Thesis for the Degree of M.D.

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Some Observations on Early Labour in the Women of New Zealand.

From February 1908 to February 1911 I have had 711 deliveries in St. Helens Maternity Hospital, Wellington, N.Z. This hospital is one of several founded by the N.Z. Government to combat against the large infantile mortality and declining birth rate by making the conditions of the lying-in period as easy as possible to the patient provided that respectable training school for midwives. The class of patient is the wife of the average labouring man or poor clerk. Except in emergency no patient is admitted whose husband is in receipt of more than £3 a week which is the average wage of a good articled or poor clerk. The patients are expected to pay £10 per week. The type varies from the strong muscular woman of the farming species to the neurasthenic member of the fairly well-to-do family who has done little muscular work till she has married a poor clerk or undertaker household duties.
They must then, I think, be taken as averaging as to a middle type of mother living under comparatively good conditions of the working people of N. L. In this reason I think the results of breastfeeding are of some interest.

Among 716 mothers there were 13 who did not nurse at all. Eight (8) of these had advanced heart disease or nephritis - two had sepptic temperature - one had blocked ducts - all others one had nervous breakdown - I had nephritis. Of the 714 babies born alive there were 93 who had supplementary dainties during the 1st postnatal week only 22 of those continued these after the first postnatal week. Of these 93 cases 79 were due to malnutrition anaemia or albuminuria on the part of the mother 7 were due to pyrosis (reflux and colitis) 3 were to children over a premature 6 2 months child three mother from domestic trouble could not stay with the child.

These results I have summed up in...
the following scheme of classification & for the sake of clearness I shall give the scheme first & deal with the subject as they come in order of classification dividing the papers into 3 sections & devoting section 3 to general observations & conclusion.

I have not tried to incorporate all causes in this scheme but those only, of which I have had practical examples.

section 1 - difficult suckling

A. Local
   (1) malena (2) depressed suppublic
   (2) blocked ducts
   (3) fissures
   (4) address
   (5) infantile (6) muscular inactivity
   (6) nasal obstruction

B. Constitutional
   (1) malena (2) malnutrition
   (3) anemia
   (4) dementia
   (5) diarrhea
   (6) pyrexia
   (7) infantile rickets

   (2) infantile (3) weakness
   (4) prematurity

C. Psychological
   (1) material
   (2) infantile
Section II


disability (iliac
A. local (1) natural | deformity
(2) infantile | deformity

B. constitutional
(1) natural (a) phthisis
(2) nephritis
(3) cedema
do:
(4) healed

(5) infantile | prematurity

Section III

General Observations C

Conclusions

Section I. Difficult Suckling

A. Depressed nipples

This condition occurred in all degrees from the merely small nipples very little raised above the level of the skin itself (that in which the nipple is represented, not as a papilla but as a small indrawn slit) depressed well below the level of the skin but provided that the ducts are freely open on the surface of the skin I believe that the mechanical difficulty can always be overcome.

The minor degree causes trouble because of the difficulty in
making the child fix on to the nipple E in the case of a non-vigorous baby or it is not completely employing the breast thereby eventually rendering the milk poor in quality. A vicious circle is set up. The already rather weakly child becomes by semi-starvation less capable of muscular exertion or desire less less. Such cases of mild malformed nipples have been numerous but they have rapidly improved with the use of a suction aspirator.

An ordinary glass nipple is filled with a little C mouthpiece attached. The mother is taught to draw out the nipple and keep it stretched for a few moments before each feeding, also to “form” the nipple with her fingers (surgically clean). The baby has to exercise under traction on the nipple a number of times before the end of the feeding. It is often a “fight” (the nurses’ term) to get the
child, to finish its meal. The heart
too, be felt - to see that it is
properly relieved. From the
history of several of the mothers
I believe that the secret of "the
wells going off" with vigorous
children was their incomplete-
emptying of the glands.
The worst cases of depressed hips
have yielded to treatment.
One mother (W. R. C.) aged 37, an
11-para had no mammilla at
all - the spot was marked by
a depression. The rest of the
flank was as well developed as
the rest of the body. The baby was
healthy. It looked hopeless (- even thinks of
her husband.) The previous
delare children had been hand
fed from the beginning. But it was
only with a great deal of
persuasion that she consented to
have the necessary treatment.
The drawing out of forming movements
with the fingers were started
some days before birth, and after
the birth, she was taught, in
addition, to use the suction
apparatus for 20 minutes every
2 hours. The child was healthy
and vigorous, with a little

premorreneance learned to pass the nipple. At nine months of age the child was well grown vigorous & entirely breast fed & quite the stoutest of the family.

A second patient (Mrs. B.B.) at 5 para came with exactly the same condition a little less pronounced. The previous 4 children had been hand fed from birth & once on each previous occasion having looked upon the condition as rendering exclusive nurses impossible. The fifth child was breast entirely.

Two other mothers who had previously nursed their infants on one breast on account of nipple retraction of the other were enabled to nurse on both. They both assured me that the added comfort was most marked, the constant teet weeping on one side had been a hindrance & in addition to the fact of experiencing much di- comfit when the secretion first came into the malformed breast.

A fifth patient (Mrs. J.P.) had...
one envelope reached as result of a
mammmary abscess with multiple
incisions after the birth of her
first child. This proved by far
the most troublesome of all the
case so the breast were had the
dame yield of milk. As long
as the patient was under
supervision, the child was made
take at least breast alternately
but the mother did not persevere
with the localized breast.

Unfortunately at 9 months
when the child was being breast
the abscess recurred again.
Caused a great deal of trouble.
I reported that I had tried to
restore the function as possibly
had do ceased secretes that
might not have occurred.
That is no doubt that the
electric tissue in Cooper's ligaments
enables a remnant of a great
deal of stretching a marked
contraction to the hard coxal

tissue the stretching of which
constantly set up pains.

In this treatment of the condition
I think it is a great point that
the mother herself provide the
swollen also. This treatment must be started immediately after the child is born. It is imperative that the formation of the nipple by the fingers be brought about during the 48th hour that the breast is before lactation sets in. After that the glands become tender and the swollen condition precludes the drawing out. A dose of boracic lotion must be smeared thickly on the breast before the mother is allowed to draw her fingers each time the nipple is manipulated. The greatest difficulty was to get the women to believe this function could be restored once they were persuaded of this they carried out the treatment wholeheartedly.

A 01. b.
The best subject I would like to refer to is that of "blocked ducts." This is a condition that I have never seen mentioned in any book but yet I believe it occurs in all degrees of severity. It undoubtedly occurs to some degree in all multiparae whose breasts have been bruised for some reason or is due to the many incomplete secretions.
In the IP, the patient just referred to, who had reddish waffle from below, the dreds were exceedingly difficult to free. The old dreds secretion came out like little approximated pieces of sand, almost the size of split peas. Each one came out with a ‘pop’; they could not have been freed had the breach been tended to the secretions. In the mother, mentioned who had not turned their previous 10 or 14 children respectively, there was a similar difficulty—i.e., these two cases the old secretions came out like little fibrous pieces of cotton, a little bit too found, after lactation was established that the breasts were not evenly emptied by the child, a careful ‘bulking off’ with the fingers removed the remaining obstruction.

The most interesting case was a well developed young primipara (A.P. E.H.) in whom there was apparently no abnormality. The child was put to the breast within a few hours of labour apparently yet nothing though it was healthy, vigorous.
Indeed well. This went on for 48 hours before it was fully recognized. The breasts by then were getting tender & an attempt was made to get the secretion to the surface. In spite of every means being tried not a drop of fluid could be brought to the surface though the glands were full of secretion. The patient suffered intense pain & high temperature & the usual means had to be taken to dry up the secretion.

This patient has been confined a second time under my care. I prescribed salt mixture with oil for the last week of pregnancy & ordered her into hospital some days before labour was expected. A small amount of colostrum was brought to the surface without much trouble but unfortunately the delivery was a complicated one & the child was born without from the amount of colostrum that was attained. I believe that the early treatment would have enabled her to suckle.

An interesting feature of partial blocking was W.J.H. a healthy
INFANTS WEIGHT CHART.
(Movable Scale.)

Day: 1 2 3 4 5 6 7 8 9 10 11 12 13 14
Lbs. Oza.
14
12
10
8
6
4
2

\[\text{Duels feed.}\]

Artificial Feedings

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"W. E. U's child."
till wounded 7 para. This woman for a history of having what she called "tough" breasts, never being able to do more than partially nurse her children so that for only about 3 months she had a thing child weighing 6 lbs 12 ozs. It lost weight steadily till the 6th day though there seemed to be an plentiful supply of good milk. It was then discovered that the glands did not become equally inflamed after suckling nor was careful massage of the resistant nodules it was stringy pieces of hard unmistakable reaction were expressed. The weight began to rise at once and three months this mother was still entirely nursing her child. She experienced a degree of comfort which she said she had never had when attempting to nurse before. I think that undoubtedly the whole gland had never functioned before this non-functioning of some parts had a deleterious effect partially from pressure upon the rest which gradually ceased to secrete in the normal way.
A.I. (c).
The subject of fissures is exceedingly difficult and unsatisfactory. I dread them as being one of the commonest causes of diarrhea & sickliness & because I have never yet found a satisfactory way of treating them. I regard them as being of 3 different varieties - (a) circular
(b) radical
(c) terminal.
The circular are by far the worst, painful & difficult to heal, they seem to be due to a want of elasticity of the skin of the nipples & to a certain degree of want of lubricant. I prescribe twice daily a paraffin lubricant, buckling for a day or two, so as to break the hardness, & be milked off by hand or the secretion given to the infant. Hand milkings render it most unimportant for there as nursing with a child or using a suction pump is almost as bad as putting the child to them. When first healed I ordain an indelible mark on the child, so I think this protects the natural skin lubrication so much as possible.
Although these cases have never
ceased to suckle while under hospital supervision. They are almost impossible to deal with in their homes.

The second or radical variety occurs more, I think, as an accident—possibly from the pressure of an overvigorous child or like a crack such as occurs after about the sixth of the hands when they have been immersed in water. This is not nearly so painful on nursing but the patient complains much and of the pressure of the clothes. I think the old fashioned rigid leather malleable shield be used when not buckling & firmly bandaged on is a considerable help in getting these healed together with the usual catheterism or benign wound paint. It also affords a great deal of comfort.

The third or terminal variety is not correctly described by the word fissure, it often amounts to a 'chewing off' of the whole of the apex of the nipple by a vigorous child that sucks facility. Such children seem to chew all the time they are sucking. It is an exceedingly
painful condition. It takes a long time to heal but the milk can be comparatively painlessly drawn off by means of the child. The leader shield is also a help in protecting these from pressure and thereby promoting healing.

A. 1. (d).

Injuries lead on to the serious condition of mammary abscess,

of which; in the cases of cases mentioned I have only had two occurrences. Both these occurred in women of very low mentality who could not be taught clearly methods in suckling the child.

In both cases it was found possible to keep the milk

draining in the injured breast and I consider important in view of the case of inadulterate chiecal infection of the nipples which I have referred to. If the gland is kept in use the cicatrical tissue has not the same chance to:

enlarge or restrict the nipple c

als press on the follicles, or ducts to their occlusion or partial occlusion - as in the case of the follicles causing atrophy.
A child suffering from localته in the part of the child... An
interesting case of this occurred in
a well formed child who seemed
to suck vigorously but where he
complained that he did not seem
to "draw". The child sucked the
milkple but its tongue seemed to
turn upward so the milkple got
against its under side so the
child "drew" apparently at the
point of its own tongue and
sucking little milk at all. The
same thing happened when it
attempted to suck the fingers
the tongue got curled back &
was partially drawn down its
own throat. There was no milk
abnormality - the nurse was
taught to constantly give her
fingers to this child to suck &
each time the tongue got into
the proper position to force it back.
The mother soon learned the
demonstration of the higher action upon
the milkple & she was taught to
put her fingers in the mouth &
push the tongue into post
position again. This child was
reported as having insufficient
consumption from the mother
undoubtedly if it had not been
clearly observed the milk would
have gone off - it would have
been known.

Heat, catarrh, or semi-obstruction
or also a nervous trouble -
occasionally accounts for a child
not increasing in weight, as it
should do. An intelligent mother
can help this partly by insisting
upon intervals in feeding before the
child is compelled by semi-
supplementary - exhaustion to drop
the nipples unsatisfied.

B.
The commonest - constitutional cases
of difficult - midwifery on the part
of the mother is malnutrition.
A large number of patients - came
into hospital in a poorly
nourished - anaemic condition,
many of them having entered
very hard night into the time
of delivery. There were 76 such
cases - in the series of 714 - in all
but 18 they reached by hospital
treatment - to hygiene - left the
hospital nursing their children.
entirely. In the cases that have I be rarely supplemented I recommend condensed milk or one of the dried milk preparations as being the safer & the food principles is safeguarded by the mother's milk.

Anæmia comes into the same category - On the 3rd day of the perineum if all is normal those below 20 as are kept on large doses of the Zenarbide, which they take as food in a bread of butter and cake. It is forced upon in part of the diet. The food hypothesis (with no carbajalization) + the recumbency together with the iron does not work wonders - the climate permits of a great many days being spent on an unfooted veranda - the philhellenic idea is not also do the anæmia in warmer weather.

It will be noticed that there is no record of non-suckling from anæmiosoria. There have been 245 cases of this treated & five out of these developed severe toxic symptoms - 2 of these arrived unattended at hospital & died of a 3rd did of heart failure. p. 10.
of the remaining 2 one had a manœuvred for his & the other reached completely. (treatment: he recovered his child 4th week). Later the infant was still breast-fed, healthy & well grown & there had been no untoward symptoms. All the allhumours cases who reached it ordinary treatment reached their children in a few cases supplementary drinks were necessary. In one case there was a history that led one to think there was some old standing weakness. The patient was kept closely under observation - in spite of transient attacks of slight allhumours the child flowered for some months on the breast alone & the mother continued in good health.

Pyrexia during the early days of the pneumonia has only been the cause of weaning in one patient who developed a serious depletion (of skeletal origin). Transient pyrexias of whom there have been some who had fever of 102 & over have not compelled weaning. The hands have been relieved a
minimum amount of times a day (usually about 12; just when they seem a little hard or uncomfortable) by hand; if the child sustained by hot water — or if necessary by artificial feeding of some milk or dried milk. It has always been found that the certainly can be readily brought back when the pyrexia has subsided.

In general, deliveries the weight-charts of the infants have never been satisfactory till some supplementary feedings have been given — even when the mother had been particularly strong and in good health.

B. (2).
The infantile constitutional causes of difficult suckling is a nearly

way can be due to weakness (prematurity). The real trouble is, I believe the loss of the normal stimulation that comes of complete emptying of the breasts. Exactly the same thing occurs with the mammary glands of domestic sucking animals when inefficient milkers are employed. One very interesting example of this occurred in a fairly developed.
principals, who was attended as an outpatient—the child was premature but vigorous. During the second week the nurses reported the child was not thriving; the milk was going away. Supplementary feedings were ordered. The child’s weight still did not improve; the nurses thought it was the hospital food, it was then seen that the child was far too weak to enjoy a partially solid menu for some days. At that time it was entirely on artificial feeding. The breast had not been given for four days—-the milk seemed to have quite gone. Another child was brought into hospital, the mother was fed into the breast, massaged with the result that in 2 days there was enough for several meals a day for the baby. The milk flowed off by the fingers, or pumped by hand. The child began to improve. In 10 days it was a fairly vigorous child. A entirely breast fed. It did well & developed into a fine child.

The writer of the case lies in the direct proof of the result.
of insufficient emptying of the breast, together with the success that attended the emptying of the function after 4 days non-secretion.

I consider it necessary in all cases to, at first, draw off some of the milk, then put the child with a nipple in its mouth at the same time to promote the movements of sucking. When placed at the breast, the child must be watched to see that it does not get milk only to empty the breast. A mother of moderate intelligence can be taught to "walk off" her own breasts in a short time, she can do it more comfortably for herself than the nurse can.
The physical and mental causes of difficult lactation constitute indeed a wide and obscure subject of discussion. It certainly seems true that a great many mothers and infants are deficient in this instinct of suckling. It is quite surprising, for instance, how many times a nurse has to watch over the process, so as to see that the mother is not as placing a tense full breast that the nipple is being drawn away from the child all the time it is taking its meal. This results in the child losing long before it has had a good meal & is often responsible for fissures of the nipple. In the early days of lactation an overshield breast is a very common occurrence & the nurse should relieve it a little manually before the child begins to wean & the child must be watched to see that it does not go to sleep. A mother will often allow this fear to make the child sit & it is hard to make her realize that prolonged moisture of the delicate nipple skin makes it little tender & liable to fissure
I have seen a woman look helplessly round her while the child was turning about trying to get the nipple on yet the face it had no guidance. Many women make no effort to prevent the child being smothered by the loose tissue of a large placenta breast falling over the child's mouth & cheeks, thereby making sucking a doubly difficult muscular action. The loose mass of tissue setting into the mouth keeps the child's jaws from coming together or much of the force of sucking is lost. That the breast secretion is often upset by nervous causes is undoubted excitement of the mother is often clearly indicated in the weight chart of the child. The following is a case which I think was due to some abnormality in the nervous control of the metabolism.

Mrs. P. S., a primipara of 38, rather of the nervous type, had a normal parturi-tion. *Lactation* set in on the 3rd day with a rush, was accompanied by a peak of pain & constitutional disturbances. *Also hyporeception*
Painful was the situation when sedatives & morphia had to be administered internally. In addition to local anaesthetics, i.e., ether, the patient seemed in a normal condition, the much reduced symptoms had subsided. Another effort was made to induce lactation - the child was put to the breast - the still tender glands were carefully massaged. On the 7th day the secretion returned with all the symptoms far worse than they had been before. There was agonizing pain, great dislocation - the patient became semi-delirious, developed a temp. of 104.6 - an almost maniacal condition supervened. The veins of the breast were hugely distended & looked for the point of bursting. All efforts to relieve the secretion were unsuccessful. Not even the weight of her ordinary night clothes could be borne on the glands.
Mycelium cedatrum was freely given as the usual means of dispersing the secretion involved C.

The temp. came down by lypho in 3 days C the patient looking as if she were convalescing from a serious illness, was able to leave hospital on the 21st day. The child having to be entirely artificially fed.

I attribute this to a want of control of the metabolic processes of the gland. The trouble was asymmetrical from the beginning or from the rapidity of occurrence of the symptoms when the secretion was dispersed it seemed there could be no infective process. The condition was infinitely more tender to touch than a metastasis to the patient - considered the Joan was severe than ordinary labor pains.
Section II.

A. Disability of Inlet.

The cases of complete or inability to
inlet from local causes have
been few - the 1st is a case of
obstrukd ducts in a
principally (already described
-sect. I. A. 1. b.) 103 is 0
has arisen, amenable to treatment
if discovered in time. I now
require nurses to report at once
if the child seems to get nothing
so she can not bring the
contents of the surface herself,
so that the precious 24 or 48
hours after birth be not lost.

Disability of Inlet on the part
of the infant from local causes
is principally brought about by
hernia, cleft palate, cleft lips at
hospital and children have always
had the mothers milk drawn
by 0 given with a pipette.

One 6½ months child - J.W.
weighing 2½ pounds was
entirely breast fed in this way
for a month & made excellent
progress - a clear finger is
inserted beside the pipette & the
mother or nurse had 1 sit down
beside the child or the
unpromised incubation, from which it was never completely lifted. The mother herself did the whole process so became very deft at it.

B. The constitutional national causes of not succumbing such as phthisis, nephritis, cardiac disease have been fully discussed in the Classics of Medicine. I adhere rigidly to meaning for phthisis but certainly I believe that in some cases it is better good for the individual in the state. One phthisical mother of six children has not enhanced the last three, they have come in very quick succession in a change of unhealthful surroundings. It seems to me that unless the state can come to the conclusion that such cases must lose their freedom altogether, it would be wise to let them fulfill all their physiological functions rather than only half of them. The particular mother always had abundant secretion, though in an advanced stage of the disease, it is most anxious to be allowed to nurse.
The case of newly born children resulting from consensual unions (ix. 8. 5.) might also come under this category, old age need not mean inability. To inculcate one's own principles (act 42) need not be child or successfully for 6 months.

B. 1. (d.

The mental "psychical" causes of constitutional origins run very closely with those of local origin. It is almost impossible to separate the two. There is some deep factor at work which we have not yet explained. I believe it is due to a certain "law of animal instinct," but it is not a perfectly natural or right step in the progress of civilization. Animal instinct must decline but we must substitute something of a higher value for it. We cannot redevelop instinct at our present stage but we can train women's minds till they are able to appreciate the importance of the question from the point of view of scientific economy.
The influence of occasional
fears, growing diabetes & the process
of child training & child caring
is, I believe, the outcome of the
former one specialization of
women for that purpose.
In times past this side has been
so emphasized that it has, to a
large extent, precluded the
development of the rest of her being.
From this she is at present
suffering a natural reaction to
like reactions of a
mathematical origin - it is
"equal in opposite". Therefore at
the present moment she is
overemphasizing her intellectual
side. Knowledge & training of the
power of judgment must in the end
helps woman to a right perspective of
their duties with regard to the race.
We shall have the substitution of
reasoning for intuitive action.
When combined proper knowledge,
judgment - & sense of duty - will make
enable woman - make for themselves
the conditions of equal - code that
we so necessary to child training &
child caring. In the meantime I doubt
thinks there is the need for anxiety -
psychological incapacity that is often
expressed.
Dr. is a very
short time — in "race" time — since
Thallous promulgated his
doctrines & alarmed England
lest the whole race should
set each other out
of existence — possibly there is
so little real need for alarm
as there was then.

Is this then seems to be so doubt-
that sucking is an important
factor in family life — mothers
constantly tell me that the child
they have nursed seems quite
different to the others — some
indescribable — after reaching bond
between mother & child which
is productive of only good
results — is set up by the process.
This factor is tacitly recognized in
most usage homes — when it is
a recognized fact that — if a
girl can be made nurse the child
for even a few months — it makes
her almost uncared — towards it
different.
Section III.

General Observations & Conclusions.

I have been led to make observations on this subject for three reasons:

(1) because it is of importance to the race;

(2) because I could find no data about it in any text-book;

(3) because I believe that such data should be the special province of a woman - a woman as a doctor.

The proper care of the breasts & lactation must eventually come under a scientific regime. The act of parturition - a purely physiological reflex has gone within the act of the physician whose ordinary function is to attend to pathological states. The act of suckling must no longer be attributed to pure instinct, which is so often done at present.

The scientific care of the breasts should come into practical application when the patient is first interviewed by a doctor or nurse with regard to confinement. Deficiency can
thus be healed or anti-pusome
preparations begun.

The important time for treatment
however is immediately after
labour - it should then be
maintained that colostrums can
come freely to the surface of
the breast. After the child has
begun to put regular meals the
breast should be carefully
palpated to see that the lobes
are evenly emptied & the
nurse should learn the
difference between a partially
emptied & completely emptied
gland. Every nurse should
fully understand that if the
breasts are not being emptied
that the secretion will disappear
so that if for any reason the child
is not doing this she must
complete the emptying herself.

And a breast needs to such
stimulation to excellently brought
out by Rene Dudin & in a
still more obvious way it is
brought before us in doing

cats

It is essential that when
the glands have to be artificially
released this should be done by
hand, the action of an
ordinary breast pump is
not sufficient stimulation
to keep the whole gland
functioning. Hand milking
is particularly necessary when
it is necessary to give the
child all its meals with a
pipette or spoon: it is a well
known fact among farmers, that
machine milking is not a
success because it always
results in a failure or partial
failure of the milk supply.
The sucking of the child
itself probably affords some
psychical stimulus & is
always continued over a longer
time than that of artificial 'drawing
off'. This extended time
undoubtedly allows the deep
follicles more time to supply
themselves into the superficial
parts of the ducts which act
as reservoirs.
The hand method has the
further recommendation that the
decretion is received directly
into a measure flask, with the risk
of contamination, if it is to be
passed to the child, is considerably
In this letter, an ordinary breast pump. The mother can be taught to use her own pumps. This obviates the necessity for a nurse's presence always being necessary or for any apparatus.

Regularity, allamomemia, debility, old age, and not bedridden, enucleating. In the 25 cases of allamomemia healed, 20 reached a treatment. The mother left hospital enucleating her child by the remaining five, 2 children were stillborn, 2 mothers died, and the mother was a case of old standing nephritis. In most of the cases supplementary drugs were given at first to conserve the mother's strength. Of the 93 babies who had supplementary feeding of first 22 were having artificial feedings on discharge from the hospital.

The debilitated patients were nearly all anemic, 9 reached anemia to the iron in their diet. All these patients have special attention paid to the massage of the uterus as each one is...
regarded as having a tendency to inanition and persistence of the cholera. When this occurred supplementary feedings had always to be given - insufficient lactation being apparently coincident with this condition.

It only remains to sum up the results in percentages -
98.2 percent of the mothers were able to nurse their children -
13% had to have supplementary feedings during 1st fortnight -
3% had to have supplementary feedings after 1st fortnight.

Of the 1.9% who did not nurse more than half were due to serious constitutional disease on part of the mother. Only .7% of healthy mothers were unable to suckle.

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