The Obstetric Experiences of a Young Physician

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Obstetric experience of a Young Physician.

It is said that the more one has the more one wants; and accordingly having received the M.D. at 3 o'clock, I set about preparing for the M.D. My first idea was to investigate the subject of "Compensation in Disease," but finding I would have to at once go into harness as an assistant, I had to give up this subject from the difficulties in private practice of investigation and adapt myself to my surroundings, and finding I was to have more experience in obstetrics than anything else, I chose that subject; not without misgivings, however, I think. The first part of the essay is not of very much value, but still I think contains some points which may be well thought by the reader out. It may be said that these simple cases do not make an important enough array for a Thesis for an M.D., but a workman must work with what tools he has, and seeing the great necessity for me obtaining the M.D., in my present unenviable postition, I hope the important matter portion of the essay will make up for deficiencies in the former.

With these preliminaries I go on the next page give a general outline of the way in which I have arranged the cases, which I may say are all drawn entirely from my own cases.
Outline Table

I. Cases with slight abnormal deviations
II. Cases with important or greater deviations
   most of these are characterized by being too slow labors.

I. Subdivide the slightly abnormal cases thus:
   A. First dependent on mother.
      1. Nervous
      2. Disappointment.
      3. Position
      4. Tough membranes
      5. Too weak abdominal pains
      6. Pendulous abdomen
      7. Too early rupture of membranes
   B. Those dependent on child
      1. Hand and Head
      2. Twins
      3. Short Cord ??

II. Severe cases are subdivided into
   1. Small Pelvis ?
   2. Hydratidiform mole
   3. Forceps.
   4. Placenta Praevia
   5. Varices of Thrombus Vulvae
   6. Rupture of Fornix
   7. Thin or contracted uterine with
      retained placenta
   8. Breach
   9. Pregnancy complicated with heart
      Disease
   10. Eclampsia
Case 1. (Nervous)

Mrs. Bruce Tige, 81, of Paris.

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

The action of fear on the nerves taking the upper hand inhibiting the uterine contractions.

Other examples of nervous fear hindering good pains are constantly seen in primiparous.
Case 2. Disappointment

Mrs. Anne Balachski. Tife. Trinpara.

The message to attend this woman came at night and my principal being unable to attend, I went at once to the woman's house, for on being in the room, I saw her face very pale and she got into a great state, not so much taking as hysterical sobbing. She had had prodigious pains for 3 or 4 hours, but they failed on my appearance (as they very often do for 1 hour or more after the arrival).

I waited quietly for 1 hour, then asked to be allowed to examine her, but she refused saying she would have none other but her own doctor, and as I saw she would be persistently foolish, I said I would as well go home but that the other Dr. would not come (5 miles in snow). When I saw me putting on my topcoat she paced in and implored me to stay which of course I did. On examining her I found her head on perimamum in about 15 minutes after pains came on and the child was born easily and naturally. The disappointment here inhibited the pains slightly; the woman curiously notes some of the acts of the body are controlled by the emotions, fear being the chief. Everyone knows how nervous fear can be.
causes frequent micturition & again sometimes spasms of the sphincter. A young friend, a minister, has often told me that before entering his pulpit he was constantly micturating in the vestry but that as he became accustomed to his position this ceased.

Case 3. (Position)
Mrs Hobson, Yeadon Leeds. Drupara, age 30. This woman in her first pregnancy 2 years ago had some mishap as she says the child had to be "extracted in pieces" at the 7th month. I can get no further explanation. In this pregnancy she fears the same would happen as at the 7th month she had pains + coloured discharge (This occurred about her usual menstrual period) Opinion + rest however prevented any miscarriage & she went on to full term of pregnancy. During the labour she was very frightened that the child was "fart" but on examining her + telling her she was "all right" her fears were quietened. I was called at 3 am. She had had pains for 2 days previously but had good nights + slept without pains i.e. the pains only came on when she was standing or walking.
The pains were scarcely perceptible when she lay on the bed. The head pains of the past. The pelvis was natural in configuration to a rough examination. He or was about size of half a crown. When she knelted at bed's end I found the head advanced with each pain & made good progress. In about 2 hours the pains seemed not so effective & I ruptured the membranes & waited. But the pains had not so much effect as I wanted. I turned her on the bed with a linden tightly round waist & in all positions for about 15 minutes & a time. I had her on both buttocks raised on hands & knees. In this last position the pains were better but still would have taken hours to deliver. In the end I had to use forceps. I will refer to the case again under "Forceps." What I want to note is the fact that the pains were mild or almost so. When reminental or later on also very slight when erect. The head was protruded. No obstruction but that the pelvis been extra roomy one might say that gravity was the cause of pains being stronger when erect but this cannot be as the pains ceased in time to be effective even in the erect posture. Could the abdominal muscles in this case be the chief
Chief cause or initiators of the pains and that in the upright position these
muscles were contracted (as is usual case) & acted on the uterus, that they were
relaxed & ineffective when recumbent. How the circulation anything to do with it?
I can understand that if in the upright position there was more blood about the
uterus & therefore more bulk that the pressure on the nerves in and about
the uterus would be greater & therefore more likely to set up reflex pains or
contractions, but I fail to see how
such a difference in the quantity of
blood could be the cause.
The aeration of blood in erect position
is certainly more complete
In the erect position the abdominal
contents would by gravity help to press
on & contract uterus & in erect position
the heart & respirations would be quickened
Possibly the cause is to be found in a
combination of the above.
Had the fetus increased in the erect
position I would have wanted to deliver
the woman standing or leaning on the bed
but the time was passing & I concluded
forceps would be easiest for all parties
especially the woman who was tired.

Case 14
Case 4.ough Membranes.

It is needless to mention ordinary cases where rupture of membranes has been necessary to hasten or complete delivery. e.g. In one case I have had the child was born with the membranes unruptured (i.e., though another the membranes were so strong that when Os was fully dilated (24 hours) & the membranes protruding to 1 inch or 2.5 cm from vulva (it was a bruised case unengaged side part) I could not introduce my hand in against them to make out presentation at Brim without perforating membranes even during the pain. In fact I could scarcely rupture the membranes when I wanted to do so as I will after explain.

In another case of Placenta Praevia I had great difficulty in breaking the membranes.

Case 5. Too much abdominal pains.

This is a fallacious expression as it is not the abdominal muscles which are at fault so much as that the prolonged resistance makes the muscles necrosed out, e.g. in the case of Mrs. Luty Yeoman the woman got an odd sight till the Os was dilated & the membranes ruptured.
ruptured and the head lawn down. Then the pain faile. How was this? The woman was natural in condition through frightened a bit by foolish nurse saying she would not manage without help. Fortunately I had to use forceps but I want to note here that she was a primipara - a fine woman - a strong resistant perineum, etc. I have tried the abdominal incision muscles so that they could not act efficiently. Whenever she tried to bear down at the "pain" she gave up very soon as if the efforts were useless. In some cases douleurs the "pains" are too weak throughout the whole labors. In the absence it was not till later on.

Case 6. Pendentous abdomen.


This woman had a very prominent abdomen so much so that everyone commented on her appearance. In pretermal times, before examining her at all, I thought it more like hydroamnion. There was no history of any forward displacement of womb. The labors was very protracted in first stage. I ruptured the membranes & soon a large child was born (male) which weighs about 8½ lbs.
The placenta was 1½ inches in its largest diameter. The liquor amnii would be about a pint or a pint and a quarter, not very excessive at all events. The perineum was good but she gave from land with prominent abdomen. She has now (8 months since) as pendulous an appearance as when she first left her bed. She is a well nourished woman but not corpulent otherwise.

What can cause so-called pendulous abdomen?

1. Forward Displacement of uterus.
2. Lack due to Proper Pendulous abdomen is seen in women with contracted pelvis because the uterus as it grows, has to give way more than usual.
3. It is proof that a weak lumbar spinal region would fall forward with corresponding backward bending in dorsal region of prominent abdomen.
4. Separation of Recti muscles in a wasted woman.
5. Serous Fatty deposits in abdominal walls in pregnancy.
6. Hydramnios.
7. Twists.

The above is my own classification. Dr. Babagladi of Finsphord tells me he has seen ovarian and paraovarian tumors simulating a pendulous abdomen. Of course both this and
and ascites cause prominent abdomen
and as they are commonest after the
climacteric period they cannot be classed
under pendulous abdomen, which is a
term generally I believe retained for
"pregnant" women.

In the above case what was the cause?

1. A large Child. 2. A large Placenta
3. A fair amount of Liquor Amnii. 4. Fatty
Deposits in abdominal wall. 5. Lastly
that the fact that the woman was near
a month by her own reckoning over her time.

What is the cause of large abdomen now?

A subinvovled uterus would have shown
some symptoms but there are none. nor
are there signs as the woman is perfectly
healthy. I think the cause now is simply
a large amount of fat in abdominal wall.

As regards the causes I mentioned under
3 4 5. No! 3 would simply signify miscarriage
4 would most probably have been miscarriage
2 therefore come under No. 2. Last.
No. 4. Separation of Rooti. This could
scarcely occur to any such extent as to
cause pendulousity. The muscles can be seen
however very prominent sometimes with
the skin and fascia between joints on
the stretch. This is most apparent in obese
women.
Case 7. Too early rupture of membranes. In this case partial prolapse of cord.

Mr. W. Fife at 37. Primipara.

I was sent for by the midwife. The first stage had been 24 hours, and when the 80 was about 2/3rds of half a crown. The midwife had ruptured the membranes as she said to hasten matters. In 1/2 an hour after the pains ceased almost entirely I was sent for.

On examination I found the 80 about the size of a two shilling piece. The head was palpated but a piece of the umbilical cord prolapsed down on one side of the head. It was fingerless. There were pains about every 10 minutes but very ineffective. From this case if it had happened with the ancients they might have said that it was a natural case as far as mother was concerned, and supported their declaration by saying that at a certain time the child forced its own way into the world (constituting labour) or that in this case due to the prolapse of cord causing the child death that the Child was now was useless to act or therefore the pains ceased or the child lay in the passages like a foreign body.

Apart altogether from any such improbability in this case I have a proof that Cecil was not the case because if the child could
could when alive force its own way then when dead it ought to be delivered easily by means of forceps, but such was not the case as it was most difficult to extract. What I want to note chiefly in this case is the fact that the nurse was wrong in rupturing the membranes. The labour was slow but going on well as far as post-pains were concerned before as in all probability there was no fracture of cord until by the early rupture of the membranes the gush of liquor amnii would carry the cord down with it.

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

B. WR P. Edinburgh Hospital.

In this case I want to note the danger of accidental rupture of membranes in first stage. This woman was standing or a bed
doing some house work. She had had some pains for 3 or 4 hours previously. When
she got up she felt very faint and began to cry. She fell down on to the floor (about 1½ feet only) and the
membranes broke. She rushed off for me in great alarm. On arrival I found the bag about
the size of a shilling. With time and patience the child was born all right except a very
prominent and hard part of succenturium. This was one of my first cases in Hindustan,
and I was in great fear as to result. The child was not born till about 7 hours after
rupture of membranes. I assisted the vagina especially with hand and so kept the parts soft.
There are two unnatural cases. In Burmah
I believe they make labour very hard
the patient lying on ground and the midwife
sitting on the woman's abdomen or a board
placed across with a woman at each end.
This way must surely rupture the membranes
prematurely. I am unable to quote any au-
thority for this but I certainly read it in
an authentic paper or journal.

Mrs. Smith, 1841. 25, Finney.

In this case the waters came away when he was
age of 2½. The 2nd stage lasting 14 hours. The cord
was one round and thick and was 39 inches long.
The longest I have had.

Dr. M. Appin, 1841. In this case the legs and arm

Came
came away 48 hours before the child was born. I was not called till 48 hours after the membranes broke. I found an age of 37 weeks, I gave Cephal in this case 10 minutes twice or last 13 hours.

Mrs. J. Yeaton - pluripara

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

When I was first called she said that the night before she had strained in bed the "waters broke". On examination I found the os vitellum closed & no waters escaped. It was certainly urine which she had voided in bed but she would not believe it. In a week after latent came on & all was over in about an hour and a half the waters coming away just before head came over perineum.

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

Case 8: Head plus hand.


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

It was a full finger length up before
the pain came on. When head was being
born I found the left arm of child
shoved behind head. By holding it back
a exerting traction on the head I managed
to have child born. The elbow of child was
quite stiff by muscular contraction, showing
that the arm must have been in that
position in utero for some time. It was
still up to for a month or so after birth.
Here again we had fear acting not pre-
venting pains. But acting the uterine contracting
as the woman was afraid of the foreeps.

Dr. Mrs. Edith Tote Drummond

I arrived at 3 P.M. Found the Os only age of
6. I went off to see the patient returning
at 5 P.M. When Os was age of half a Crown.
A some distance from home I waited 2
2 hours (5 P.M.) The Os was dilated almost
cut of Reach. The head receded quickly after
each pain but did not rotate any thing else.
Head rotated well forward. The membranes
broke naturally but till the head was right
and seemed to advance little in compassion
to the strength of the pains. I had in the
end to use foreeps which I put fired
without
without difficulty. On seeing the head down with right hand, the present of head was very apparent & with my left hand I now discovered the cause of the right hand of child flat down on a level with and behind the right ear. By pushing the hand back & easing the head down I delivered the head easily & then the arm came flat on chest side.

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

Case 9. Twins

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

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

1. In the first case a midwife was present and after the delivery of the first child (4 months pregnancy) which was easy enough she extracted a placenta. I then feeling "something else" she reel off for me...
In this case there had either been two cases with absorbed walls converting the 2 into one or else the nurse in extracting No. 1 placenta ruptured Dr. J. McCullow. This was my idea on arriving & discovering the second head engaged & hearing the fainting. Both children were born alive & both died within a week. There were 2 placentas & she would have most likely have had some breech marriage after extraction of fetus but there was not.

After extraction I found two distinct placenta 2 amniotic cases. A male & female child so that most probably we had two over to begin with (Levith 221)

2. Smne plus Large goitre
Dr. Lee quaidi 8uiltipura
Had five children before all died in infancy except one. I was called in a month before labour did come on. She then complained of shortness of breath (due to pito i.e.) & also had discharge from the womb without pain. Being near at hand I gave orders to send for me when the haemorrhage came on again, but heard no more of her till I was called in to her at labour. Before entering the house I could hear her breathing with evident difficulty. The final stage
Stage had been almost nil & the as must probably have undergone some dilatation
"fairly" which I believe to happen occasionally
a month or nearly always in multigravida where
the parts are very soft & lax. I found
the pains & to be very useless or slight
I positively feared she would choke at
every pain, so difficult was her breathing,
that the pains would not come on. She
had been 36 hours in labour before I
was called. In a previous labour a Dr
when called to her wanted to leave when
he saw her condition, & in this labour
refused to attend her. Let her alone till
the os was fully dilated. She had had
forceps in one labour previously & I was
prepared to her to have them again, but
she absolutely refused. I did not diagnose
twins, as she was so small, but the
small children (as after seen) accounted for this.
At 2 a.m., I gave her 10 minims of
 Ergot liquid extract. This strengthened the
pains, & helped to note also relieved
the breathing to some extent. In an hour
a half, I gave her the other 10 minims
of Ergot, and at 4 a.m., the first
child was born, when to my dismay (for
the woman's sake) I found another in
the womb. She thinking her trouble over...
got more cheerful and I believe would have broken down if I had not been there were two. Instead of this I suggested to strategy saying that the afterbirth would take a little time to come away might set up some pains which would do her good. She requested nothing till the second head was at perineum 20 minutes after the first. There was one large placenta two amniotic sacs. There was post-partum haemorrhage not withstanding that she had had 20 minutes of Ergot I stopped it by 10 minutes Ergotin injected and manual expulsion of uterus 10:120 which was so high I think due to the breathing. She had a dilated heart. These twins died in a fortnight. The mother at some time after a good recovery got bronchitis but recovered.

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

In this woman it projects most to the right side. Circumference of neck 18 inches. One part of tumour on right measures 8 inches across. A most interesting clinical fact is to be noted in the effect of the ergot of
nej: easing the breathing. Could the con-

vation of the tumour necessarily greater
at this time be lessened by the Engst

contraction the bloodvessels in it? I certainly
think this was the case or else it would
have made matters worse by forcing blood
from the contracting arteries some of which
have caused more congestion about neck of
course it could not alter the contents of the
gland farther than the effect it had on the
bloodvessels.

The children were male and female

y. In the third case under notice there were
these placenta (one large & one small) one pair
a male & a female - a large & a small one which
were connected to the large & small placenta respec-
tively. One child died at 3 months.
The 3 cases therefore then.

<table>
<thead>
<tr>
<th>Two placenta</th>
<th>One placenta</th>
<th>Two placenta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two sexes</td>
<td>Two sex</td>
<td>One sex</td>
</tr>
<tr>
<td>Both heads</td>
<td>Both head</td>
<td>Both heads</td>
</tr>
<tr>
<td>Male &amp; female</td>
<td>Male &amp; female</td>
<td>Male &amp; female</td>
</tr>
<tr>
<td>One placenta taken away first</td>
<td>one placenta taken away together</td>
<td>the placenta at all</td>
</tr>
<tr>
<td>Both children died in a week</td>
<td>both died in a fortnight</td>
<td>one child died in 3 months</td>
</tr>
</tbody>
</table>

Case 10. In 3d. Only yard from where the shortest ways had by Wirches.
Cases of recent deprivations

Case 11. Small Pelvis ??

Mr. Burrows. 33. 23. Principals short height 5ft. 6in.
History - Was had a very irregular menstrual life being often 5 - sometimes 6 - one 7 weeks between her menstrual periods. It is now eleven months since she menstruated last. She does not know when she first quickened. When first I was called to the case I thought it must be that she was carrying the child a very long time but I think the proper explanation is that she must have been impregnated say 6 weeks or 2 months after her last menstruation. Ayliffe & Lind ('11) hold the 49-68 days immediately after menstruation to be the most likely time for impregnation i.e. after the debris and lining of uterus is cast off. But in this case there must have been a very old lining in the uterus, or else some slight discharge must have taken place. I find the lower classes very careless in observing a discharge from uterus. Be this as it may this woman would in all probability have menstruated had she not been impregnated. But impregnation I think must have occurred here just before the menstrual time at the end of 5 months. The child when born reas
received a healthy 9 months child or
rather 10 months (lunar) During the last
three months of pregnancy she was very much
eats of blood with sickness pain in the
head & body She is a small woman
with a pelvis in comparison but the
interfragments & intercrural measurements are
10 & 11 inches respectively The first stage
of labour was 9 days & second 5 hours.
The child a female was well shaped
in first stage the pains were short & weak
made little progress. There was post partum
haemorrhage which left woman very weak.
This was one of the hardest labours I had
attended. Was it due to 1 the small woman.
2 The small pelvis or to the large child for
it was large compared with mother's stature.
It is impossible except by guessing to say what
was the cause untill the woman is examined
again (which she objects to) or untill she
has had another child.
There was some inflammation high temperature
103.4° F for some days.

Case 18. Hydatid Mole

Mrs. Braggshaw & 36 multipara.

I was sent for at 11 a.m. and found the
woman in a collapsed state in bed.
History. She has had three children previously. The youngest being now 4 years old. She became pregnant in June 1886 and went on all right till September (3½ months) the womb growing large very quickly as she herself remarked. About mid of Sept (3½ months) she began to have pains across hips and womb. They were short pains, and at this time she also began to have some discharge from womb at first small in amount but increasing in quantity up to the present time (6 December 1886) i.e. 6 to 7 months. During the last 2 or 3 weeks she was never free from discharge which was bloody & had some clear globules in it. Sometimes a small clump came away by themselves. This is her own description. During the last 2 or 3 months she did not increase in size much and in last month she says she got no larger. She never quickened which surprised her and made her think the child was either 'fast or dead' but not liking to speak of it she had no doctor.

On Sunday I found the bed saturated with blood. The woman's pulse thready and scarcely perceptible. I gave her a draught of liquid extract, spirit, and in a few minutes 3r of brandy. The ositure was about the
the size of a shilling and a large soft mass protruding and filling it up. This I hooked out with my fingers combined with abdominal pressure, but had to use (against my will for I detest to do it) some forceps to extract a piece higher up. The uterus was contracted, swelled it out with a weak carbolic solution warm (1 in 50) and gave her 10 minutes ergot 1/20 of acid sulphuric every 4 hours, with a tablespoonful of the following mixture every hour:

One white of egg well beat up.
One tablespoonful of brandy.
A little plain milk 9 sugar.

I have found this a very effective solution in many cases.

On examining the first mass destributed I found it was about the size of a good sized fist, and consisting of the typical apoplectic globules mixed up and hanging from a red shelly substance or framework with of course some blood coagulated on it. Lush says these vesicles are due to hypertrophy of chorionic villi with mucoid degeneration. Can there be also come "edema" occurring from the water of the blood into the vessels? The woman said she parted with a piece as large as a child's head before I came.
There was the visual discharge for 4 days. On the second night she had a severe rigor about 9 P.M., pulse rising to 110, temperature 101°F. I washed out vagina with a warm solution of Condy's fluid and gave her 15 grains of Pulv. Quin. Co. and she soon began to decrease and got warm 2 twilight. On the third night she was all right but on the fourth she had another rigor, shaking. The state had improved it as before. She made a good recovery.

The cysts (Chart 283) contain a semi-fluid substance, albuminous, and like liquor amnii which would support my theory that some amnii occurs especially in these cysts which would at first project to where the liquor amnii should lie. The cysts in my case were mostly about the size of a pea and all rise down-wards. Luck also says the larger cysts are richer in water which may be derived from the liquor amnii. Constituents filtering through the shreds, placenta would be interesting to know if any of the salts or solute in the liquor amnii are to be found depoined in the tissues of the placental shreds. I found no trace of the fetus, and as the whole connection of the ovum to the uterus was
involved probably (judging from the size of the mass) the fetus would be destroyed at an early period from want of nutrition. Luck says about the first month.

The woman and her husband are robust healthy people with no signs of syphilis which is mentioned as a cause.

The "secondary" cause I say is a "miscarriage" or privation of elements the appendages taking the nourishment due to the fetus. The primary cause is still to be sought for in some idiosyncrasy or peculiarity of constitution inherent in the mother which Luck supports (p. 255) by saying that this is probable by the repeated occurrence of the disease in the same patient.

Underhill p. 5 says Cerebro- or syphilitic aspirates in the mother are present in the majority of cases.

The mother is much affected at parturition than the fetus.

Case 13. Forceps.

The first case I mention may well laugh at but I believe what I say to be what really happened, and a Dr. who was present told me: "Too early rupture of membranes can change a vertex into a face presentation."
2. Mr. Fowler. Life 27. Primipara.

I was called at 11 P.m. I found the os about one inch from the introitus. I admit the os and was recalled at 5 a.m. The head presented by abdominal palpation & rotation. The labor was very slow, but still a la primipara. At 7.30 the os was about the size of a two shilling piece but the pains were weaker instead of stronger. The membranes were very strong. I ruptured them, the presentation being vertex, but not rotated. See at p. 183. paras.

"Most writers ascribe great importance to the oblique position of the Fetus, and of the uterine inlet in the etiology of face presentations — as a rule, however, the first pains straighten the fetus, the narrowing of the uterus in its transverse diameter serving to press the breech towards the Fundus and the head into the pelvis. So long as the back of the child is directed downward, the presentation would inevitably be followed by head flexion. When however the back is turned towards the Fundus, and the change to the vertical is not readily effected, the pressure of the adjacent uterine wall, may during contraction act in a special degree upon the occiput and direct it backwards towards the mouth while the forehead moves forwards into the brim of the pelvis." He says further...
that "this may only be temporary and
that there may be fusion in the end
but that if it is continuous, a point is
reached at which the force is exerted
especially in the direction of the chin
and face presentation becomes complete.

In this case after rupturing the
membranes about a breakfast-cupful of
liquor amnii escaped and I then found
a face presenting with Chin to the
right and posterior. Now the child
as turned out after was very small.
How of course one may say it was a
Face from the first that I made a
mistake in diagnosing presentation, and
of course that is possible, but as the
patient was one of the better class and
her husband and mother very anxious
about her, I took especial pains in
making sure of diagnosis and believe
it was a Vertex at first, and that
the rapid rush of liquor amnii made it
into a Face as it would have more
effect on the small head. Still it is difficult
to explain why the occiput did not close
second. Had the occiput been hitched
in any way the explanation would be
easy but it was not. Extension did occur
at all events. I now tried to push the chin
up and to pull the chest backwards as in the position of figure which is half returned this way. This method of Schadz I could not accomplish in this case, and was the pain increased and to my dismay I found the head rotating with Chin going back to snarum, or rather I should say with head rotated for obliquely I left it to nature never for one moment thinking but that the Chin would come forward. I needed for assistance as I was an assistant then, and gave chloroform tried forceps but was afraid I waited till my principal came in a few minutes the delivered the woman easy enough. This is a case which but says to be almost impossible but here I fancy the smallness of the child allowed it. The woman had retention of urine for 3 days but recovered well.

B. Mr. Saweett. 43. Multipara (5)
She had her last Child 4 years ago. This labent began three days before I was called when the membranes broke. An alcoholizing doctor was called in & visited.
The woman on each of the 3 days, but
did not even examine her on the third
day, despite the fact that she had pains.
They got alarmed and asked if I would
attend her, saying they had assured the
Dr. first engaged to give up. I therefore
agreed on examination. The woman had had no
sleep for 3 nights and was very much
worn out. pulse 100. I found the head
presented (Vestig) but was high up at
the Brim. He was fully dilated but
the vagina very hot and dry. There
were pains about every 1/4 hour. I
waited an hour and as the head did
not advance much I proposed to
first I "greased" the vagina well with
perineum and card (Carbolgesed). Its chloroform
on each attempt to introduce Dr. 2 bals.
a violent pain came on, however I managed
in tune with gentleness and delivered the
woman in 1/4 hour. The recovered well except
pain in the back for a week with occasional
rise of the temperature to 100 to 101 F.

The child was large and she was an "old
multifaria." The oldest woman I have ever
seen in to. This case was certainly neglected
as she ought to have been delivered sooner
at least. I thought so. The vagina was quite
dry.
The ward of chloroform increases the difficulties of setting on Forces though when on the pains are stronger than if chloroform is used which is an advantage as it allows of traction to be more effective.

3. Mrs. Happier Wife (gynioporia)

In all this woman's children the cord had been round neck. I have referred to this case already under "Rupture of membranes". Rent at 6 P.M. Course had ruptured membranes 16 hours before when cc was size of 2/3. The pains had weakened 1 hour after. The cc was between one & two plucking pieces. The head was rotated but some cord was prolapsed due to rupture of membranes. Too Soon let the midwife manage to dilate the cc with persistent working round it with carbonized cord and my fingers squeezed up the umbilical cord and got on the Forces. Chloroform was used. The cord was useless. I had great difficulty in delivering the child. First the head would scarcely move and required strong traction. I don't believe I could have had power with the ordinary forces. I used Axis traction then. After the head was born I had difficulty with the Shoulders but managed by finger (index of each hand) hooked into axilla.
The child was dead. There was a good deal of hemmorhage which was scarcely controllable by branding the uterine. I injected 10 c.cms. Euphyn and this is the only case where I have found it set up irritation. The parts swelled and were painful but were subdued in a few days by Glycerine and Extract Belladonnae (equal parts)

Mrs. Nesburt, 740 61st St.
This is the case already referred to under "effect of Position on the uterine contraction."

In this quarter the antipathy to Chloroform is very great. Every one of the forego cases I have had refusing it. In this case like No. 3, the pains became useless but the mere introduction of the blades set up uterine contractions, so powerful that the child would have been born. I believe if I had stopped, but as it was one of my first forego cases after I came here, I was determined to pursue and not give in, as the old woman in attendance would certainly have talked about it. This shows a want of principle. I know but in the hurry I did not think of this.

It is useless relating ordinary cases like this, but I will only mention one other case in
that of Dr. Luty a patient whom I delivered with forceps and on the third day was attacked with puerperal fever. Antiphlogistic treatment appeared, unfortunately did not do much good until I began to apply Iodoform to the torn forceps (which was only a small raw area). Immediately after this she improved and got all right.

This small surface Iodoform was the all-important first aid where absorption of the poison 

was occurred.

I wish especially to note the advantages and disadvantages of Chloroform. In Scotland I always used Chloroform. Here I have never done so with Chloroform we have the advantage of having the woman completely under control not flinching and jerking and crying out. We can apply the forceps without setting up no severe uterine contractions. We do away with fear. Some persons to give it is necessary. Without Chloroform we have to be constantly speaking to the woman thereby taking some attention off the application of the instruments. The woman suffers pain by catching the pubic or labial hair. Why the mere introduction of bladder. The woman is not steady and we have the great advantage that when on the traction can be used with the pains to full advantage. No extra hand is required to give the Chloroform.
Case 14. Placenta Praevia

I now come to one of the chief points in my thesis. Within the last two years, I have been fortunate enough to have had two cases.

Last quoting Müller says they occur about 1 in 1000 cases. Like a Dr. I was assistant to Remer, I may not have another for 17 years.

1. Mr. Injio, Yeoman - aged 31. Multiple (3)

Honeymoon.

Present History. She had her first two children naturally. Her third required forceps from the slowness of the labour. She did not recover well after this last, as she often had bearing down pains, and uterine walking.

This the fourth pregnancy occurred in April 1886. In June (2 months) I was called in to see her as she was "out of sorts." She complained of bearing down pain - pain on defecation, and could not walk well. On vaginal examination, I found the posterior fornix filled up with a hard body - she had not menstruated for 10 weeks. I concluded there was "Retraction of the gravid uterus." This was blamed to be rare, being often retroversion. The os uteri was high and looked down and back had more downward motion.
back. The uterus seemed fixed. A medical man from Bradford (Mr. Appleyard) confirmed my diagnosis. The fundus of uterus filled up and occupied the cavity of the peritoneum. The uterus was about size of a closed fist. The os was soft and admitted tip of index finger. I tried by steady firm pressure with fingers to reduce it but could not. I feared doing damage. Mr. Appleyard in a few days examined her and found the os looking more forwards. It had some difficulty but managed to restore the uterus to normal position when the os came down as the fundus went forwards. I gave her soda and gentian for stomach and the woman despite all the force used went on all right till the 26th October 1886 (7 months). When I was called about 3 a.m. I found the woman in bed, the bed being saturated with about a pint of blood. She had gone to bed as usual all right and awakened feeling very faint with ears ringing and the bed wet. There was no pain and the haemorrhage had come on when asleep. I gave her 1 1/2 grains Opium in pill. On examination I found the os uteri high up. The posterior fornix was soft and boggy and contained something.
about the Asciphonon I was strick and
concluded it was a placenta present-
The bleeding had stopped - I got the bed dry
and as I lived close, I kept her with vides
bored at once if bleeding came on again.
I gave her some acid methyl aromat: she
had no more bleeding that night nor on
the next day nor pains. She kept quiet
in bed all day, all night and next night.
I was sure it was placenta personaci-
The pulse kept 80 and was thready. This
made me anxious - next day (28th) as the
pulse still kept up I feared lest bleeding
should again come on and weaken her more
and I advised her husband and friends
to let me deliver her - but they seemed
anxious to avoid interference. The 80 was
high and admitted try of induce easily. The
woman felt the fetal movements and the
fetal heart was audible between the
sternal spine and mumbiotics on the left side.

28th On this afternoon bleeding again came on
about 5 P.M. It was slight (3th) I found
the Vagina soft and full of blood clot.
I now told the husband, that unless he
allowed me to deliver her that I would
not be responsible for the consequences
and I felt eminently to do as I thought best.
I cleared out all clots and gave her
an injection of Cordy's Fluid. With present
I could get my index through the os and
could feel the placenta. Taking the advice
of a friend I had staying with me, I put
in a sponge ton巫 intending to leave it in
all night. It was introduced about midnight.
Early next morning, I removed the ton巫, and
found the os now admitted 2 fingers
in diameter about one inch. The os was very
fleshy and rigid like a ring. I separated
the placenta all round as far as about ½ to
1 inch, washed out vagina with a weak
solution of Cordy's Fluid, and put in a
second large ton巫 together with a smaller
one. These I left in 4 hours. On removal
the os was about ¾ of a 2½ piece
but still rigid. She had lived all day
on a little beef tea & some whisky and
white of egg mixture. I then gave her Syrup
Chloral Hydrate 3 ½ and put in the medium
sized Barnes Bag which I distended with
water at first rapidly and then slowly
and pulling on the tube when distended
as much as it would bear. I left this
Bag in for ½ hour but it seemed to have
time & it was going to do so regards
dilatation, and I now removed it and
put in the large size Barnes Bag
and tried slow dilatation as I thought
...
Rapid dilatation would 'stimulate the os to resist more'. I gave her another 3/4 of syrup chloral and left in the Barnes for 4 hours - after which I found the os softer but only about 2 inches in diameter, and still rigid. While the Barnes was in the os I also put in a very old kind of vaginal dilator which was used by an uncle of mine about 35 years ago in an Australian practice. It is much on the principle as Barnes's Bag but the bag is round and has no waist. It would do to replace a backward displaced uterus in the rectum. In this case it acted doubly viz: it dilated the vagina, and also promoted dilatation of the cervix by its extending the vaginal attachments to the floor. As the directions of the arrows in figure 4 show with the os about 2 inches I passed my left hand (after scrubbing in carbolic lotion and smeared on back with carbolic grease) in the form of a cone into the vagina (my hand is small in form of a cone being only 5 inches round at the middle joint of medium and 7/4 inches round the widest part at the metacarpo-phalangeal joint). The woman had no anaesthetic as yet, and bore this pain very well. I began with fingers to dilate the os and in about 20 minutes managed...
with steady prolonged pressure to get all my fingers into the 3rd up to their middle joints, but the pain from hereave decreased my power to give chloroform to the full extent and pressing steadily with my fingers it now gave way suddenly and expanded and allowed my hand to enter the uterus. The sudden expansion was doubtless due to the Chloroform. I had felt the placenta in the way all the time, and now found difficulty about it. I could not find my way up behind the placenta. I tried therefore to pass my hand up between uterus and placenta in front and succeeded easily but then I found that I could not use my left hand here to advantage, and I accordingly changed hands (this is a mistake I believe and causes a lot of extra handling but I could not avoid it). The woman was semiprone in position on left. I now withdrew my right hand, and gradually got beyond the placenta which lay more posterior than anterior. There were no uterine contractions. I found the umbilical cord accidentally and found it pulseless which relieved my mind from trying to save the child, and allowed all attention to the mother. I now separated the placenta freely in front. The child presented its head but arms were extended over its head. The liquor amnii was copious and
and the child "bobbed" about on the slightest touch. Dr. Rabaghlati tells me that he has often found this to be a sign of a dead child. If certainly was so in this case but I see nothing to prevent a living child doing the same in similar circumstances. The membranes were very tough, and I failed to rupture them with my finger nails. I now seized a foot which slipped, again I seized it with some resell till I caught it between my Index and middle fingers when it was fast. (I believe in this group as the current) I now easily ruptured the membranes by pushing my thumb in between the edge of the foot and my Index finger. I think this a good idea as it enables the operator to have a sure hold of child before the waters burst. Directing the assistant to keep up pressure on the abdomen. I slowly got the breech engaged, and left it for a few minutes to see if the abdominal pressure would set up uterine contractions but no. I then exerted steady but gentle traction till the second leg came down which I extended and now comes a very important fact viz. when the head is passing through the Os retine for with my small hand I don't think the Os was sufficiently dilated to allow of the free passage of a fated head.
for the "circumference" of the fetal head being accept. front: 14 - 14½ inches rear: 16 
Subsequent bregma: 11½ - 13 inches and my hand 7½ in largest circumference there is a significant difference more especially as here the head was extended giving a large diamet-
Of course the above are full term measurements whereas this child was only 7 months advanced and softer. But what I want to note is that "gentle" traction is to be expected more than at any other time. This was allowable too as the child was dead. There was no hurry for its sake - and even if the child was alive I would do the same to avoid any laceration in the more important mother. I have not seen this printed out in any books I have read on the subject, nor the way in which I seize child and rupture the membranes.
The arms being extended I released them in the usual way. The head being small and extended I delivered by the smaller grasp 1½ right hand on back of neck the neck lying between Index and Middle and the left Index and Middle pressing on each side of the nose on malar bones to flex head which I easily passed over the well distended perinaenum. And now
now there was a great rush of blood
the assistant was pressing steadily on
the abdomen. Immediately injected 10 minutes
of Ergotin (prepared in cases by Jones of Liverpool)
which I had ready. tied the material end
of the cord and injected warm (110°-116° F)
water with Condy's solution in it slowly into
uterus. This I did till the water came
back almost as clear as it entered (violet
coloured) The womb responded and contracted
but about 15 points of blood must have
been lost. Injected ether 5 minutes of
Ergotin and removed all clots. I removed
the placenta and membranes when the rush
of blood followed the child and before
injecting the warm water.
The placenta lay mostly posterior with
exception of about 2 to 3 inches which was
anterior thus being from 6 to 7 inches
anterior. This constitutes what Link (p 552) calls
Placenta Praecox Centralis i.e. nothing can
be felt at 01 but placenta. The woman
came out of the chloroform all right in
about 7 or 8 hours, and vomited a little
which seemed to make the uterus contract
still firmer. I now gave her some of the following
mixture: one white of egg well beaten, 3/2 brandy-
spirit with 3 1/2 a little sugar. She got 3 1/2
of this every 1/2 hour and I also gave her
alcohol
about 5 o'clock in the same day injection into her abdomen. This ruined her considerably in about two hours. She had not so much pain in her body as I expected though she said she was all sore especially where I had injected the ergotin. The uterus began to contract well and caused some pain which however I was glad of. The pulse at first was faint and weak (100) the heart beat regularly but feebly. I put a tight binder on and ordered the above mixture every 1 hour. She felt sleepy which was a weakness sign and I ordered them to wake her every 1/2 to 3/4 hour for her nutritive-stimulant mixture. I left 10 minims ergot (qj: 8th) and 10 minims acid sulph. around to get in 1 hour. And this she took regularly every 6 hours for 4 days after the operation. On leaving in 2 hours after delivering her pulse was considerably stronger and 110 per minute.

29th. 10 a.m.

This morning she felt better. Pulse 128 per minute. Temp: 99.0°F. She had "strain" which came on about once an hour and lasting about 10 minutes in her back. I gave her a warm injection of the Coddy solution thus to Potassum Permanegmatiri per 40 grains 

Slightly to a pint of warm water

about 108° or 110°F.
She had this injection 3 times today.

10. a.m. Pulse 128 Stronger Temp. 99.4° F. Injection.

9. a.m. Pulse 130 Temp. 99° F. Injection. The bed clothes were changed. All day she had had the brandy and egg mixture and also about 3/4 a motion tea well strained from half every hour or two. She made water all right. The bowels moved possibly by the stimulating injection. Setting up peristalsis? ?

30th.

10. a.m. Pulse 140 stronger Temp. 102.8° F. gave 5 grains of quinine sup.; and injection of Condy’s fluid. 

1 p.m. Pulse 138 Temp. 101° F. gave 5 grs. of quinine and one injection of Hydrag. perchlor. (1 in 4000)

8. p.m. Pulse 132 Temp. 99° F. injected with carbolic acid lotion about (1 in 200). I gave therefore today three different injections viz. 

1st. Patais Rhusangarat. about 1/2 grain to once 

2nd. Hydrag. perchlor. 1 in 4000 

3rd. Carbolic acid 1 in 200.

in order that if any germs escaped to one they might account to the other. This theory though somewhat undeveloped more can as yet deny although the Hydrag perchlor. is from all accounts more noxious to germs than the other.

31st. 10. a.m. Pulse 140 Temp. 99.4° F. pulse strong and steady. She had had a fine night sleep as the pains were less severe now. The discharge today was less quantity and white.
October 21st.

White but smelled badly. The bed linen and body clothes were changed today. She had a very bad cough which she had had for a month which a few drops of chlorodyne eased. Ordered the nurse to perfume with the injections 3 or 4 times in the 24 hours.

Prior to the breast milk first appeared in breasts but was watery. This I took to be a good and healthy sign. Pube 128. Temp. 101°F. applied Hygeine & St. Belladon (equal parts) to the breasts.

Pube 110 Temp. 99.6°F. She now complained of hunger and got mutton broth with bread crumbs in it and also some oat cake (English, which is a thin light wafer, a substance also the off & branded mixture and a little gruel. She had had Ergot every 6 hours up to this time.

October 22nd. Pube 138. Temp. 99°F. had had a good night. Soothed liver and small lemmet. 3 injections.

1. Pube 100 Temp. 99. Had a piece of mutton done on the Fred. night. Pube 118 Temp. 99.6°F.


3. " 102 " 99° " 2 "

4. " 96 " 98.4° " Setup in bed. 2 injections.

5. " 98 " 98.6 " Had a piece of lean goose were none for her.

6. Pube 96 Seeks well. Pone her to stay quiet.
powers of the 13echratized Carbomate of iron
5 grains three times a day - legs feel weak
when up. One injection.

Convalescent some slight discharge - The iron
powders set up heartburn so I gave her
sodium instead in 12 drops doses in glycerine with
syrup lemon which agreed much better.
This woman made a good recovery and was
out walking in a month.

Resume:  
1st. The haemorrhage first came on painlessly
when asleep in bed. This surely proves
(as it is often the case) that some dilatation
of the os uteri occurs before pain is felt
and most probably happens in normal labors
as well, as any part in childbirth with soft parts.

2nd. The rigidity of the os which felt like
a hard fleshy ring and the sudden
relaxation of it when paralyzed (nume) by
chloroform.

3rd. The toughness of the membrane.

4th. The way of seizing the foot.

5th. The way of rupturing membranes.

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

7th. The necessity to be prepared for
post partum haemorrhage as the

[Handwritten notes and paragraphs follow, but due to the nature of the handwriting and the page layout, the content is not fully legible.]
placenta being in part detached blood will pour from it till completely rea and
also the uterus which may be dilated and
partially paralyzed, and also as blood collects during operation.

Clear out uterus thoroughly after
the birth of the child.

Dissection of white of egg and brandy
mixture per rectum.

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

The woman is healthy just now (6 months)
and has no signs nor symptoms of retro-
flexion again. Could the placenta be dis-
lodged by the efforts made at reduction
of the uterus and fall down over the os?

This is doubtful. I think the two were
independent of each other. I do not know
for sure whether the Retroflexion was
antecedent to pregnancy or not but should
think no. I think they were independent and
an interesting accidential coincidence only.
The case however shows what a lot of
interference the uterus (pregnant) by an
otherwise healthy woman can tolerate.

March 26
1887

I have today called on Mrs. In. Was complaining
of shortness of breath for the last month. She
is stronger and fatter than she has ever been.

Armonia Currit and Digitale has relieved The
Eppuram.
This second case of Hæmatura Praevia was really the first I ever met with. There was not much of a look, and the labour was much

- pub. Free. Life (1858-6) act 22. principal.

- My principal then attended the woman for a week. She had repeated attacks

- of haemorrhage, and slight back pains. He told me about it and said it was an

- abortion threatening. He examined the woman each day for five days but did not

- diagnose anything further. He admitted

- Index. There were three attacks of haemorrhage

- two in bed at night, and one when sat

- on a chair.

- On 15 Jan. 1886 I was sent for hurriedly about

- 10 a.m. to go off and see her (6 miles) as she

- was dying. I went prepared for all meanwages,

- but ready for anything up to amputation.

- On my arrival I found her almost in a

- state of collapse, with thick red hair, pulse

- and pale face. The bed was saturated with blood

- which had begun to come away about 3 hours

- before. There were no "pains" which aroused

- any suspicions regarding the supposed meaurings.

- On examination, I found the OS about 3½ in

- diameter, and admitting the point of

- Index finger. It was high up in pelvis.

- Whether close to the exparining, or not I do not

- know, but pains began to come on about
...one in 10 minutes and at each "pain" the bleeding became more severe. I immediately plugged the vagina, and applied cold to the vulva and abdomen, in the form of snow (it was winter). The woman was 7 months advanced in pregnancy. The bleeding however still came on with the pain. I was not sure it was placenta previa, more especially as I could not get upward through the os and "feel something soft presenting." I went off for my principal and gave her a teaspoonful of Brandy over 1/2 hour and also put an small aged Barnes Bag till accouchement came. This was my first case of placenta previa. The Barnes controlled the bleeding. The complaining very much of the pain of manipulation. When the Dr. arrived he gave chloroform which strengthened the pulse considerably. I now put in the larger Barnes, and detached the os in about 10 minutes by steady injection here the os was very soft. In my other case where the os was rigid I used slow expansion. Here it was easily done. I believe the slow way to be the better (unless any need for haste) as it subjects the part to less possible separation of molecules as it were. After removing this Barnes, I passed my hand into the vagina and index and middle in through the os and...
and separated the placenta then passed in my whole hand and perforated the membranes (early) and secured a foot which I brought down. The bleeding was now controlled, I employed traction but the child (a 9 months one) threatened to tear as I waited a few moments. 10 minims of Epsom and 5 of Sulphuric Ether were now injected into the buttocks and by slow gentle traction the Child was delivered. I washed out the uterus with Carbolic acid lotion and gave 3/4 brandy. Put on a tight binder. The woman felt very done and complained of her ears ringing but before was left (1/2 hours) she was considerably revived. This woman took digested iron and glycerine for a month which considerably improved her and made up for the loss of blood.

This case differs from the last especially in one point viz. So much more blood was lost in this last care as she was a distance away I believe in immediate delivery at the second hemorrhage if not after the first. The child in the last case died in 12 hours.
Case 15. Pregnancy with Thrombus of Vulva
(and suspected Tumour of Uterus?)
Mr. Henry G. Saunders, Matron, act 35.

History. She had had three children before this.
The last from her account must have been a cross
birth (transverse) with "Spontaneous Evulsion", as she
says when the Dr. (an Ind. at least a year or 2) years
(experience?) came, he waited till an arm came
down, and then he lifted her and came back
and then a leg came down, and he "pulled the
child from her by hand and foot". This is an
extraordinary explanation, and must be taken
for what it is worth. However, she suffered from
menorrhagia and metrorrhagia afterwards till she
became pregnant 12 months after. All the pregnancy
from the 3rd month onwards she suffered from
very bad varicose veins, due to the high venous
pressure which might be set up by any en-
largement pressing on the inferior vena cava.
The right leg especially was affected, and she
had a thrombus about the size of a hen's egg
in the right iliac vein. (It was difficult for it
to feel the OS). I could scarcely take on the
case as I was called in shortly after I
came here and I feared trouble at the
labour, but I did engage, and was prepared
for the worst. Towards the 9th month the
thrombus and veins got less.

During the 1st stage of labour the
Vulva was soft and lax. I ordered her not to bear down during the "pain" to as to dilate with the soft waters as long as possible. During a very strong pain the membranes ruptured and the head was forced right down to the perineum. The vagina before rupture seemed dilated very much and allowed head to descend at once. I kept up very gentle pressure on the right throbbing labium with a soft oily cloth. It was about the size of a small Tangerine orange. The child was born easily with about 3 or 4 pains only. The membranes ruptured without any accident. The placenta was removed in about 18 minutes and I could then feel a swelling about the size of a small orange on the "left" of the uterus which was hard and painful on pressure. It felt exactly like a double uterus (and in figure). This swelling I could feel for 4 days after labor getting smaller every day. On the 4th day I could not feel it abdominally.

I decided it was one of two things viz. 1. Fibroid tumour 2. A Varix with blood clot. The woman felt it herself and had not done so in any previous labor - in 10 days the Crina which
had been diminishing in quantity again
became copious, so much so that I
sent her on Ergot and Iron. Since then
(5 months) she has had repeated attacks
of hemorrhage at irregular periods, and
has occasional pain about uterus which
is worse at the left side. She complains
of severe oesophageal headache. On seeing
her a few weeks ago the uterus seemed
fully inviolated, no displacement. Os all
right for a multipara, and could find
no trace of any tumour. Her pain on pressure
in the foreparts. It of course might have
been a tumor or a varix, and gets less as
the uterus inviolated, and with the ergot
the case will be followed and will be
interesting further, but I am undetermined
what the swelling was.

Another case of Torsion of Vulva some
time ago made it necessary for me to see
Joseph. He Os also shared in the engorgement
with the pressure. I thought here to lessen the
damage by getting the head through as soon
as Os was sufficiently dilated as I think this
is less damaging than long continued pressure.

Case 16 Rupture of Perineum
The only case of Rupture of Perineum right
through of binet and that I have seen in
my practice occurred in a case of mine
Mrs. L. T. F. where the head was born
just as I entered the room, on ranging
here I found the perineum gone, I at
once after birth of placenta put in 3
strong silver sutures deep. The stomach
and perineum united well. The lochia
fortunately were scanty. The legs were tied
together and water drawn off at first
Another case where I assisted in a
place and did not unite well at all.

Case 17. Hour Glass Contraction of uterine and
retained placenta.
Mrs. E. Green, quintipara, age 37, has always
had long severe labours, in all of which the
membranes ruptured very early, in this instance
the days before the child was born. I was not
called till end of 2nd day when I found the
head low down but went unless pains. Gave
10 minutes ergot, and soon the pains got strange
and when sitting over a chamber bucket during
a pain the head was born with umbilical
cord found next. 30 minutes after birth
during which time my hand had been laid
gently on uterus. I tried to remove the placenta
by combined method but I found it fall
and the cord springing back after traction.
Soiled my hand and passed it into vagina, and through the os. When I found no resistance but about an inch above was a contracted ring which allowed cord to pass. It might be the size of a shilling or less. I gradually massaged my hand (cone shaped) and got the placenta which was now loose and gradually pulled through. It was very bloodless white and calcareous. The cause of the contraction was not due to any pressure on uterus but must have been due to the effects of the grasping while putting streaming over the foot, when the head was forced down. She parted with some clot for 3 days. But was all right.

Case 18. Breech.

1. I wish in this case to point out the mistake of allowing midwives especially those with no training to undertake cases.

Hop of 4 pounds. Primiparous at 20.

I was sent for at 1 a.m. I found a midwife in attendance. She had been all day since 5 a.m. (8 hours). At 8 a.m. the waters came away naturally, and a foot presented and came down which she pulled at till 7 a.m. The foot extended from vulva to knee and was livid and cold. I suspected presence of cord which caused death, and rush was the case.
I told them to have patience and all would be right except the child which was dead. The pains came on and soon expelled the child to the chair. The arms were extended, which I thought done in unusual way. It was dead.

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

2. In this patient Mrs. C. Yeoman, there was severe chronic bronchitis, and she has had all her children (8) at the 8th month and by these 8, there were 1 breech.

I think here severe cough brings on the labour. I thought this might stand as a proof that the child in womb has the breech downwards till near labour and then makes a somersault and presents head but this cannot be so for then the fetal heart would not be heard as constantly below the umbilicus to left or right which it can be in the latter months of pregnancy in most cases which I have tried in endeavouring to make out the sex.

3. In this case Mrs. B. a Dr. was called in but not finding all as smooth as he wanted he left. I was sent for and found with difficulty that a breech presented but in an irregular manner--in fact it was incompletely.
more a Baccal presentation, as the buttocks lay in left iliac fossa with back of the child down and head up in right lumbar region something in the form of the figure which is very diagrammatic and is as if abdominal wall of mother was removed (it is exaggerated). She had been in labour all day but had advanced little. Introduced hand well up in cone shape through the fully dilated 8 or ruptured membranes and brought down a foot, as I feared it might and in a transverse. A healthy child was easily delivered.

Case 19. Pregnancy + Heart Disease
This is I think the most interesting case in my thesis. M. Sister primipara, age 21.
I was called on the morning of the 29th January 1897 to see this patient about 3:30 a.m. and found her sitting up in bed, recovering from an attack of haemorrhage. She was 6 months pregnant.

History. When 16 years old she had an attack of acute rheumatism which was very severe for 6 weeks but did not leave her for 6 months. After 6 months she got "well" and
and remained pretty strong to all appearance and able to work up to the present time (5 years) with the following exceptions. 1. She had palpitation on very exertion. 2. She had breathlessness on going upstairs or up hill so that she used to take a roundabout way going to her work to avoid a steep hill. She was habitually constipated. 3. Her digestion was impaired (due I think to bad teeth) 4. She fell pregnant 6 months ago and got同一 at term. She has had a hardish life as her parents were dead.

On examination this morning I found her pulse 120 per minute, small rapid and slightly irregular. Temperature 100.4. There had been vomiting of scarce and frothy expectoration was going on which was mixed with bloody sputum, very much like the rusty appearance of pneumonia. The face was flushed at the lips and notable prominence on the other parts very pale and cold. His sedation off legs. She could not lie down—

Ordered her to put her feet in hot water. I am antid for a half hour and gave her

the following

P. Nit. Digit. 3/4

Aconite Card. 6 gr 

By. 3 pills 20 times every 3 hours

She got 6/12 of brandy every 3 hours in between the doses of medicine. She soon revived and got some sleep will appear up. She had her

Body
cough, and dyspnoea which remained worse or less for 2 or 3 days but was otherwise fairly well. The os uteri was closed. No uterine pain on auscultation. At the umbilical area there was a rough blowing prezystotic murmur which was continued into the systole. The Cardiac impulse was seen and felt as a thrill over a large area from Xiphisternum to 2 inches beyond the left nipple most apparent in the 6th intercostal space. In the 3rd space there was a transverse dullness of 4 inches. In the right pulmonary area the second sound was thumping and abrupt (accentuated) due doubtless to the increased tension in the pulmonary artery. There was no reduplication. There were coarse breath sounds all over the chest except at bases of lungs which were dull and motionless. At first I gave her 500c.c. of ammoniac and then with the hot water bath and brandy received her.

On my visit at 11 am. same day I found her sitting up in bed “pretty well” as she expressed it. There were rales all over the chest, her heart was firmer and more regular. But the murmur could be heard (prezystotic) and also the systole was accompanied by a murmur, except that it seemed to be more than before as the rales were not so loud, allowing the murmurs to be clearer.
Jan. 30th

1st 2nd

February 1st

Heart - Light food - Brandy. Digitalis & common
vomitus continued. Her bowels moved naturally today.
Homeopathic granules 10.5 Grs. less in quantity
than normal for last 3 months (women told
her it was always so then pregnant) Her
anaesthesia very slight 
about 3-2 p.m.
in 1000. There was a very slight trace of
albumen - urates copious.

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

Was refreshed in the morning but still had
some depression - against my orders dressed and
came downstairs pulse 110. Lungs 99. Medicine
and Brandy as before.

31. Found her downstairs drowsy. Had felt
child moving in uterus freely all morning
has cough of spilt phlegm less marked
bases of lungs still dull - pulse 104.

Downstairs as on the 31st

At midnight I was called in haste as she
was dying. On my arrival in 5 minutes
I found her bordering on unconsciousness
with face pale & cold except lips and
malar prominences which were purple. Her
arms were cold and fall dead down
if raised. The heart was pumping well
under...
Shuffling away irregularly and slowly 90 per minute. I was very much afraid she was going to die. Injected 15 minutes of ether strongly just feet in hot water & mustard with better water slowly added first cold water mustard. Placed behind each calf and one on the precordium. The lungs were very edematous and base dull. I heard left arm, found it, and with a sharp bisturi (all I had with me) opened a vein in front of the elbow. Black thick blood oozed slowly out but never came freely, so I bound it up again, and went on with hot water. To feet and breasts internally. Also injected 10 more minims of ether. She felt the prick of the needle more this time which encouraged me. She was lying back in a woman's arms. I was how she recognized me and complained of the feet being soaked with the water. The calories of precordium were now red and the mustard was removed. I thought of using precordium and had leeches but thought the mustard would be more effective. Dinner came, recovery in one or two more deaths. She got 10 minims of sulphur ether of 10-15 drops ammonium around every 3 hours, and then began with the old mustard of ammonium by digitate.

9 Feb. 11am. I saw her now. She had had some sleep which was accompanied by dreams. From present
a consultation, and arranged with a Dr. of 50 years experience in the next town. We could not come till the next day so we waited and went on as before.

3 Feb: Had passed a good night. Had consultation. The Dr. saw her at her best and gave a good prognosis, despite the dulness of lung bases & the heart murmers. The stertor was quiet. I believed another attack like the last would finish her and told them so. After the Dr. had gone but hoped he (the Dr.) would be right. I prepared bringing on labor but he would not hear of it. Continued old treatment. Rather more alarmed in mind.


5 Feb: 11 a.m. Had passed a good night (best for sometime) and was up in bed. Breathing flat, but the face specially now the malarus was congested. Her breathing rapid 22 per minute & shallow. Pulse 110. Made her promise to stay in bed and take her medicine and breadly.

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

11 a.m. An hour later I was sent for and on arriving in 10 to 15 minutes found her dead, the only drawing one breath as I placed to the bedside. Teeth was cozy from.
The mouth and nose. The face was ashy pale and cold, the lips were purple, and the nose drawn. Injected branny and either, raised chest and lowered the head and 3 or 4 ounces of serum poured out of the mouth and nose. I then began artificial respiration (warm plates on heart) and worked at it for 20 to 25 minutes with the result except the mechanical forcing up of post and serum.

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

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

1. Intra thoracic and incompetence - as regards the aortic valve I am not confidant.

2. The left ventricle dilated with the walls perhaps hypertrophied which hypertrophy according to Larcher (in Donald p.h) occurs in all pregnancies and which Durazig supports from an examination of 135 women in poni (p.10) Doblein denies this.

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

3. There would be serous effusion into the
The pericardium

The cardiac valve would be irregularly thickened and partially some vegetations.
The orifice would be contracted and the chordae tendinae shortened not allowing the orifice to be closed.

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

5. Necropsically the alveoli of lungs would be congested, and more or less full of serous bloody exudate, making them solidified.

6. Pores of lungs condensed and full of exudate making them solidified.

7. Bronchi red, edematous and full of bloody serous or pus. Blood vessels in and around them congested, maybe apoplexies.

8. Kidneys congested.

Dr. Angus McDonald in his book on Heart Disease during pregnancy says "64.4 per cent. are fatal." 9 out of 14 cases. In 2 cases of primiparae all died, (death were after delivery). 117 of these cases were preserved to be due to subludie. He says "few go to full term, but after delivery, there is not a correspond.
improvement in the symptoms, the reason being, that plus shock and exhaustion, during delivery, to the already weakened heart, the evil results of the original disease. Perfusion, or the introduction of the blood, are nearly as powerful as in the later months of pregnancy.

Premature labour may then be useless or worse for the case, and for this reason passage I did not press it in this case. As p. 26. In Smellie says, quoting Casorso, that if hydramnia ascites, or the presence of any may bring on labour to facilitate the action of the chest.

This case was doubtless due to the Rheumatic Fever 5 years before, as all during the 5 years we had more or less palpitation and breathlessness. Aperiublubs (A. D. 28) says, "Ventricular disease is worse than Asthma," Fritsch (B. S. p. 35) says, "A healthy heart can meet the requirements of the case in pregnancy, it can accommodate itself to the increase of blood." (Which occurs normally in pregnancy) "But that the diseased organs fail here.

What was the Cause of Death in this Case?

In B. D. 35 we have Panum saying, "A sudden projection of blood into the heart will paralyze it," Fritsch says, "In worst cases, are those of advanced mitral stenosis, Aperiublubs, as I above mentioned say also that...."
that disease is worse than Cancer.

Here their trusting their authorities and judging
from the severe, ending of the case we have
the worst possible complications to pregnancy.
The cause of death here was this. The heart
acted as far as it was able in the first
6 months of pregnancy fighting or against
the increase of blood. Till a time came when
it failed to continue the struggle, the
increase of blood wearing out the heart.
Till it failed to force sufficient blood
away through the lungs to make room for
that coming in behind. Then the lungs became
engorged and congested further adding to
the heart’s embarrassment. Till they became
at last blocked paralyzing the heart not
from a “budden projection into its cavities
but from a failure to get the blood out of it.
This is the only explanation I can offer in fact
we had acute pulmonary suffocating edema.”

We had fair compensation when not pregnant
but this failed when in pregnancy we had extra blood.

Jimbeling and Mr. Peter believe in venesection
In my case this did not seem sufficient
via a lynch. To render the opening of a vein
of any use, at any rate, there was not
at the time I did so, perhaps if I had
seen her sooner there might have been.
If done earlier, my opinion is that it might...
avert the attack, but it would only put off the evil day, for the blood would soon return, and then the effect of the bleeding would also weaken the system. My idea is that bleeding is of little use. The chief symptoms in my case are to be noted.

Cough - Dyspepsia - Rales - cyanosis - Pulse - hypostatic - vomiting - uterine inert. Probably due to the cerebral spinal system not sharing so much in the attack, if it was paralyzed labour would come on. (Frankenhauser & Obermeier pp 110)

Conclusions A woman with such disease should not marry and yet it seems hard to debar a woman from marriage for this reason. If I have had two women both with loud mitral systolic murmurs, head children well, one had 4, the other 3 children and have had no heart symptoms shown in fact it was only by accident I happened to listen to and discern the murmur. There seems to be a "something else" latent besides the heart.

If I were knew as least a case again where death seems inevitable I have resolved to give the woman a chance by "bringing on labour" for I cannot help thinking that it is my duty that if death is so certain as this case proved that delivery might give at least a small chance of prolonged life.
Case 20. Eclampsia

I have had two cases of Eclampsia, one Eclampsia praematura and the other E. Peramnna but unfortunately have not full notes of either.

The former occurred in a young woman a primipara aged 27, in the 9th month of pregnancy. In October 1855 just when I was starting for a country round, I was called by the woman's husband who said she was in a fit, 2 p.m.

History. She had had constant micturition for a fortnight with restless legs, vomiting, sleeplessness, headache. She was cleaning the house when this first fit came on. It lasted about a minute, was epileptic in character and left her dazed for sometime.

20 grains each of Pot. Brom. & Chloral Hyd. were given every 4 hours. The urine on heating becomes nearly solid with albumen. She remained unconscious till 6 p.m. when she had another fit much the same as the former during the night she had 3 fits and at 8 a.m. she had a very severe one. Gave her all at once and use Chloral to minimize the fits. She was now unconscious between the fits with heavy breathing pulse 98. Temp. 100.7. During this day she had about 20 fits of worse or less severity. I now...
now directed a grain of jaborandi extract in 20 drops of water and gave 2 injection of the solution 5 drops at at time with 2 hours between. This caused copious sweating but did not prove her at all. I also allowed her to inhale nitrite of amyl (10 drops in a handkerchief) I had never heard of it used for this disease. This had little or no effect on the unconsciousness. mustard was applied to nape of neck and to kidneys on back but all seemed of no avail. Some fits were restrained by the chloroform fumes were lessened in severity while some were not arrested or lessened at all. A consultation was held about bringing on labor. I believe it might have been of service but the constant asked res. He died the same night being had about 30 fits in more.

The second case was favourable. The woman had had 2 children before and after each one had had an attack of eclampsia. In this case as soon as child was born she began with 20 pains of tet. brom: of 20 of chloral hydrate every 4 hours. She had one slight fit and slight albuminous urine but recovered well. I believe in emptying the uterus as soon as possible in such cases.
off the renal pressure at any rate and allows of free excretion to
the whole system.
This finishes my thesis. The cases I have
mentioned are some of the more important
I have had, and I trust may be of
sufficient importance to merit the much
costed h.v.d.

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