An Analysis of 1,000 Cases in Obstetrics
The selection of a subject upon which to write a thesis, although always difficult, must be much more so to a country practitioner than his more fortunate brother engaged in city practice. The latter is able to consult any authority at will, whereas the former is restricted, almost entirely, to what literature he may have in his own possession.

At first, I had intended writing on "Midwifery Statistics," but, after many fruitless efforts to obtain access to works on the subject, I changed my mind, and resolved to confine myself to an analysis of my last 400 confinement.

After graduating, I had the good fortune to obtain an acquaintance with Galashields, under St. Murray, and, whilst in that comparatively young and thriving town, gained experience in midwifery which has proved me in good stead.
In some time after taking my degree, I commenced having difficulty in diagnosing the various uterine presentations, and in order to make my statistics the more reliable, I have put over 100 of the first cases attended.

In listing cases of any cases, as they occurred, I have endeavored to be as accurate as possible, but have found it difficult to obtain trustworthy information in some points. For example, it is often easy to find out the exact age of a patient, and, so the duration of labour, statements are often so unreliable and misleading that I have ceased to take notes on this subject.

In order to make what follows more easily understood, I shall begin by giving a table, showing the relative frequency of the various presentations.
The 400 labours reached in the birth of 409 children, there being 9 twin births.

<table>
<thead>
<tr>
<th>Presentation</th>
<th>No. of Cases</th>
<th>Per Cent.</th>
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</thead>
<tbody>
<tr>
<td>Second stage completed before arrival</td>
<td>129 or 18.1</td>
<td></td>
</tr>
<tr>
<td>Left occiput Anterior</td>
<td>321</td>
<td>45.2</td>
</tr>
<tr>
<td>Right occiput Anterior</td>
<td>156</td>
<td>22.0</td>
</tr>
<tr>
<td>Right occiput Posterior</td>
<td>61</td>
<td>8.5</td>
</tr>
<tr>
<td>Left occiput Posterior</td>
<td>11</td>
<td>1.5</td>
</tr>
<tr>
<td>Face</td>
<td>10</td>
<td>1.4</td>
</tr>
<tr>
<td>Brow</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Breech</td>
<td>15</td>
<td>2.1</td>
</tr>
<tr>
<td>Footling</td>
<td>2</td>
<td>0.2 p.a.</td>
</tr>
<tr>
<td>Transverse</td>
<td>3</td>
<td>0.4</td>
</tr>
</tbody>
</table>

It will be seen from the above, that, in 129 cases, the second stage was completed before my arrival, and, to one unaccustomed to country practice, this number may appear high. The distance to be travelled by the messenger, (as after arrival on foot) and then by the medical attendant, explains this. Of these 129 cases, the large majority must have been presentations in the first or second positions. (23% or 92%).
as, when the head lies in the third or fourth (B. or L. or R.), there is generally sufficient delay, before delivery, to allow the descent to be present. Here is not always this delay however, I have seen a right occipito-posterior case, in which, after rupture of the membranes, three uterine contractions were sufficient to cause rotation and expulsion of the head.

Reducing 129 cases mentioned above from the total number, we have then 580 cases for analysis. On adding up the "head" presentations, it will be found that they amount to 560 or 96.5 per cent, leaving a very small percentage for the presentations such as breech, transverse lie. Playfair's opinion that "head" presentations amount to 49 per cent of all cases, but, in all probability, to estimate is too low.

With regard to the relative frequency of the various vertebral presentations, my means agree better with statistics...
gathered in recent times, than with those of older writers. For instance, Hagedoer was of opinion that the foetal head occupied the right oblique diameter of the pelvis in 99 per cent of cases, and this seems to have been upheld by Simpson and Barry. Evangie, on the other hand, allowed 12 per cent for the left oblique diameter and 87 per cent for the right, whilst Murphy, more liberal still, allowed 20 per cent for the left oblique diameter.

The following table gives the percentages of the various presentations which numbered 649.

<table>
<thead>
<tr>
<th>Side</th>
<th>AEE</th>
<th>Act</th>
<th>Per Cent</th>
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</thead>
<tbody>
<tr>
<td>Left</td>
<td>33</td>
<td>58.4</td>
<td>58.4</td>
</tr>
<tr>
<td>Right</td>
<td>28</td>
<td>28.4</td>
<td>28.4</td>
</tr>
<tr>
<td>Right</td>
<td>11</td>
<td>11.1</td>
<td>11.0</td>
</tr>
<tr>
<td>Left</td>
<td>2</td>
<td>2.0</td>
<td>2.0</td>
</tr>
</tbody>
</table>

This gives us in the right oblique diameter 69.6 per cent, and in the left 30.4 per cent, which, in my opinion, must be nearer the mark than the statistics of older writers would lead one to suppose. From constant observation, however, I have formed the impression...
That, in many cases, the foetal head lies in neither oblique diameter but straight across the pelvis. In the ordinary form of sincipital pelvis, in which the constrictions of the head commonly press, but I do not refer to that. The phenomenon is noticed in large pyriform pelvises, where the head descends without, and there being influenced by the long pelvis. In such large pelvises, I have, on several occasions, also noticed that. The body rotated on the sagittal diameter after the birth of the head. For instance, quite lately, I attended a case where the head was certainly in the first position before birth, and where afterwards the shoulders rotated to the right, so that the breast formed a right hip of the child. That this happens sometimes I am certain, although I have never seen it mentioned by writers on the subject of midwifery.

So necessary the one to diagnose
The presentation early, and not brisk in watching the external rotation alone, as some do.

Dr. Andrews gross, who appears to have studied the subject of acute uterine cases most carefully, is of opinion that 3 out of their 350 cases are terminated with breech and forceps. Of my 72 acute uterine presentations, 19 terminated in this way, giving a percentage of 13.8 per cent., but the frequency with which such cases require the application of forceps appears far for practical purposes, at least, far as rotation is concerned.

I shall proceed to the subject when speaking of breech presentations. Pelvic presentations come next in the order of frequency, and of these I have 19—two footlings and fifteen breech. I class the footling and breech presentations together, as I consider the former to be simply a modification or consequence of the latter, owing to an early escape of the liquor amnii, when the breech was more lateral. The
from. Counting those three, out of 709 births, there are 17 pelvic presentations or 2.3 per cent. According to Churchill, breach presentations occur once in 52 labours, while Ramabhadran estimated that in present obstetrics, viz. once in 38.8 labours. On the other hand, Dr. Robert Durne had only 25 breach presentations in 3821 cases of midwifery, in his practice. My numbers agree pretty closely with those of Churchill, of the 17 children, four succumbed, but two had been dead for at least a week before birth. The third was the second of twins, a funny little thing, which never breathed although the heart pulsated feebly for a few minutes. The fourth was a protracted and difficult case, the mother being a primipara aged 34 years. Considerable practice was required and, although efforts at manipulation were vigorous, the birth of the body, before the arms could be liberated and the head delivered, the child was dead. My mortality
Therefore, in breech presentations, 67-4\%, not very far from Churchill's estimate of 1-3\%, and considerably above that of Ruben, who thinks, with proper management, the mortality should not be higher than 1-11. M. Robert Dunn, in 1821 laborors, met with 28 breech presentations, and of these 9 were stillborn. There seems to be a species tendency in this presentation when the fetus has been dead for some time. Thus, M. Dunn mentions that 5 after children, in 712 cases, were successfully delivered of my 17 cases, 11 had the vertex in the left and anteriorly, 2 to the right and anteriorly, and 4 to the right and posteriorly, giving a percentage for the right oblique diameter of 88-2, and for the left 11-8. In the failure case above referred to, the breech was in the third position, (R.S.P.) and there were very great difficulties and delay in obtaining rotation forwards of the occiput. Had it been a sacro-anterior presentation, I am confident the result would have been
difficult.
The face presentations occurred in the
400 childbirths, with one death. Authorities
seem to differ widely as to the frequency of
face cases. Thus, according to Collins,
there was only 1 in 4,970 births in the
Portland Hospital, whilst Churchill
gives 1 in 249 as the average in Great
Britain. In Germany it appears to be
more frequent, viz 1 in 189. It seems to
me very improbable that the position
of the baby, during labour, can
take any appreciable effect in
changing originally vertex to face
presentations. In my opinion the cause
is more likely to be 1st obesity of the
uterus, 2nd peculiarly in the shape of
the pelvis or 3rd the distensibility
form of cranium in the infant.
My patients invariably lie on the
left side, in the ordinary statistics
position and, in spite of this, only
per centage of face presentances
is 1.4. One of the last mothers had
pendulous belly, but secondly appendice
And probably that had something to do with the production of the unusual presentation. The same in this gave birth to his first case, in consecutive labours and, on both occasions, the child's head was long in shape with a prominent occipital protuberance. By the last children, one was born dead. It was the first of two, and presented as the arm, with the clavicle anteriorly and left, and an arm lying alongside of the head. Thinking of the case now, I can easily see that the correct treatment was turning, before the head got engaged, but, when that was thought of it was impossible. After waiting a considerable time, I saw if nature could not effect delivery without assistance, it was decided to employ forceps and, after several attempts, (the bladder of the foetus caused not to get to lack) the labour was terminated by the birth of a dead child. The presentations of the last cases came as follows:

Besides the case mentioned above, another required delivery by forceps, but, with their two exceptions, no assistance was required. The second case requiring forceps was that of a woman, who, in four previous labours, had required instrumental assistance three times. The pelvis was generally contracted.

That strikes one most, on looking at the list of presentations of these cases, is the great frequency with which the clin. L. is placed anteriorly, showing that it is principally, by the conversion of breech-patellar vertex presentations, that false cases arise. Why should this be so? For some reason, the posterior wall of the pelvis must be more liable to obstruct the downward movement of the occiput than the anterior. The forward inclination of the sinciput, in postlumbar tiltly, and later in cases...
that the uterus. The application of force is greatly in producing this change. Dr. Matthews Duncan's theory, as to the way in which uterine obliquity assists, or fails to cause, the production of face presentation, is exceedingly ingenious. He believes that, in obliquity of the uterus, the part of the foetus occupying the concavity of the curve, in the general passages, tends to descend more rapidly than the part on the side of the concavity. If the uterus obliquity be extreme, he believes that, the spine first occupying the concavity of the curve, may descend less. The originally vertex presentation is changed to a face. I am, however, inclined to have more faith in the generally accepted theory, that the conversion is produced by a hitching of the abdomen in the term of the pelvis. Both uterine obliquity and the Pelvis...
cephalic form of foetal head, must
appear greatly in favour. In this case, the
forearm by directing the temples against the brain.
Of **Recalled Birth Presentations**,
I am happy to say, I have only seen
one example, and as it was a very
different case, and of some interest,
I shall give it in detail. The woman
was the wife of a shepherd, living among
the hills seven miles from Balachita,
so that I could obtain no assistance.
Case No. S. Dec. 24. Para. On arrival,
I found the head fully dilated with the
membranes, unruptured, bagging out the vagus.
The head was at the brim, but I could
feel the orbit, and the bridge of the
nose, to the right and anteriorly,
and the anterior fontanelle to the
left. In order to make the diagnosis,
the hand was introduced into the
vagus, which was very loose.
After rupturing the membranes, every
effort was made to convert the
presentation from brow to vertex,
but, failing in my attempts, things
were left to themselves for one hour. Then, the head was found to be fixed in the pelvis and making no advance with the uterine contractions, which were strong and very painless. At this stage, it was thought to night to interfere and, as turning was impossible, had to face back upon the forceps. The blade of the forceps were only inserted with great difficulty, and, after quite half an hour of hard work, at my part, the head was delivered, as a 
free case, with slight forceps. 

The brow was an immense Cephal Suceedaneum, but the whole head was much smaller. It was only at my request that the child was discovered to be suffering from Hydrarthrosis, to which it succumbed three months later.

Pudallic Version

This operation has been performed by the seven times, thrice for transverse presentation, and four times for deformity of the pelvis. Two of these
Transverse presentations gave little or no trouble. In the first the foetus dead for a week or two, as shown by putting up the cuticle, etc. lay with the right shoulder occupying the spinous of the pelvis, with head to right and dorsum posteriorly. Although the liquor amnii had escaped for an hour or two, I had no difficulty, without choreiform massage, in seizing a foot after gently pushing the shoulder to the right. In the second transverse presentation, the foetus lay in exactly the same position. It was the second of twins and there was but the slightest difficulty in turning. The third case, that of a primipara, was very different. Here the membranes had ruptured five hours before my first visit and, on examination, I found the right shoulder presenting, head to right and dorsum posteriorly, with the arm in the vagina and the part firmly jammed into the pelvis. The patient was at once put under the influence
of chloroform, and several unsuccessful attempts made to get the hand past the presenting part. After persevering in my endeavours, for I dare say half an hour, I at length succeeded, but found the uterine contractions spasmodically, so that my hand in a few seconds became perfectly powerless. At last, after changing hands several times, I managed to get hold of the left foot, but was unable to make the foetal part move, even with the assistance of the hand outside. Retaining a string piece of tape, I made a "clown hitch" and, introducing it on the tip of the fingers, put it on the ankle of the foetus. Having gentle traction on the tape with the hand outside, and pushing up the presenting part with the left hand, the foetus was made to rotate and extracted dead after a couple of hours exceedingly hard work.

The four cases of placenta deformity were all of the same nature, viz. contraction
of the term from Pueris.

The first case that of a woman, who, on seven previous labours, had been delivered six times by turning, and once by the introduction of a premature labour. Her Os always failed in this case, and all the children survived except one delivered by turning. The measurement of the true conjugata, as ascertained afterward, was 8½ inches, and deliverance presented no great difficulty.

In this second case, I made a careful examination of the pelvis, a fortnight before the commencement of labour, and hoped to be able to deliver by forceps. The patient informed me that in two previous labours, she had been delivered, once by forceps, and once twice by turning. Here the sacrum seemed to project very little, but, even with this laxity, the forceps could not be got to engage in the true turning. The head came out, but the child sustained fracture of the zygomaticus in its
upper third but was healthy and vigorous. She escaped secured when bringing the extended arm over the face. The same woman supplies cases 3rd, 4th, and 5th labours. When called to see her for the first time, I found the first stage well advanced with the membranes unruptured, and with the head at the brim, presenting in the foul-out position (LOP). The faecal protrusion was easily within reach of the examining finger, and on questioning the attendant, I found that in the three previous labours, the children had been lost in turning. The previous man, who attended her in those labours, had given it as his opinion that she could never have a living child at full term. First, I tried the semi-traction forceps, but found that the blades would not take a secure hold of the foetal head. When only slight traction was put upon the cross handle, the blades slipped from the head. In turning these was no special difficulty, the head reached the
from, when things appeared to come to a dead lock. I did everything I could think of to get the head past the obstruction, but failing, had to perform it behind the ear. After that procedure, delivery was comparatively easy.

Then next Mrs. woman became pregnant, I made a thorough examination of her pelvis, and was assisted by Mrs. by Dr. N. Bureno. The true conjugate measured 3½ inches, and Dr. Bureno & I advised that premature labour should be brought on at the eighth month. To this she refused to give consent, and went on her time. When sent for, to attend the labour, I found the os fully dilated, the membranes unruptured, and the face of the head in the right occipito-posterior position. Having administered chloroform, I attempted, but failed, to perform version by the combined method. The head was introduced into the pelvis, a part rejected, and the child extricated with perfect ease, the head reaching the tension as before.
Applying pressure to the after-coming head, I pulled as hard as I thought I could, but with as appreciable success. After removing the blades, however, and whilst applying steady traction, the head was felt to slip gently past the obstruction and a living male child was born. This happy event astonished everyone, myself included. The foreps had evidently almost disappeared, although the head was not felt to descend during traction. Very well. Whilst allowing the head, and without undue roughness, something was felt to give way and this proved afterwards to have been the sternum-mastoid muscle, which had ruptured about its middle. A tumour formed over the rupture as large as half a walnut, and the belly patient suffered from way next for a few minutes, but eventually the swelling disappeared and the neck became quite straight. Immediately after-birth there was a distinct depression on the side of the child head at the juncture of the frontal and parietal bones,
but this was not to be felt four days afterwards.

Great Authority assumes that in special obstructed cases, a living child, by means of forceps, where the internal conjugate is not less than 3½ inches, although in this case, the conjugate measured 5½ inches, it was still the greatest difficulty that the foetal head was not just the protruding of the paracentesis, after tearing, so that it seemed it would have been quite impossible to have delivered by forceps. Of course, had the child been a female, with a smaller head, forceps might have succeeded, but both times I attended this patient, the child was a male with a large well-assisted cranium.

Paralysis of the Umbilical Cord has occurred four times in the 700 labour terminations at the commencement of this paper, or once in 175 cases. Churchill calculated that in 100,000 deliveries, it was only met with once in 240. In Germany it would appear to occur often viz 1-156.
All my four cases occurred in multiparas who had previously borne children without specific difficulty, and in some cases I detected the slightest deformity of the pelvis. The four children survived, although Scanzoni calculated that 45.0%, and Church that 47.0% only, are saved. Englishers found that only 36.0% of the children survived, out of 202 vertex presentations, and, as all my cases were of this nature, I seem to have been particularly fortunate. The fact that all the mothers were multiparas lives in my favour. As these cases are of some interest I shall give them separately in the form of short notes taken at the time.

Mr. H—Oct. 32. 6-Para. When first seen, 2/3s dilated, head at L.O.P. in fourth position, and a loop of cord between the foetal head and the membranes. After rupturing the-calls, (postural treatment had failed) unsuccessful attempts were made to replace the cord. Tones applied and labour terminated. The cord, which protruded from the vagina after the rupture of the membranes measured 31 inches.

Mr. P—Oct. 34. 3-Para. On arrival, found the membranes ruptured, and the head low down in the pelvis in the fourth position (L.O.P.) with a loop of cord before its pulsating between the uterine contractions. Tried to replace the cord behind the pubes by Mr. Clinton's method, but failing, delivér'd by forceps. The child was a male and the first of twins. Body 9 inches.

Mr. W—Oct. 25. 4-Para. On arrival found eight inches of feebly pulsating cord protruding from vagina. Head in first position (L.O.P.) low in pelvis. Assisting the uterine contractions by firm pressure on the abdomen, succeeded in delivering in four or five paris. The
Child, age nine, required artificial respiration and the cord became 25 inches.

I concur in having very little faith in the various methods of replacing the prolapsed cord, when the head has become engaged in the pelvis. With the head at the brim and the membranes unruptured, it can certainly do no harm to try postural treatment; but after the head is engaged, I advocate the application of the green,布莱特的Labour (not the termination naturally in a very short time. In the second case I advised have pressed turning, but, as the patient wished not consen to take chloroform, I had to use green instead. As might be expected in such cases, the umbilical cord seems to be longer than usual. As advised by writers on this subject, it is a good plan, before applying the blades of the green, to draw the cord to one on the paro-oblige syndrome. This gives thecirculation the best chance of being carried on satisfactorily.
And, at the same time, when you know where the cord is, there is less chance of it being caught between the blades and the foetal head.

From a perusal of the above it will be gathered that I place little faith in attempts at replacement, but prefer turning when the head is at the brim and not engaged, and forceps when the foetal head is engaged in the pelvis and the labour most likely to be a rapid one. Sometimes, when the pelvis is roomy, the pains strong, and the descent of the head rapid, such cases are best left alone, but it should always be remembered what great assistance may be got by firm abdominal pressure during the uterine contractions.

From Births. In the 400 labours there were 9 twin births, or 1-4%, so that I appear to have had more than any place judged by the statistics of others. This place the average frequency of twin births to be in England, 1-116, in Scotland, 1-95.
And in Scotland, 1-64. My numbers appear to be too high for Scotland, but I may mention in passing, that three of the mothers were Irish and that may have had some influence. Dr. R. Dunn, in 4049 cases of smothering, occurring in private practice (England), had 45 turn births, or 1-89, whilst Dr. Harrison, in his paper on Obstetric Statistics, states that in his practice, turn births seemed rare in every 100 labours. Dr. Dunn's tests were on the older the woman is the greater the tendency to the production of twins, and that the tendency increases with each pregnancy. This includes primiparæ, in whom there is the greatest tendency to turning. If the table on the following page be examined, it will be seen that, in my cases at least, there is no evidence in support of Dr. Dunn's theory. None of the mothers had been delivered of twins previously, but eight of them came here of dear relatives who had. Of the eighteen twin children born, 13 were male and 5 female.
<table>
<thead>
<tr>
<th>Lewis Cases</th>
<th>frem Cases</th>
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<tbody>
<tr>
<td>Stomach</td>
<td>Presentaion</td>
</tr>
<tr>
<td>Age of Mother</td>
<td>Duration of pregnancy</td>
</tr>
<tr>
<td>(a) 31</td>
<td>1</td>
</tr>
<tr>
<td>(b) 23</td>
<td>2</td>
</tr>
<tr>
<td>(c) 24</td>
<td>3</td>
</tr>
<tr>
<td>(d) 27</td>
<td>6</td>
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<td>(e) 39</td>
<td>6</td>
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<td>(f) 29</td>
<td>3</td>
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<tr>
<td>(g) 33</td>
<td>4</td>
</tr>
<tr>
<td>(h) 25</td>
<td>3</td>
</tr>
<tr>
<td>(i) 26</td>
<td>3</td>
</tr>
</tbody>
</table>

Playfair states that "in the largest number of cases of twins the children are of opposite sexes, and most frequently those are male females and twin males are the most uncommon. My numbers are, of course, far too limited to be of any importance but from these one would imagine twin males the most common, male and female and twin females least common of all. In light of the Lewis cases there were two distinct and separate placenta and two bags of membranes showing that the twins
had developed from separate ova, but in the midst there was only one chorionic with but one amniotic sac, and the placenta were fused into one mass, of which the two cords entered separately. In this case (No. 8) the twins, his males, must have developed from a double fertilized ovum. This agrees with the opinion of Schnedler, who holds that twins developed from a single ovum are always of the same sex. Of the eighteen children, six were either still-born or survived a few hours only, so that their mortality has been 1-3, instead of 1-13, the estimate of Clarke. Of the twelve remaining children, at least half have succumbed to infantile diseases during the first two years of childhood.

This would appear to be a great tendency to arrest of development in twins. One of my twin children had a meningema in the cerebral plexi, as large as an orange, covered by a transparent membrane and containing blue bloody fluid.
The umbilical region was a hernia, as large as the fetal head, covered by a transparent membrane through which could be seen the intestines and what was taken for the right side of the heart. The umbilical cord was inserted into the most prominent part of the hernia. The child died one hour after birth, but its neighbor survived and developed double inguinal hernia in early childhood.

Two others of the twin children (different twins) suffered from club-foot; one was operated upon, their treatment was of little benefit. Of the two twin births only one was described under "Face and Armwise Orientation." The first child (face and arm) was defined by Jeeves and the second (armwise) by Leslie Pearson.

The second interesting case is as follows:

Mrs. P. Oct 25, 3-8, had rather a tedious but quite natural labor, her arm-the birth of the first fault, when smart
haemorrhage set in. The second bag of membranes was punctured at once, but this procedure had no effect on the bleeding, which continued. At this stage I advised the friends to allow one to deliver by turning or breech, but the mother, who was a particularly discontented individual, gave her opinion that no such interference was required. After three hours, during which the patient had been losing blood continuously, I obtained permission to give forceps. It proved a difficult case (presentation L.P.) and it was no surprise to me when the child was found to be dead. Now my theory is that the child's death was here caused by separation of the placenta, after the birth of the first child, and I am the more inclined to this belief, from the fact that the placenta were found to be fused together and evidently developed from a single ovum. Besides this, it was found in expressing the afterbirth...
that a large ecapulum (Retro-placental haematoma) still adhered to its maternal surface, of which it covered more than one half. Had I, in this case, been allowed to deliver, when I thought it right to do so, I cannot but think that this child's life must have been saved.

Forceps. During the last few years, I have employed the anti-traction forceps in all difficult cases, but, with the rods and cross-handle, this instrument is so awkward to carry about that, in ordinary cases, I still use Simpson's long forceps.

Of the 700 labours of, or nearly 1 in 11, have been terminated by means of forceps, and of the 6th mothers, 32 were primiparous and 32 multiparous. The total number of primiparous being 133, that gives a forceps delivery once in every four first labours. In the multiparous the average is much lower, viz 1 in 17. But for the strong objection to the
employment of groups in the district. Any average learned have been much higher. Many cases are allowed to linger for hours simply because this is under a cloud of misinterpretation. It is only when interference is seen to be absolutely necessary that consent to the procedure is obtained. The following table gives the number of the various vertebrate presentations, and the proportion of each requiring groups.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Vertebrate Presentations</th>
</tr>
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<tbody>
<tr>
<td>L.O.A. 321</td>
<td>Foruse 32 = 1-10.3 or 9.7 p.c.</td>
</tr>
<tr>
<td>R.O.A. 156</td>
<td>14 = 1-9.1 or 10.9 p.c.</td>
</tr>
<tr>
<td>R.O.P. 61</td>
<td>9 = 1-6.7 or 14.7 p.c.</td>
</tr>
<tr>
<td>L.O.P. 11</td>
<td>3 = 1-3.6 or 24.2 p.c.</td>
</tr>
</tbody>
</table>

Since one of the group's operations are determined for above, the remaining three were in 1 Driver and 2 Free Cases. As might have been expected, the occlusal-posterior cases show a much higher number, in the above table, than the incisors anteriors but it is difficult.
to understand why there should be a difference of 12.5 per cent, between the right and left beautiful posterior presentations. Perhaps, in a large number of cases, the difference between the two might not be so great. Of the children, 36 were male and 28 female; that sex appears to have only a slight effect.

The "fixation of the head" was performed 24 times and the "fixation of the head" and a glance at the following table will enable one to see the various causes. Reckoning the applicability of fixation with the head at the pelvis or brim.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Contracted Brim</td>
<td>11 cases</td>
</tr>
<tr>
<td>Inertia</td>
<td>8</td>
</tr>
<tr>
<td>Orolapse of Funic</td>
<td>2</td>
</tr>
<tr>
<td>Hydrocephalus</td>
<td>1 case</td>
</tr>
<tr>
<td>Rigid Carcin</td>
<td>1</td>
</tr>
<tr>
<td>Rimmoss of Face (one and both)</td>
<td>2 cases</td>
</tr>
<tr>
<td>Rimmoss of Temporal Posteriorly</td>
<td>2 cases</td>
</tr>
</tbody>
</table>

The case of Hydrocephalus was described under the head of Brain Enlargement, and Orolapse of the Funic and face cases.
have also been mentioned. The management of the 11 cases of contracted term, with one exception, was not particularly difficult, although 6 of the mothers had never been delivered without instrumental assistance in any of their previous labours. The exceptional case deserves mention as a subsequent labour demonstrated the fact that a living child could not be delivered even by turning. The patient was a primipara, of diminutive stature, who was only seen by me after she had been in the hands of a midwife for forty-eight hours. On arrival, I found the os two-thirds dilated with the pearly promontory easily within reach of the examining finger. The foetal head, which was reached with some difficulty, presented well-far long axis straight across the pelvis. I attempted to deliver by means of forceps but failing, sent for Dr. Murray (Glaschick). After I despair, an hour and a half of hard work, the labour was terminated
At the birth of a dead child, on the back of whose head there was a
deep depression near the junction of the frontal and parietal bones. The patient
made a good recovery, and, in her next labour, Dr. Murray, having turned,
(there left Calashik) found it impossible to deliver without first perforating
behind the ear.

Tetulia, which, in my opinion, is more
teleologically cause delayed when the foetal
head has ascended into the pelvis;
announced the approach of death
eight times. The only case deserving
of mention was that of a poor
woman, in the last stage of Puerperia,
who showed signs of eclampsia rubetens
when the 3rd was only about two-thirds
dilated. Immediately after delivery,
alarming haemorrhage set in which
heavily pressed failure. The patient rallied,
however, but died three weeks afterwards
from Puerperia.
The case of Feudal Cerebral Atics was
really the most trying in my career.
The patient was a farmer, aged 21, of very delicate constitution. After three days of extreme pain, which were regular and very painful, the岘 reached, the size of the mouth of a small leech, and felt like a maggot. Chloral, chloroform, and the hot douche were tried in turn—but had no effect on the cervix. I attempted to ease Barnii's task but failed among the teeth pressing down so firmly. Having left the cervix, in three or four places, incised undoubtedly have been the correct treatment here but, failing to obtain assistance, I prepared to remove the foetus, the bladder of which were passed with difficulty through the partially dilated 88, using the right hand as a trident. I tried, with the fingers of the left, to delate and push up the cervix but, for a long time, all my efforts were unavailing. At length, after many fruitless stirs, Dr. Mil the head slipped through, but it was
found on examination, that the cervix had given way. A strip, about one inch broad, was torn from the tendons of the circumference of the OS and hung into the vagina in the form of a loop. The patient made a slow, though ultimately good recovery. The two cases in which the head got jammed in the breech with the occiput posteriorly, were between anxious ones. My experience is that when the occiput lies posteriorly and refuses to rotate forward, the blades of the forceps are invariably twisted until trouble. Here, of course, with the head high, there was more difficulty than usual even with the assistance of the left hand in the vagina to guide the blades of the forceps in which the 'low' operation was performed. The cause of delay, in the great majority, was either inertia or rigidity of the soft parts. Two cases of contracted outlet, occurring m. elderly primiparous, gave
Lilli. Trouble except that one of them had retention of urine for eight days. To prevent this, he did not use the risks of ligation of the urethra or the cecum through the bladder, but the subject in a case of rupture of the femur, and in this case, I have noticed in my notes that the only apparent cause of delay was "large and perfect head."

A most interesting case of hypertrophy of the cervix, which occurred in the practice of Dr. Murray, Galahad, must be described more fully.

Case No. 2 - Act 49. 10 Paro. This woman was in labour when first seen by me, and gave the following history. Her labour had been perfectly natural in every respect. Three months previous to my seeing her, she had consulted Dr. Thomas of Berwick, who, finding a freely movable tumor in the lower part of the abdomen, thought the case for one of ovarian disease. On being sent to the Edinburgh Infirmary, however, pregnancy was diagnosed...
In arriving at these found that the membranes had been ruptured for several hours. The face of the head, low in the pelvis, in fact almost in the perineum, was pressed close against the thickened cervix. Although this was nearly fully dilated, and the uterine contractions frequent and very painful to judge from the uteringo, no advance was made. All efforts to get the cervix out of the head failed, as though the anterior lip was pushed up, the posterior came further down and vice versa. This state of affairs lasted for nearly two hours, when the labour was terminated by forceps. Considerable difficulty was experienced in getting the head through the thickened and elongated cervix, which came down as far as the vagina. There was no haemorrhage and every thing appeared good natural, after removal of the placenta, except that the uterine, when contracted, seemed tight in the abdomen and some trouble from this side led Miss Wineland.
On the following day the patient was thought to be doing well, but on the second, I was sent for and found her suffering from all the symptoms of peritonitis viz. rapid pulse, pulse 108, Temp. 104°, a cold sweat, faint on pressure on the abdomen, slight hypothermia, &c. The discharge had not stopped but, on the contrary, was copious. In spite of treatment, the patient continued to get worse, and eight days after labour, fluid began to accumulate in the abdominal cavity. Although regans had occurred once, and sometimes twice daily, the thermometers never registered more than 102°. In the morcella, commonly it was between 100° and 101°. Ten days after delivery, the fluid had accumulated to such an extent that tapping was determined upon, and Dr. Murray, in presence of Dr. Thomas and Murray, drew off, by the Asperini, 120 ounces of thin yellow fluid, containing fins as proved by microscopic examination. Afterwards, on one occasion 100 ounces,
and in another 90 hours, if the same amount were drawn off. The first and second tapings were followed by rapid accumulation, but, after the third, the patient began to recover and, by the eighth day, was able to get up and for an hour or two every afternoon. At one time, it was proposed to drain the abdominal cavity through the pouch of Douglas, but it was thought better to give tapping a trial first.

The case puzzled us all at the time but, after considering it carefully, we came to the conclusion that it was an example of Hypertrophy of the Cervix. Even eight weeks after delivery, the Cervix was elongated and thickened and the uterus caused to distend to the full extent of the pelvis, at which time the uterine sounds passed 1½ inches from the external OS. Coming down 1 foot, I am happy to say that, with the exception of one woman who died from phthisis,
Three months after-delivery, all the
mothers died, none of the children
however recovered. It was proved
in one case, by a subsequent labour,
that a living child could not be de-
livered even by turning as in a-
delivery. I be wondered at this force
failed. The Mrs. was the friend of
twins, and death probably resulted
from asphyxia of the placenta, after
the birth of the first child.
Recovery of the perinæum occurred
three, twice to the sphincter, and
once through it. The three cases were
stitched at once and his head
well; the Mrs., that in which the
continuity of the sphincter was
broken, required a second operation.
Unilateral paralysis of the infant's
face, from pressure of the in-
strument on the facial nerve,
was noticed three times, but dis-
appeared within a few days.
Trice, blood issued from under
the infant's neck shortly after-delivery.
In some, but practised, cases, more from protracted labour than pressure by the instrument. The pain subsides, disappeared entirely but very slowly.

Before leaving the subject, allow me to compare the results of my own practice with those of acquaintance, who lived thirty or forty years ago, when cases had not come into general use.

Mr. Harrisson, in a paper on 1000 cases, his blisterers, when describing his case of prolapsus of the fundus, acknowledges that five of his children died in birth, and Mr. P. Denme, in his paper on "Statistics of Midwifery," says that "of 11 cases, in which there was a prolapsus of the fundus, 8 were born dead." Both of the above mentioned gentlemen seem to have made in their works to interfere with the natural powers caused effect delivery, and seem to have had om the slightest consideration for the life of the child. The placenta and membranes have, in a considerable number of cases.
Cannot answey and trouble, and
I mean purpose to say a few words
on that subject. In the removal of
the placenta, I invariably employ
Pudel's method, contenting myself with
keeping the hand on the uterus, and
driving gently rubbing during the
uterine contractions, for ten minutes
at least. Then, if the placenta has
left the uterine cavity, wholly or in
part, I assist it in removing by pressing
downwards and backwards towards
the hollow of the uterine. If the
placenta refuses to leave the uterine
I keep my hand on the latter for
about half an hour and then intro-
duce the hand to discover the
cause of delay. Some writers ad-
vice waiting for hours to allow
the placenta to come away naturally,
but in country practice, there is
no time for such experiments.
Then the placenta has reached the
vagina and refuse to leave the
hollow of the uterus. I prefer
guiding it forward with the hand, or rather a few fingers, in the way of
Dr. Hart's method of hooking back the perineum. The latter is the more
painful operation of the two.
On inserting our ordinary 100 pounds I found that in 20 cases, there
was trouble small - the placenta adherent to the bed of the uterus.
The placenta was adhesion to 6 cases and retained (undetached) in 8 and
three of the latter had
"surflax" contraction of the uterus.
It is believed by some that, in called
"surflax" contraction, the constriction
is always at the uterine or, but
in two of my cases, I am positive
it was higher up. In two cases, the
hand, after passing through the
Pennis, reached a cavity in which
was a part of the placenta and
in following the latter up the uterus
was found firmly contracted on it.
In the third case the whole of
the placenta was above the con-
duction, which was also, in my
opinion above the intemal os.
In all three cases I was able, with
a little patience, to dilate the con-
struction and remove the placenta
from the dilated portion—of which
beyond. Probably the piece of placenta
which gave trouble in such cases
does not separate so early as its
other part, and the weight of the
placenta dragging on the attached
portion causes by irritation, con-
traction of the uterine at that loca-
tation.

of Placenta Gravida I have seen one
example, which occurred in a pre-
monstrant labour, at the seventh month.
I arrived I found the 20 inches
bulla dilated, with the membranes
ruptured, and the edge of the
placenta to be felt, about half
an inch inside the margin of the
cervix. When the membranes were
ruptured, the foetus and placenta
came away in a very short time
but the haemorrhage continued.
Chloroform was administered and a small piece of placenta picked from the uterus was sent, after which I proceeded. The haemorrhage was now ceased and the patient made an excellent recovery. 

I may mention another case in which a small portion of placental tissue was retained until a more unsatisfactory result. The labour was easy & satisfactory in every way. There was no more loss of blood than usual and nothing was noticed until the placenta. Three hours after delivery, when called, I found the patient blanched and almost collapsed from shock. The pulse at the wrist scarcely perceptible. Having injected ergotin subcutaneously, I introduced the hand and cleared the uterus of clots. This was done without detaching any cause for the bleeding which stopped almost immediately. Stimulants were freely administered and, although the woman showed symptoms of having lost a large quantity
of blood, she appeared to be doing
knee for a week. On the 8th day,
however, bleeding again set in, and a
small piece of placenta, about the size
of a hazelnut, came away. There was
no more loss of blood after this, but
the patient died on the fifth week
after delivery, from septicaemia
coming on the back of phlegmasia
albae. At the time. No case resembled
me as being any instructive aid,
though I ever be my misfortune
to meet one similar, I shall be very
careful to search for retained placenta.
Although the portion expelled in this
case was so small, so firm, large
enough to cause haemorrhage which,
although not directly fatal was,
indirect cause of death;
scrapping an adherent placenta from
the uterine wall to always be a
very anxious proceeding, it
was so difficult to distinguish between
what passed remnant and what
passed come away. In none of
My case, I may say, did I succeed in removing every particle of placental tissue although careful endeavour was made to do so. In four of my prior cases of adherent placenta, the placenta was not large, perhaps 1/4 or 1/6 of the whole surface, or the film was nearly, and in the fifth it was totally adherent. The last mentioned case is quite unique in my experience and will require to be described more fully than the others. The patient, 23, Para 2, suffered from albuminuria with ascites and had a very slow and tedious labour, terminated by forceps. After waiting for the better part of an hour without any signs of placental separation, I proceeded to examine the interior of the uterus and found the adherence so complete that the fingers could not be inserted beneath the edge at any point. Not the slightest separation had taken place as proved by the entire absence of hemmorhage.
Being completely baffled in my attempts at removal, I sent for Dr. Murray (this case occurred near Caledon) who, with great difficulty, scraped away perhaps 1 or 2 parts of the placenta. The umbilical cord was attached in the position removed. Dr. Murray informed me, that in his extensive midwifery practice, he had never seen a case of totally adherent placenta before. The patient, in spite of such a large piece of placenta being left in the uterus, made a good recovery, which happy result was due mainly in great part due to the nursing care afterwards. As part of the placenta was seen to come away in the discharge on which the dextre, and two years afterwards, the woman had her second labour normal in every respect, the placenta coming away quite easily.

Of the 8 cases in which the placenta remained attached, although there did not appear to be any positive
adherence, three, as mentioned previously, had hourglass contraction of the uterus.

Even with this complication, the cases were not troublesome, as the placenta separated easily when the fingers were gently inserted between its substance and the uterine wall. The case, which ended in inversion, was of particular interest owing to the comparative rarity of the accident.

Case, Dr. MM, Oct 22, 2 Para. After the first confinement, which was tedious but normal, the woman was confined to bed, by some form of uterine inflammation for ten weeks, and, when examined at this time, a good deal of thickening was felt all around the uterus, but more especially to the left side. Owing to this old inflammatory deposit, the first stage was considerably prolonged. Immediately after the termination of the second stage, alarming haemorrhage set in, but introducing the hand part of the placenta was encountered at the internal os, but its suffer
Part was found to be still attached with the uterus, grasping it firmly.delaying the contraction slowly, I got my fingers in; I thought, between the attached part and the uterus and withdrew the placenta. During this procedure, the haemorrhage had been continuous and the patient was now collapsed, with pulsations at the wrist, cold extremities, skin covered with purpura, perspiration, palpitation, etc. The above alarming symptoms were supposed to be entirely the result of haemorrhage, and it was very discovered, half an hour after delivery, that the uterus was misjudged. The misjudged part was about the size of a hen's egg and projected into the vagina an inch or an inch and a half. After some trouble, the was returned by gentle pressure, and with stimuli and hot baths. The patient at once began to revive. She was feverish and complained of pain over the uterus for a week.
but the temperature never rose higher than 104°F, and recovery was
satisfactory although tedious. Here,
my belief is that part of the placenta
that remained attached, when I
attempted to withdraw it, and that
this, aided by the anaemic and
debilitated condition of the patient,
caused the miscarriage. At the time,
I feel positive that every adhering
portion of the placenta had been
separated, but I must have been
mistaken, I suppose.
With regard to the separation of the
membranes, I believe the misconception
and retention of a portion to be
less dangerous, at least in country
practice, than it is generally supposed to be.
The first time this accident happened
in my practice, I was considerably
grieved as to the result. On
introducing the hand, it was found
impossible to remove the whole of
the membranes, and for a week,
I was in constant dread of recurrence.
Symptoms of this acute disease, however, failing to appear, I was able, when the case was secured, to look upon it with some complacency. In a populous district with its crowded atmosphere, this accident, indeed, of course, be more liable to lead to serious results, but in the pure air of the country with attention to cleanliness and the use of antiseptics, there would appear to be little danger. The deduction to be drawn from my experience as yet: Once, in my experience, the placenta came away without a scrap of membrane attached, and in spite of this, the recovery was rapid and satisfactory. This poor woman's previous labour (twins) had been a very severe one, followed by metritis, from which she recovered slowly. The metritis after this previous labour was the cause, so all probability, of the difficulty with the membranes. No force was
tended on the removal of the placenta, which came away almost of itself, in the condition already described. From this alone, it might be inferred that I have little doubt, in removing the placenta, to see that the membranes are whole, but this is not so. I am, on the contrary, as careful as is possible to be, but, when anything is left, I never reach beyond the cervix. Most writers on this subject agree, that phthisic women, and those suffering from albuminuria, are more liable to incrustation of the placenta and membranes than healthy women, and my experience tells me that this is a fact.

The longest umbilical cord, which has come under my observation, measured 41 and the shortest 10½ inches. The former wound three rounds the neck and once round the arm, and apparently did not affect the labour in any way. The clitoris caused delay after the birth.
Haemorrhage. Mention has already been made of my only case of Placenta Praevia, as that too serious need be said on the subject of Unavoidable Haemorrhage of Accidental Haemorrhage. I have seen four examples, all occurring in women, who had previously borne many children, and all from the same cause, viz. secession with the hands above the head. In four instances, although extremely anxious for women, made comparison good reasons, but only two of the children survived. Another case was mentioned, amongst the twin births, where the oneth, owing to the presence of the placenta after the birth of the first child, had a severe attack of haemorrhage. This however was much a case of "Accidental" as postpartum haemorrhage.

The treatment required by all my cases of accidental haemorrhage was
The same, viz. rupture of the membranes, urget and a Journ abdominal bandage. The condition of the patient was deemed so critical as to call for treating in any interference of the post. Besides the above four cases, in which labour pains set in shortly after the accident, I have seen two of severe haemorrhage in the last months of pregnancy, which, after treatment by rest in the horizontal position, spinous etc., went on to their natural termination. The placenta in one of these, showed signs of having been partially separated for some time, but in peculiarly, was noticed in the mother.

Three cases of severe Post Partum Haemorrhage have already been mentioned in this paper. First, there was the phthisical woman, who nearly perished from flooding owing to metritis, second, the case of retention of a small piece of placenta, and third, the case of hemorrhage of the placenta.
ending in miscarriage. Besides those, I have noticed 14 cases of flooding, but only one of the 14 was a regular flood. The cause in the great majority was mental and a good many had difficult mult. In placenta. One peculiarity about my list of 14 is that three of the women are diabetics, who have come to look on a flooding as a natural sequel to their labour. Here mental plays an important part as a cause. Vomiting invariably contracting badly. Although blanched and weak for some time after each confinement these women think better of it as "our mother was the same before them." Adherent placenta was the cause, in other cases, of severe bleeding which however stopped immediately after the removal of the cause. My worst case of postpartum haemorrhage required to be given more fully. I shall give extracts from my notes later at the time.
Case No. 2 - Aug 22, 2 Par. I was seen for the first time, the patient was well advanced in the first stage of labour. After the completion of the second stage, the patient, for more than ten minutes, held the hand on the uterus, which contracted still. Having attended to the umbilical cord of the infant, I removed my hand for a minute or less and found on returning to the bedside that blood was rapidly pouring from the patient's vagina. The uterus was extended as high as the umbilicus and felt globular. In five minutes, the woman was almost collapsed, with the pulse felt at the wrist being respiration, panting, and in fact all the symptoms of great loss of blood. At this stage, syncope supervened, and seemed to have a beneficial effect as the bleeding gradually shutoff. The woman, who had nearly lost her life from haemorrhage after her first confinement, fortuitously never mentioned this fact as I never have.
been more prepared. The treatment em-
ployed was egg yolk subcutaneously,
leuc (L. leucos) and turpentine by the mouth,
and cold to the abdomen and vulva.
At her next confinement, the
medical man in attendance had
prevented intrauterine injection of
hot water before the haemorrhage could
be controlled, but as she had left
my district, I heard no more par-
ticulars.
When Liefer commenced to attend
cases of midwifery, my custom was
almost invariably to give a full
dose of the liquid extract of egg
yolk, the removal of the pleurisy.
In time, I began to lose confidence
in this drug and never gave it
any seldom. If there was any
appearance of haemorrhage, I, of
course, gave it, but more as a duty
than with any great hope of it.
Being fond of sometimes to see
it act exceedingly well, but at this
time it is properly useless. Egg yolk
In my opinion, a much closer test of action than the liquid extracts of vessels, I am accustomed to look upon the pulse as a very good indicator as to whether there is retention of haemorrhage or not, but it sometimes fails. At his occasions, I have seen pretty secure flooding when the pulse rose above 90, and in one case, the pulse remained at 120 for two hours, without once haemorrhage occurring. Although the patient was a healthy young woman and the labour an easy one, the very peculiar case, which I may mention here, was that of a woman, who for more than twelve hours after labour, had no pulse at the left wrist. The right pulse was free and regular, but, with the slightest care, it ceased just as if she were on the left side. Twenty-four hours afterwards, the left pulse felt as strong as the right, and the woman herself informed me, that the same peculiarity had...
been noticed after all (6) her labour.

That the explanation of this was,

I cannot even conceive, but that

to recur both times I attended

the patient & cure.

Coming now to mortality, the only

two instances which died soon after

labour have already been mentioned.

The one died from phthisis, three

months after delivery, but this can

be less doubtful that the end was

hastened, by a considerable excr-

cution, by the great loss of blood

at that time. For a woman in

the last stage of phthisis, suffering

from extreme emaciation, night sweats,

the quantity of blood lost was

remarkable. Even a healthy woman

would have suffered from the

effects of such a loss; so it is

not surprising that it hastened the

fatal termination of this case.

The other case has been so

fully gone into already that it is

not necessary to dwell more than

mentioning it.
it here. In spite of this phlegmasia dolens, the patient appeared to be doing well for four weeks, but, after the pneumonia symptoms manifested themselves, she rapidly sank. Death took place on the thirty-first day after labour.

Coming now to the foetal mortality it will be seen from the following table that, of the 409 children born, 24 were either still-born or only survived a few hours.

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>No.</th>
<th>M.</th>
<th>F.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature at 7th month</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Accidental Haemorrhage</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Faulty Development</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Contracted Brima (1 group and 1 during after failure of forceps)</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Face and Arm presentation (forceps)</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Separation of Placenta (2 cases)</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Emphysema of Neck</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>No apparent cause</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
<td><strong>19</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>
In a few of these marked instances in the foregoing table, there was a strong suspicion of Syphilis; but in the absence of direct proof, it is perhaps better to leave the cause of death—an open question. Of the last cases of faintly-developed one, a twin with,—Lydia Bengda, vertical kernicterus, has been already described. The other, a strong healthy male child, cried lustily when born, but the respiration stopped almost immediately after the tying of the umbilical cord. The heart continued to beat for five minutes, after the cessation of respirating efforts. Here there must have been some condition of the circulatory system incompatible with life—apart from the mother. The case of emphysema of the breast was rather puzzling to begin with, but, before the child's death, the diagnosis was more easy. The child was a large male, weighing 9½ lbs, and after the thrill of the
head, had great difficulty in coming to the
shoulders, owing to the size of the
labor. Directly after birth, a small
dwelling appeared, on the left side of
the neck above the clavicle, and
then gradually increased till it filled
the whole side of the neck. The
dwelling did not pulsate, and was
untouched by the respirating
movements. The breathing was labored
and the face cyanotic. At first, it
was suspected that one of the large
bloodvessels of the neck had ruptured,
but, from the coolness of the skin
after its enlargement, it was recognized
to be a case of emphysema, due to
rupture of the lungs' apices during
the passage of the shoulders. This
was an appearance of general swelling
of the air evidently being confined
by the clavicle. Death took
place seven hours after birth.
As a result of this 400 labours
409 children were born, and of them
344 were male, and 332 female.
The heaviest child weighed 12\frac{1}{2} and the lightest 4 lbs; the latter had more
the appearance of a one month foetus than a child at term, but it grew rapidly and proved a healthy
infant. The oldest one was 148, and the youngest 16\frac{1}{2} years of age.
One child had imperfect development of the fingers of the left hand, the digits being represented by short
stumps. Another had imperfect development of the whole right side of the body. In this case the anomaly
was not so noticeable at birth, but became more apparent as the child grew. The face had a most pec-
uliar appearance, owing to the smaller size of the right side, and the
part of the right ear was only half its natural size and badly formed.
The fingers and toes on the
right side were shorter than those on the left, and the greatest point
was at rightangles to the others, more like a thumb than a toe.
One case of imperfect Annæ occurred, and was consequently operated upon. In the place of the perineum, where the anus should have been, there was a slight dimple but no bulging of the bowel. After marking in the center line of the perineum, careful dissection was made, upward and backward toward the rectum, till the bowel was found about an inch from the skin. Considerable difficulty was experienced in getting the bowel far enough down to allow of the stretching of the mucous membrane to the edges of the rectum; but, in the end, this was accomplished, for some time, there was a great tendency to contracting of the artificial opening, but the finger was passed twice a week, and this tendency overcome. The result was most satisfactory, then, adding longevity to life.