Thesis for the degree of
Doctor of Medicine
on
Obstetrics and Gynaecology
by
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II obstetrix

Since the publication of the "Pyynke of mankynd or the woman's Book" in the year 1540, obstetricians have had very encouragement and every opportunity both through the various societies and various obstetric journals of informing fellow practitioners of what has occurred and is occurring during their every day practice. And while in offering my notes and remarks on the following two cases of midwifery, I apologize for the want of thoroughness and completeness as well as a want of revision in any way adequate to the importance of the subject: I also plead as an extenuating circumstance the want of time at my disposal, having since my graduation nearly six years of extensively employed in a practice which afforded little or no time for any thing like careful...
note-taking. During these years while I have had perhapes as much general practice as usually falls to the lot of most practitioners in the same place yet of no special distress or affliction have I seen sufficient to entitle me to attempt any thing like a treatise on that subject. Having however had the experience of nearly 100 cases of midwifery I have attempted to select the more interesting of these and cursorily sketch them and with a few remarks on some of the diseases of women which I have observed now submit them as my "thesis" for the degree of M. D.

Although the great majority of midwifery cases are natural labours requiring nothing to be done by the performer beyond rupturing the membranes and the usual extraneous duties yet pain is no more harassing branch of the healing art than is a large hysterie combined with a large general practice. As at times it is the easiest so also is it the most difficult.
Note

exploded my reliance in carbolic oil as a disinfectant. "The fact he says is very noticeable. That carbolic acid in oil or in alcoholic solution is absolutely without effect on the bacilli and spores of splenic fever."

I therefore prefer to carry the pure carbolic acid and make a watery solution for my hands. In the carbolic oil, the acid seems to combine too strongly with the oil to be of any use as a disinfectant.
branch of medicine.

The contents of my obstetric bag may be enumerated, namely: Simpson's dry forceps, which are equally useful for
than the low operation is required; liquid extract of Ergot; Chloroform,
a set of Barn's bags; Active forceps; Pure Carbolic acid; Carbolic oil for cut
forceps; a few opium pills and a peppermint suppositor.

Of course a very large proportion of
the 162 cases required no interfer-
ence on the part of St. Thomas or
myself beyond the occasional rep-

ture of the membranes or the admin-
istration of an enema of castor oil for

placenta and warm water. This we
very often found very efficacious in
accelerating labour. In multiparas
it was our practice to rupture the mem-

branes after the presentation had been
inexpediently the to soft and dilated to
about the size of half a crown.

This practice has been attended
with good results.

In primiparas I never do ex- 

pose the membranes until the 12
It is fully dilated. Stomach in this case I seldom rupture the mem.
brane as they are usually too tough before the head reaches the state of
dilatation. When the head has
reached the "second stage" of labour
and the "contractions" of the uterus are
slow indications of lessening in
duration I have often noticed that
a marked increase in the duration
as well as the strength of the contrac-
tions is produced by pressure
backwards on the "Fenestrate" during
a contraction.

During the expulsion of the head
and also of the shoulders in Primipar
I make a practice of always
supporting the perineum as in this
way rupture is often avoided - so
also in some multiparous women.

I state that only about
one and a half of the big Schuch's
forceps was used during the time
that 800 confinement had been
attended by Dr. Thomas and my
self, and part of this has been used
for 'hemorrhoids and seminals, it
it will readily be understood that the so-called oxytocic remedies were seldom resorted to, and such was the case. My early obstetric experience, and before having attended a course of lectures on midwifery, caused me such as to leave the impression that to the inexperienced obstetrician an effort is unlooked for as the "one true" run of a successful issue and that it would be perhaps better for both mother and child if the effort was left behind and the accoucheur induced to take with him a Stiggins's syringe by which the bowels can be cleared, a part of treatment not by any means unnecessary or uncomplimentary amongst the class of patients he is first called on to attend. Then would thus I am convinced be fewer still born children and less of the untoward symptoms post partum. Still born children have been whose deaths could be attributed to no other cause than that abuse of effort, and I have
Dr. S. Schayer (Berl. Klin. Woch., 1881; Der Prakt. Arzt, 1881, 1882) says (p. 174) that the progress of nuts to close its activity on being kept depends upon the time that may have elapsed since the crushing of the individual corneals and that a certain result can only be expected from exposure directly divided of its horny covering and placed.

* Note
I have seen nausea, sickness and vomiting produced in the woman so often and moreover its action is so uncertain that I now do not place much reliance for importance in its use during labour and feel convinced that groups during the second stage (and I should not administer the drug during the first stage of labour) to be applied with less harm to child and mother.

I suggest, as a prophylactic against post-partum haemorrhage, as recommended by Dr. W. S. Raffair who gives a dose of the drug immediately labour is concluded, I have had no experience of. I may state that in my experience I have never had a serious case of post-partum haemorrhage and never used ergot unless I observe some of the premonitory symptoms of this alarming complication, such as, pulse irregular or remaining about 100, when I should then consider it a dereliction of duty amongst other reasons not to give a full dose (3/4) of the ergin extract.
Signature of cord I do not perform immediately after the child is born but wait for about a minute or two and sometimes until pulsation in the cord ceases. This short delay gives I think the child a little more blood than if the cord were tied at once and as the lungs, with a vacuum or shrivelled back into place, begin to expand, more blood can be accommodated than previous to birth and moreover I think it tends towards separation of the placenta.

Expulsion of the secondaries. The cord being properly ligature and the child removed I remain by the patient's side for about 15 minutes if placenta not expelled previous to this with my hand firmly pressed over the abdomen which usually in multifurled sets of contractions which expel the placenta.

If at the end of this time uterine contraction has not occurred I then place my two first fingers within the os and make slight traction on the cord which usually often succeeds in e.
exciting contraction. If now the placenta gives no indication of leaving its abused I never have any irritation in warming an aseptic hand into the uterus and gently withdrawing its contents, taking care that the membranes do not as they sometimes may get clenched by a firmly contracting ut and cervix and if they do to have them well wound into a coil which will bear slight traction sufficient to withdraw them.

The use of light I have noticed often increases the difficulty of removing the placenta as it seems to cause contraction more at the ut and cervical part than through the body of the uterus.

Often simple expression with the left hand over the fundus uteri suffices to remove the placenta.

After treatment, now that the uterus has been emptied and firmly contracted the binder is applied in conjoint to the gradual removal of the dark clothes. Dr. Playfair says at page 351, "I have long been in the habit of"
of administering the drug (Epsol) at this period and believe it to be of great value not only as a prophylactic against haemorrhage but as a means of lessening after-pains. I never administer the drug unless under some of the conditions already mentioned nor do I think it advisable to use it indiscriminately amongst the healthy class of patients found in country and country-town practice, and with a firmly contracted uterus and a pulse of from 60 to 70 beats per minute I much prefer to leave well alone.

Presentations. In giving my experience of presentations I merely content myself with giving those presentations which have had some deviation from the normal and their management. A posterior presentation I have detected in four cases only, two of these ended satisfactorily by rotation, one persistent ended without operation interfering, and one also persistent required the use of forceps and in three cases the instrument which I prefer to use is the
April 26th 1863. Today and since writing the above I have had one more
breach presentation in a primefar which ended satisfactorily for
child now

Sir, I think it important to know that this
rotation does take place. The
head of the child's head may still be
returned.

2. Face of this: I have seen but one
presentation which also termi-
nated favourably for mother and
child although the labour was
prolonged for 24 hours.

3. Breach of this presentation. I
have been in attendance during
several cases and you had to say
that all the children were born
alive, five of them being born in
principals. The method I adopt-
ed was to hasten delivery imme-
diately part of the abdomen was
born and with a cloth round
the body or legs of the child, to pre-
vent my hands from slipping,
and a finger in the mouth of
have not had any difficulty
as far as delivery was concerned
although I have had to resort to arti-
ficial respiration and hot and cold
baths alternately to restore unin-
hibited circulation.
Suspended animation. The method I have resorted to for resuscitation during suspended animation in newly born children is a combination of artificial respiration simultaneous with the hot and cold baths used alternately, and is done as follows. My fingers and palms of both hands from a little bed on which rest the back of the child, the feet hanging free and the head drooping back between the wrists. My thumbs are then placed over the shoulders and clavicles and rest on the upper part of the chest—on plunging the child into the hot or cold bath my thumbs are depressed and consequently the chest of the child. This brings the head forward by acting on the sternocleidomastoid muscles. On lifting the child from the bath my fingers are slightly tilted up and my thumbs raised. The muscles being restored the head of the child falls back between the wrists and outwardly the chest is elevated. Again it is depressed when plunged into the next bath and thus artificial respiration is repeated.
be respiration and the heart
one curbed on simultaneously.

The two most trying cases of
suspended animating occurred in
one week. The one was the
second child of a twin partnership.

The first child was all but
the head of the second was born
before my arrival. The child was
pale and showed no sign of breathing
when delivered but on pressing
I found over the heart I thought
I felt the heart beat, but whether
or not I proceeded as soon as
an hot hand cold baths were
performed in the manner above
described and although it
seemed a hopeless undertaking
for fully half an hour yet
in the end I was rewarded with
success and the girl is, as far
as I am aware, a healthy and sur-
vives her twin companion who
die 12 days after the above case with

The second was that I a "uti-
city" presenting and followed two
days after the above case with
Equal success, both time as well as other less serious cases, being treated in the above manner.

I have succeeded on two occasions in which there was this presentation in pressing the fundus within the os and retaining it there by means of the index finger until the head pressed sufficiently on the os to prevent prolapse of the cord. One case in which there was fundus and hand presenting along with the vertex ended fatally to the child and which concludes my list of fundus presentations, as well as anything worthy of notice that has occurred during my experience as abnormalities in presentations of the child proper.

Obstructions during labour are naturally classified into two belonging (A) to the mother and (B) to the child. Of those belonging to the mother the most common have been stated in the present and depend on the constriction of the cervix uteri.
being removed by means of an enema. The latter being partly obviated or removed by that C.S. being supported by the index finger. A less common cause of obstruction in my experience and one which never required operative interference but the removal of a small deal of parti- tion on the part of the woman and her attendant was a rigidity of the uterus. On one occasion a curious condition of the ovum presenting a cauliflower sensation to the fingers yielded to comparative ease under the uterine contractions.

Of those belonging to the child that most prismatic. There noticed was Hydrocephalus and as it was my first and only case of this kind I shall give the history of the case somewhat fully. Diagnosis at first as in most of these cases was not easy. I have visited many that one half of the cases I collected were wrong diagnosis.
J. N. aged 25 years. Single pregnant with her second child was seized with labour pains on the evening of 15th July 1880 and was seen by Dr. Thomas. Her pains were so irregular and protracted as to make her leave instructions that we be informed if the trained nurse during the night. The patient lingered on very much in the same condition as when Dr. Thomas saw her until my visit on the following morning. On making a P.P. examination I could detect that as enlarged to about the size of half a crown high up and as far as I could touch with at the time a normal head pressing on. At 4 I felt the patient at 9 ant. and the uterine contractions were very feeble as well as irregular. About 3 p.m. a message came that the patient was much worse. I found her complaining of very acute pain circular in its
Inspection, and corresponding in its seat very much with the margin of the patient's pelvis, and also of short pains down both legs.

On latter I attributed to pressure and often accompany ordinary labour but the peculiar circumscribed circular pain was new in my experience of parturient symptoms. On making a vaginal examination I found the os well dilated but the head still high up; on pressing the forefinger well towards the presenting head I felt a structure soft with a certain amount of firmness, due to the structure lying on the stretch and bounded on each side by a band from margin.

These long margins I surmised might be the either the parietal lines abnormally separated or that was extremely improbable from the general contour of the abdomen. The edge of the edge of the scapula in which case a back presentation would be the ab.
normality. At this time the presentation was still too high that I could not be quite certain that there were no osseous processes to be found between the head margin. At all events the osseous processes were not felt and the presumption in my mind was that the presentation was a hydrocephalic head. I went for Dr. Thomas and told him of my afterbirth sensations. He confirmed my diagnosis, and a timely use of the extractor revealed the true state of matters by allowing an insufficient evacuation of fluid to escape. This was followed by immediate relief from pain of all kinds for a short time and of the circular pain entirely. A few minutes later uterine contractions set in and by introducing my finger into the hole made by the pears, an easy delivery was effected. It would have been a mere impossibility to have attempted to
deliver with the forceps a head which would have almost to a certainty, yielded under pressure, and consequently to slipping of the forceps. And were such a delivery possible as it may be a dysphalamic child is scarcely worth the risks incurred to the mother from the Caesarean which would have been certain to have occurred under such circumstances. The woman made a good recovery.

Mothers. Some of those have occurred during my experience. One aphihsalamos, one aphihsalamos and having "spina bifida" and one aphihsalamos with an exomphalos. In all patients the pain during parturition was excruciating which was probably due to the irregularity of the head which was but a series of protruberances consisting of two large eyes and the hand edges of the partially developed cranium passing through but of primaarily dilated as their
cases were all premature in their delivery.

Placenta Previa have occurred just in five different cases. Two complete or apparently and three incomplete or partial. The first occurred in a young woman pregnant with her second child and also attempted concealment of her condition although harmless. There had been one more or less for nearly a week and even up to the time that the patient said to be examined to bed she continued to perform her duties in the kitchen. She confessed that she was run by Mr. Jones in a dying condition. I summoned the assistant of Mr. Thomas who thought transport might be attempted although at all appearances the woman was dying. This seemed the only resort under the circumstances and it was done easily but the woman
Smell shortly after delivery.
2. W. R. a multiparous weak and delicate woman, pregnant for the fourth time - previous to this she was delivered of twins and made a good recovery. She suffered from what at first appeared a complete placenta previa. She had had two other hemorrhages, one previous to, and during Dr. Thomas' visit. I was sent for and found what appeared to be a complete placenta previa and as the os was soft and dilatable we resolved to turn should any return of hemorrhage occur. Shortly after my arrival the pains slipped down showing partial separation of the placenta had taken place. This was very soon after followed by strong "having down pains" which had the effect, probably, of separating more completely the placenta and which soon ended the labor without any recurrence of hemorrhage. The woman appeared well cheerful but to our
astonishment such about twelve hours after delivery probably from 
epilepsy or exhaustion.

I do not think that Barnes' case would have done any good 
and any of those cases as they just 
was in a hopeless condition be- 
fore the was born and the clamps 
had lost nearly all the blood 
She did ever before they could 
have been applied.

The other cases were those of 
Partial placenta previa and 
although all had lost a con- 
niderable amount of blood 
before I saw them hemorrhage 
was almost complete assi- 
crated by the rupture of the 
membranes, and labour ended 
very satisfactorily in all. 
But other case of 
Partial 

Instrumental delivery has been 
resorted to in only three percent
Among a small percentage of instrumental deliveries, and in a sparing use of forceps, it may be suggested that Dr. Thomas and myself must have had very few sedatives by our patients' bedsides. As a matter of fact, however, such is not the case, a circumstance accounted for no doubt by the healthier condition and stronger physique of the woman in the country than in town. During nearly six years experience, Dr. Thomas and I, have delivered as long as twelve hours and in most of these cases part of the time was taken so that birth after delivery by section Dr. Thomas was
on one occasion attended nearly 30 hours due to a rigid 55, and over nearly as long because of a poor presentation. Moreover leaving in mind that we attended between 220 and 230 cases of midwifery yearly. Some of them as far as 23 miles from our residence. I attended one confinement 23 miles from Selkirk as well as attending to the general practice of a wide and populous district. It will be easily understood that we had not much time to spend unnecessarily at our "tlying-in" bedside.

It may now be asked how does this affect our mortality statistics? And first as regards the death rate amongst the mothers. During my 34 years experience I have visited in all eleven mothers who have died within three weeks after delivery. Two were from septicaemia, two of them as already mentioned had placenta praevia and died immediately after delivery...
being in a sinking condition when first seen, one about twelve hours after delivery, one who had Eclampsia during parturition and died on the third day after delivery. Perhaps his case should hardly even be included amongst our constant lamentations to swell the mortality list, as I was only called in by an assistant sometime after the woman had taken convulsions. I assisted an easy delivery with periphrases. He had been almost on the perimacter, without much exertion and no laceration. Whether his case should, or not, remain amongst my fatal cases may be doubtful but I include it as one of my fatal ones. The 7th was that in which there was vertex preces and presentation in which 57 1/2 and I turned, she died on the 5th day while attempting to sit up in bed, probably from exhaustion, and the exhaustion from amylloid degeneration.
from which she suffered for some time previous to her confinement. Persistent diarrhoea set in immediately after parturition and she died on the eighteenth day after.

Indeed the mortality amongst our children has not been very high. I am not however in a position to give a complete statistical account of the deaths of stillborn children. In no case can I assert that an earlier interference or intervention at all would have saved the life of any of the children stillborn with perhaps one exception. This is in the case of the child of Mrs. S., a premature labour began by early rupture of the membranes and very weak pains which continued thus for near 30 hours at which time the cord, which I felt for the first time, being called then by Dr. W. was soft and placed but the uterus very irritable. The long processus was then
Applid and a stillborn child delivered. Probably had the forceps been applied at an earlier period the child might have been born alive. This however is even doubtful. At page 14 of Dr. Ray's work on another case "nothing more convincingly shows the constructive effects of early interference as regards the child than the results of the practice of those who resorted to it." And then referring to Dr. Hamilton's practice he says "that gentleman uses the forceps on an average once in every fourth or fifth case, and at times delivered 731 successive children without a single still-birth; a result which he justly describes as altogether unprecedented in obstetric history." Does he mean by this statement that he "delivered by means of the forceps 731 children without a single still birth?" If so I can only say that it is an experience I think I all that this child has, so to speak, nothing to fear from.
Early interference with the precepts.

Or does it mean that in 73 delinquis of all kinds in which he had used precepts in the pro-
ected portion of our in seven or eight he had not had a single stillbirth? If so we cannot con-
gratulate him on his success but I do not quite understand
how such a success is due to the use of the precepts. nor
as I see why it should be used as an argument in favour of
the use of precepts. Statistics of
the mortality amongst all mothers
might have been more instructive

I never apply precepts unless
I find that the uterine contra-
tions begin to have no progressive effect on the head. When I think
that are justified in interfering;
a condition recurring not often
from about three times in every
hundred confinements in the

Anaesthisia during the operation

the first time I witnessed
The application of forceps was during my student days in the case of ©erbia ©or the utem. The operation was performed by Dr. J. McLeod then resident house physician at the Royal Infirmary. There were two of us present and that of course. The administration of chloroform and the application of forceps at the same time were easily enough accomplished but it struck me as being rather awkward for a physician miles away in the country and away from assistance to apply the forceps and struggle against or control the movements of a semi-conscious aged patient. Much better I thought if by dint of practice in the handling of instruments and frequent application on the "burning" the physician could come to apply forceps especially for the low operation without the administration of chloroform and turn to maceration before making traction.
Now by a system of "dummy" practice which was regularly gone through under the supervision of Professor Simpson on the Saturdays and was required of every student who had the interests of humanity at heart, could not fail to have a thorough understanding of the mode of application of the precepts. And thus into the habit of using the instrument properly even on a "dummy" to application on the living subject becomes very easy indeed. And nowhere can the student become thoroughly conversant and at home into practice with the use of instruments better in each classes as those on the Saturdays or apart from the systematic and of which I am happy to say not a few availed themselves.

I now do not administer chloroform while applying the precepts and find that with care and quickness the instrument can be applied without much in-
convenience and little or no pain to the patient. The fact of the patient being swollen enables her to assume and maintain the position the accoucheur desires. Indeed in my only case I applied the tram and while in a primipara I applied forceps without chloroform although Dr. Y. was present and pain made trachin often unnecessary was established. The application in this case was easily done giving no pain almost to the patient. Sometimes in multiforme with capacious pelvis and other obstructions made tram and de albin with out giving chloroform. In primipara case however I think it always advisable to make upship before making tram to assist in drawing the perinamina from evacuation.

I have been present during the operation of rupture - twice with Dr. Y. and twice by myself - four times
in all with a mortality that is rather serious. All the children being stillborn and two of the
mothers succumbing after the operation.
My first was also my first of placenta Praevia and the child
being at the twelfth month
and the woman in a dying con-
sition before the 26th June
the state of matters then is no
wonder that the child should
be dead. The second was that
of a combined firmis hand and
head presentation and the woman
succumbed on the eight day
while sitting up in bed appa-
rantly from Ambition.
The third was that of a primipa-
la who felt pains first about
5 P.M. which continued
more or less during till between
four and five afternoon when
I was called and found a
hem and arm as far as the
elbow blown. I immediately
put the patient under Chloroform
Notwithstanding this she being
a young woman of my 15 years. It was not easy to get my hand up past the arm and into the womb. Once introduced, however, version was easily accomplished. The child was dead but the mother made an excellent recovery.

The fourth occurred in a multipara in whom the membranes had burst and the liquor amnii escaped, permitting to any "point" being felt. Version was easy the child in this case also being dead. The mother's temperature rose on the third day to 107. I ordered the purging of the sulphate of amnii night and morning with the result that next day the temperature had fallen to 99.6. She quickly improved after this and made a final recovery ultimately.

Echymophlebitis of this alarming complication I have seen but one example and that only by being called to assist Dr. C. of
When principal Dr. Muir was not conveniently near.

The woman was a primipara aged 21 years and had felt Mr. clinics before about 3 A.M. which lingered on until about 3.30 P.M. when convulsions set in. In the absence of Dr. Muir I saw the patient with Dr. E. about four o'clock and not until she had had several convulsive attacks. When I saw her she was breathing short and fast but quiet as if she had just had a short paroxysm shortly before. On examination the head was found well down and I advised forceps delivery of a dead child. I then removed the placenta and then ordered a strong external compress to be taken immediately.

Dr. Muir arrived about 7 P.M. and found the patient sleeping
sleeping calmly and ordered the draught to be repeated. I was informed that the convulsive paroxysms returned about 8 pm and continued more or less till about 2 a.m. I understand that she took an attack of pen trunkis subsequently and died on the following Monday. She was delivered on the Friday.

The probability is that had forces been applied earlier and kept not at all both mother and child might have been saved.

The Purperium

During the first day after delivery I allowed the patient nothing but a little toast and tea the latter luke warm occasionally I administered a little stimulant in very delicate women but I must say that such treatment is seldom re-quired although pump who have had it during previous purperal conditions claim it on the second day I think a
Little beef tea is salutary and much enjoyed as the weak café diet such impels a woman. I also allow from the third day onwards a little Bovista mixture with milk and such nourishing but light diet.

Amongst the diseases and affections which I have observed during this period were a symptom album which I have noticed in only two cases out of which had the disease in both legs. Both were successfully treated by gentle friction with a mixture of camphorated oil and camphor, and by keeping the limb rolled in cotton abraded and slightly elevated. In the case of a woman (Mrs. B.) in the country there were present the symptoms of 'embolism' with a detached embolism unpacked in the right lung. The patient took sudden ill with pain in the back part of the right shoulder and was visited by Dr. Thomas...
had many of the symptoms of a localized patch of pneumonia. On seeing her next day, there was found dulness on percussion certainly but on auscultation scarcely any breathing sound was heard. There was slight rush in respiration, pulse 90, temperature 99.6. Respirations slightly increased about 28. There was not seen the urgent symptoms of an acute attack of pneumonia. The patient however complained of a crampy pain in the left lower leg and on pressure in the popliteal space on that side the sound of a distinct thrombus was felt. She made a good recovery at that time but in such cases I should be careful in giving a favorable prognosis as I should feel somewhat cautious as to the ultimate effects of the congested portion of the lung as well as of the embolism itself. What struck me most in this case was also what the patient
complained most of at the time, namely, the suddenness and severity of the pain over the region of the supposed impacted expulsion and this followed immediately afterwards by the moist eruption of the retained membranes.

If this often happens immediately after the placenta escapes, the uterine contracts firmly on the membranes a small portion of them may be 20 joints held by the 3rd that the most perfect rolling and the traction may fail to remove them. And although by retaining half of the protruding portion until slight uterine relaxation occurs we can usually remove the imprisoned membranes yet sometimes we have felt confident from stains or sacrum, that a portion has been left.

One particular cause which I have noticed in three or four occasions, and which I have no doubt occurs often than it is noticed, is the formation of
a large clot of blood on the surface of the retained portion of membrane.

On the first occasion I observed this cause of retained mem-
brane I was astonished to find, instead of the thin slice which
usually comes away, a lump about
the size of an egg, enveloped in
and slightly adherent to a fold
of the membrane.

In any cases in which I have
suspected retention of membranes
I have not run any very alarming
symptoms and beyond a
little diminution and small areas
revolve no other treatment was
necessary to restore the consti-
tutinal symptoms to their nor-
mal. If such cases recur,
now I should certainly wash
out the uterus with a weak
solution of carbolic acid (1:500.000)

3. Suppressed torpor with no
post constitutional disturbances
usually yielded to treatment with
drop dose of strychnine along with
four drop doses of Liq. Morphine Acet.,

sometimes a warm poultice applied

over the pre-aural superficial area assists

in re-establishing the cuticular air

space. And sometimes a

six or seven grain dose of Cinchonine

aids the result.

4. Septicemia. I have had what

practitioners call "a run of

two or three acute cases of Septi-

cemia. My cases have recently been

said to have come in a "run" in the ordinary acceptance of the

phrase as they have occurred at

different periods of my experience.

four in which the poison seemed

to have a strong hold resisted

all that was done to remove the

poison or support them until

the poison exhausted itself and

died.

When however collected a series

of cases in which high temperatures

and quick pulse occurred usually
between the second and fifth days - one on the sixth day -

In connection with these cases, in which I have used the injection of a weak solution (3/6 to 8) of carbolic acid, I cannot speak too highly of the use of this remedy as antiphlogistic and may state that I have not used it in any case of a high temperature during the phlegmorrhea without a marked fall in the temperature shortly after its use.

The first case in which I noticed the benefit of carbolic injection and washing of the uterus was in that of MRS. H., a mulatto woman on the sixth day after confinement felt "a little weaker."

Temperature 99.8, pulse 98. I ordered 5 pain-doses of bromide night and morning. In the following morning she had a worse rigor and temperature had risen to 101°, pulse 110, and the diuresis had ceased.

Mixing 3/4 of carbolic acid in spirit of wormwood with this I washed...
out the worms. The patient experienced great relief from the operation and had a general sense of comfort afterwards. About two hours after the operation, the temperature had fallen to 100. In the evening, the temperature rose to 102°. Again, the worms were similarly treated, and before leaving the house (about an hour after the operation), it was nearly 101°. Pulse still kept up from 115 to 130 per minute. On the following morning (2nd August), the temperature had returned to 102° pulse 120. The washing of worms was again given through with a similar result. On the morning of the 3rd, she felt much improved: pulse 100, temperature 100°. In the morning of the 4th, I was astonished to find the temperature up again to 102°, pulse 120 to 130, with little fever being present and already not lasting oltre. The lesion had now returned - a circumstance due
probably to the action of the carbolic acid. In the evening the
temperature reached 103 and
pulse was from 130 to 140 and
I was beginning almost to dre
pain of the决议. Prunes
and rice had half small
sherry. I had kept under
and had the urine washed
as before morning and night.
In the morning of the 5th the temp
ature was still high 102.6 but in
the evening it fell to 101.6.
On the 6th the temperature fell to
100° in the morning and 99.6 in the
evening. For three days after this
the urine was washed out once
a day and was sent straight
and the patient intuitively
made a good recovery.
So infected was I in the effect
of carbolic acid as an antiphlogistic
and as aqueous to have a little
more favorable sign before leav
ing my patients behind that I al
wasp remained sometime after washing the uterus; at times not longer than half an hour, and never did I leave her bedside without my assurance that she felt more comfortable and my own satisfaction that the temperature invariably fell after the carbolic acid injection. And this was my experience even when letting the vagina and cervix syringed with the carbolic.

Mrs. W also a multipara was confined on the 6th August with twins. On the third day she felt ill, coughed rusty, petor. 120. temp. 98. With my usual lotion I washed out the uterus and brought away in the stream a debreeving clot which had a very offensive smell and was about the size of half a walnut. The clot had a very offensive odour.

The patient in this case also experienced immediate relief and a sense of comfort and elipt. Alive and entire.
after the temperature had fallen to 100° and pulse about 120. Later in the evening there was a slight tendency for the high temperature to return and after the weather was changed with the result that the temperature again fell. For two days after that the weather was washed twice daily and the temperature never rose higher than from 99.5 to 100 and the patient made a very satisfactory recovery.

In another case that of Mrs. A. who was delivered on 22nd Dec. the child being born before I arrived, her temperature also rose to 102° on the third day, pulse 120 small and thready. In her case the injection was used only twice to bring the temperature back to near the normal.

My notes contain other three cases, where temperatures ranged from 101° to 102° which were true in similar manner and I sometimes happen today with a similar
result namely that carbolic acid in weak solution injected in a gentle stream into the uterus, or even into the vagina only, acts as a very useful and easily administered antipyretic, and moreover the general sense of comfort the patient experiences after its use should even recommend it. Never I expect from it fail to reduce the temperature in such cases as I have described, which of course are limited in my experience.

In the July number of "The London Medical Record" and instead that "Mura and Mirandi" had published in the Gaz. Med. di Torino 1881 a research on the use of carbolic acid as an antispasmodic and as thorough suppression of pain that I quote their conclusion.

"The best method for the internal administration of carbolic acid..."
is the metal passap.

2. Carbolie acid has the constant effect of lowering the tempera-
ture but its action does not last long.

3. Further administration of the remedy may arrest a fresh rise of temperature.

4. Before repeating the remedy it is necessary to wait until the tem-
perature shall have again at-
tained 91 deg. Cent (102.2 Fahm.

5. Carbolie Acid has a different action in different persons. It is more ef-
fective in women in whom its ef-
effects should be watched from the commencement. In their case the dose should be smaller.

6. The dose of Carbolie acid in an emma should not exceed 2 grammes (30 grain).

7. The action of the remedy in all probability is less appreciated on the pulse and still less on respiration, but further observations are necessary on this point.

8. It would be well during treatment to watch the condition of the heart and
the arnica although the authors of the research have not had the opportunity of recording any signs of cardiac weakness or of albumina that brought on by the use of this remedy.

While appreciating the value of such interferences in the cases of high temperature I must say that the condition of the and frequency of the pulse influences me nearly as much as the state of the temperature. Because unless the pulse is correspondingly high the high temperature usually turns out to be a very temporary and evanescent condition. As for example, in the case of Mrs. D., a multipara, when on the beginning of the third day I found a temperature of 103.5° and a pulse of 75 I felt certain that this was merely a temporary and insensible rise of temperature and ordered a small dose of castor oil with the result that in the evening the temperature had fallen to nearly normal.
If with such a temperature I had found a pulse of from 100 to 120 I should have considered it rather alarming. Several other cases I have noticed which afford proof that as a rule in cases of typhoid fever the pulse and temperature relatively deviate from the normal.

With a strong full pulse pulse I usually give drop doses of acrimi which usually helps to reduce the pulse but only in one case in which the pulse exceeded 120 did I find that it would be safe to use acrimi. Most other cases in which the pulse was over 120 being better suited for stimulants on account of weak, weakly pulse.

The case in which I found it advisable to use acrimi in a pulse over 120 was that of a young woman with pleu. Scarlatina and cannot case I give below.

Scorlatica while a most dangerous complication at this stage of a
women's life has not I think been sufficiently proved to be peculiarly liable as some have asserted, to attack the woman during the puerperium. It has often been said that the blood of the lying-in woman being similar to that of a patient suffering from scarlatina renders her more liable to the disease, but I do not think that practice bears this out. Indeed any information I have been able to collect during a severe epidemic rather disproves that a woman, going through the ordinary puerperium, is more liable to be attacked with scarlatina than she would otherwise be.

Having noticed especially the effects of a very continued and epidemic of scarlatina on lying-in women which lasted from 14th June 1878 till a corresponding period of the following year I find that at home and myself attended over 300 cases of scarlatina and 220 confinement out of all these pregnant women I find that about 8% had scarlatina.
had Scarlet fever. Some of these too were not only confined in the same house with the scarlatina patient but the latter in some cases had to be removed to allow the woman into the very bed which had been vacated by the little scarlatina patient for her confinement—a circumstance which gave every chance of the scarlatina virus reaching the women. Of 2,200 pregnant women I find only four who were attacked with scarlatina, and each case differed from the other in the nature and period of attack and therefore the result in some of them is worthy of notice. One (Mrs. R) took place at the sixth month of pregnancy and did not miscarry or have any bad after effect. A sister (Mrs. D) took the disease some weeks after her confinement and went well through the attack. A third took it six weeks after confinement and also did well. The fourth showed the scarlatinal rash...
about 12 or 14 hours after her delivery which was by means of forceps and during the passage of the head there was slight rupture of perineum. Now if lying-in women are particularly liable to the scarlatiniform poison why did such a large percentage of those who never had the disease escape it? Why did one take it then and another six weeks after confinement? And why did the fourth case take it immediately after her delivery? Why the latter took the disease so soon after delivery was I think because she was the victim of a lacerated perineum. And recalling the case of traumasim which were followed down into by what is very often seen namely an epispidiasous fistula an attack of scarlatinina as can understand why some lying-in women are more liable than others to scarlatinina namely those with a laceration produced during or near their time of delivery.
Whom after being 12-14 hours in labour I delivered with short German forceps. There was a slight tear in the perineum which was not stitched. There were no scarlatinial cases in this part of the town which contains about 600 inhabitants and is separated from the rest of the town by about 600 yards space and the river. In this tear in the perineum was due I think the rapid absorption of the poison and the rapid appearance of the rash. The rash appeared about 12-14 hours after delivery and disappeared again about eight hours after this and reappeared and remained bright until the fourth day when the symptoms assumed the aspect or scalled “pustular” type. Temperature at this stage was 104.5.

Treatment in the two first cases required no specialty beyond the ordinary Jubiques. In the case of the patient with the evacrated perineum and in whom
The "paresthetic" symptoms developed
sulphate of soda was at
first tried, but the bowels became
too loose, it was stopped. Some
grain every dinner every three
hours and drop doses of salt
every half hour were now given
with the result that the pulse
fell 20 beats during the first 10
hours of its administration.
And now the pulse from 160 fell
rapidly to 90-80-70 and the
external sphincter which was
uncontrolled became free due to
the action on the nerves of
the strong doses of Brimine
which I have found valuable
in inducing contraction of the
uterus in large doses. Beyond
the knowledge that I am
impressed nothing more was done to bring my patient
through my attack of scarlatina.

6. Roberta Muirina. I mention more as
a pathological novelty in my experience
than as having any particular influence
during the puerperium. I have just
seen one case and was unable to diagnose the eruption until I saw the affection described in one of the medical journals.

Dr. Anderson of Selkirk informed me that he had noticed this affection two or three times only during an experience of over 40 years practice.

### Gynecology

My experience in the diseases of women has been limited to those of metritis, cellulitis and those arising from displacements, metrorrhagia, dysmenorrhea, and amenorrhea.

In acute endo-metritis and cervicitis I have used the ordinary antiphlogistic remedies combined with contra-indicative and warm douches applied by means of a syringe to the vagina and cervix of uterus.

In chronic metritis I have seen good results follow repeated counterirritation over the uterus externally with the introduction into the uterus of a little drop of iodine or pure carbolic acid.
The use of the latter Dr. Thomas and I have had excellent results in the treatment of the chronic form of enteritis and - cœlitis.

In all I have treated under my care 15 cases of displacement of the uterus which have presented any of the nature of Retroflexion or Retroinversion. I have never felt convinced of its existence in our cases of Retroflexion probably because it is so rare that I may have overlooked its presence from want of experience in its detection.

Dr. Traill Hewitt some years ago brought somewhat prominently before the profession in his "System of Obstetric Pathology" a thrilling account of the females that may be found in the uterus with their treatment. The effect of those lectures, which to some appeared somewhat overdrawn, was not to reveal any new and certain method of treatment, nor to impress most cogently on the practitioner the necessity for active interference when such a
a condition presented itself, but
to impress on him that such con-
ditions of uterine displacement were
more prevalent than the practi-
tioner got the credit of detecting;
and also to recapitulate the
numerous objective subjective
signs and symptoms which are char-
acteristic of and traceable to a
displaced uterus and which are
greatly lessened sometimes com-
pletely removed by the timely and
judicious use of a pressy.
Any experimenter in the use of the
pressy and particularly of the bliss-
variety, has been attended with
varying results. Results which taken
collectively have been very dissatisfac-
tory as to the amount of benefit
derived over all but which taken
separately as regarding the effect
on each individual patient show
an amount of palliation varying
from those who from the insta-
ment gain perfect relief to those
to whom it at least formed an
accessory to the ordinary palliation
and restorative treatment for being going on to prolapse. Lime and again I have seen a patient who
inspired herself suffering from all manner of diseases or as she would herself say “all upon
without” experienced almost perfect relief from her previous symptoms by the introduction of a stupidity
pessary. Others I have seen principally those however in whom
the flexure had been of long standing and with predominating soon
pessaries had to be frequently removed and astringent injections
often resorted to. These Carrié I
often recommend with good
effect in all cases in which “cottons” are used as they not only
cleanse but very incense that
may lodge about the pessary but
by virtue of their astringent action
and to produce a certain amount
of contraction in the vaginal canal
whereby the pessary and uterine
are kept more firmly in place
as it would in superfluous
and depressive on my part to enumerate the various signs and symptoms which accompany puerperal fever. I will here only in a few pertinent cases illustrate of what I have met in practice and in whom the fever was used with more or less favourable results.

Mrs. A., aged 25, about 9 months after being confined of her first child, which was a breech prematurity, complained of a severe pain across the lumbar and sacral costal regions, considerable pain during menstruation, and pain down the legs especially that on the left side. Pain was increased during menstruation. Colds were occasionally found during menstruation. She menstruated more rarely when in bed than at any other time or in any other position. Such were symptoms I considered them due to a displaced uterus. On making a per vaginam examination...
tion I found the 12 uriri forward and what appeared to be the fundus uriri in the space of Douglas. The introduction of the uriri seemed unusual and doubt as by the digit in the posterior fornix va
final the sound was distinctly felt with the uriri and vesical times intervening, the form being easily turned forward by moving the handle of the sound. 

There being a good deal of iri-
tation about the vesical tissues and the 12 uriri being very tender I introduced a pledge of lint soaked in glycerine and told the patient to rest as much as possible for 24 hours. At the expiration of this time I removed the lint and intro-
duced a pledge soaked measur-
ing about 2 inches or 2½ inches long, and informed the patient to dip once with spirit and warm water two or three times weekly or otherwise which might be discontinued after a month.
Patient experienced a considerable amount of nausea for a few minutes after the introduction of the pessary, due probably to pressure on the left or both ovaries. With this exception, she has not suffered any inconvenience from wearing the pessary (after two years use). On two occasions during this period I removed the pessary because she complained of slight uneasiness and I became suspicious of the pessary being too large, and during those occasions she expressed herself perfectly well for her very day work and her previous disagreeable and painful symptoms returned. The pessary had therefore to be replaced with the result that the same symptoms again disappeared and the patient was again fit for work, and her symptoms of uterine torsion reduced almost to nil.

In several cases which I have seen at an early stage of the
displacement I have had equally good results but unfortunately all are not seen at any early stage of which class and the attendant result of treatment the following may be given as an example in my experience.

Mrs. K aged and has had a large family had suffered from ulceration of the neck of the uterus with chronic induration of cervix for a number of years. On making examination with the speculum the cervix was found considerably congested and slightly ulcerated on the posterior lip. The cervix was indurated especially the posterior lip. Patient had suffered much from menorrhagia and had cervix contracted apparently which operation usually gave her a slight temporary relief. On repeat examination decided resection with partial procedures. For 20 months she has had the use more or less constant of a diaphragm which has proved a comfort...
enable help along with the other palliative treatment in supporting the action and in removing the present symptoms of which she com-plaints so much. The patient is never perfectly well but she ex-
periences great relief from the use of the passy. Since its first introduction in this case the dressing has often been removed but the patient always requests its re-
introduction as it always arrests the "shaving down" pain and
weight which she previously endured so much from. This
latter is perhaps one of the
most of all our cases of flexion
been attended with the least-
satisfactory results and yet
with so much satisfaction as
to favour the use of a hedge or
filter from a passy in such cases.
The ring spring and gutta
percha passy's I have not used
but in those cases in which
the bulge might could not be borne
but wherein it is possible I pre-

for the immature.

Adhesions vaginal

I have seen but one case of this

disorder which was inflammatory

in its origin.

A single aged 28 and residing

in the country fell ill on the evening of 25 Dec. 1878

and swelled and formed a tumor

below the left side of her abdomen. She suffered so much from pain

before my arrival. A quantity of

discharge_membrane was still coming

from the uterus or vagina.

I made a per vaginam examination and found lying in the

vagina a mass resembling to

touch a small placenta or part

of a placenta. On removal the

mass had all the appearance

of a decomposed placenta and

had a most offensive smell.

The discharge was also very offensive and of a coffee ground appearance. Patient had a child about

years previous to this. I then thought the post-bid mass might

be the placenta.
In a placenta retained for that
length of time but on making
an enquiry of the patient and
subsequently of Dr. Thomas who
attended her during her confinement
was assured that the placenta
came freely away at the time
of her delivery. The mass must
then I thought be either a clot of
blood as a result of a hæmoma,
or a decomposed tumour.

The discharges were quite what might
be expected from a hæmatoma.
The patient had suffered no
inconvenience previous to this no
indeed at any time but during
the twelth that this mass must
have been passing probably 2 or
8 months after this.

She again presented herself com-
pletely of symptoms noted.

The mass only manifested once
at 1 or 2 months after the 25th
year and the dimensions
at each menstruation period
made a vaginal examination
and found the vagina completely
receded. I operated and found
the vesica but only a small
membrane of menstrual fluid
escaped. I then packed the vesica
with lint soaked in carbolic
oil. When seen a few nights after
this there was a strong tendency
for the parts to contract. I then
then rather than cut the tissue
and repacked the vesica with
carbolic lint at first for some
time after this the
vesica kept more open than
subsequent to the first opera-
tion. I now gave little of the patient.

Three months latter I was called
in a room to see the same patient
who on my arrival was lying
almost on her back which was periodic
and "slaving down." The bed by this
time had been moved another month
or six weeks. There was no incli-
ning externally and on attempting
a per vaginam examination I
found the vesica open perfectly
closed. Supposing the "slaving
down" pains to be due to re-

turned monstrosal fluid into dined a history through the incising tissues. This was
followed by a rush of blood
for rack-coffee-ground-cooking
fluid very similar in appearance
and smell to that which had
come away when the de
composed mass was passed.

Then enlarged the opening
pretty fully by tearing and stretch
ing the tissues. Since this operation
the patient has continued
to menstruate regularly but the
menstruation at each time is very
small and the menstruation has again
contracted to a point which
would admit the little finger
or perhaps a good sized needle.

This seems to be in each
case, from all that I have been
able to gather about the subject
a great tendency to wretching and
contraction even when sponge
and cast tents have been used.
The result in most cases being
unsatisfactory. In most of these

Cases of which I have read, the various tests seemed to do no good. They put the blame on the heart for the time for no reason has the mechanical side to be removed. These contracts too set in Metaphasia.

The uterus is said to have about 16 contractions every minute. Whether its contractions being regular or irregular have anything to do with regular or irregular menstruation. Or do I know whether we might not look upon the uterine as an organ under the management or control of what we are to speak and whose contractions were regular or irregular according to tone of the heart and whether this and whether Metaphasia may not depend always as it does sometimes on some cardiac disturbance. Certain it is that I have found those remedies which are the most powerful cardiac sedatives in use.
ascites and digitalis, also most useful in bringing on
and favouring the menstrual flow. Two cases of special inter-
est to me have impressed me-
more during my short experience interesting they are in so far
that they are the only cases
which I have had the opportunity
of testing and which have always
failed by means of Nativelles
digitalis granules.

The first was that of R. M.
aged 19 born in Scotland but had
lived in America for some
years when she had had a long
and rheumatic fever which left
enlarged spleen and mitral dis-
turbance of the heart. She was
with the rheumatic and very breath-
less on exertion and her menses-
struation was very irregular.
With a view to combat the
cardiac symptoms and drags
I gave her the above formulæ.
At first she got one night
and morning and then about
day. Her breathing, dyspnoea and other symptoms which were indicative of heart affection were considerably abated, and her menstruation returned and became regular. Since first using these granules she has often removed them and when I saw her last she told me she kept a few usually beside her and that she was quite regular in her menstruation.

The appearance of regular menstruation in this case might be looked upon as coincident with the disappearance of the dyspnoea and irregular heart action.

Case 2 however presented itself with meningitis but within fifteen or irregular heart action and her menstruation became regular after the use of the granules.

No 2 continued to use the granules after about the menstural periods with results quite as beneficial as in the first case.
These cases are not conclusive proof that digitalis in this form is preferable to all other medicines in this disorder but the results are so satisfactory as to make us wish for a more extended use and experience of digitalis granules in metro
rhagia.

Dysmenorrhea. I have often had patients suffering from this affection and have sometimes had to resort to remedies
spiritous and fermentation for the relief of pain. But as such cases are to a great extent produced by some mechanical obstruction other palliatives have only a temporary effect.

Small doses of liquor morphiae hydrochloratic along with drop doses of pepton I have found useful in relieving the pain and tension, warm douche and fomentations have also found serviceable for this purpose but I believe that
operative interference is attended with the best results. I have seen good results follow the passing of the sound into the uterus even although there is no great constriction. Greenhalgh's uterine firm passage I have used only on one occasion with not very satisfactory results. Dilatation with a tent or incision by means of the scissors gives perhaps the best results.