Thesis

for

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by

Austruther Lowdson MB. CM. Glasg.

Subject.

"An Analysis of Obstetric Cases with Observations"

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ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
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In this Thesis I have endeavoured to record faithfully my obstetric experiences of the last four years. I have kept careful and accurate notes of each case and if the total results show little extraordinary, they at least show many an useful lesson.

Although some of the more unusual cases may not be sufficiently numerous to warrant very definite conclusions, yet they are such as to demand more than a passing observation.

Situated as I am in a country district without access to any books of reference I am unable to distinguish what observations are new or old. My only work of reference is Dr Leishmans admirable work on Midwifery

During the last four years I have been called to attend 260 cases of ~~conf~~ Labour. of which 40 were either over. on arrival, or so low in the pelvis that the position could not be satisfactorily diagnosed. unless. I had judged solely by the movement of restitution a test considered by authorities as unreliable. Why it should be so no sufficiently weighty arguments can I think be adduced No doubt the cases of 3ro or 4th position may have changed to the first or second in its descent but authorities say it is no accurate test of even the first and second positions

Now so far as I have observed and I have all along given this my close attention, the movement of the head is a correct index of the

position it occupied in the pelvis.
I do not know whether any series of observations
have been made and recorded on the
proportionate number of cases in which
the movement of restitution corresponds
to or contraindicates the prior position in
the pelvis. If such an average was struck
it would greatly facilitate the record
of the various positions a point by no
means always easy of solution as I
have frequently found to my cost.
In the 220 cases in which I have ascertained
the position of the head some of course were
already engaged in the pelvis and may
have possibly changed. To be perfectly
accurate all observations ought to have
been made while the head was still
at the brim. The following numbers give
my percentages under the circumstances
detailed.

| 1st position | 2nd | 3rd | 4th. |
|---|---|---|---|
| 8th. 5. | 8. 6. | 2. 1. | 4. 5 |

Whether from faulty observation, or exceptional experience I cannot say, but these percentages differ materially from those given by Dr. Leishman. His numbers are.

| | | | |
|---|---|---|---|
| 67. | 10. | 20. | 3. |

The 2nd and 4th. nearly correspond, while the 1st and 3rd. are very dissimilar and this difference cannot be accounted for by rotation previous to my arrival as then the 2nd position ought to have been more frequent. The 3rd position is usually supposed to rank next in frequency to the first but such has not been my experience I found that in the 3rd position as is usually happens rotation is most frequent and more easily accomplished than when in the 4th. Of 5 cases of 3rd position 4 spontaneously changed, while of 10 in

the 2nd ~~presentation~~ was changed. and 2 were delivered as such 3. of them by the use of forceps. Of face. presentations there were. 3.
Two of these were in the 4th position, and in one of them on account of the narrowness of the pelvis podalic version was. successfully ~~applied~~ effected; while the other terminated as it presented In the third case. the position was a 1st. and forceps were applied at the brim, and the case ~~terminated~~ obtained turned into the 4th and delivery effected without any further use of the forceps.
In one case of Hydramnios. at the 7th month the feet presented; in another the breech doubled in the 1st position

There were 2 cases of twins, one pair. at the 8th month. died next day; the others all survived.

## Management of Normal cases

These have in the majority of instances been left entirely to nature. Assistance has been most frequently rendered in cases of primiparae, and in these has been chiefly limited to dilation of the os by use of the fingers

A very little experience is sufficient to convince anyone that the great hindrance to the expulsion of the child is the os. After the os is fully dilated I am in the habit of in nearly all cases, of pushing back the anterior lip of the os if it is descending in front of the head whether it is edematous or not. The rapid advance of the head after this is sufficient reason for the adoption of this procedure be the arguments against it what they may.

Some argue that this movement is of

no benefit unless the os is edematous
This I think is just as great an error
as the assertion that it always does
good. The truth I think lies between
the two extremes. While there is no doubt
the benefit is most marked in cases of
edematous os. yet it is of sufficient
benefit in other cases as to justify its
adoption. In cases of shallow pelves the
lip comes low down below the pubes.
and can only with difficulty be pushed
back and retained and even when ac-
complished does not result in any very
appreciable benefit. but in cases of
deep pelvis such procedure is followed
by a marked change in the progress of the
labour, and so, to these alone would I advocate
the pushing back of the anterior lip in
normal labours.
I have seen a sufficient number of cases

in which the pushing backwards of the os, has been followed by the changing of the site of the pain from the ~~back~~ front to the back, as to lead me to infer, that the two have more than an accidental relation If this should prove, on further investigation to be otherwise than a mere coincidence, a further argument in favor of thus pushing back the os will in consequence be adduced, as the frontal pain is either less easily borne or more acute than the lumbar.

In multiparae the benefit of such a procedure are naturally less marked than in primiparae

It has been frequently remarked that delicate women deliver themselves more easily, and frequently more rapidly than do their strong neighbours. This is no doubt due to the more feeble resistance of the os

Among delicate women. I have found them most rapid who have almost always been and still are the victims of leucorrhoea, and it is reasonable to suppose that in such cases the continued discharge has induced a more than ordinary atony of the pelvic structures which normally impede delivery

Chloroform I have seldom used, and in all cases. I have observed an increased tendency towards excessive ~~loss~~ post partum loss. Chloroform has been found to have a less paralysing influence on the heart during labor than at other times. This is I consider due to two things. First. the heart during pregnancy is somewhat enlarged above the normal and, in consequence is probably more. so capable of resisting its depressing effect.

Secondly. Each contraction of the uterus

causes an excitation of the sympathetic sufficient to cause an increased action of the heart. In the normal labor the increase of the pulse beats with each successive pain, are very apparent and though less marked under the influence of Chloroform yet the increased action of the heart must have a decided beneficial effect.

How the heart has become enlarged during the period of pregnancy it is difficult to say. It cannot likely be due to increased blood pressure or resistance or we would find it enlarged in various disease. Perhaps the rhythmic contractions of the uterus, which continue all through the period of pregnancy may reflexly influence the heart in a similar but less marked degree than during the continuance of labor, and lead to gradual

increased development of the ventricular muscles

## Forceps.

In rather over 14 per cent the cases were terminated by the use of the forceps. In 3 of these the head was low down in the 4th position and was delivered as such.
In all the other cases the position was either 1st or 2nd.
This proportion is higher than is usually considered necessary but I am not aware of having resorted to the forceps without due necessity. Here as in all country places ~~are~~ a large number of the poorer women are unattended by medical men and our advice is only sought when the natural powers have proved unavailing, and this tends to increase

unduly the proportion of forceps cases.
In cases where forceps have been used more of the usual kind; either atony or slight disproportion between the child and the pelvis. In 3 cases only was the disproportion so great as to render delivery by the forceps a difficult matter In all 3 cases a living child was produced though in 2 of the 3 had still born children at this previous accouchement.
In a few cases I have applied forceps when the pains were sufficiently powerful to effect it if a long time were allowed This I resorted to in the interests both of the mother and child, to save the former from the debilitating effect consequent on prolonged suffering, and the latter from the risk of death from pressure. To this I in a great measure attribute the almost complete immunity from post partum fever in my practice.

Laceration of the os. should I think be most particularly guarded against for reasons to be afterwards referred to.

In no case has there been any laceration of the perineum which required stitching, because I have always removed the forceps at the outlet in primiparae and in multiparae when the position is either 3no or 4to. These two points cannot I think be too highly insisted on.

## Maternal Mortality

In one case only has death resulted and from a cause entirely extrinsic to the labor. The mother aged 34. had 6 months previously consulted me for a large bulging aneurism of the aorta quite apparent at the ~~root~~ episternal notch and accompanied by a thrill audible to the patient herself

For. the last 3 months she was. confined to bed with increasing ~~anasarca~~ edema and orthopnoea, and at the time of lying in the legs, and body, were exceedingly edematous. Labor was very rapid and over before my arrival.. I removed the placenta from the vagina. there was no hemorrhage. but she gradually sank and died 48 hours after.

## Infant Mortality

Of stile born infants there were 17.
Of which
10 of these were premature, four were.
dead some time and. were more or less.
decayed. Three were. the subjects of encephalocele and spina bifida
Three were under. 8 months.
One at the 8th month. in a case of Placenta
praevia was. stile born.
Two. died from accidental Hemorrhage.

Two were syphilitic. One lived for a few minutes, the other probably died from the premature detachment of the placenta, which came away with the child. The suspicion was thereby raised in my mind that the Ergot administered in this case was the cause of its detachment:

In the remaining two the child died from no apparent cause. Both were delivered with the forceps as both suffered from inertia. One of the children (the only one I have ever seen) presented the rare phenomena of rigor mortis. In this case the child was certainly living for some hours after the labor began. but as I never ~~suspected~~ expected its death I took no note of the time when rigor mortis set in. It would be interesting and in some circumstances important to know how long after death this condition

appears. I am not aware whether any observations have been made on this joint.

## Induction of Premature Labour

has been performed in 2 cases.

In the first a primipara at the 8th month were convulsions set in. In the 3 hours that had elapsed before my arrival she had had 15 convulsions. I administered chloroform and ruptured the membranes after which all pain ceased and labor coming on 24 hours after. She was safely delivered, and made a good recovery

In her subsequent confinement ~~xx~~ there was no recurrence of the fits.

There was no albumen in the urine at any time. She was a woman of much intellect.

In the other case - a more unusual. com-
plication called for its adoption.
The mother, a pluripara had. aborted at.
the 6. mth. was in her previous pregnancy.
The foetus. was. deformed by a large.
encephalocele, and complete spina bifida,
and was accompanied by an excessive
secretion of. amniotic fluid.
When 7th month form in the pregnancy in
question she. complained. of great pain
and tension of the abdomen. which al-
lowed her little rest- either night or.
day, and. completely prevented her from
walking. Examination revealed a marked hydramnios.
Sedative treatment was tried but proved
futile and the pain and. sleeplessness.
increasing I invite the knowledge of her
previous condition, and. the frequent. co.
existence of hydramnios. with abnormal
development of the foetus without hesitate

induced labor at the 8th month by rupturing the membranes... On evacuation of the Liquor amnii escaped. the foot presented and the Os being soft and easily dilated labor was completed in 1½ hours after The foetus presented exactly the appearance of the one previously spoken of.
In the succeeding pregnancy she arrived at the full term and bore a healthy male.

## Hydramnios

I have met with 3 cases of this condition three in the case of the woman spoken of above and once in another. In all. premature labor occurred from the excessive distension
One of them exemplified the danger of rupturing the membranes in these cases

during the continuance of a pain. In the case the gush of fluid carried the cord past the feet which presented. This is a result very apt I think to happen and I think it would be advisable in all such to rupture the membranes in the interval between the pains, so as to allow the slower draining away of the fluid and the more convenient manipulation of the presenting part.

In all three instances the foetus was abnormal, all similarly being the subject of ~~complete~~ encephalocele and complete spina bifida All illustrate the now well known - association of female children with hydramnios, In two the feet presented a likewise frequent observation, as the separation of the foetus from the uterine walls seems to interfere with those adaptive movements which Simpson

considers necessary for a normal presentation. The frequent association of hydramnios and abnormal foetus has been sufficiently established. Whether the hydramnios is the cause of this abnormality has not yet been shown. Possibly it may have some malign influence for although its effects are not apparent until the 5 or 6th month of pregnancy, yet it has been ~~shown~~ recognised in cases of abortion at a very early date in the life of the ovum. ~~The quantity of~~. The ~~colour of the~~ fluid in the case of the woman who twice had suffered from this complication was ~~the~~ straw coloured, and very much resembled pale blood serum. So much so indeed that it occurred to me that the excess was in a great measure due to transudation from the foetus whose spinal column was covered by

only a thin layer of epithelium
This woman had previously borne 6 healthy children. but on the death of her husband had 2 years after married a delicate man the subject of phthisis three first two children living, abnormal as stated ~~the~~

## Systemic Diseases producing Abortion

I do not mean to speak of the many general diseases which may produce abortion but only of two severe affections of which I can give cases to illustrate
In one the mother a strong healthy woman was 6 1/2 mths advanced in her 5th pregnancy when she was seized with a moderately severe attack of left lobar pneumonia
Two days after pain was complained of in the lumbar regions and on the 4th day ~~[illegible]~~ a living foetus was expelled with one

severe pain. Next day the pulse was 120. sputa still rusty. and diarrhoea somewhat troublesome. She progressed favorably until the 6th day when coughing violently the uterus was completely prolapsed externally This was easily reduced. On the following day. great pain was complained of over. uterus and propus. perspiration had shown itself. That same evening sudden and complete left. hemiplegia supervened and she became was almost moribund Stimulants were freely given and she rallied showing markedly all the symptoms of. septicaemia, and embolic obstruction of the blood vessels.. The sputa again became. rusty., pulse pyrexia increased, and sweating became more profuse. From then she gradually recovered. almost her usual health, but with impaired motion of the leg and complete paralysis of the arm.

Since then she has been going both to a healthy child and made a perfect recovery.
The other case was one of blood poisoning following a slight wound of the left forefinger which was followed 10 days after by inflammation of the axillary glands and most severe, and diffuse cellulitis of the breast beneath the pectoral muscles, from the clavicle to the base of the mamma. In the early stage of suppuration, severe acute pleurisy supervened which for a few days endangered life. Free incisions were made into the affected structures, and large shreds of necrosed tissue were daily removed.
Twenty seven days from the receipt of the wound she aborted the child 6½ months old being still born.
Two weeks later slight phlegmasia of left leg followed, and soon subsided.

under the ordinary treatment, only to recur with double severity one month later. In 2½ months the breast had healed and she was well again.

These cases are both startling illustrations of the remarkable recuperative power of the human frame under very adverse circumstances. Both are recognized serious complications which almost always lead to abortion. The explanation of this tendency is to be found in the observations of Brown-Séquard on the influence of imperfectly aerated blood on the contraction of involuntary muscles. His observations show the powerful influence the presence of carbonic acid in the blood, exerts on the uterus.

The imperfect aeration of the blood, its contamination by gaseous products, the disturbed circulation and evacuation, as marked in both pneumonia and blood poisoning

easily account for the liability to premature expulsion of the foetus in these diseases.

I have at present under treatment a case of Pneumonia in a woman in the 6th month of pregnancy. The attack was a severe one; and the cough has all along been troublesome. Ten days have now elapsed since the acute and recovery seems now well assured without any tendency to abortion having declared itself

## Accidental Hemorrhage.

This complication has been met with in 3 instances. In two of them the haemorrhage was moderate and no unusual feature presented itself. In the other the hemorrhage was severe and concealed. The labour had been

progressing favorably when she somewhat rapidly got pale and fainted, Ergot and brandy were administered she soon recovered and labor terminated easily 3/4 hours afterwards. The placenta followed the child and with it were expelled a large number of clots of blood. The head being engaged in the pelvis before the hemorrhage took place prevented its escape even if the conditions otherwise allowed it, so that no indication was given of the cause of the fainting. The child was of course still born.

## Placenta Praevia.

In thirteen instances in which the placenta presented it has been central in two.

In the first the hemorrhage set in some

when profusely at the 6th month, and when visited a few hours afterwards. the presenting placenta was easily felt. For 3 days she remained well until labor pains and severe hemorrhage again occurred

The placenta was then upon separated from the horns of the os. as recommended by Barnes and this head dissected in a great measure the hemorrhage. As soon however as the gom separated had been encroached on by the dilation of the os. the flow began again. D. Barnes bag. was then introduced, and os. dilated; when sufficient room being made. ~~the~~ Chloroform was administered, the bag removed and the child turned and delivered. The infant died. next day. ~~dead~~ but. the mother made a good recovery.

The next case also central was characterized by sudden severe primary hemorrhage

causing almost immediate fainting. The woman had not recovered when I arrived and taking advantage of the cessation of hemorrhage, and the relaxed muscular contraction I passed the fingers through the os, and beyond the placenta. ruptured the membranes turned and delivered the child 8½ months dead. Her recovery was uninterrupted In her subsequent pregnancy she suffered from partial placenta praevia for which I ruptured the membranes and delivery was completed without any further difficulty In this time again the child was 8½ months old living born and still lives.

# The Placenta.

(1) Its manner of presentation

FB and Lecque. described the placenta as inverted during its expulsion, but this was shown by later authorities to be incorrect, the usual point of presentation being the edge.

Dr Leishman says that the inversion of the placenta with its foetal surface outwards so far as the natural process is concerned is quite incorrect. When such authorities as Drs Leishman and Duncan give the weight of this per contra to the assertion others less experienced may hesitate before they question it. I have duly examined and noted the natural expulsion of the placenta in many of my cases, and I do not hesitate to assert that they are in error. There is no doubt the edge most usually presents but in a good few cases left entirely to

nature the placenta passes inverted The explanation of the variation seems to me to ~~lie in the~~ depend on the original site of attachment If at the fundus it will most probably pass inverted; if laterally in a lateral manner.
Dr Duncans illustration of the lateral presentation is likewise misleading He represents it presenting on almost the very edge a thing which rarely if ever happens the presenting point being always 2 or 3 inches from the edge & towards the centre.

Extraction of Placenta

My usual habit is to pass the hand over the uterus to excite contraction, and after one or two pains, use Credé's method ~~of~~ to further its descent into the vagina from which it is easily removed by traction on the cord In the use of Credé's method I at first made the

mistake of trying to expel the placenta by pressure without allowing the uterus time to contract sufficiently over it. When a little time is allowed to elapse before attempting compression the results are much more satisfactory

Leaving the expulsion entirely to nature is a fallacy. In the case of strong healthy women no evil results but if they are in any way weak the placenta is frequently but partially expelled, and considerable loss of blood has been observed under these circumstances.

Time of separation of Placenta.

The placenta is usually separated by the contraction of the uterus on the expulsion of the child, and in normal circumstances if any pains succeed the it is expelled into the vagina in 5' or 10 minutes after.

I do not think the effusion of blood between the placenta, and the uterus is in normal circumstances a factor of any moment. It is most ~~good~~ readily detached in those cases where ergot has been administered, and where Hydramnios and syphilis are present. In hydramnios the placenta partakes in a proportionate degree of the expansion of the membranes. so that the contraction of the uterus on the escape of the liquor amnii leaves wide surface on which to act. In one such case the diameter of the placenta after removal was measured. found to measure 13 inches In syphilis on the other hand the attachment is probably ~~more loose~~ less complete than usual.

## Adherent Placenta

In 4 instances the placenta adhered to its site and had to be removed by hand

in the ordinary manner. In 5 of these the fication was complete. In 2 cases. it had previously existed and of the 5 others two had at their previous confinement suffered from some inflammatory ~~effect~~ mischief

I do not much relish these cases. not because of the difficulty of removal. ~~but~~ because probably in consequence of the introduction of the hand. they are liable to be slightly more feverish afterwards.

## Case of Placental disease?

This case is peculiar and so far as I am been able to learn unexampled.

Mrs W. a thin delicate woman who had suffered from albuminuria in her first pregnancy and has ever since suffered from prolapse of the womb.

She had been pregnant about 4 months. when a bloody discharge began to flow from the uterus. In a few weeks she had become semiprumbent. Great pain was experienced over the uterus, she was unable to lie on her back. Appetite very slight, tongue dry and glazed. Temperature 100°. Feb 1 1886. For the last 6 wks she has steadily become weaker. The discharge a mixture of blood and pus has increased. The feverishness and debility are more marked, ~~and upon [illegible] during the last few days been pregnant.~~

Feb 4. Last night after some severe pains two clots of blood about the size of a fig were expelled and since then she has been free of pain.

Feb 7. Since the 2nd she has had repeated rigors followed by profuse sweating and collapse. She is very weak, unable to eat

up in bed. Pulse. 100. Temperature 102°.
I decided to procure abortion next day in the hope of saving the mother who. I would inevitably succumb in a few days. if left alone. What the cause of the blood poisoning was could only be conjectured as the child was still alive

A severe snowstorm setting in I was unable to see her next day, and on the following morning on my arrival. I found she had aborted during the previous night. The child lived for a few hours and seemed quite healthy, and normal in every respect. On examination of the placenta revealed the cause of all the mischief.
In nearly half of its surface it had been separated from the uterus wall was thinned, smooth softened by

degeneration and coated with pus.
In all probability the case was one of accidental hemorrhage in part of the placenta insufficient to cause abortion at its commencement. The retained clots had set up inflammatory mischief, which led to blood poisoning and its usual sequence abortion

The uterus was daily washed out with Condy's fluid and she made a good recovery. Twelve months after she gave birth to a healthy child and made an uninterrupted recovery.

# Post. partum. Hemorrhage.

The atypical post. partum hemorrhage. spoken of. in obstetric works. I am happy to say I have never seen. In a few cases. the loss has been more marked than usual. but the uterus never. was at any time much relaxed

I have. however. met with no. less than 8 cases. of ~~what~~ intrauterine or concealed. hemorrhage.

I cannot think however that the hemorrhage in these cases is what is usually described as uterine hemorrhage in the Leishmans book. He says. it is characterized by "the formation of an soft. eclamsic and soft. abdominal swelling progressively increasing. along with general symptoms"

The cases I have met with present a

different history - usually such as this
The labor has been somewhat severe,
but the placenta has been removed the
binder applied with as little dis-
turbance as possible, and the woman
looks well. In 10 minutes or so after
the pulse quickens a little and on putting
the hand over the uterus it is found.
perhaps 2cc or 3cc its normal size and
firm as a ball This goes on until
it reaches the umbilicus (I never wanted
to see it go further) when the hand
has to be introduced into the vagina to
clear out the clots of blood which pack
the uterus. This done. there is usually
no more trouble. In two cases it
recurred. in about ½ an hour after
and had to be again cleared out:
but these were exceptionally severe
labors.

This sto form of haemorrhage through trouble some to the attendant, and somewhat painful to the woman is so far as I have found it not at all alarming and as I said before shows little tendency to recur.

In some instances I would not have detected the existence of clots in the uterus had it not been my habit always to examine the uterus externally before leaving them, as the pulse gives no decided warning of this unless the hemorrhage is very great.

The cause of this concealment is no doubt the stopping of the os with blood clot and to avert this I am always in the habit of pressing the forefinger and clearing away all clots left after the removal of the placenta.

In enquiry among my neighbouring

professional friends. I found them blissfully ignorant of such troubles. I could not believe it to be more common with me than with any other, as my methods in the management of labor cases are now adays so similar as I was left to think they overlooked it as a cause when it was so serious as to cause prominent general symptoms.

On instructing case, soon after presented itself. After the labor which was not a protracted one, the uterus slowly filled up until it reached the umbilicus. The os on examination was firmly closed and as the swelling did not increase I left her alone. The pulse was not appreciably affected.

For the next few days the lochia was most profuse and slightly ~~smelling~~ fetid and much mixed with blood clot-

She showed slight feverishness for 2 days but made a very good recovery.

If such cases as these are overlooked, small wonder is it septicaemia prevails

In only one of these 8 cases in which this gradual hemorrhage occurred did any bad result follow. In this case in previous Phlegmasia ~~of leg appeared. this second time~~ hemorrhage appeared in one of the limbs which had been similarly affected after one of her previous confinements.

More serious hemorrhage than I have spoken of I have never met and this result among a community in which Goitre is somewhat prevalent is somewhat fortunate.

In the ~~After~~ careful compression of the uterus while the child was being expelled, the administration of ergot in any suspected case and the absolute rest enjoined after. I attribute my success.

In one of various subject all the previous labours were complicated by severe post-partum hemorrhage which both times I have attended her this had been averted by these means.

Why the subject sufferers from Goitre should be so liable to hemorrhage has never been satisfactorily explained

The thyroid gland exercises a powerful influence on the blood constituents and in cases where it has been extirpated Myxoedema has been frequently seen to follow This is however due less to the alteration induced in the blood than in the nervous system. The blood of various subjects does not I think differ from that of the normal. nor does its presence seem to exercise an unfavourable effect though accompanied by anaemia. The proof of this is seen in the com-

parative infrequency of Phthisis among such people. Bronchitis on the other hand is a very frequent concomitant The liability lies I think in the deficient innervation, and consequent weakness in the vascular structures These women so far as I have observed are more prone to suffer from excessive menstruation and are almost all the subjects of varicose veins.

## Secondary Hemorrhage

In this instance after labor the placenta was ~~not~~ expelled manually and in 3/4 of an hour after the uterus began to slowly fill with blood. On introducing the hand to clear away the clots a small portion of the placenta was found adherent and was removed. For the next 24 hours the lochia was somewhat excessive.

and. on the 2nd day hemorrhage began. I dilated the os. f. inserted fingers into the uterus and found. a few small. sessile bean. shaped bodies adhering to the placental site These I removed. and no further recurrence of the hemorrhage took place.

Phlegmasia Alba. dolens.

followed. in 3 instances. The exact pathology of this affection remains still in obscurity. but of this there is no doubt. viz it is most common in severe or complicated labors.; it has a tendency to recur. One. of these suffered from considerable. Internal hemorrhage, & another had Adherent placenta. The former. of these had previously suffered. from the same affection The 3rd case. followed on abortion while suffering from blood poisoning as already detailed and illustrated the tendency

it sometimes shows to relapse at a considerable period after the first attack — Unconnected with pregnancy I have seen phlegmasia follow a Bronchitic attack in a woman the subject of Ovarian dropsy in one man the subject of hemorrhagic hemiplegia, and another while recovering from acute arthritis of the hip joint.

## Ergot.

Its value as an oxytocic agent cannot be doubted Many men however seldom use it either on account of its supposed uselessness or its liability to occasionally do serious injury, The preparation I always use is Richardson Liq Secalis Annuus and I have had every reason to be satisfied, with its uniformly successful action. I have used it chiefly as a preventative of hemorrhage given

in cases of debility just prior to the birth of the child As an aid to labor. I seldom use it preferring the use of the forceps The only drawback to its use in general is the influence it exerts on the spinal nerves which ~~also~~ supply only the constrictor fibres of the os. The special tendency it possesses of causing contraction of the circular fibres of the os is the main argument against its use in inertia in the primiparae. In them more particularly is its influence on the os shown., and the following case will illustrate the injury it may cause. In this instance it had been given by a fellow practioner in the ~~first~~ 2nd stage of labor and on examination of the ~~fluents~~ os afterwards ~~the os~~ it was found spasmodically contracted.

It was found impossible to dilate the os with the fingers, until Chloroform had been administered, when the loosened placenta was without any difficulty extracted. It seems on account of this property to be altogether inadvisable to administer in primiparæ unless the os is fully dilated and incapable of contraction for while it increases the expulsive powers, it likewise opposes by contraction of the os increased opposition In pluriparæ this constricting property is not so observable probably on account of the potential energy having been in a great measure destroyed by previous dilatations

The detrimental influence of ergot on the child has been frequently spoken of, and in one case already referred to. I blamed the ergot for causing the

death of the child by prematurely separating the placenta. The mother was Syphilitic which no doubt increased the liability to separation

I have not observed any evil effects from the pressure on the child caused by the use of ergot in prolonged labors. While the good effects of Ergot are generally conceded those of the alkaloid Ergotine are generally doubted. I have in a few cases administered Huggetts' ergotine subcutaneously and I have had every reason to be satisfied with its action The cases however have been too few to generalize from, but as illustrations of its action I may mention that in two cases in which it was administered in men for haemoptysis both suffered after each dose from spasmodic contraction of the sphincter vesicae which interfered

with micturition

## Puerperal Fever.

This title is not a scientific one. but as I have (with one exception) only seen slight pyrexiae and altered lochial discharge without any definite inflammatory mischief I am compelled to group them all under this heading.

The exceptional case was I fear an example of latent septic infection. I had scarcely before been called into consultation by a neighbouring practitioner to see a case of septicaemia. The woman was suffering from rigors fever &c. and the lochia was excessive in quantity, and very foetid

I suspected from the state of the os and the size of the uterus that some part of the placenta was retained

and on administering ether. I passed my hand and detached a large mass of placenta which was still adherent. This was a matter of considerable difficulty as the placenta was almost as hard as cartilage. The operation proved successful however, and she made a good recovery.

The fourth case I attended afterwards was a tedious one with rigidity, and forceps had to be applied ere delivery could be effected. Three days afterwards pain began over the uterus, the lochia ceased and temperature began to rise. The inflammatory action was either metritic or parametritic, and for a few days caused some anxiety. In 10 days it had quite subsided and recovery was assured.

The next case was a rapid one in a multipara who had shewn no untoward

symptom but in the succeeding case.
a primipara - slight feverishness and pain
was experienced for a few days.

These complications I am convinced were
due to infection in spite of all the precautions
I personally tried, and were the most serious
I have had to contend with.

Puerperal fever using the name in its widest
sense, is the result of either auto genetic infection
or hetero genetic infection The cases above recorded.
are examples of the latter and I have
seen a few cases where slight feverishness
and altered lochia has followed as
the result I think of the former
In these cases where it has been seen the
labor has either been complicated by
necessary loss or been rendered tedious
by a rigid os

It is usually supposed that infection
takes place by the uterine sinuses

but in this I cannot concur. It seems to me that in cases of autoinfection at any rate the laceration lacerated os is the starting point of the trouble. In no case have I observed any puerperal follow on a normal labor in a primipara or pluripara where the os has been soft pulpous and easily dilated, whereas in many cases where the os has been somewhat rigid and become lacerated in consequence, puerperal is not unfrequent.

The anatomical structure of the os favours absorption more readily than does the uterus The epithelial lining of the os is squamous, not glandular and its absorbent functions are not so naturally affected by desquamation as those of the uterus are and when added to this it is lacerated to some extent, the probabilities of infection are thereby materially increased

for this reason whether a right reason or not. I am very unwilling to apply the forceps in primiparae and in any such case where it has been used I always order the vagina to be daily syringed with Condy's fluid.

There can be no reason to doubt the observation made by accoucheurs of experience "that the liability to fever is in direct proportion to the loss of blood". yet on examination of the histories of the subjects of placenta praevia, seems to show a greater maternal mortality than the loss of blood can well account for. Is it possible that the mere fact of the placenta being attached in part to the os, a part differently constituted as regards to epithelial lining covering and blood supply may in a measure account for this?

# Mammary Abscess.

Of the many agonies lying in women are the victims of this is one of the most common though seldom a serious affection as regards life yet it is in many ways a most annoying affliction. The initial pain is so severe the formation of numerous sinuses so frequent and the loss of function so inevitable does not even terminate the injury ~~I have~~ In subsequent pregnancies it tends to recur Having in the early stage of my practice found that leeches, fomentations, and Belladonna were utterly powerless in averting suppuration in deep abscesses it occurred to me if I treated these cases as I do Whitlow and Furuncles by early free incisions suppuration might be entirely averted.

A case for trial soon presented itself in a primipara. 5 days after confinement The breast presented the full & painful

character of a deep seated acute abscess. With a straight bistoury I incised the centre of the mass to its very base. Profuse hemorrhage ensued and I had, temporarily to plug the wound to restrain it. Next day the inflammation had, in a great measure subsided, and in a few days she was quite well, having never required to go to bed. I have since then operated repeatedly, and in no case where incision was made prior to the formation of pus, has pus formed. For the attainment of this result it is however necessary that the case must be seen early. It may be argued that it is impossible always to strike the exact point where suppuration is imminent. I am not certain that, this is altogether a necessity as the profuse bleeding must forthwith relieve the tension in the inflamed focus

and the subsequent heeling from the wound. which is left open prevents the emptying of the capsule. by the subsequent products of inflammation which are undoubtedly the cause of the intense pain, and rapid suppuration in the part.

When suppuration is more. Most extensive superficially a less deep incision is required to attain the result.

The immense advantage accruing from this mode of treatment need not be dwelt upon, it's benefits are so obvious that I can only recommend all practitioners when they meet with mammary abscess to. go and do likewise

Yours

Augustus Woodson