On the Management of the Third Stage of Labour
In fulfilling my task, I have endeavoured to make the following pages the medium of as much practical information as the very limited time I had at my disposal would allow. I must apologize for the absence of any original ideas on this interesting subject, but my object was most to make a digest of Professor Simpson's lectures on this subject, which notwithstanding the many faults and imperfections of the paper I hope I have
succeeded in performing
(pigned)

Edmond Hoile
On Retained Placenta

The management of the Placenta, in cases where it does not come away after the Birth of the Child, is still a subject of controversy. From the writings of Hippocrates, we learn that it was the custom to use only the most gentle means, for extracting it; but Celsus asserts to have recommended a more hasty removal of the Placenta, and in this he was subsequently followed by both Alcimus & Paré.

In more modern times, two extremes of Practice are here followed, these are
The immediate removal of the placenta, as recommended by Moodray, Chapman, and Mauriceau.

Leaving its expulsion entirely to nature, supported by Russel, Hunter, and Wesenthorn.

The recklessness of the former practice, and the dangers arising from the latter, have caused the adoption of a more intermediate line of practice, in which the expulsion is left to nature for a limited period, at the end of which time, if not expelled interference is wanted to.

The limitation of this period varies with different authorities. Burns fixes it at one hour, and in this he is followed by Hamilton, Simpson.
and Lee, Ramsbotham gives the period at one and a half hours, Collins two hours, Denuan four hours: But the period of interference may be hastened by the occurrence of any urgent symptoms, or delayed in cases where the uterus has lost its irritability, by a tedious labour.

Should the placenta not be expelled within the limited period, one hour, the term “Retained Placenta” is applied to it:

The causes by which the Placenta is retained are usually divided into three, one of them may alone be present or there may be two present
acting in concert

I. Inertia or Atony of the Uterus
II. Irregular Contraction
III. Morbid adhesion between the Uterus and Placenta.

Besides these two other causes are treated of by some authors.

First: Hyperthrophy of the Placental map, and second the occurrence of air in the Uterus, causing a sucker-like adhesion between the Placenta and Uterus.

From a Table of Statistics collected by Dr. Churchill, it appears that in 329,670 Cases of Labour, Attachement Placenta occurred 824 times or about 1 in 400.

We shall now consider the Causes of
Retained Placenta, individually with their appropriate treatment—

I. Insertia of the Uterus

This atony or inability of the womb to throw off its contents, is the most common cause of retained placenta. In Dr. Collins’ 16,416 cases, the hand was introduced into the uterus 66 times; 37 of these were cases of atony, 19 irregular or spasmodee contraction and 10 were cases of adhesions; 6 out of these 66 cases were fatal to the mother, but these were all cases of irregular contraction.

The causes of uterine inertia are several. First the temperament of the woman may be such, as to
lead to a relaxed state of the whole muscular system, second the uterine from numerous labour may have lost than energy necessary for the proper and permanent contraction of its fibres, or the previous stages of the labour may have been too prolonged as to have exhausted the irritability of the muscular fibres; or the inexperienced accoucheur may have suddenly and improperly withdrawn the body of the fetus, on the birth of the head, the normal stimulus to uterine contraction being thus removed.
Diagnosis

This atonic state of the uterus, causing retention of the Placenta, may generally be recognized from the following signs:

First by observing that there are no after-pains; and on placing the hand over the vagina, observing its large size, its medium state of firmness, and the absence of any constriction such as occurs in Hour-glass contraction. In examination "per vaginam" finding little or no part protruded into it, and according to Ramsbotham the arteries and veins of the cord will be loose and fleeced, and will not present an infected and
distended appearance, neither will the cord give that elastic bound on the sudden withdrawal of traction, both of which last signs occur in cases where the placenta is retained from other causes. The occurrence of Haemorrhage, or its nature when present, is no criterion to go by in this variety of Retention, as has been pointed out by some authors; for occasionally we have no Haemorrhage so long as the Placenta is retained, in other cases we have a spurt of blood from time to time, a clot forming in the interval and preventing the flow. The Haemorrhage at other times may
take the form of a gradual oozing.}

**Treatment**

With regard to the treatment of retained placenta, first in cases where it is complicated with profuse hemorrhage, there is but one alternative, viz. the immediate introduction of the hand for its instant removal, measures more mild and less powerful than this are hazardous to the patient's life. The following is the manner in which the operation should be performed. The patient should be placed in the same position as that for the application of the forceps, lying on her left side across the bed, with her legs flexed on the abdomen. The operator
should then grease his hand, some authorities recommend the left, but I
should much rather employ the more disciplined right hand—
having greased it well, but not
the palm, and kneeling by the
patient's bed, she should introduce
it in the form of a cone, twisting
the end round the forefinger of
the right hand, and using the
funic as his guide, he must
then gradually insinuate his
hand into the uterus, an assistant
keeping down the organ. If any
irritability still remains in the
uterus very likely it will contract
and expel the placenta along with
the hand of the operator, this
is a very favourable occurrence, should this however not happen it is desirable that he should leave his hand in the uterus, for a short time and by gently moving his fingers excite the organ to contract. 
After the removal of the placenta the assistant must still retain his hand in the uterus, so as not to allow it relaxing and effort and other means must be employed to keep it in a state of permanent contraction. 
But should neither haemorrhage nor symptoms of fainting occur a milder treatment may be had. because to fifteen or twenty minutes may be allowed to
I advise from the birth of the child without any artificial means for the contraction of the uterus being had recourse to, then as our first object is to induce uterine contraction, at the end of half an hour we should give stimulants, a glass of wine or brandy, which of itself may effect the expulsion of the placenta; should this however not succeed we must give Ergot, use external irritation by rubbing the abdomen or breasts, in order to excite reflex action, at the same time keeping the cord in the stretch, we seldom if ever require the introduction of our hand into the uterus in this variety of retention, for by
using both hands, and applying traction on the cord in the usual manner steadily downwards towards the hollow of the sacrum, and in the "axis of Caeus" the placenta may always be brought away.

Retention from Irregular Contraction

In Irregular Contraction the organ may take a globular form causing the "incarceration" of the whole placental mass, or it may have the Hour-glass form, where a variable quantity is held within the constriction. In this Hour-glass Contraction some of the circular fibres are acting powerfully, while others are relaxed, the fibres which are acting cause a constriction thro' which the
Inconceivable portion of the placenta is prevented from descending; Velleau refers to the occurrence of more than one constriction. This irregular contraction may be due to a whimsical state of the organ itself, or to malpraxis on the part of the Accoucheur by pulling and jerking at the funis before the organ has passed from the uterine cavity, when the nuchal loop contraction arises from this source there will inevitably be adhesion present either normal or morbid.

Diagnosis

The diagnosis of retention of the Placenta from Irregular Contraction, is very unsatisfactory.
and after the difficulty cannot be settled until the structure is felt in internal examination.

The following symptoms will mark may and as in recognising the Hour-glass contraction, and it would be impossible to predict, the presence or absence of marked adhesions in combination with the Hour-glass contraction unless the hand be passed "in utero"—the first symptoms then is the occurrence of me or two strong pains after the birth of the child, which are ineffectual in removing the placenta, and the hand being applied over the abdomen.
the uterus may generally be felt contracted into the form of two round masses of equal or unequal sizes and lying either laterally or one above the other. Examining "per vaginam" the whole placental may generally be found to lie within the uterus, the umbilical cord presents a full and turgid appearance during the pains; there is no loosening of the cord, and on traction it does not yield but springs back with an elastic sound. When the traction ceases, generally speaking there is little if any hemorrhage, the constriction acting as a ligature and preventing
the blood escaping from the "incarcerated" portion of the placenta; the only positive symptom is feeling the stricture on the introduction of the hand.

Treatment

In this variety of Retention the general rule formerly was, after having given a full apie, or bleed from the arm to bap up the fingers and introduce them slowly & successively into the neck of the uterus, making them form a conical wedge and thus overcome the contractions, that is both difficulty and danger attending this process, which is proved by Dr. Collins six fatal
Cases, which where all of this variety. However since the introduction of chloroform into the obstetrical pharmacopoeia, the treatment of retention from lower lab contrac- 
traction is both easier and safer. The rule of Practice now according to Dr Simpson is, first give a large dose of chloroform, we then relax the fibers sufficiently to allow the passage of the hand, and if floating has come on, we are enabled to get the extraction over sooner and without difficulty and then arrest the hemorrhage. In these cases he should dilate the stricture slowly by introducing finger after finger through
the surface, but at the same time he must try to bring down the placenta through it by pulling at the cord with the other hand.

Retention from inviolable adhesion

We next come to this the third variety viz. adherent placenta, in this case we have more danger to apprehend from Haemonchus, than in either of the other forms, the cause of the inviolable adhesion is the atrophy or atresia between the opposed surfaces of the uterine and placenta, the result of the throwing out of a quantity of coagulable lymph, the product of inflammation.
which the lining membrane of the uterus has taken on during pregnancy, this inflammation most generally occurs when the Placenta is attached to the external wall of the uterus; as in this position it is more liable to blows and injuries; those in the humbler ranks of life are much more liable to it than the rich, from their being oftener the subject of accidents and violence. The extent of the adhesion may be variable, from the size of a supraviscerous, to the whole surface of the Placenta, the firmness of the union is alike variable, it may be such as to give way on the slightest traction.
or unaided action of the uterus; or it may be to such an extent, as to require the picking off, of the Placenta from the uterine wall, by the fingers of the operator; the firmness of the adhesion, I think will be found to depend on the early or late occurrence of the inflammation during the period of Pregnancy; for in two cases attended by me where the adhesion was so slight, as to require but little manual interference, the chief indication of adhesion being the appearance of the Placenta; the injury causing inflammation occurred late during Pregnancy about four weeks before delivery.
In one of these cases, which was under my more immediate care, the placenta was recognised by auscultation, and palpation, to be situated on the anterior wall of the uterus, and a little to the left side. In another case where the adhesion was so firm as to necessitate manual interference for its removal, the woman stated that she had suffered pain in the right iliac region, the position of the attachment of the Placenta, from about the seventh month of gestation, the pain was so severe as to incapacitate her for work.
The inflammation of the placenta is caused by the excitement of the maternal, and not the fetal circulation; adhesion has been found to recur in successive pregnancies in the same female.

**Symptoms**

In diagnosing malarial adhesion, a good clue to its presence may be derived from the patient's history, either in former occurrences or the reception of some injury, such as from a blow or from falling on some article of furniture, there will be pain over the uterine region, and greatest opposite the point where the placental couple is heard
loudest, as occurred in the case previously mentioned: Our suspicions will be strengthened if the following symptoms be present, if the uterus continues active, after the birth of the child, but notwithstanding the placenta does not descend, and if on pulling at the funis we find it does not yield, and on letting go suddenly it springs up with an elastic a jerk: With each contraction there is usually a gush of blood, this according to Prof. Simpson is the most diagnostic sign. This gush of blood as Prof. Simpson
positively demonstrated will be more or less copious according
to the amount of adhesion,
then the adhesion is large the
haemorrhage will be copious and
vice versa.

There are however two
classes of cases where the usual
and general pathognomonic sign
the gush of blood is absent:

I. Where the adhesion is complete

II. Where it has only taken place
round the edges of the placenta

TREATMENT

In this variety of retention
interference is not always necessary
for where the person is of a good
constitution, and the adhesion is
is not complicated by other
unfavourable symptoms, we may
trust for a few hours at least
to the "vis medicatrix naturae",
for judging from what is done
by the animal economy in
the removal of foreign bodies
and in cases of extra-uterine
fetation, we may expect that
as soon as the placenta is
no longer needed nature will
act about removing it in a
healthy manner, notwithstanding
the existence of morbid adhesion,
we are further encouraged to
wait from the fact, that altho'
the connection of the Placenta
with the Uterus is in general
sreved on the birth of the child, or within a short time after
yet we find in many cases that the separation may be
delayed a little longer and yet be perfectly natural.
In all cases of delay we must make sure that the consequences
of it will not be more danger-
ous than those of manual
interference. 
However in
Midwifery the great danger is
of doing too much, there is
everything to lead us to interfere
when there is an apology for
our doing so, for nothing is
more difficult than to stand
by an alarmed and suffering
patient and let hour after hour pass without our doing anything to relieve her. Should nature however be found insufficient for the task, or should complications arise, as fainting and Hæmorrhage, we must proceed immediately to empty the Uterus by extracting the Placenta and then induce uterine contraction as speedily as possible, in order to effect this we must grasp our hand in the manner described previously for atony of the Uterus, having as our guide the umbilical cord which should be stretched on the
fingers of the left hand, having reached the placenta, we must then proceed to separate it. Two different modes have been described for separating the adherent mass, the first as advised by Dr. Hamilton is to separate the Placenta from the circumference by spreading out the fingers over it and raising it off from the subjacent portion of the uterine wall; the other plan recommended is separating it from edge to edge, by scraping it off with the tip of the fingers; the first plan is most suitable in cases where the whole
placental mass is attached, there being no loose edge. and when the uterus is so much relaxed as to admit of this manipulation, however in adopting this plan, there is always a risk of leaving a portion of the placental mass attached, which may irritate and excite fever. The second kind of practice is most applicable when there is an edge of the placenta separated and lying loose. In adopting this practice we are always to search for a loose edge, and having found, proceed to separate in the following manner.
Keeping the palm of the hand to the placenta, and the knuckles to the uterus, we must insert the fingers cautiously between the placenta and uterine surface, and separate it by a sawing motion, until the placenta falls loose from its attachment. But often the adhesion is too firm to be thus overcome, we must then by cautiously picking remove the adherent portions, the hand should not be removed from the uterus, until entire separation is effected, and we should take care to remove the entire mass along with the hand and if possible
During a pains, sometimes disruption of the Placenta occurs and a portion is left behind which becomes of this portion is still a subject "sub judicio." In a case which I had an opportunity of watching, a partial placenta weighing three quarters of a pound was brought away, no ill consequences resulted and although the Lochia were carefully watched, there was no appearance of any portion being thrown off. If must consequently have entered into intimate connection with the uterus, so as to admit of it becoming absorbed.
sometimes in cases of abortion when
air has entered the uterus, the
placenta acts as a sucker, which
may delay for a time its extraction
in order to obviate this we may
have to press the hand into the
uterus, and raise up the edge
so as to allow the air to sap
under it and thus dissipate the
attraction, but if possible we
should avoid the risk of introducing
the hand, from the consequent danger
to the mother.