a second bag of membranes.
All sorts of ideas crossed my mind as I
had never had such a case before till I
concluded the first membrane to be Chorion
and the second amnion with some liquor
between. I now ruptured the amnion &
waited ½ hour - but the pains were very
useless, and I proposed instruments. She
would not have chloroform - I had the
warm water ready & forceps greased. (I
use grease in preference to oil as it adheres
better)
when a strong pain came on and forced
the

the head down and over perinaeum
It was a full fingers length up before
the pain came on When head was being
born I found the left arm of child
flexed behind head- By holding it back
& exerting traction on the head I managed
to have child born- The elbow of child was
quite stiff by muscular contraction, showing
that the arm must have been in that
position in utero for some time It was
not supple for a month or so after birth-
Here again we had fear acting not pre=
=venting pains but setting the uterus contracting
as the woman was afraid of the Forceps-

B. Mrs Edmie Fife Primipara.
I arrived at 3 P.M. & finding the Os only size of
6d I went off & saw other patients returning
at 5 P.M. when Os was size of half a Crown-
As some distance from home I waited &
2 hours (8 P.M.) the Os was dilated almost
out of reach. The head receded quickly after
each pain but did not notice anything else.
Head rotated & well flexed. The membranes
broke naturally but still the head was high
and seemed to advance little in comparison
to the strength of the pains. I had with
me Forceps which I got fixed
without

without difficulty. On easing the head down with right hand, the recoil of head was very apparent & with my left hand I now discovered the cause viz. the right hand of child flat down on a level with and behind the right ear. By pushing the hand back & easing the head down I delivered the head easily & then the arm came flat on chest side.

These two cases show delay caused by the hand engaging with the head. What I can scarcely understand is the easiness with which both bodies were born after with the hand and arm so much in the way.

Case 9. Twins

All know the delay which is often caused in cases of twins, sometimes not very much, at other times prolonged.

Within the last few months I have had three cases of twins which are the only three I will mention

1. In the first case a midwife was present and after the delivery of the first child (4 months pregnancy) which was easy enough she extracted a placenta, & then feeling "something else" she sent off for me —

In

In this case there had either been two sacs with absorbed walls converting the 2 into one or else the nurse in extracting No: I placenta ruptured No: II membranes. This was my idea on arriving & discovering the second head engaged & hearing the history Both children were born alive & both died within a week. There were 2 placentas else would have most likely have had copious haemorrhage after extraction of first but there was not.

After extraction I found ~~two distinct placentas~~ 2 amniotic sacs. A male & female child so that most probably we had "two ova to begin with" (Lusk 221)

2 Twins plus Large goitre.

Mrs Lee yeadon Multipara.

Had five children before all died in infancy except one. I was called in a month before labour did come on. She then complained of shortness of breath (due to goitre v. p.) and also had discharge from the womb without pain. Being near at hand I gave orders to send for me when the haemorrhage came on again, but heard no more of her till I was called in to her at Labour.

Before entering the house I could hear her breathing with evident difficulty. The first stage

stage had been almost nil & the os must probably have undergone some dilatation "painlessly" which I believe to happen occasionally & usually or nearly always in Multipara where the parts are very soft and lax. I found the pains now to be very useless & slight I moreover feared she would choke at every pain, so difficult was her breathing, that the pains would not come on. She had been 36 hours in labour before I was called. In a previous labour a Dr. when called to her wanted to leave when he saw her condition, and in this labour refused to attend her – I let her alone till the os was fully dilated. She had had forceps in one labour previously and I now proposed to her to have them again, but she absolutely refused. I did not diagnose twins, as she was so small, but the small children (as after seen) accounted for the At 2 a.m. I gave her 10 minims of Ergot liquid extract. This strengthened the pains, and strange to note also relieved the breathing to some extent. In an hour & a half I gave her other 10 minims of Ergot, and at 4. a.m. the first child was born, when to my dismay (for the woman's sake) I found another in the womb – She thinking her troubles over

got more cheerful and I believe would have broken down if I had told her there were two. Instead of this I resorted to strategy saying that the afterbirth would take a little time to come away & might set up some pains which would do her good. She suspected nothing till the second head was at perinaeum 20 minutes after the first. There was one large placenta – two amniotic sacs. There was post partum haemorrhage notwithstanding that she had had 20 minims of Ergot. I stopped it by 10 minims ergotin injected and manipulation of uterus. Pulse 120 which was so high I think due to the breathing. She had a dilated heart. These twins died in a fortnight – The mother at same time after a good recovery got Bronchitis but recovered

Goitre. I have only seen one larger than this one. It is very common in this part of Yorkshire and many women say they have had it "since one or other of their children were born"

In this woman it projected most to the right side. Circumference of neck 18 inches. One part of tumour on right measures 8½ inches across. A most interesting clinical fact is to be noted in the effect of the ergot

N.

viz: easing the breathing. Could the congestion of the tumour necessarily greater at this time be lessened by the Ergot contracting the bloodvessels in it? I certainly think this was the case or else it would have made matters worse by forcing blood from the contracting uterus some of which would have caused more congestion about neck. Of course it could not alter the contents of the gland farther than the effect it had on the bloodvessels.

The children were male and female

y. In the third case under notice there were two placentas (one large & one small) One sack a male & a female - a large & a small one which were connected to the large & small placenta respectively. One child died at 3 months.

We 3 cases therefore show.

Two placentas	"One" placenta	two placentae
Two Sacs	two Sacks.	One sac -
Both heads	Both head	Both heads
Male & Female	Male & Female	Male & Female -
One placenta taken	one placentae taken	two placentae
away first	away "together"	at end.
Both children died	Both died in	One child died
in a week.	a fortnight.	in 3 months.

In a 4th case of twins I have had the first was a head and the second followed in 5 minutes a breech in a "caul"

Case 10 - Short Cord. I only want to mention the shortest I have had. 7½ Inches -

II Cases of severe deviations

Case 11. Small Pelvis ??

Mrs Barlow. Headon - act. 23. Primipara. height 4ft. 7 inches

History - Has had a very irregular menstrual life being often 5 - sometimes 6 - & once 7 weeks between her menstrual periods. It is now eleven months since she menstruated last. She does not know when she first quickened. When first I was called to the case I thought it must be that she was carrying the child a very long time but I think the proper explanation is that she must have been impregnated say 6 weeks or 2 months after her last menstruation. Ahlfeld & Lusk (p. 111) hold the "first days immediately after menstruation to be the most likely time for impregnation" i.e. after the debris & lining of uterus is cast off, but in the above case there must have been a very old lining in the uterus, or else some slight discharge must have taken place - I find the lower classes very careless in observing a discharge from uterus. Be this as it may this woman would in all probability have menstruated had she not been impregnated. But impregnation I think must have occurred here just before the menstrual time at the end of two months. The child when born seemed

seemed a healthy 9 months child - or rather 10 months (lunar) During the last three months of pregnancy she was very much out of sorts with sickness - pain in the head & body - She is a small woman - with a pelvis in comparison but the interspinous & intercristal measurements are 10 & 11 inches respectively The first stage of labour was 3 days. the second 5 hours - The child a female was well shaped - In first stage the pains were short & weak & made little progress. There was post partum haemorrhage which left woman very weak - This was one of the hardest labours I had attended - Was it due to 1. the small woman. 2 The small pelvis: or to the large child for it was large compared with mother's passages - It is impossible except by guessing to say what was the cause until the woman is examined again (which she objects to) or until she has had another child -

There was some inflammation & high temperature 103.4° 7 for some days

Case 12. Hydatid Mole -

Mrs Brayshaw - del 36 multipara -

I was sent for at 11 P.M. and found the woman in a collapsed state in bed -

History

History - She has had three children previously the youngest being now 4 years old - She became pregnant in June 1884 and went on all right till September (3½ months) the womb growing large very quickly as she herself remarked. About end of Sept^r (3½ months) she began to have pains across hips and womb. They were short pains & at this time she also began to have some discharge from womb at first small in amount but increasing in quantity up to the present time (6 December 1884) i.e. 6 to 7 months. During the last 2 or 3 weeks she was never free from discharge which was bloody & had some "clear globules in it". Sometimes a small clot came away by themselves. This is her own description - During the last 2 or 3 months she did not increase in size much and in last month she says she got no larger - She never quickened which surprised her and made her think the child was either "fast or dead" but not liking to speak of it she had no doctor.

On Exam: I found the bed saturated with blood. the woman's pulse thready and scarcely perceptible. I gave her a drachm of liquid Extract Ergot: and in a few minutes ℥j of brandy. The os uteri was about the

the size of a shilling and a large soft mass protruding and filling it up This I hooked out with my fingers combined with abdominal pressure - but had to use (against my will for I objected to them) ovum forceps to extract a piece higher up - The uterus was contracted I washed it out with weak carbolic lotion warm (1 in 50) & gave her 10 minims ergot & 10 ♏ acid sulph aromat. every 4 hours. with a teaspoonful of the following mixture every hour -

One white of egg well beat up -
One tablespoonful of brandy -
A little skim milk & sugar -

I have found this a very effective nutrito-stimulant in many cases.

On examining the first mass I extracted I found it was about the size of a good sized fist and consisting of the typical opalescent globules mixed up and hanging from a red shreddy substance or framework with of course some blood coagulated on it. Lusk says these vesicles are due to "hypertrophy of Chorionic villi with mucoid degeneration. Can there be also some "osmosis" occurring from the water of the blood into the vesicles?

The woman said she parted with a piece as large as a Childs head before I came

Here

There was the usual discharge for 4 days.
On the second night she had a severe rigor about 8 P.M. pulse rising to 110 & temperature to 101° F. I washed out Vagina with a warm solution of Condy's fluid and gave her 15 grains of Pulv: Ipecac: Co: and she soon began to sweat and got warm & slept.
On the third night she was all right but on the fourth she had another rigor, shaking the whole bed I treated it as before. She made a good recovery.
The cysts (Lusk 283) contain a "semifluid substance, albuminous, and like liquor amnii" which would support my theory that some osmosis occurs especially in those cysts which would at first project where the liquor amnii should be.
The cysts in my case were mostly about the size of a pea and all sizes down=wards. Lusk also says the "larger cysts are richer in water" which may be de=rived from the liquor amnii constituents filtering through the shredy placenta. It would be interesting to know if any of the salts or solids of the liquor amnii are to be found deposited in the tissues of the placental shreds. I found no trace of the Fetus, and as the whole connection of the ovum to the Uterus was probably

involved probably (judging from the size of the mass) the fetus would be destroyed at an early period from want of nutrition Lusk says about the first month.
The woman & her husband are robust healthy people with no signs of Syphilis which is mentioned as a cause -
The "secondary" Cause I say is a "Misappropriation of elements" the appendages taking the nourishment due to the Fetus.
The "primary" cause is still to be sought for in some idiosyncrasy or peculiarity of constitution inherent in the mother.
Which Lusk supports (p 285) by saying that this is probable by the repeated occurrence of the disease in the same patient.
Underhill p. 5. says Cancerous or syphilitic dyscrasiae in the mother are present in the majority of cases.
The mother is much oftener at fault than the fetus.

Case 13. Forceps.

"The first case I mention, many will laugh at but I believe what I say to be what really happened, and a Dr. who was present supports me - viz: "Too early rupture of membranes can change a Vertex into a Face presentation"

Mrs

a. Mrs Fowler Fife 27. Primipara.

I was called at 11 P.m. & found the os about size of 6d admitting Index - I left and was recalled at 5 a.m. The head presented by Abdominal palpation & waited. The Labour was very slow, but still a la primipara. At 7.30 the os was about the size of a two shilling piece but the pains were weaker instead of stronger. The membranes were very strong - I ruptured them the presentation being Vertex but not rotated. Lusk at. p. 183. says.

"Most writers ascribe great importance to the "oblique position of the Fetus, and of the uterus "in the etiology of Face presentations --- as a "rule however the first pains straightens the "fetus, the narrowing of the uterus in its "transverse diameter serving to press the breech "towards the Fundus and the head into the "pelvis. So long as the back of the child "is directed downwards the rectification would "inevitably be followed by head flexion. "When however the back is turned towards the "Fundus, and the change to the vertical is "not Readily effected, the pressure of the adjacent "uterine wall, may during contraction act in "a special degree upon the occiput and "direct it backwards towards the neck "while the forehead sinks forwards into "the brim of the pelvis" - He says farther

that "this" may only be temporary and
"that there may be flexion in the end
"but that if this continuous, a point is
"reached at which the force is exerted
"especially in the direction of the chin
"and Face presentation becomes complete".

In this case after rupturing the membranes about a breakfast-cupful of liquor amnii escaped and I then found a face presenting with Chin to the right and posterior. Now the Child as turned out after was very small. Now of course one may say it was a Face from the first & that I made a mistake in diagnosing presentation, and of course that is possible, but as the patient was one of the better class and her husband and mother very anxious about her, I took special pains in making sure of diagnosis, and believe it was a Vertex at first, and that the "rapid rush of liquor amnii made it into a Face" as it would have more effect on the small head. Still it is difficult to explain why the occiput did not de-
-scend. Had the occiput been hitched in any way the explanation would be easy but it was not. Extension did occur at all events. I now tried to push the chin up

up and to pull the chest backwards-
as in the position of figure which
is half returned this way
This method of Schatz I
could not accomplish in
this case, and now the
pains increased and to
my dismay I found the
head rotating with Chin
going back to sacrum, or rather I should
say with head rotated for stupidly I left
it to nature never for one moment
thinking but that the Chin would come
forward. I send off for assistance as I was
an assistant then, and gave chloroform
tried forceps but was afraid & waited till
my principal came in a few minutes
He delivered the woman easy enough. This
is a case which Lusk says to be almost
impossible but here I fancy the smallness
of the child allowed it The woman had
retention of urine for 3 days but recovered
well

B. Mrs Fawcett. 43. Multipara (6).
She had her last child 4 years ago.
This labour began three days before I was
called when the membranes broke. An
"alcoholizing" doctor was called in & visited
the

the woman on each of the 3 days, but did not even examine her on the third day, despite the fact that she had "pains" They got alarmed and asked if I would attend her, saying they had ordered the Dr. first engaged to give up. I of course agreed

On Examination - The woman had had no sleep for 3 nights and was very much worn out pulse 100. I found the head presented (Vertex) but was high up at the Brim The Os fully dilated but the vagina very hot and dry. There were pains about every ¼ hour - I waited an hour and as the head did not advance much I proposed Forceps. First I "greased" the vagina well with sweet lard (carbolized) - Ad Chloroform on each attempt to introduce Rt. 2 blade a violent pain came on, however I managed in time with gentleness and delivered the woman in ¼ hour - She recovered well except pain in the back for a week with occasional rise of the Temperature to 100° & 101° F The child was large and she was an "old multipara" The oldest woman I have used Forceps to This case was certainly neglected as she ought to have been delivered sooner at least I thought so. The vagina was quite dry -

the want of chloroform increases the difficulties of putting on Forceps though when on the pains are stronger than if chloroform is used which is an advantage as it allows of traction to be more effective.

3. Mrs Napier Fife (quintipara)
In all this womans children the cord had been round neck. I have referred to this case already under "Rupture of membranes". Sent for at 6. P.m. Nurse had ruptured membranes - 4 hours before when os was size of 2/6. The pains had weakened ½ an hour after the os when I arrived was between one & two shilling piece. The head was presented but some cord was prolapsed "due to rupture of membranes" too soon by the midwife. I managed to dilate the os with persistent working round it with carbolised hand and my fingers squeezed up the umbilical cord and got on the Forceps. Chloroform was used. The cord was pulseless. I had great difficulty in delivering the child. First the head would scarcely move and required strong traction. I do not believe I could have had power with the ordinary Forceps. I used Axis traction ones. After the head was born. I had difficulty with the shoulders but managed by fingers (Index of each hand) hooked into axilla The

The child was dead. There was a good deal of haemorrhage which was scarcely controlled by kneading the uterus. Injected 10 minims Ergotin and this is the only case where I have found it set up irritation. Here the parts swelled and were painful but was subdued in a few days by Glycerine and Extract Belladonnae (equal parts)

4 Mrs Hobson Yeadon duipara.
This is the case already referred to under "Effect of Position on the Uterine Contractions."
In this quarter the antipathy to Chloroform is very great Every one of the Forceps cases I have had refusing it In this case like No 3. The pains became useless but the mere introduction of the blades set up uterine contractions, so powerful that the child would have been born I believe if I had stopped, but as it was one of my first forceps cases after I came here, I was determined to persevere and not give in, as the old women in attendance would certainly have talked about it. This shows a want of principle I know but in the hurry I did not think of this.

It is useless relating ordinary cases like this but I will only mention one other case in That

that of Mrs Luty a primipara whom I delivered with Forceps and on the third day was attacked with puerperal Fever- Cutaneous douches Opium, stimulants did not do much good until I began to apply Iodoform to the torn fourchette (which was only a small raw area) Immediately after this she improved and got allright. This small surface I believe was the all-important part viz: when absorption of the lochiae do occurred-

I wish especially to note the advantages and disadvantages of Chloroform. In Scotland I always used Chloroform. Here I have never done so With Chloroform we have the advantage of having the woman completely under control not flinching and jerking and crying out We can apply the Forceps without setting up so severe uterine Contractions - we do away with fear - some person to give it is necessary. Without Chloroform we have to be constantly speaking to the woman thereby taking some attention off the application of the instruments. The woman suffers pain by catching the pubic or labial hair - & by the mere introduction of blades - The woman is not steady but we have the great advantage that when on the traction can be used with the pains to full advantage. No extra hand is required to give the Chloroform

Case 14. Placenta Praevia

I now come to one of the chief points in my thesis within the last two years, I have been fortunate enough to have had two cases
Lusk quoting Müller says they occur about 1 in 1000 cases. Like a Dr I was assistant to Homer, I may not have another for 7 years

1. Mrs Ingers. Yeadon – aet 31. Multipara (3) housewife –
Former History. She had her first two children naturally. The third required Forceps from the slowness of the labour. She did not recover well after this last, as she often had bearing down pains, and "uterine" walking. This the fourth pregnancy occurred in April 1886. In June (2 months) I was called in to see her as she was "sadly out of sorts" She complained of bearing down pain – pain on defecation, and could not walk well – On Vaginal examination. I found the posterior fornix filled up with a hard body – She had not menstruated for 10 weeks. I concluded there was "Retro-flexion of the gravid uterus". This I believed to be rare, being oftener retro-version with pregnancy. The os uteri was high and looking down and back but more "down"

back. The uterus seemed fixed. a medical man from Bradford (Mr. Applegard) confirmed my diagnosis. The Fundus of uterus filled up and occupied the cavity of the Sacrum. The uterus was about size of a closed fist. the os was soft and admitted tip of Index finger. I tried by steady firm pressure with fingers to reduce it but could not. I feared doing damage Mr. Applegard in a few days examined her and found the Os looking more forwards. He had some difficulty but managed to restore the uterus to normal position when the os came down as the fundus went forwards. I gave her Soda and Gentian for stomach and the woman despite all the force used went on all right till the 26th October 1886 (7 months) when I was called about 3 a.m. I found the woman in bed, the bed being saturated with about a pint of blood. She had gone to bed as usual all right and awakened feeling very faint with ears ringing and the bed wet. There was no pain and the haemorrhage had come on when asleep. I gave her 1½ grains Opium in pill. On Examination I found the Os uteri high up the posterior fornix was soft and boggy and contained something

about the Retroflexion I was struck - and concluded it was a placenta presenting - The bleeding had stopped - I got the bed dry and as I lived close - I left her with orders to send at once if bleeding came on again - I gave her some acid sulph: aromat: She had no more bleeding that night nor on
27th the next day nor pains - She kept quiet in bed all day, all right next night. I was sure it was placenta praevia -
The pulse kept 100 and was thready - This
28th made me anxious - Next day (28) as the pulse still kept up I feared lest bleeding should again come on and weaken her more and I advised her husband and friends to let me deliver her - but they seemed anxious to avoid interference. The os was high and admitted tip of Index easily - The woman felt the fetal movements and the Fetal heart was audible between the Iliac spine and umbilicus on the left side.
28th On this afternoon Bleeding again came on - about 5. Pm. It was slight (℥i) I found the Vagina soft and full of Blood Clot. I now told the husband, that unless he allowed me to deliver her that I would not be responsible for the consequences - and I got consent to do as I thought best - I cleared out all clots and gave her -

an injection of Condys Fluid - With pressure I could get my Index through the os and could feel the placenta - Taking the advice of a friend I had staying with me. I put in a sponge tent intending to leave it in all night - It was introduced about midnight Early next morning, I removed the tent, and found the os now admitted 2 fingers in diameter about one inch - The os was very tense and rigid like a ring - I separated the placenta all round os for about ½ to 1 inch. washed out vagina with weak solution of Condys Fluid, and put in a second large tent together with a smaller one - These I left in 4 hours - On removal the os was about size of a 2/- piece but still rigid - She had lived all day on a little beef tea & some whisky and white of egg mixture - I now gave her Syrup Chloral Hydrate 3ij and put in the medium sized Barnes Bag which I distended with water "at first rapidly and then slowly" and pulling on the tube when distended as much as it would bear - I left this Bag in for ½ hour - but it seemed to have done all it was going to do as regards dilatation, and I now removed it and put in the large size Barnes Bag - and tried slow dilatation as I thought rapid

Rapid dilatation would "stimulate the os to resistance" more. Now gave her another 3ij of Syrup Chloral and left in the Barnes for 4 hours - after which I found the os softer but only about 2 inches in diameter, and still rigid While the Barnes was in the os I also put in a very old kind of vaginal dilator which was used by an uncle of mine about 35 years ago in an australian practice. It is much on same principle as Barnes's Bag but the bag is round and has no "waist" It would do to replace a backward displaced uterus in the rectum. In this case it acted doubly viz: It dilated the Vagina, and also promoted dilatation of the cervix by its extending the vaginal attachements in the directions of the arrows in figure Now with the os about 2 inches I passed my left hand (after scrubbing in carbolised lotion and smeared on back with carbolic grease) in the form of a cone into the Vagina (my hand is small in form of a cone being only 5 inches round at the middle joint of medius and 7¼ inches round the widest part at the metacarpo-phalangeal joint). The woman had no anaesthetic as yet, and bore this pain very well. I began with fingers to dilate the Os and in about 20 minutes I managed,

with steady prolonged pressure to get all my fingers into the os up to their middle joints, but the pain now being severe I ordered my friend to give chloroform to the full extent and pressing steadily with my fingers it now gave way suddenly and expanded and allowed my hand to enter the uterus. This sudden expansion was doubtless due to the chloroform. I had felt the placenta in the way all the time, and now fresh difficulties arose viz. I could not find my way up "behind" the placenta I tried therefore to pass my hand up between uterus and placenta "in front" and succeeded easily but then I found that I could not use my left hand here to advantage, and I accordingly changed hands (this is a mistake I believe and causes a lot of extra handling but I could not avoid it). The woman was semiprone in position on left. I now introduced my right hand, and gradually got beyond the placenta which lay more posterior than anterior. There were no uterine contractions. I found the umbilical cord accidentally and found it pulseless which relieved my mind from trying to save the child, and allowed all attention to the mother. I now separated the placenta freely in front. The child presented its head but arms were extended over its head. The liquor amnii was copious and

and the child "bobbed" about on the slightest touch. Dr. Rabagliati tells me that he has often found this to be a sign of a dead child. It certainly was so in this case but I see nothing to prevent a living child doing the same in similar circumstances. The membranes were very tough, and I failed to rupture them with my finger nails — I now seized a foot which slipped, again I seized it with same result till I caught it between my Index and medius when it was fast. (I believe in this grasp as the surest) I now easily ruptured the membranes by pushing my thumb in between the edge of the foot and my Index finger I think this a good idea as it enables the operator to have a sure hold of child before the waters rush. Directing the assistant to keep up pressure on the abdomen — I slowly got the breech engaged, and left it for a few minutes to see if the abdominal pressure would set up uterine contractions but no — I then exerted steady but gentle traction till the second leg came down which I extended and now comes a very important part viz. When the head is passing through the Os uteri for with my small hand I do not think the Os was sufficiently dilated to allow of the free passage of a fetal head

for

for the "circumference" of the fetal head being

occipit. front: 14 – 14 3/4 inches

" vert. 16 "

Suboccip Bregmat: – 11 1/2 – 13 inches and

my hand 7 1/4 in largest circumference there

is a significant difference more especially as

here the head was extended giving a large diameter

of course the above are full term measurements

whereas this child was only 7. months advanced

and softer. But what I want to note is that

"gentle" traction is to be exerted now more

than at any other time. This was allowable

too as the child was dead & there was no

hurry for its sake – and even if the child

was alive I would do the same to avoid

any laceration in the more important mother.

I have not seen this pointed out in any

books I have read on the subject, nor the

way in which I seize child and rupture

the membranes.

The arms being extended I released them

in the usual way. The head being small

and extended I delivered by the "Smellie

Grasp" Viz: right hand on back of neck

the neck being between Index and medius.

and the left Index and Medius pressing

on Each side of the nose on malar bones

to flex head – which I easily passed over

the well distended perinaeum – and

now

now there was a great rush of blood the assistant was pressing steadily on the abdomen. Immediately injected 10 minims of Ergotin (prepared in cases by Jones of Liverpool) which I had ready. tied the maternal end of the cord and injected warm (110° to 115° F) water with Condys solution in it slowly into uterus. This I did till the water came back almost as clear as it entered (violet coloured) The womb responded and contracted but about 1½ pints of blood must have been lost. Injected other 5 minims of ergotin and removed all clots. I removed the placenta and membranes when the rush of blood followed the child and before injecting the warm water.

The placenta lay mostly posterior with exception of about 2 to 3 inches which was anterior there being from 6 to 7 inches posterior. This constitutes what Lusk (p 552) calls. Placenta Praevia Centralis i.e. nothing can be felt at os but placenta. The woman came out of the chloroform all right in about ½ an hour, and vomited a little which seemed to make the uterus contract still firmer. Now gave her some of the following mixture One white of egg well beat. 3ss brandy. skim milk 3i & a little sugar. the gol 3i of this every ½ hour and I also gave her about

about 3ij of the same by injection into her rectum This revived her considerably in about ½ an hour - She had not so much pain in her body as I expected though she said she was all sore especially where I had injected the ergotin - The uterus began to contract well and caused some pain which however I was glad of. The pulse at first was faint and weak (100) The heart beat regularly but feebly - I put a tight binder on and ordered the above mixture every ½ hour She felt sleepy which was a weakness sign and I ordered them to wake her every ½ to ¾ hour for her ~~nutrito stimulant~~ mixture. I left 10 minims ergot (Liq: Gt) and 10 minims acid sulph aromat to get in 2 hours - and this she took regularly every 6 hours for 4 days after the operation - On leaving in 2 hours after delivery her pulse was considerably stronger and 110 per minute.

29th 10. a.m. This morning she felt better pulse 128 per min: Temp: 99.° F. She had "pains" which came on about once an hour, and lasting about 10 minutes in her back. I gave her a warm injection of the Condy solution.

thus ℞ Potassae Permanganatis grs 40.
aquae ℥viii:

℥ 3ij to a pint of warm water
about 108° or 110° F

9th

She had this injection 3 times today

1. noon. Pulse 128 stronger Temp^{re} 99·4° F. Injection.

9. P.m. Pulse 130 Temp^{re} 99° F. injection - The Bed Clothes were changed - all day she had had the Brandy and egg mixture and also about 3ii of mutton tea well skimmed from fat every hour or two - She made water all right - The bowels moved possibly by the stimulating injection setting up peristalsis ??

30th

10. am. Pulse 140 stronger Temp^{re} 102·8° F. gave 5 grains of Quinine sulph: and injection of Condy's fluid

1 noon - Pulse 138 Temp^{re} 101° F gave other 5 grs quinine and an injection of Hydrarg: perchlor (1 in 4000)

8. P.m. Pulse 132 temp^{re} 99° F injected with Carbolic acid lotion about (1 in 200) I gave therefore today three different injections viz:

1st Potass Permanganat: about 1½ grains to ounce

2nd Hydrarg Perchlor: " 1 in 4000

3rd Carbolic acid " 1 in 200.

in order that if any germs escaped the one they might succumb to the other. This theory though somewhat crude none can as yet deny although the Hydrarg: perchlor: is from all accounts more toxic to germs than the others.

31st

10 am - Pulse 140 Temp^{re} 99·4° F. pulse stronger and steadier. She had had a fair nights sleep as the pains were less severe now The discharge today was less scanty and whiter

whiter but smelled badly. She bed linen and body clothes were changed today. She had a very bad cough which she had had for a month which a few drops of Chlorodyne eased. I ordered the nurse to persevere with the injections 3 or 4 times in the 24 hours. time about as before mentioned

Oct. 1. morning. Milk first appeared in breasts but was watery. This I took to be a good and healthy sign Pulse 128. Temp: 101°. F. applied Glycerine & Et: Belladon: (equal parts) to the Breasts

night. Pulse 110 Temp: 99°.6 F. She now complained of hunger and got mutton broth with bread crumbs in it and also some oat cake (English which is a thin light wafery substance) also the Egg & Brandy mixture and a little gruel She had had Ergot every 6 hours up to this time

Oct. 2. Pulse 108. Temp: 99°.7. had had a good night Lochia less and smell better - 3 injections

3. Pulse 100 Temp: 99. Had a piece of mutton done on the grid - night pulse 118 Temp: 99.6°.F.

4 Pulse 98 Temp: 99.8°.7 better 3 injections

5. " 102 " 99° " 2 "

6. " 96 " 98.4° " Sat up in bed - 2 injections

7. " 98 " 98.6 Had a piece of lean goose no worse for it

8. Pulse 96 feels well - Gave her today some powders

powders of the saccharated Carbonate of Iron 5 grains three times a day - Legs feel weak when up. One injection

Oct. 9. Convalescent some a slight discharge - The Iron powders set up heartburn so I gave her instead dialysed iron in 12 drop doses in Glycerine with Syrup Limonis which agreed much better This woman made a good recovery and was out walking in a month -

Resumé.

1st The haemorrhage first came on painlessly when asleep in bed - This surely proves (as it is often the case) that some dilatation of the Os uteri occurs before pain is felt and must probably happens in normal labour as well, at any rate in Multipara with soft parts

2nd The rigidity of the Os which felt like a hard fleshy ring and the sudden relaxation of it when paralysed (nerves) by Chloroform

3rd The toughness of the membranes -

4th The way of seizing the foot.

5th The way of rupturing membranes -

6th The passing of head through Cervix which is a point not sufficiently noted. so as to avoid lacerations.

7th The necessity to be prepared for Post partum haemorrhage as the Placenta

placenta being in part detached blood will pour from it till completely so, and also the uterus which may be dilated and partially paralysed, and also as blood collects during operation.

8th Clear out uterus thoroughly after the birth of the child.

9th Injection of white of egg and Brandy mixture per rectum.

10th How far was the Placenta Praevia due to the former Retroflexion and the efforts made to reduce it? ?

The woman is healthy just now (6 months) and has no signs nor symptoms of retro-flexion again. Could the placenta be dis-lodged by the efforts made at reduction of the uterus and fall down over the os? This is doubtful. I think the two were independent of each other. I do not know for sure whether the Retroflexion was antecedent to pregnancy or not but should think so. I think they were independent and an interesting accidental coincidence only. The case however shows what a lot of interference the uterus (pregnant) of an otherwise healthy woman can tolerate.

March 26 1887. I have today called on Mrs M. who complains of shortness of breath for the last month. She is stronger and fatter than she has ever been

April. 4. Ammonia Carb: and Digitalis has relieved the dyspnoea—

2. This second case of Placenta Praevia was really the first I ever met with. I have not such full notes however.

Mrs Mackie Fife (1885-6) act 22. primipara - History. The Dr my principal then attended this woman for a week. She had repeated attacks of haemorrhage "with slight back pains". He told me about it and said it was an abortion threatening. He examined the woman each day for five days but did not diagnose anything further - He os admitted Index. There were three attacks of haemorrhage two in bed at night, and one when sat on a chair -

On 15: Jan: 1886 I was sent for hurridly about 10 PM. to go off and see her (6 miles) as she was dying - I went prepared for a miscarriage but ready for anything up to Craniotomy

On my arrival I found her almost in a state of collapse - with thready weak pulse and pale face - The bed was saturated with blood which had begun to come away about 2 hours before - There were no "pains" which aroused my suspicions regarding the supposed miscarriage On examination I found the os about $\frac{1}{3}$rd inch in diameter, and admitting the point of Index finger It was high up in pelvis Whether due to the examining or not I don't know, but pains began to come on about

one

one in 10 minutes and at each "pain" the flooding became more severe - I immediately plugged the Vagina, and applied cold to the Vulva and abdomen in the form of snow (it was midwinter) - The woman was 7 months advanced in pregnancy. The bleeding however still came on with the pain. I was now sure it was placenta praevia, more especially as I could now get Index through the Os and "feel something soft presenting." I sent off for my principal and gave her a teaspoonful of Brandy every ½ hour and also put in the small sized Barnes Bag till assistance came - This was my first case of placenta praevia. The Barnes controlled the bleeding. She complained very much of the pain of manipulation. When the Dr arrived he gave chloroform which strengthened the pulse considerably. I now put in the larger Barnes and dilated the Os in about 10 minutes by steady injection. Here the Os was very soft. In my other case where the Os was rigid, I used slow expansion. Here it was easily done. I believe the slow way to be the better (unless any need for haste) as it subjects the parts to "less forcible separation of molecules" as it were. After removing the Barnes, I passed my hand into the Vagina and Index and medius in through the Os and

and separated the placenta then passed in my whole hand and ruptured the membranes (easily) and secured a foot which I brought down - The bleeding was now controlled, I employed traction but the child (a 7 months one) threatened to tear so I waited a few moments. 10 minims of Ergotin and 5 of sulphuric ether were now injected into the buttock and by slow gentle traction the child was delivered I washed out the uterus with Carbolic acid lotion and gave ℥ss brandy - Put on a tight binder. The woman felt very done and complained of her ears ringing but before she left (1½ hours) she was con= =siderably revived - This woman took dialysed iron and glycerine for a month which considerably improved her and made up for the loss of blood -

This case differs from the last specially in one point viz. so much more blood was lost in this last case as she was a distance away I believe in immediate delivery at the second haemorrhage if not after the first The child in the last case died in 12 hours -

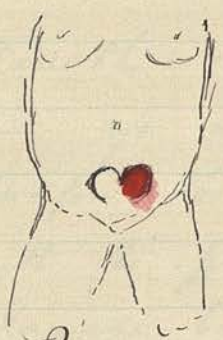
Case 15. Pregnancy with Thrombosis of Vulva
(and suspected Tumour of Uterus?)

Mrs Penny Yeadon- Quartipara aet. 35.

History. She had had three children before this. the last from her account must have been a cross-birth (Transversa) with "Spontaneous Evolution" as she says when the Dr. (An Irish. A Andrews of 20 years (experience?)) came, he waited till an arm came down, and then he left her and came back and then a leg came down and he "pulled the child from her by hand and foot" This is an extra-ordinary explanation, and must be taken for what its worth. However she suffered from "menorrhagia & metrorrhagia afterwards till she became pregnant 12 months after" All this pregnancy from the 3rd month onwards she suffered from very bad varicose veins, due to the high venous pressure which might be set up by any en-=largement pressing on the inferior Vena cava- The right leg especially was effected, and she had a thrombus about the size of a hens egg in the right labium (It was difficult for it to feel the Os), I would scarcely take on the case as I was called in shortly after I came here and I feared trouble at the labour, but I did engage, and was prepared for the worst. Towards the 9th month the thrombus and veins got less.

During the 1st stage of labour the

Vulva was soft and lax. I ordered her not to bear down during the "pain" so as to dilate with the soft waters as long as possible - During a very strong pain the membranes ruptured and the head was forced right down to the perinaeum The Vagina before rupture seemed dilated very much and allowed head to descend at once - I kept up very gentle pressure on the right fronboard labium with a soft oily cloth. It was about the size of a small Tangarine orange. The child was born easily with about 3 or 4 pains after the membranes ruptured without any accident. The placenta was removed in about 18 minutes and I could then feel a swelling about the size of a small orange on the "left" of the uterus which was hard and painful on pressure. It felt exactly like a double uterus



(Red in figure) This swelling I could feel for 4 days after labour getting smaller every day. On the 5th day I could not feel it abdominally - I decided it was one of two things viz: 1. Fibroid tumour 2. a Varix with blood clot. The woman felt it herself and had not done so in any previous labour. - In 10 days the lochia which

had been diminishing in quantity again became copious, so much so that I put her on Ergot and Iron, since then (5 months) she has had repeated attacks of haemorrhage at irregular periods, and has occasional pain about uterus which is worse at the left side - She complains of severe occipital headache - On examining her a few weeks ago the uterus seems fully involuted, no displacement - Os all right for a multipara, and could find no trace of any tumour - No pain on pressing in the fornices. It of course might have been a tumour or a varix and got less as the uterus involuted, and with the ergot the case will be followed and will be interesting farther but I am undetermined what the swelling was -

Another case of Thrombus of vulva some time ago made it necessary for me to use forceps - The Os also shared in the congestion with the pressure - I thought here to lessen the damage by getting the head through as soon as os was sufficiently dilated as I think this is less damaging than long continued pressure -

Case 16 Rupture of Perinaeum

The only case of rupture of perinaeum right

through sphincter ani that I have seen in my practice occurred in a case of mine Mrs S Fife where the head was born just as I entered the room, on gaining her I found the perinaeum gone. I at once after birth of placenta put in 3 strong silver sutures deeply. The sphincter and perinaeum united well. The lochia fortunately were scanty. The legs were tied together, and water drawn off at first Another case where I assisted & put in stitches did not unite well at all.

Case. 17. Hour Glass Contraction of uterus and retained placenta.

Mrs L Geadon - quintipara aet. 37. has always had long severe labours, in all of which the membranes ruptured very early, in this instance two days before the child was born. I was not called till end of 2nd day when I found the head low down but weak useless pains. I gave 10 minims ergot, and soon the pains got stronger and when sitting over a chamber utensil during a pain the head was born with umbilical cord round neck. 20 minutes after birth during which time my hand had been laid gently on uterus, I tried to remove the placenta by combined method but I found it "fast" and the cord springing back after traction I

I oiled my hand and passed it into Vagina, and through the Os. Where I found no resistance but about an inch above was a contracted ring which allowed cord to pass It might be the size of a shilling or less- I gradually insinuated my hand (Cone shaped) and got the placenta which was now loosened gradually pulled through - It was very bloodless White and calcareous - The cause of the contraction was not due to any pressure on uterus but must have been due to the effects of the ergot while sitting straining over the pot. when the head was forced down - She parted with some clots for 3 days. but was all right.

Case 18. Breech -

I. Wish in this case to point out the mistake of allowing Midwifes especially there with no training to undertake cases -

Miss - Y. Gradon - primipara aet 20.

I was sent for at 1 noon & found a midwife in attendance, She had been all day since 5 a.m.. (8 hours) At 8 a.m. the waters came away naturally, and a foot presented and came down which "she pulled at till fast". The foot extended from Vulva to knee and was livid and cold - I suspected pressure on cord had caused death, and such was the case.

2

I told them to have patience and all would be right except the child which was dead. Strong pains came on and soon expelled the child to Chest. The arms were extended which I brought down in usual way. It was dead.

Had this child either not been pulled upon or the cord looked to it could have been born alive.

2. In this patient Mrs C. Yeadon. There was severe Chronic Bronchitis and she has had all her children (8) at the 8th month and of these 8, three were by Breech. I think the severe cough brings on the labour. I thought this might stand as a proof that the child in womb has the Breech downwards till near labour and then makes a somersalt and presents head but this cannot be so for then the foetal heart would not be heard so constantly below the umbilicus to left or right which it can be in the later months of pregnancy in most cases which I have tried, "in endeavouring to make out the sex"

3. In this case Mrs B. a Dr was called in but not finding all as smooth as he wanted he left. I was sent for and found "with difficulty" that a Breech presented but in an irregular manner - in fact it was

more a Sacral presentation, as the buttocks lay in left iliac fossa with back of the child down and head up in right lumbar region something in the form of the figure

which is very diagrammatic and is as if abdominal wall of mother was removed (it is exaggerated) She had been in labour all day but had advanced little I introduced hand well up in cone shape through the fully dilated Os ruptured membranes and brought down a foot, as I feared it might end in a transverse. A healthy child was easily delivered.

Case 19. Pregnancy + Heart Disease.

This is I think the most interesting case in my thesis

Mrs Slater primipara aet. 21.

I was called in the morning of the 29th January 1884 to see this patient about 2.30 am, and found her sitting up in bed recovering from an attack of breathlessness. She was 6 months pregnant.

History. When 16 years old she had an attack of Acute Rheumatism which was very severe for 6 weeks but did not leave her for 6 months. after 6 months she got "well" and

and remained pretty strong to all appearance and able to work up to the present time (5 years) with the following exceptions - viz: She had palpitation on easy exertion - she had breathlessness on going up stairs or up hill so that she used to take a roundabout way going to her work to avoid a steep hill - She has habitually constipated - Her digestion was impaired (due I think to bad teeth) She fell pregnant 6 months ago and got married at Xmas - She has had a hardish life as her parents were dead -

On examination this morning I found her pulse 120 soft. small rapid and slightly irregular Temperature 100.° F. There had been vomiting of mucus and frothy expectoration was going on - which was mixed with bloody sputum, very much like the rusty sputum of pneumonia - The face was flushed at the lips and malar prominences the other parts very pale and cold - No oedema of legs. She could not lie down -

I ordered her to put her feet in hot water & mustard for a half hour and gave her the following

℞ Tinct Digitalis ℥ij

Ammon. Carb. grs xl

Sij ℞ tablespoonful every 3 hours.

She got ℥ij of brandy every 3 hours in between the doses of medicine. She soon revived and got some sleep well propped up - She had her

Coughs

cough, and dyspnoea which remained more or less for 2 or 3 days but was otherwise pretty well — The Os uteri was closed - No uterine pains -

On auscultation. At the mitral area there was a rough blowing presystolic murmur which was continued into the systole. The Cardiac impulse was seen and felt as a thrill over a large area from Xiphisternum to 2 inches beyond the left nipple most apparent in the 6th intercostal space. In the 3rd space there was a transverse dullness of 4 inches. In the pulmonary area the second sound was thumping & abrupt (accentuated) due doubtless to the increased tension in the pulmonary artery - There was no reduplication

There were coarse loud rales all over the chest except at bases of lungs which were dull & noticeless.

At first I gave her Ether & ammonia and then with the hot water & feet and brandy revived her -

29th On my visit at 11. a.m. same day I found her sitting up in bed "pretty well" as she expressed it - There were rales all over the chest, her heart was firmer and more regular but the murmur could be heard (presystolic) and also the systole was accompanied by a murmur which they seemed planed than before as the rales were not so loud, allowing the murmurs to be clearer heard

heard - Light food - Brandy - Digitalis & ammonia mixture continued - Bowels moved naturally today - Urine. Specific gravity 1026. less in quantity than normal for last 3 months (women told her it was always so when pregnant) The solids were - roughly estimated - about 52 parts in 1000. - There was a very faint trace of albumen - urates copious -

Tonight in the evening she wanted to get up but I forbade any exertion whatever and also warned the friends of the gravity of the case - She remained in bed and slept fairly well during the night.

Jan: 30th Was refreshed in the morning but still had some dyspnoea - against my orders she dressed and came downstairs pulse 110 Temp: 99. Medicine and brandy as before -

31. Found her downstairs sewing. Had felt child moving in utero freely all morning has cough & spit - Rales less marked bases of Lungs still dull - pulse 104.

February 1st Downstairs as on the 31st

1st to 2nd At midnight I was called in haste as she was dying & on my arrival in 5 minutes I found her bordering on unconsciousness with face pale & cold except lips and malar prominences which were purple - Her arms were listless and fell dead down if raised - The heart was pumping and fluttering

fluttering away irregularly and slowly
96 per minute. I was very much afraid she
was going to die. Injected 15 minims of Ether
& Brandy put feet in hot water & mustard
with hotter water slowly added - put cold water
mustard plaster behind each calf and one
on the precordium - The lungs were very
oedematous and bases dull - I bared left
arm, bound it, and with a sharp bistoury
(all I had with me) opened a vein in front
of the elbow - black thick blood oozed slowly
out but never came freely, so I bound it
up again, and went on with hot water
to feet and brandy internally. also injected
10 more minims of ether - she felt the prick
of the needle more this time which encouraged
me - She was lying back in a woman's arms.
In ¼ hour she recognised me and complained of
the feet being scalded with the water - The calves
& precordium were now red and the mustard
was removed. I thought of leeching precordium and
had leeches but thought the mustard would be
the more effective - I never saw recovery in
one so near death. She got 10 minims of Sulphuric
ether & 10 of Sp: ammon: aromat: every ½ hour
for the next 3 hours, and then began with
the old mixture of ammonia & Digitalis

2nd Feb: 11. am. I saw her now, she had had some sleep which
was accompanied by dreams - I now proposed

a consultation, and arranged with a Dr
of 50 years experience in the next town
He could not come till the next day so we waited
and went on as before -

3 Feby: Had passed a good night. Had consultation
The Dr saw her at her best and gave a good
prognosis, despite the dullness of lung bases &
the heart murmurs. The uterus was quiet.
I believed another attack like the last would
finish her and told them so - after the Dr
had gone - but hoped he (the Dr) would be right.
I proposed bringing on labour but he would not
hear of it. Continued old treatment. Rather more albumen in urine

4 Feby: Had a good night & felt refreshed pulse 108.
Rales still loud & bases dull.

5. Feby: 11. am. Had passed a good night (least pt sometime)
and was sat up in bed knitting but the face
specially over the malars was congested. The
breathing rapid 22 per minute & shallow.
pulse 110. Made her promise to stay in bed
and take her medicine and brandy -

10. Pm. Had some neighbours in and talked in a
very lively strain somewhat hysterically, but
said she "felt queer" as if something was
going to happen. Was short in breath

11. Pm. An hour later I was sent for and on
arriving in 10 to 15 minutes found her
dead, she only drawing one breath as I
sat to the bedside. Froth was oozing from the

the mouth and nose. The face was ashy pale and cold the lips were purple and the nose drawn - Injected brandy and ether, raised chest and lowered the head and 3 or 4 ounces of serum poured out of the mouth and nose - Then began artificial respiration (warm plates over heart) and worked at it for 20 to 30 minutes with no result except the mechanical forcing up of froth and serum.

So ended the worst case I have ever seen - No post mortem could be had -

On a P. M. Examination there would be found in my opinion the following conditions

1. Mitral obstruction and incompetence - as regards the aortic valve I am not confident.
2. The left ventricle dilated with the walls perhaps hypertrophied which hypertrophy according to Larcher (McDonald p. 6.) occurs in all pregnancies and which Duroziez supports from an examination of 135 women in Paris (p. 10.) Löhlein denies this.

   In this case from percussion and position I am sure there was enlargement towards the left especially, but this would tell back on the right heart, and we would have an attempt at compensation by dilatation and hypertrophy there too.
3. There would be serous effusion into the

the pericardium

The mitral valve would be irregularly thickened and possibly some vegetations -

The orifice would be contracted and the chordae tendinae shortened not allowing the orifice to be closed

4. Both auricles dilated specially the left & by the increased pressure in the pulmonary artery the right would dilate secondarily, and which would account for the accentuated second sound. The auricles would be full of dark thick blood specially the right in fact right side of heart would be full - on its contents.

5. Microscopically the alveoli of Lungs would be congested, and more or less full of serum & Blood Corpuscles -

6. Bases of Lungs condensed and full of Corpuscles - making them solidified

7. Bronchi red, oedematous and full of bloody serum or froth. Blood vessels in and around them congested. may be apoplexies -

8. Kidneys congested.

Dr. Angus McDonald is his book on Heart disease during pregnancy says "64.4 per cent - are fatal "Viz: 9 out of 14 cases. In 2 cases of primi- "iparae all died, (most were after delivery) p116. "and of these none were proved to be due "to embolism" - He says "Few go to full term "but after delivery there is not a corresponding

"improvement in the symptoms, the reason
"being, that plus shock and exhaustion, during
"delivery to the deranged heart, the evil results
"of the original disturbed relations of compensation
are nearly as powerful as in the late months
" of pregnancy.
Premature labour may then be useless if such
be the case, and for the above passage I
did not press it in this case.
At p 26. McDonald says quoting Gusserow,
"that if hydramnios, ascites, &c be present
"you may bring on labour to facilitate the
action of the chest"
This case was doubtless due to the Rheumatic
Fever 5 years before, as all during the
5 years we had more or less palpitation
& breathlessness. Spiegelberg (McDonald p 28)
says "Mitral disease is worse than Aortic"
Fritsch (McD. p 35) says "a healthy heart can
"meet the requirements of the case in pregnancy.
"it can accomodate itself to the increase
"of blood" (which occurs normally in pregnancy)
"but that the diseased organ fails here.
What was the cause of death in this case?
In McDonald. p. 35. we have Pamm saying
"A sudden projection of blood into the heart
will paralyse it." Fritsch says "the worst cases
are those of advanced mitral stenosis
Spiegelberg as I above mentioned says also that

mitral disease is worse than aortic.
Here then trusting these authorities and judging
from the severe ending of this case we have
the worst possible complications to pregnancy.
The cause of death here was this. The heart
acted as far as it was able in the first
6 months of pregnancy fighting or against
the increase of blood - till a time came when
it failed to continue the struggle, the
increase of blood wearying out the heart
till it failed to force sufficient blood
away through the lungs & make room for
that coming in behind. Then the Lungs became
engorged and congested further adding to
the hearts embarrassment till they became
at last blocked paralysing the heart not
from a "sudden projection into its cavities"
but from a failure to get the blood out of it.
This is the only explanation I can offer - in fact
we had "acute pulmonary suffocative oedema" M.C.D. p. 100.
We had fair compensation when not pregnant
but this failed when in pregnancy we had extra blood -
Spiegelberg and M. Peter believe in Venesection.
In my case there did not seem sufficient
vis a tergo, from the left ventricle to render the opening of a vein
of any use, at any rate there was not
at the time I did so, perhaps if I had
seen her sooner there might have been -
If done early my opinion is that it might

avert the attack, but it would only put off the evil day, for the blood would soon renew and then the effect of the bleeding would also weaken the system My idea is that bleeding is of little use. The chief symptoms in my case are to be noted. Viz: Cough - Dyspnoea - Rales - cyanosis - Palpitation - Vomiting - Uterus inert (possibly due to the cerebro-spinal system not sharing so much in the attack, "If it was paralyzed labour would come on" (Frankenhäuser & Obernier Lehrb. p. 110)

Conclusion: A woman with such disease should not marry and yet it seems hard to debar a woman from marriage for this reason - Viz: I have had two women both with loud mitral systolic murmurs, bear children well, one has 4 & the other 5 children and have had no heart symptoms shown in fact it was only by accident I chanced to listen to and discover the murmur - There seems to be a "Something else" latent besides the heart

If I ever have so bad a case again where death seems inevitable I have resolved to give the woman a chance by "bringing on labour", for I cannot help thinking that it is my duty that if death is so certain as this case proved that delivery "might" give at least a small chance of prolonged life.

Case. 20. Eclampsia

I have had two cases of Eclampsia one Eclampsia gravidarum & the other E. Puer = =perarum but unfortunately have not full notes of either -

The former occurred in a young woman a primipara act. 27. in the 9th month of pregnancy - In October 1885 just when I was starting for a country round, I was called by the woman's husband who said she was in a fit, 2. Pm.

27.

History. She had had scanty micturition for a fortnight with swollen legs - vomiting sleeplessness. headache - She was cleaning the house when this first fit came on. It lasted about a minute, was epileptic in character and left her dazed for sometime. 20 grains each of Pot. Brom: & Chloral Hydrat: were given every 4 hours - The urine on heating became nearly solid with albumen. She remained semiconscious till 6. Pm. when she had another fit much the same as the former

28th

during the night she had 3 fits and at 8 am. she had a very severe one - I remained with her all forenoon and used Chloroform to minimise the fits - She was now unconscious between the fits with heavy breathing pulse 98. Temp: 101°7. During this day she had about 20 fits & more or less severity I now

now dissolved a grain of pilocarpine nitrate in 20 drops of water and gave 2 injections of the solution 5 drops at at time with 2 hours between. This caused copious sweating but did not rouse her at all. I also allowed her to inhale nitrite of amyl (10 drops on a handkerchief) I had never heard of it used for this disease. This had little or no effect on the unconsciousness. Mustard was applied to nape of neck and to kidneys on back but all seemed of no avail. Some fits were restrained by the chloroform. others were lessened in severity while some were not aborted or lessened at all. A consultation was held about bringing on labour. I believe it might have been of service but the consultant said no. She died the same night having had about 30 fits or more.

The second case was puerperal. The woman had had 2 children before and after each one had had an attack of eclampsia In this case as soon as child was born she began with 20 grains of Pot: Brom: & 20 of Chloral Hydrate every 4 hours. She had one slight fit and slightly albuminous urine but recovered well. I believe in emptying the uterus as soon as possible in E. Grandarmus as it takes

off the renal pressure at any rate and allows of freer oxygenation to the whole system.

This finishes my thesis. The cases I have mentioned are some of the more important I have had, and I trust may be of sufficient importance to merit the much coveted M.D.

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