SECTION OF OBSTETRICS.

CLINICAL REPORT OF THE ROTUNDA LYING- IN HOSPITAL, FOR ONE YEAR, ENDING NOVEMBER 1ST, 1903.

BY R. D. PUREFOY, M.D. (UNIV. DUBL.), F.R.C.S., Master.

[Read in the Section of Obstetrics, January 8, 1904.]

DURING this year 1,992 women were admitted to the Maternity, of whom 1,694 remained under treatment, so that an annual increase in the number of admissions continues. Amongst the interesting cases will be found one closely resembling scarlatina, ending in perfect recovery ; three cases of puerperal aphonia, one of paraplegia, arising shortly before the end of pregnancy ; and one of missed labour, in which pregnancy lasted nearly 11 months, and was terminated by the abdominal removal of the uterus and contained foetus. There was also a case of Cæsarean section, in which mother and child were saved.

TABLE NO. I.—*Admissions to Maternity Department.*

—	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Total
Total deliveries -	120	139	129	120	142	130	134	145	171	150	160	154	1,694
Total abortions -	2	2	5	10	7	8	4	4	5	6	5	7	65

TABLE NO. II.—*Dispensary for Out-Patients.*

Number of first attendances	-	-	-	5,132
„ repeated „	-	-	-	6,478
Total	-	-	-	11,610

TABLE NO. III.—*Showing Nature and Number of Cases Treated in the Extern Maternity, 1902–1903.*

Total number of cases	- 2,045	Mania	- 2
Abortions	- 237	Mortality, maternal	- 5
Hæmorrhage—		Twins—	
Accidental	- 17	Females	- 11
Placenta prævia	- 11	Males	- 10
Post-partum	- 21	Male and Female	- 4
2nd Post-partum	- 1		—25
	—50	Triplets, 2 F., 1 M.	1
Eclampsia	- 4	Operations—	
Hydramnios	- 8	Curetting for abortion	124
Infantile conditions—		Forceps	- 60
Anencephalus	- 4	Manual removal of	
Hydrocephalus	- 2	placenta	- 26
Talipes	- 1	Version	- 14
	—7	Decapitation	- 1
Moles—			—225
Hydatidiform	- 2	Presentations—	
Phlebitis	- 2	Breech	- 55
Mortality, infantile (born dead)—		Brow	- 4
Macerated	- 16	Elbow	- 2
Non-viable	- 23	Face	- 4
Premature	- 20	Footling	- 5
Recent	- 45	Occipito-posterior	- 21
	—104	Transverse	- 1
			—92
		Prolapse of funis	- 6

MATERNAL MORTALITY IN EXTERN DEPARTMENT ; HISTORY OF CASES.

CASE I.—M. M., aged twenty-three, 1-para ; delivery Dec. 19th. Patient was delivered, by natural efforts, of a dead child after a slow labour. The placenta came away in 12 minutes, but was followed by *post-partum* hæmorrhage, which could not be controlled by massage and ergot 3iss by mouth. On arrival of clinical clerk the pulse was found weak, and the hæmorrhage continuing in a slow but steady flow. Massage was tried a little longer without effect. Then the uterus was curetted and douched with hot creolin solution. The uterus contracted well several times, but relaxed again, and the hæmorrhage continued. Douching was persisted in for a little longer, when the patient

suddenly collapsed, respiration failing, and the pulse becoming imperceptible. Patient presented symptoms of profound shock. Stimulation by strychnin was tried, but patient died in 10 minutes after the sudden change.

CASE II.—R. O'H., aged thirty-seven, sixth pregnancy; January 13th. Patient delivered herself naturally. The placenta came away normally, but some membranes were retained. These were removed at time of delivery by fingers and douching. Owing to slight *post-partum* hæmorrhage occurring the uterus was lightly curetted. On third day, temperature 102.6°, pulse 112, the uterus was curetted and douched. Fourth day, pulse 102, temperature 101.8°. Fifth day, pulse 130, temperature 104.2°. Patient had developed phlebitis, and evidently had acute sepsis. Temperature varied from 105° to 100°; pulse from 120 to 140. This continued for ten days. The uterus was douched on several occasions, and patient kept on stimulants. She was greatly neglected by the friends who were supposed to be looking after her, but would not carry out any instructions given to them. The patient died on January 26th, the thirteenth day.

CASE III.—Mrs. F., 3-para; first pregnancy normal, child lived two months; second pregnancy, five months, miscarriage. This pregnancy terminated in the eighth month. The child was born normally, but the placenta was retained for over an hour, and then had to be removed manually. There was then some very free *post-partum* hæmorrhage. The placenta was found adherent to anterior aspect of lower uterine segment. There had been no *ante-partum* hæmorrhage, and none during third stage until it had lasted for forty-five minutes. The placenta was with great difficulty detached, some parts being exceedingly fibrous in their attachment. During this the hæmorrhage became very profuse, so that manual efforts to remove some fragments were stopped, and hot douching used. This controlled the bleeding, and then some pieces were removed with a blunt curette. The patient was showing signs of collapse, so further efforts were stopped and the uterus douched and massaged, and then plugged with iodoform gauze. Saline injection by rectum was given, and also subcutaneously; pulse

154, temperature 96.8°. Nothing could be taken by mouth, as patient vomited each time. Three hours later—temperature 97°, pulse 132—another rectal injection was given, and patient slept. Rectal injection repeated with milk and alcohol. Next day—twelve hours after plugging uterus—the plug was removed and uterus douched; temperature 102.8°, pulse 160; complaining of great thirst; patient slept at intervals, was fed by rectal injections of egg and whisky. The pulse and temperature continued high for next day. For the next three days the pulse was very rapid, but the temperature had come down to 100.8°. Stimulants and iron were given regularly, but patient died on fifth day.

CASE IV.—M. M., aged thirty-five, 14-para; delivered August 29th, after eight hours in labour, with a breech presentation. The child born to umbilicus with one arm down, the second arm was in the nuchal position, and was difficult to deliver. The head was extracted by the Prague method. Placenta born in twenty minutes, and patient appeared quite normal—pulse 86, temperature 99.4°. Sent for doctor two hours later, but patient was dead on arrival. No hæmorrhage had occurred since delivery.

CASE V.—M. D., aged thirty-seven, 11-para; died undelivered. Patient sent up to hospital supposing herself to be in labour. Complaining of pain in abdomen; appeared normal; no bleeding showing; uterus apparently normal to palpate; pulse and temperature normal. On examination the os admitted two fingers, and the child presented by the head; membranes unruptured. Two hours later there was slight discharge of blood. When student was with case the uterus had become more tense, and the patient had become pale; the pulse and temperature were little altered. The case was diagnosticated as concealed hæmorrhage, and so the vagina was plugged and tight binder applied. When this was completed the patient was very collapsed, though she came from under the anæsthetic well, and spoke a little. She rapidly collapsed, and died before transfusion could be carried out. The plugs were removed from the vagina when the collapse occurred thinking there might be some vaginal tear, but there was absolutely none, and the amount of external bleeding was not more than 4 or 5 ozs.

INTERESTING CASES IN THE EXTERN MATERNITY.

CASE I.—M. W., aged twenty-eight, 1-para; delivered of a female child alive on August 24th. Just as head came to vulva patient had an eclamptic fit, and two more followed before delivery was complete. Patient was in bad health during pregnancy. After delivery patient had seven fits within eighteen hours. She was treated by morphin, and sweated by means of hot bottles and blankets; also hot stupes over abdomen and region of kidneys. She passed no urine, and only 1 oz. came away with catheter during the labour. After the stuping the kidneys began to act, and patient slept after the sweating. No more fits occurred after eighteen hours, and patient recovered. There was morbidity for seven days and rapid pulse (110–125). The temperature became normal on eighth day. The uterus was curetted and douched during the puerperium.

CASE II.—J. C., delivered on September 26th of a living child; twenty-four hours later patient developed eclamptic fits, and had 15 altogether; she was comatose for fifty-one hours; very oedematous about the face and both legs. The pulse was never more than 105; temperature up to 100°. She made a good recovery.

CASE III.—B. O'N., 1-para, was in hospital for ten days owing to eclampsia; she had several fits during this time. Albuminuria and oedema of the extremities and face. The child was evidently dead, and the period of pregnancy seventh month. The eclampsia passed off, and the oedema disappeared on low diet and confinement to bed. Patient left hospital, and was confined a month later in the Extern Maternity of a macerated foetus. There was no return of the albuminuria or the oedema at this time. Patient was quite well on the eighth day.

CASE IV.—E. H., 1-para; delivered of a living child on October 26th. On fifth day—temperature 103.6°, pulse 120—the uterus was douched and explored; a mass of firm blood-clot was found adherent to lower uterine segment and removed; the uterus was then curetted and douched and packed with iodoform gauze. The temperature and pulse remained high; douching was done daily. On fifteenth day patient had a rigor; pulse

150, temperature 104.2°; douched, and gauze packing again done. Next day a small hæmatoma of posterior vaginal wall was found. The same condition of pulse and temperature continued for three weeks, when phlegmasia alba dolens developed. This subsided in four days, and the pulse and temperature became normal. Patient discharged well.

CASE V.—B. F., aged thirty, 6-para; delivered October 31st. The child was presenting with the arm prolapsed, the head oblique in iliac fossa. The cord was prolapsed and had ceased to pulsate: therefore delivery was effected by decapitation.

CASE VI.—M. G., aged forty, 13-para; delivered on October 26th of triplets. All were vertex presentations; the third, occipito-posterior. The three children were alive and well when patient was seen on tenth day.

CASE VII.—Mrs. R., aged forty-one, 12-para. Patient considered herself three months pregnant. She had profuse bleeding on December 19th, which ceased; recurred slightly on December 29th, and again ceased. On December 30th patient sent to hospital on account of profuse watery discharge, which had occurred some hours previously. When seen there was very little bloody discharge; the fundus was tender and two inches below umbilicus. The cervix was patulous at external os; the internal was closed. Hæmorrhage being inconsiderable, and the pulse and temperature normal, the only treatment adopted was rest and quiet in bed. On January 2nd hæmorrhage again occurred slight, so the vagina was tamponed. Next day patient complained of pain and vomited. The plugs were removed, and the os admitted a finger; then it was found that the uterus contained a hydatidiform mole. This was broken up with curette and removed; there was very little bleeding, and after douching none, so the uterus was not plugged. Three days later bleeding occurred, so the uterus was again douched and then curetted; very little removed. Patient well on fourteenth day.

CASE VIII.—H. M., aged twenty-two, 2-para. Patient considered herself six months pregnant. She had sanious discharge for a month before being seen. When first seen the uterus was half-way to umbilicus; pain above symphysis complained of. The os was patulous, admitted two fingers, and the vagina was found to contain characteristic parts of a hydatidiform mole.

Intra-uterine amputation of Left Arm above Elbow.

Child.

Child's hands, both alike.

Mother.

Wm H. Archer.

Section showing Myxoma of Chorion in situ. Patient died suddenly before treatment.

TABLE NO. IV.—*Accidental Hemorrhage Cases in Extern Maternity.*

Name	Age	Date	Para	Variety	Treatment	Result to Child	REMARKS
S. B.	29	Dec. 4	4	Ext.	Plugged and tight binder	Dead	6 months pregnant.
J. F.	26	April 26	2	"	Foot brought down	"	Breech presenting; 6 months pregnant; in labour.
M. R.	26	May 2	2	Mixed	Plugged and tight binder	"	Labour followed in 10 hours; clots with child.
K. W.	19	May 4	1	Ext.	"	Alive	Labour in 2 hours; forceps delivery.
M. B.	28	May 8	1	"	None	Dead	Macerated; labour not commenced.
M. B.	—	May 9	3	"	Plugged and tight binder	"	7½ months; labour in 2 hours.
H. H.	43	July 14	3	Int.	"	"	Labour in 4 hours; plugs expelled with child.
M. C.	49	July 11	19	Mixed	"	"	Labour in 24 hours; membranes ruptured; patient delivered herself; 2 quarts of old blood clots, with macerated child.
M. K.	—	Sept. 5	13	Ext.	"	"	Labour soon after; breech presentation.
M. B.	—	Sept. 7	11	Mixed	"	Alive	Plugs removed in 18 hours and replaced; labour followed in 5 hours more; some old clots with child.
— L.	34	Sept. 8	1	Ext	Foot brought down	Dead	Macerated child; foot and arm presenting; patient in labour.
J. F.	—	Sept. 16	—	"	Plugged and tight binder	"	8 months; macerated; plugs expelled with child in 12 hours.
E. W.	36	Sept. 19	9	Mixed	"	"	Labour in a few hours; clots with child.
K. F.	36	Sept. 28	13	Ext.	"	Alive	Plugs removed in 18 hours; no more bleeding; patient delivered herself 2 days later.
— Q.	—	Oct. 12	7	"	Version	"	In labour; also prolapse of cord.
E. D.	—	Oct. 28	6	"	None	"	In labour.
M. D.	37	Oct. 28	11	Mixed	Plugged and tight binder	"	Patient very collapsed; was plugged, but died before delivery could be effected.

In eleven out of a total of seventeen cases the vaginal tampon was used.

The uterus was also filled with this. The pulse was rapid, and temperature 103.6°. The uterus was emptied with two fingers passed in, and when all was removed the walls were lightly curetted with a blunt curette. Hæmorrhage was very profuse during the emptying of the uterus and was difficult to stop, but was controlled by hot douching. The patient made a good recovery, and was convalescent on the fourteenth day.

TABLE NO. V.—*Showing Number and Nature of Cases Treated in the Intern Maternity.*

Total number of cases	- 1,694	Multiple pregnancy—	
Primiparæ	- 576	Twins, viz. :—	
Abortions	- 64	Female	- 10
Deformed pelvis	- 10	Male	- 8
Eclampsia	- 7	Mixed	- 3
Epilepsy	- 3		- 21
Erythema	- 25	Myoma uteri	- 17
Œdema vulvæ	- 4	Aphonia	- 3
Uræmia	- 1	Puerperal ulcer	- 2
Hæmorrhage, viz. :—		Rupture of uterus	- 2
Accidental	- 13	Phlebitis	- 4
Unavoidable	- 7	Operations, viz. :—	
Post-partum	- 28	Cæsarean section	- 1
Secondary	- 1	Forceps	- 60
Hæmatoma	- 2	Induced abortion	- 4
Hydramnios	- 10	Induced labour	- 8
Morbidity	- 146	Manual removal of	
		placenta	- 24
Mortality, infantile—		Perforation	- 3
Macerated	- 32	Version	- 8
Premature	- 11	Diseased infantile conditions, viz. :—	
Putrid	- 1	Anencephalus	- 1
Recent	- 34	Cephalhæmatoma	- 7
Died in Hospital	- 33	Hydrocephalus	- 2
Mortality, maternal	- 9	Ophthalmia	- 2
Mania	- 4	Spina bifida	- 1
		Hare-lip and cleft palate	- 3
		Supernumerary fingers	
		and toes	- 1
		Abnormal Presentations—	
		Breech and Footling	- 47
		Brow	- 2
		Face	- 3
		Occipito-posterior	- 14
		Transverse	- 2
		Prolapse of funis	- 9
		Compound	- 2

INDUCED ABORTION.

CASE I.—H. T., 9-para, aged thirty-five ; admitted March 7th ; four and a half months pregnant. A watery, brownish discharge had been present for some time, so tents were placed in cervix, tampon in the vagina, and a tight binder applied. On the next day these were removed, and the uterus emptied with the aid of Schultze's spoon forceps.

CASE II.—M. V., 5-para, aged twenty-six ; admitted February 23rd suffering from ascites and the usual prodromata of eclampsia ; pulse 120 ; six months pregnant. A vapour bath was given, one bougie passed into the uterus, eight tents in cervix, and tampon in vagina. Pains set in soon after, and in about eleven hours the vagina was emptied, and the uterus expelled its contents.

CASE III.—M. S., aged twenty-six, 7-para ; admitted February 11th ; five months pregnant. Threatenings of miscarriage had been present for several days, and the os was patulous. Some hours later bleeding came on and a vaginal tampon was inserted, and on the next day it was found possible to empty the uterus.

CASE IV.—M. M'D., aged thirty-three, 10-para ; admitted February 11th ; hæmorrhage had been going on for some time ; pregnancy somewhat over three months. Tents and vaginal tampon were used, and later on dilatation was aided by Bossi's dilator, and the uterus emptied.

TABLE NO. VI.—*Application of Forceps.*

Indication	No.	Dead Children	REMARKS
Delay in 2nd stage, with danger to mother and threatened death of foetus - -	48	—	
Threatened rupture of uterus - -	2	—	
Prolapse of funis -	2	—	
Pelvic contraction -	1	—	
Hæmorrhage - -	2	—	
Persistent occipito-posterior - -	3	—	
Rupture of vagina -	1	—	
Eclampsia - -	1	—	
Total, - -	60	—	

SUB-TABLE A.—*Showing No. of Pregnancy.*

I.-para - - -	45
II.-para - - -	7
III.-para - - -	3
IV.-para - - -	2
V.-X.-para - - -	3
Total -	60

SUB-TABLE B.—*Showing Ages of Forceps Cases.*

17-25 - -	20
26-30 - -	18
31-35 - -	14
36-40 - -	8

In many of the cases included under the heading "Delay in Second Stage with Danger to Mother or Child" we had reason to believe the second stage had been prolonged considerably beyond the customary time limit of four hours. We have always been of opinion that there are other and more important indications as to the proper time for terminating the labour artificially. In the case of E. G., 5-para, very troublesome vomiting was present for forty-eight hours before delivery. In three cases rotation took place to such a degree that the forceps was taken off and reapplied. In the case of E. C., aged twenty-eight, 5-para, there was anterior fontanelle presentation, and the shoulders were born in the transverse. In the case of A. B., 3-para, the funis was twice round neck, and so tight that it was tied and cut. Child was born alive. In two instances the hand came down in front of shoulders, and in one the hand was felt lying beside head and was pushed up before forceps was applied. In the case of M. N., 10-para, the foetal heart could not be heard before delivery, though the child was born alive. In seven cases there was *post-partum* hæmorrhage, and manual removal of the placenta was required in three instances. In six cases the child was dead when delivery was effected.

In the Case of K. M., 1-para, aged thirty, much delay occurred owing to early rupture of membranes. Extraction with forceps was easy (the child weighing only $5\frac{1}{2}$ lbs.), and was deemed advisable owing to rise of temperature and escape of the meconium. On the third day, the temperature having again risen, exploration of the vagina disclosed numerous thread-like adhesions between cervix and vaginal walls, some tears in the latter and in the cervix, and offensive discharge. Thorough cleansing of the affected parts and the insertion of iodoform gauze for a few days in succession secured a perfect convalescence on the tenth day.

The history, progress, and treatment of rigid os are well exemplified in the two following cases.

CASE I.—R. B., aged thirty-six, 1-para; admitted August 14th; palpation disclosed a tense, unyielding condition of the uterus; a prominent tense condition of the round ligaments; pain and tenderness to pressure over the fundus. Foetal heart very feeble, and varying from 70 to 120 beats per minute; os = size of a shilling, with hard, thin edges; membranes ruptured; $\frac{1}{4}$ gr. morphin was given.

August 15th.—Hip bath and morphin $\frac{1}{4}$ gr.; dilatation taking place slowly.

August 16th.—Hip bath, hot vaginal douche and morphin; os larger. Foetal heart inaudible.

August 17th.—Os much larger, tightly stretched over head; anterior lip impacted and swollen. Forceps passed inside cervix, and gentle traction exercised, combined with digital pressure upwards on the anterior and posterior lips; when dilatation was nearly completed, perforation was performed (without removing the forceps), and the head delivered. Shoulders impacted; the delivery greatly aided by inserting blunt hook in axilla. Convalescence quite normal.

CASE II.—M. A. M., aged thirty, 1-para; admitted October 1st; membranes already ruptured. Os patulous, and very little labour for some days.

October 6th.—Patient complains of abdominal pain, so a hip bath and vaginal douche were given in the morning, the os being then the size of a crown piece; vaginal douche repeated at 5 p.m. At 8 30 no further dilatation observable; some dirty vaginal discharge is present; the uterus is tense; the pulse 140. Morphin given and repeated in six hours, and sleep procured.

October 7th, 12 30 o'clock.—Forceps passed inside partially dilated cervix, and gentle traction used; but as the advance was very slow perforation was performed as in preceding case, and the delivery of the shoulders much aided by a blunt hook placed in axilla. Convalescence normal.

In a few cases where a rigid perineum appeared to be one of the causes of delay, extraction was much facilitated by opisiotomy. In three cases the uterus was deformed by fibroids, to the presence of which, very probably, inefficient pains were due.

TABLE No. VII.—*Uterine Fibroids.*

Name	Date	Age	Para	Presentation	Duration of Pregnancy	Child	REMARKS
C. M.	Aug. 5	33	VI.	Vertex	Term	A.	Small fibroid on anterior wall of uterus.
A. G.	Aug. 5	35	I.	"	"	D.	Forceps. Two small fibroids in front.
B.M'H.	June 23	40	II.	"	"	A.	Fibroid posteriorly, p.-p. hæmorrhage.
M.M'D	April 4	34	I.	"	"	"	Fibroid at right cornu
H. B.	April 3	35	IV.	Abortion	—	—	Was in hospital with fibroid uterus two years ago, not much increase in size since.
K. C.	April 3	20	I.	Vertex	Term	A.	Fibroid at each uterine cornu, smart p.-p. h.
M.J.S.	Jan. 3	42	I.	"	"	"	Forceps. Large fibroid on left side.
J.M.C.	Nov. 16	38	IV.	"	8 months	"	Fibroid at left cornu.
E.M'D.	Sept. 2	30	I.	"	Term	"	Pedunculated fibroid at fundus.
C. M.	Sept. 17	30	II.	"	"	"	Several small fibroids at fundus.
R. D.	Oct. 21	27	I.	"	"	"	Fibroid on anterior wall.
B. D.	Sept. 8	31	I.	"	"	"	Forceps.
— W.	—	29	I.	"	"	D.	Large fibroid in lower uterine segment; hysterectomy.
M. R.	Jan. 1	37	I.	"	"	A.	Forceps.
A. M.	Oct. 7	30	I.	"	"	D.	Forceps. Fibroid on anterior wall.
E. B.	Jan. 4	38	XII.	"	"	A.	Some p.-p. hæmorrhage
N. M.	Dec. 26	32	II.	Breech	"	"	Both feet brought down

Seventeen cases in all.

In only two of the 17 cases in this table was the tumour of considerable size; in one of these, though it probably weakened the contractile energy of the uterus, no obstruction to the presenting part took place. In the other the growth encroached so much on the area of expansion that I considered it necessary to amputate the uterus above the cervix. The patient, whose case is separately recorded, made an excellent

recovery, and the thinness of the uterine wall in the immediate vicinity of the fibroid shows how justifiable was the proceeding. It is interesting to note that in only three of our cases did *post-partum* hæmorrhage occur.

The diagnosis of pregnancy in a fibroid uterus is sometimes attended with much difficulty, as the following case will show :—

Many years ago a lady from the country consulted me with regard to a large uterine fibroid in anterior wall and fundus of uterus, reaching to the navel. She was forty-one years of age, twelve years married, in excellent health, and had never been pregnant. She did not suffer from pain or menorrhagia, but had recently missed a menstrual period. I advised her to continue without any special treatment; and similar advice was given her by an ex-Master of the Rotunda, who saw her at the same time. She returned to the country, and underwent electrical treatment at the hands of an enterprising local physician; and when vigorous and painful uterine contractions ensued after each treatment, she was comforted with the assurance that these were evidences of great improvement. One morning unusually severe pains set in, and in a couple of hours a healthy infant was born.

In former Reports will be found notes of cases in which each successive confinement was followed by steady diminution in the size of these tumours, while in others no such change was observed. In one case of great interest, pregnancy was attended with such rapid increase in the tumour that I deemed panhysterectomy advisable. A drawing of the uterus with a full account will be found in my Report for the year 1897–8. I think it is interesting to note, taking this table in connection with the similar ones in my former Reports, that—

I.—More than 90 per cent. of the patients affected with fibroids were considerably under forty years of age.

II.—In only a small proportion did *post-partum* hæmorrhage occur.

* Fibroid.

Missed labour in Fibroid Uterus. See Case.

III.—In a small proportion diminution in size of tumours followed or attended pregnancy.

IV.—In a still smaller proportion increased size of the tumours was observed.

The comparative youth of many of our Maternity patients affected with fibroids is, I think, a very interesting fact in connection with the origin and growth of these tumours, and affords some ground for the belief that pregnancy favours their development.

MISSED LABOUR IN A CASE OF FIBROID UTERUS ; SUPRAVAGINAL AMPUTATION ; RECOVERY.

K. W., aged twenty-nine, 1-para ; admitted February 12th. About five weeks previously, when, according to her own reckoning, she had reached full term, foetal movements ceased, and a few days subsequently the breasts became swollen and painful. This sign of the death of the foetus *in utero* I regard as of much significance, though it is not mentioned in any of our text-books. On examination some sanious uterine discharge was observed ; the os was dilated enough to admit one finger, but no presenting part could be reached. Ten laminaria tents were passed into cervix, and a tampon placed in vagina. When they were removed, some hours later, I was able to detect a somewhat flattened fibroid, lying chiefly to the left side, and encroaching on internal os for about one-third of its circumference, as well as half filling pelvic brim. The head could be reached at a considerable height, its descent being plainly prevented by the tumour—an interstitial myoma. The cervical canal was of unusual length, considerably deflected to the right ; and the uterus was tightly moulded round the foetus, and liquor entirely absent. At no time since her admission had the patient felt any labour pains. Having regard to all the conditions present, I determined to remove the uterus, and carried out the proceeding in the usual manner, providing ample peritoneal flaps to cover the cervical stump. Recovery was entirely satisfactory.

The rarity of cases of “missed labour” may be judged from the scanty notices of them in medical literature, and

this is the only instance which has come under my own observation.

I desire to direct special attention to the condition of the internal uterine surface in this case, as shown in the illustration. There is no trace of the projection commonly spoken of as Bandl's ring.

CÆSAREAN SECTION.

M. R., aged twenty-four; admitted to hospital in miserable health. She had been in labour for some hours, and the head was still free above the pelvic brim. Cæsarean section was performed the day after her admission. For a few days her pulse was very rapid, but apart from this convalescence was uneventful. The child was in very good health at time of leaving hospital.

CONVULSIONS.

During the year twelve patients suffered from convulsions. Of these, three were ordinary epileptic seizures, and in the remaining instances puerperal eclampsia was diagnosticated.

CASE I.—C. M., aged twenty-two, 1-para; had been in labour several hours, the breech presenting, when an epileptic fit of the ordinary type occurred, and made it expedient to hasten delivery, which, accordingly, was effected, and a living child extracted. A small dose of morphin was given, and there was no recurrence.

CASE II.—S. D., aged twenty-three, 1-para; had an epileptic fit a few minutes after delivery; no recurrence.

CASE III.—M. C., 1-para; delivered on October 4th at full term; had an epileptic fit of the ordinary type on the 7th; no recurrence.

ECLAMPSIA.

The cases of eclampsia were as follow:—

CASE I.—C. D., aged twenty-eight, 2-para; admitted on the 11th and delivered on the 13th of August, in the eighth month. She had been in bed for some days suffering from pain in back and head, constipation and sickness. No foetal movements for three weeks. Some hours after a convulsion she was admitted

to hospital, the limbs being much swollen, and the urine highly albuminous. Morphin ($\frac{1}{4}$ grain) was administered, and a vapour bath for thirty minutes. No more fits occurred, and on the following day patient delivered herself of a stillborn child. On the following day two more fits occurred, after which the patient became somewhat hysterical, but relief and improvement again followed the injection of morphin, and the subsequent course of the puerperium was satisfactory.

CASE II.—E. E., aged twenty-seven, 2-para; admitted May 4th, in an unconscious state, with a history of having had several fits. Her pulse was then 96, but soon rose to 110, and the temperature to 100° . The fits increased in frequency, the interval sometimes being only a few minutes; the increase in their duration was more remarkable, some of them lasting from ten to twenty minutes, though not violent in character. The injection of morphin and other measures used had no beneficial effect, and the patient expired about fifteen hours after admission to hospital, the temperature rising to 110° just before death. The size of the uterus was that of a six and a half months' pregnancy, and the urine was highly albuminous.

CASE III.—A. F., 1-para; admitted February 4th; eight months pregnant; unconscious, and suffering from frequent fits, which had begun at 4 a.m., and at time of her admission were coming at intervals of seven and eight minutes. There was apparent improvement after injection of morphin, as an interval of one hour and twenty minutes occurred, followed by two at intervals of half an hour. I then thought it wise to try the effect of bleeding, and one pint of blood was allowed to flow, followed by the transfusion of two pints of saline solution. An hour after this was done one fit occurred, at six o'clock p.m. Digitalin ($\frac{1}{30}$ gr.) was given, and the patient's aspect improved. At seven o'clock another fit, shorter and less severe than any that preceded it, but our efforts to re-establish respiration were unavailing, and after two short gasps she expired. We were informed that she had been subject to epileptic attacks from childhood, and that at the time of quickening a convulsion had occurred.

CASE IV.—C. G., aged twenty-nine, 1-para; admitted September 11th. Two hours after an easy labour patient had a fit, and

during the succeeding twelve hours two more. The urine was very albuminous. Morphin ($\frac{1}{4}$ gr.) was given twice, followed by aperient medicine, and a satisfactory convalescence ensued.

CASE V.—B. O’N., aged thirty-five; admitted September 11th. Previous to admission patient had eight fits, and morphin ($\frac{1}{2}$ gr.) had been given. She was at time of reception into hospital comatose. A vapour bath was immediately given, but the skin did not act well. Croton oil and turpentine enemata were administered. Urine nearly solid with albumen. A long sleep followed, without any return of convulsions; the bowels were freely moved; the quantity of albumen present in urine speedily grew less, and she left the hospital soon after. She has since been safely delivered in the Extern Maternity.

CASE VI.—B. F., aged nineteen, 1-para. Patient was suffering from cedema of face and legs when admitted, but did not complain of anything. When the head was visible at the vulva an eclamptic fit occurred, so chloroform was speedily administered and labour completed. Some hours later a second fit occurred; patient was given a vapour bath, and convalescence was soon established. The urine was loaded with albumen.

CASE VII.—K. S., aged thirty-seven, 7-para; admitted on October 6th suffering from much swelling of face and limbs and highly albuminous urine. Two days later a great headache was complained of and relieved by vapour bath. On the next day a fit occurred. Morphin was given, and another vapour bath, which again relieved, and was followed by increase in the amount of urine. She continued in somewhat the same condition for a few days, when labour set in. She was safely delivered of a macerated foetus, and made a good recovery.

CASE VIII.—J. D., aged twenty-eight, 5-para; was seen in the Extern Maternity, and was reported to have had two fits. She gives a history of several fainting fits in a former pregnancy. The patient’s aspect was bad, the limbs were swollen, and there was a large quantity of albumen in the urine. The usual precautionary treatment was adopted, and she was delivered of a dead child on the day following her admission.

CASE IX.—In the case of M. F., aged thirty, 2-para, the fits were somewhat anomalous in character and in their sequelæ.

Patient passed through an easy labour on March 24th, but had a rise of temperature on third day, for which a uterine douche was given. On March 29th patient had a fit, accompanied by involuntary escape of urine, and subsequently the right side of the body showed clonic movements. She regained consciousness, but talked wildly and incoherently, and tossed herself about very much. In three hours later there was another fit having very much the character of an eclamptic seizure. When coma had passed off, the right side again showed inco-ordinate movements. Hyoscin hydrobromide was given, and sleep and rest secured, followed by a normal convalescence. The urine contained pus and granular casts.

URÆMIA.

To the foregoing I desire to add the record of a case in which I believe uræmia was the cause of death, though the general aspect and condition of the patient suggest an affinity with those just recorded:—

M. O., aged thirty, 5-para; six months pregnant; had been complaining during the day (May 30th) of headache and vomiting, and about 9 30 p.m., without any convulsion, she became suddenly unconscious, and did not subsequently recover from this condition. About one hour later she was admitted to hospital in a moribund condition, respiration so failing as to need frequent stimulation, and aspect very bad. A vapour bath was tried, but sweating did not follow its use. Faradic stimulation was also tried, and then I allowed about fourteen ounces of blood to flow from her arm, and then practised transfusion of saline solution. Death followed soon after. The pulse all through remained below 100, and at first was full and of good volume; temperature remained normal. She had been pregnant five times, and in the four preceding pregnancies had aborted at the third month. Though no œdema was observable the urine was loaded with albumen.

I have mentioned these cases somewhat in detail, as I believe their importance warrants, and because there is no obstetrical complication regarding which so much has been

written and so many theories propounded. Though venesection did not benefit the cases here recorded, I think it a measure worthy of more general adoption and practice, as it is not contra-indicated by any theory ; and in the last century, when for a long period it was the almost invariable practice (chloroform and morphin being still unknown), recovery, even in severe cases, was by no means infrequent. Ample evidence of this I have found on reading over records preserved by former Masters of the Rotunda. The importance of hastening and facilitating the emptying of the uterus in these cases can scarcely be over-estimated. I am not yet convinced of the wisdom of trying to secure this object by indiscriminate forcible dilatation of the cervix.

During the earlier years of my Mastership the treatment by morphin secured such good results that our mortality was about 7 or 8 per cent. Our diminished success in later years is, I believe, mainly due to the greater severity of the cases.

MANIA.

Four patients became affected with mania ; in three it was of a mild type, and in one it was associated with paraplegia.

CASE I.—M. M., aged thirty-seven, 1-para ; passed through a short labour, lasting only eleven hours, but was quite maniacal for a short time before and during the passage of the head over the perineum. No recurrence subsequently.

CASE II.—N. L., aged twenty-nine, 1-para ; delivered naturally of a very small child after a short labour attended with some bleeding during the second and third stages. Placenta required manual removal. On the third day (pulse and temperature both normal) she became noisy and troublesome, and refused food. However, with some persuasion the food was taken, also some medicine, and in four days she was quite right again.

CASE III.—S. H., aged twenty-four, 4-para ; went through an easy labour safely. Five days afterwards she became sleep-

less, affected with delusions and loss of sleep; refused food. Morphin was given, also hyoscin, with some benefit, and soon after leaving hospital she became quite well.

CASE IV.—M. R., aged twenty-four, 1-para; unmarried. Patient complains of loss of power in both legs, which came on gradually, with an attack of retching, three days before admission. April 26th.—She is quite unable to stand. Abdominal palpation proved to be useless owing to rigidity of muscles. April 28th.—There is incontinence of urine and fæces, and patient states she is unable to move her legs. The plantar reflex is very badly marked in both feet; the patellar reflex is well marked, and there is sensation in both legs. No ankle clonus observable. April 29th.—Patient has occasional vomiting, and can retain food only in small quantities. April 30th.—Labour has started to-day, and the pains which were very feeble before rupture of the membranes soon after increased, and in less than two hours afterwards child and placenta were born without any trouble. The rigidity of abdominal walls before observed continued after conclusion of labour. May 1st.—No improvement in motor power. Patient complains of lancinating pains in both legs; the left plantar reflex is a little more marked, but not the right; wasting of muscles is observable. May 3rd.—Patient has a marked elevation of temperature in the evening without obvious cause. There is still incontinence of urine. May 5th.—During the night or early morning patient has had a violent hysterical attack, being very noisy and abusive in language. She has also had an hysterical fit, with muscular spasms in face and one arm, but not losing conjunctival reflex. Morphin and bromide were given. May 6th.—Patient was quiet during the night, but in the morning had another noisy fit, lasting two hours, after which she became quiet and rational. The catheter is passed twice daily and no dribbling of urine occurs. May 7th.—Refused food during early part of day, but took it in the evening. May 8th.—Has been quite insane all day; is very obstinate and refuses food; has been singing and incessantly throwing her hands about. May 15th.—Remains in much the same condition; sometimes noisy and troublesome, and sometimes refusing food; transferred to North Dublin Union.

TABLE NO. VIII.—*Prolapse of Funis.*

Name	Age	Para	Date	Period of Pregnancy	Result to Child	Presentation	REMARKS.
E. C.	30	III.	July 9	Full	D.	Vertex	Forceps
M. W.	25	V.	June 5	„	A.	„	Version ; reposition, in genu-pectoral position, tried without success
E. D.	25	I.	„ 18	„	A.	„	Expression
M. M.	42	IX.	Apl. 26	„	D.	„	Version
A. F.	22	I.	Feb. 2	„	A.	„	High forceps
S. L.	34	XIII.	Jan. 26	6½ months	D.	Hand & head	—
E. D.	32	VII.	„ 2	„	A.	Hand and vertex	Replacement, recurrence, expression
M. D.	30	I.	Dec. 16	7 months	D.	Breech	Anencephalic foetus and hydramnios.
N. M'C.	32	II.	„ 26	Full	A.	„	Both feet brought down
M. C.	24	I.	Sept. 6	„	D.	Vertex	Bipolar podalic version

Ten cases in all.

Prolapse of funis being a complication of labour fraught with peril to the foetus, the results of our treatment, as shown in the accompanying table, may be regarded as satisfactory.

In the cases of S. L. and M. D. the birth of a living child was not to be expected.

In the case of E. C. the head was on the perineum when the prolapse was discovered, and in the genu-pectoral position reposition of funis was effected and forceps afterwards applied. The heart was still beating at time of birth, but respiration could not be established.

In the case of M. W. prolapse immediately followed rupture

of the membranes, and when reposition was tried without success rapid delivery by version was effected.

In the case of A. F., 1-para, a large loop of cord was found protruding from the vulva at time of admission, the head being still at brim. The os being fully dilated, the forceps was applied, rotation taking place during extraction, and a living child was born.

S. L., in her 13th pregnancy at thirty-four years of age, was admitted in the 7th month, a loop of funis, pulseless, protruding beyond the vulva, while the head and one hand could be felt just inside os. The patient was put under chloroform, and Bossi's dilator passed into cervix and expanded to 10°. At this point the head easily fitted between the blades, which, by a reverse movement, were made to grasp and extract it.

M. D., 1-para, was admitted suffering much pain from hydramnios. When some pints of liquor amnii had escaped a loop of funis was found prolapsed and pulseless; labour was expedited by pressure. The child was anencephalic and affected with spina bifida.

In the case of E. D., 7-para, head, hand and cord were presenting. Membranes ruptured during examination. The hand was easily pushed up, but the cord became prolapsed, and, after an attempt to replace it, pulsation ceased. The head was then pushed up and pulsation again became perceptible, and an attempt to push the cord over brow of child was successful. As the head descended, however, another prolapse of cord occurred, but by vigorous pressure on fundus labour was completed and child easily resuscitated.

In the case of E. D., aged twenty-five, 1-para, as the head appeared on the perineum, a loop of the funis appeared in front of it. Pressure was made on the fundus, and the head delivered quickly, child being alive.

TABLE No. IX.—Cases of Contracted Pelvis.

Name	Age	Para	Pelvic Measurements					Mode of Delivery	Result to Child	REMARKS
			C. V.	Trans.	Ext. C.	I.-C.	I.-S.			
E. F.	38	II.	8.5	10.5	—	—	—	Natural	Alive	In 8th month ; labour induced.
E. B.	37	IV. ^a	—	—	—	—	—	Natural	Alive	Labour induced.
M. K.	40	XIV ^a	—	—	—	—	—	Natural	Alive	(7th time) Labour induced.
M. C.	39	XIV ^a	—	—	—	—	—	Version	Alive	Labour induced.
M. R.	29	II.	7.25	10	—	—	—	Forceps	Dead	Labour induced.
M. Q.	26	II.	—	6.75	15.5	25	20.5	Natural	Alive	Labour induced.
T. C.	30	V.	—	—	16.5	28	25	Natural	Alive	Labour induced.
M. M.	30	VI	9.6	10.5	17.5	27	24	Natural	Alive	Labour induced.
M. C.	24	I.	7	—	—	—	—	Version	Dead	Funis prolapsed.

^a See former Report.

CONTRACTED PELVIS.

Amongst the forceps cases were three, in which, from difficulty in delivery, some pelvic contraction seemed highly probable; in two of these narrowing of the pubic arch was observed. Attention may be directed to the two cases, M. K. and M. C., aged respectively thirty-nine and forty, both in their 14th pregnancy, and both of whom have gone safely through induced premature labour on seven occasions, a living child being secured in nearly every instance. In several of these cases I tried to start uterine action by placing tents in cervical canal and a tampon in vagina, and sometimes a tampon of gauze in cervix, but subsequently I found it necessary to pass bougies into the uterus.

Their action was supplemented by 5-gr. doses of quinine; and on many occasions by the application of the interrupted current, which seldom failed to cause pains, though not always permanent in character.

The case of M. R., aged twenty-nine, 2-para, illustrates forcibly the difficulties and uncertainty which often attend our efforts in such cases. Her first delivery was effected by forceps, and the child was stillborn. When she had reached the eighth month in the second pregnancy, on April 8th, two bougies were passed into the uterus and ten laminaria tents into the cervical canal, the vagina at the same time being lightly tamponed. In about twelve hours pains set in, and were stimulated with faradic current, and became fairly strong. Thirty hours after their introduction, tampon, tents and bougies were removed, and, as there was hydramnios, membranes were ruptured. April 10—os very imperfectly dilated. Sagittal suture can be felt close to pubis. At 11 o'clock p.m. same day, forceps was passed within cervix and traction used for half an hour, but very little descent of head or retraction of cervix was effected, and I thought it safer to desist. The next morning, April 11, the cervix was

entirely retracted and the head visible on separating the labia. Even then considerable traction was requisite to complete delivery. The foetal heart was beating at time of birth, but respiration could not be established. A considerable experience in these cases has convinced me that no one stimulus to uterine action is entirely reliable ; and this uncertainty as to the behaviour of the uterus constitutes at once the chief source of danger to mother and child and of our anxiety as to the issue of the case. As I have observed in a former Report, a patient who has gone through one successful proceeding of this kind has, for this reason, a favourable anticipation which greatly helps her under similar circumstances.

MULTIPLE PREGNANCY—TWINS.

Male and Female	..	..	..	..	3
Both Male	..	..	..	..	8
Both Female	..	..	..	..	10
Both Vertex	..	..	..	..	15
Vertex and Breech		..	..	..	3
Breech and Vertex		..	..	..	2
Both Breech	..	..	..	..	1

In one instance the first child presented occipito-posterior ; the second, complete breech. One compound presentation was met with (head, cord and hand). As reposition failed, podalic version was performed ; both children were born alive.

Persistent occipito-posterior presentation of first twin occurred in the case of F. T., 1-para, and owing to delay forceps was applied, the os being still imperfectly dilated.

In the case of B. S., primipara, aged twenty-seven, both children presented by the breech ; but the first lay so obliquely at brim that it was necessary to bring down a foot ; the second was spontaneously expelled, and both were alive. The second sac was hydramniotic.

In the case of B. R., 2-para, who was suffering from mitral

valve disease, some accidental hæmorrhage preceded the birth of the first child.

BREECH AND FOOTLING PRESENTATION.

During the year fifty cases of presentation of the lower pole occurred, in thirty-five of which a living child was born. Of the stillborn children, nine were macerated, six were lost owing to difficulty in delivery of the arms and head. Four were complicated by maternal hæmorrhage and eclampsia. Four of the macerated and three of the living children were delivered by natural efforts, without any assistance.

MANUAL REMOVAL OF PLACENTA.

This proceeding was found necessary in twenty-four instances. Seven of the patients were 1-paræ; six suffered from elevation of temperature subsequently, and of these one, I greatly regret to record, died of acute sepsis in two days. The history of the case is as follows :—

B. W., aged twenty-six, 1-para, was admitted on February 5th, and was delivered naturally after a labour lasting thirteen hours. When the third stage had lasted forty-five minutes, and on examination the os was found closed, two fingers were passed into the uterus, and the placenta was found to be firmly adherent to anterior wall; its removal was not attended with much loss. The patient had a swelling under the right arm in front, which ran into the axilla and down to the upper lateral margin of right breast. The swelling, though not red, was very painful. In the evening of February 6th aperient medicine was given as temperature was 103°. Some vomiting followed, but with the aid of morphin she slept, and on the morning of the 7th the temperature was 98°. She took nourishment during the day, but in the evening at 6 o'clock her temperature had fallen to 96.6°, and the pulse had become weak and rapid. At 10 o'clock p.m. she was cold and pulse imperceptible; complaining of pain in back and head; respiration 30; tongue clean; abdominal conditions normal. Strychnin was given hypodermically, followed by a transient improvement, but the patient presently became

restless, difficult to manage, and inclined to shout noisily. Later she got an injection of morphin with strychnin, which was followed by some rest. At 2 o'clock a.m. patient had a fit consisting of a distinct preliminary stage lasting about one minute, followed by tonic and clonic convulsions. A condition of coma ensued which lasted until death about one hour later.

While I cannot help regarding sepsis as the chief cause of the rapid and disastrous ending of this case, I confess myself unable to explain many of its details, for which I can find no parallel in my own experience.

One of the patients dealt with in this section required manual removal of the placenta in all her labours—five in number.

ACCIDENTAL HÆMORRHAGE.

During this year no case of severe accidental hæmorrhage came under treatment. But I desire once more to point to the results which we have obtained in this and in former years by the judicious use of the vaginal tampon, which controls bleeding, and in a few hours initiates uterine action, the absence of which forms the chief source of danger to the patient's life. This mode of treatment is not a new suggestion; it is fully described in Spiegelberg's admirable treatise on obstetrics, as well as the risk (which I believe to be greatly exaggerated) of internal bleeding following its adoption. But it is not too much to say that the teaching and practice of it as carried out in the Rotunda Hospital mark a very important epoch in the successful management of this most formidable complication of labour, and the results shown in our Reports furnish evidence in its favour which no intelligent obstetrician can afford to disregard.

TABLE NO. X.—*Accidental Hæmorrhage.*

Name	Age and Para	Date	Variety	Treatment	Result to Child	REMARKS
1. M.J.G.	27, VI.	July 25, 1903	Mixed	Tampon	Dead	Local signs of bleeding before it became visible; more than 1 lb. of clot with placenta.
2. E. C.	30, IV.	May 4	External	—	Alive	Bleeding before admission. Delivered naturally.
3. R. M.	30, VI.	Mar. 5	Mixed	—	Dead	Delivered naturally.
4. K. K.	24, II.	„ 12	„	Rupture of membranes	„	Six months' pregnancy; temp. on admission 95.2° F.
5. E. F.	36, VI.	„ 26	„	„	„	Uterus persistently tense, and foetal parts impalpable some hours before delivery.
6. M. C.	30, VIII.	Feb. 1	„	„	„	—
7. A. T.	26, IV.	Nov. 22	External	Forceps; rupture of membranes	„	Head free above brim, so that lock of forceps was within vulva.
8. E. M'A.	33, I.	„ 27	„	Forceps	Alive	Placenta degenerated.
9. E. M'D.	39, III.	Sep. 10	„	Tampon	Dead	6½ months' pregnancy.
10. C. M.	28, VI.	„ 16	„	„	Alive	6½ months' pregnancy.
11. E. K.	29, IV.	Jan. 17	Mixed	—	„	Fatty degeneration of placenta. Child syphilitic. Delivered naturally.
12. C. H.	26, V.	Nov. 26	Concealed	—	„	Delivered naturally; large retro-placental clot.
13. B. R.	25, II.	Sept. 4	External	—	—	Twins; macerated; smart <i>ante-partum</i> bleeding.

POST-PARTUM HÆMORRHAGE.

We have to record nine cases of severe *post-partum* hæmorrhage, and amongst these I grieve to add one ended fatally—the only death from this cause which occurred during my Mastership:—

The patient E. M., aged twenty-one, 2-para, was admitted, apparently in good health, on February 16th, and labour was completed in about eleven hours unaided. The third stage was very short, only five minutes, and was followed by considerable bleeding, which ceased when some portions of membrane were removed by curette and hot douche. The uterus contracted feebly, and twice ergot was administered and the binder applied. About twenty minutes later there was some return of bleeding, and rapid collapse set in, to avert which injections of ether and strychnin, followed by saline transfusion, were unavailing, and death occurred about two and a half hours after delivery.

E. B., aged thirty-three, 8-para, was admitted on July 12th. Labour was unaided, though very slow, during the first stage especially, and attended with so much suprapubic pain that morphin was twice administered hypodermically. The third stage was of moderate duration and unattended with hæmorrhage. About two hours later considerable loss of blood occurred, and it continued after some clots had been expressed and good uterine contraction established. The vagina was explored, and a rent in the anterior vaginal fornix was found. A very hot uterine douche was administered and the vagina tamponed. The patient was very prostrate for some hours, but a very good convalescence, without pyrexia, followed.

Secondary hæmorrhage occurred on the fourteenth day after delivery in the case of M. H., aged twenty-six, 3-para, who had passed through a normal puerperium, and had left the hospital on the eighth day. When the bleeding occurred she was re-admitted, and, on examination, a sessile tumour, with broad base, was felt by the finger projecting from anterior uterine wall. A hot douche and light use of the curette were followed by rapid restoration to health.

Concealed *post-partum* hæmorrhage occurred two hours after delivery in the case of M. R., aged thirty-six, 5-para.

The third stage had lasted only eight minutes. The usual treatment was successfully used. In two instances marked retroversion occurred soon after delivery, attended with troublesome loss, which ceased when the uterus was douched and replaced. Marked hypertrophy and prolapse of cervix was observed in two cases, attended with moderate *post-partum* bleeding.

In the case of M. M., 1-para, aged twenty-two, troublesome bleeding occurred from a rent in the vestibule, where a spouting vessel was observed; it was controlled by passing a ligature under it.

Irregular contraction of the lower uterine segment, causing retention of placenta, was attended with considerable loss in two cases. In six cases calling for manual removal of the placenta some *post-partum* bleeding took place; and seven cases of forceps delivery were complicated with *post-partum* hæmorrhage. In many of these cases bimanual massage of the uterus proved to be of great use in restoring efficient contraction.

MORBIDITY.

Morbid temperature occurred in two cases of *post-partum* hæmorrhage, in five of manual removal of placenta, in two cases of abortion, in three breech cases, in two cases of fibroid uterus, in eleven forceps cases, and in four cases of *ante-partum* bleeding. Of the patients under the first heading—viz., 100.8°–101.2°—twenty showed one rise of temperature during an otherwise normal puerperium, and no treatment was adopted. In two there was a very protracted first stage, owing to rigid os. One was a case of accidental hæmorrhage, and the rise occurred only on 11th and 12th days; one was a case of delay with hæmorrhage in third stage, requiring manual removal of placenta. Highly albuminous urine was present, with œdema of abdominal walls in one case. In two cases the nipples were cracked and painful, and in another a

bruised unhealthy state of labia, attended with non-union of perineum, was present. In a few others a uterine douche was sufficient.

Between 101.2° – 102.2° there were nineteen cases, in which one rise occurred, but there was no need for treatment. In fifteen the uterus was douched and curetted, generally with the result of removing some unhealthy contents. In one a macerated breech presentation had occurred; in one the vaginal wall presented a deep tear. In a case of placenta prævia influenza was the cause of temperature. In a case of hydramnios, with œdema of limbs and albuminous urine, the temperature ran up on the 14th, 15th and 16th days, and the uterus was drained with iodoform gauze.

Between 102.2° and 104° there were five cases in which one rise occurred and no treatment was needed. Two cases of *ante-partum* hæmorrhage were douched, curetted and drained with iodoform gauze. Two cases of forceps delivery were douched and curetted. In twenty-six cases, including one of breech presentation and two in which manual removal of placenta was necessary, douching and curetting were adopted, followed by speedy convalescence. In one case (elsewhere detailed) death occurred on the third day. One case had been delivered in the lift. Mastitis was present in four cases. In two others bronchitis and pneumonia respectively. In another fits of an anomalous character occurred between 4th and 10th days of the puerperium; the urine contained albumen, pus and blood.

Of the cases which reached 104° and over, two were cases of mastitis, one ending in suppuration; two were cases of decidual endometritis, in one case associated with acute pulmonary phthisis, which ended fatally in four weeks (patient unmarried). In one (see elsewhere) a rash closely resembling that of scarlatina developed on the fifth day, and was followed by desquamation and recovery. One patient who required

forceps delivery was much troubled with vomiting during and after labour, but made an excellent recovery. One patient who had suffered from concealed *post-partum* hæmorrhage developed a temperature of 104.5° on the 10th day, up to which time it had been normal; treatment was followed by rapid convalescence. In five cases a very high range of temperature was present for several days; in one of them very loaded bowels, and in another a labial abscess, helped to delay recovery, which, however, followed slowly in all of them. One other case (described in detail) was suffering from physometra and stinking uterine discharge at time of admission, and died on the 8th day.

Mastitis was present in one case on the 7th day. Puerperal ulcer was found in one case. One patient on 13th day and two following days had a rigor, with a swollen, painful state of breasts, and this has happened to her in every confinement. Beyond giving 5 grains of quinine nothing was done. Chronic phthisis was present in one case. Retained offensive lochial discharge caused one elevation in one instance. One elevation of temperature occurred after manual removal of placenta in a case where a macerated foetus presented by the breech. Two elevations of temperature followed by speedy convalescence were due to retention of portions of placenta, giving rise to sapræmia and foul, profuse lochia; removal effected by curette and fingers. Five of the patients in this section were delivered by forceps, two of them being cases of persistent occipito-posterior; one a case of twins, in which the second twin was macerated; and one a case of fibroid uterus. In very few of the cases in this section did the abnormal temperature last more than 2-4 days.

CAUSES OF HIGH TEMPERATURE, OTHER THAN SEPSIS.

Mastitis	Bronchitis	Phthisis
Influenza	Pneumonia	Scarlatina (?)

TABLE NO. XI.—*Morbidity.*

Temperature	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Total
100.8° to 101.2°	1	4	1	2	5	1	1	2	3	8	1	9	38
101.2° to 102.2°	6	3	5	4	2	3	5	5	4	9	5	4	55
102.2° to 104°	1	1	3	3	8	2	4	4	—	8	7	—	41
104°	1	1	2	—	2	—	—	1	1	1	2	1	12
Total per month	9	9	11	9	17	6	10	12	8	26	15	14	146
Percentage per month	7.5	6.4	8.5	7.5	12.9	4.6	7.4	8.2	4.6	17.3	9.4	9.1	

TABLE NO. XII.—*Placenta Prævia.*

Name	Age and Para	Date	Variety	Presentation	Period	Result to Child	REMARKS
1. M. G.	22, III.	Aug. 10	Marginalis	Head	Term	A.	Several bleedings during fortnight before admission; tampon used and vigorous labour pains followed.
2. L. H.	31, VIII.	July 16	Centralis	„	„	D.	No bleeding for some hours after admission; when os was wide enough to admit two fingers podalic version was performed.
3. C. L.	35, IX.	„ 2	„	Breech	7 months	D.	Placenta required manual removal owing to hæmorrhage.
4. A. M'C.	32, VII.	May 2	Marginalis	Head	7 „	D.	Podalic version.
5. M. S.	32, V.	Feb. 4	Lateralis	Breech	Term	A.	Much difficulty in delivering head, as face was anterior.
6. M. W.	38, VII.	Sept. 2	Marginalis	„	„	A.	Tampon used and foot brought down.
7. A. H.	44, IX.	„ 24	—	Head	8 months	D.	Podalic version.

Cephalhæmatomata.

As in the two preceding years, our cases of placenta prævia during this year are free from any maternal fatality. The cases for the three years number 32.

ABORTION.

The cases of abortion and miscarriage were over 60 in number, and in two instances there was an insignificant rise of temperature. In eighteen cases no treatment was needed ; in eight the bleeding was severe. Retroversion was observed in two cases ; and in three a complete decidual cast was found. It is not a little surprising how uncertain and timid most modern obstetric writers are in giving instruction as to the treatment of inevitable and incomplete abortion and miscarriage. Masterly inactivity on the part of the physician cannot be too strongly condemned in these cases.

HYDRAMNIOS.

This condition was present in six cases. In one the foetus was anencephalous, and affected also with spina bifida. In one spontaneous version occurred shortly after the escape of the liquor amnii. In Williams' recent work on obstetrics it is dogmatically stated that this interesting process can take place only before the rupture of the membranes.

ERYTHEMA, WITH HIGH TEMPERATURE.

B. B., aged twenty-one, had an easy, natural labour. On the third day the temperature reached 102° , and the pulse 108 ; the uterus was douched and curetted ; nothing abnormal was found. On the fourth day the temperature was again normal. On the fifth evening the temperature was 103° , pulse 110 ; slight headache ; uterine douche again revealed no cause for the symptoms. On the sixth morning the face was flushed, the eyelids somewhat red, and a scarlatiniform rash was evident on the legs, extending up the body, and visible over the sternal region ; nausea, slight retching, and sore throat were complained of ; though the lochial discharge had been all through healthy, another uterine douche was given as a precaution. Temperature varied between 105° and

103° for a few days, and became normal on the twelfth day. Between the seventh and eleventh days the patient was delirious, and urine and fæces were passed involuntarily. Nephenthe, hyoscin, and bromides were found beneficial at this time. A few pustules appeared on the buttocks about the twelfth day, but soon dried up. On the seventeenth day desquamation began. The urine between the ninth and eleventh days was slightly albuminous. Further convalescence was uneventful. See "Morbidity."

CRANIOTOMY, PHYSOMETRA, COMPOUND PRESENTATION, ADHERENT PLACENTA, MANUAL REMOVAL—DEATH.

M. G., aged twenty-nine, 3-para; admitted with a history of having eight days previously fallen off the tram; the membranes ruptured shortly afterwards. On examination, the os was found closed, cervix unobliterated, and presenting part not fixed. As there was no evidence of labour she was allowed out, but returned next day having a temperature of 103°, though the pulse was quiet. On examination a foot was found protruding through an imperfectly dilated os, and lying at pelvic brim what was at first thought to be the breech, but proved to be the head. Chloroform was given, and as early escape of liquor amnii rendered version impossible, and an undilated os prevented the application of forceps, delivery was effected by the aid of the perforator and cranioclast. The placenta was morbidly adherent, and required manual removal. It should be added that a putrid discharge was pouring from the uterus all this time. The utmost efforts were made during the following days to restore the uterus to a healthy condition, but douching, packing with iodoform gauze, &c., were all unavailing to prevent death, which occurred on the eighth day.

PRESENTATIONS OTHER THAN VERTEX.

In twelve cases of persistent occipito-posterior presentation the birth of a living child took place unaided. Two brow and three face presentations ended also in the birth of a living child, unaided.

RUPTURE OF UTERUS.

K. G., aged thirty-five, 8-para; admitted on December 27th at 3 30 o'clock p.m. Patient has had a cough for

several months; rhonchi and râles can be heard all over chest; tubular breathing in lower lobe behind on the right side. Some days previously she had been visited by a pupil, who noticed the chest trouble, but as there was no sign of labour, did not continue to visit her. So far as could be ascertained abdominal pains, attended with retching, had begun on the 25th, but she continued to do her household work on that day. On admission she looked very ill, vomited occasionally dark brown fluid; the respirations were rapid, pulse 124, temperature 98.8°. The urine contained a large quantity of albumen. She slept for two hours after an injection of morphin. On palpation the abdomen was found to be very tender and flaccid; the foetal parts could be felt with unusual distinctness, especially at the fundus, where the cranial bones were felt and heard to crepitate. Per vaginam the cervix was felt to be long and imperfectly dilated; the placenta could be detected in front and low down, attached all round except at left side. I thought I felt a rent in the wall of the uterus, through which the foetus had escaped into the general peritoneal cavity, but the condition of the cervix and the presence of the placenta made an exact opinion very difficult. With much trouble I reached a foot, which was very high up, and brought it down into the vagina. Some hours later the pulse was 120, temperature 100.6°; no vomiting had occurred since. Chloroform was given and delivery completed. The placenta was detached and drawn down by the funis. The uterus, fairly contracted, lay to right of mesian line; a deep longitudinal tear was felt extending up from junction of vagina and cervix for a considerable distance. The intestines were not perceptible. After copious douching, iodoform gauze was placed in rent and partly in uterus and vagina. Strychnin and digitalin were given hypodermically, but to no purpose, and the patient died about four hours later.

Though I do not believe any treatment could have saved this poor woman's life, I freely admit the rational treatment, at any rate by daylight, would have been to deliver by abdominal section, followed by either removal of the uterus or an attempt to repair the rent.

Other questions of great interest in this case are :—(1) What

caused the rupture ? and (2) When did it occur ? So far as I know the previous labours had not been difficult, and there was no ground for suspecting pelvic contraction. There was no history of violent pains during the few days preceding her admission ; nor of any traumatism arising from a fall or a blow. As to the time of its occurrence, I should conjecture that it was probably twenty-four hours before she came into hospital.

RUPTURED VAGINAL FORNICES.

M. C., aged thirty-five, 7-para ; admitted January 20th, 1903, shortly after midnight, with a history of the membranes having ruptured on the previous day. The os was dilated sufficiently to admit one finger, and the head could be felt lying on the pelvic brim, but not engaged in the cavity ; foetal heart 144. She was having occasional pains of moderate strength ; she was given 30 drops of laudanum. Some hours later, as she did not appear to be making advance, an examination was made ; the os was found to be two-thirds dilated, the head still lying at the brim. She was now having good pains, and, as the progress of labour was so slow, it appeared wise to give her some assistance, especially as the high position of the hand rendered it very difficult to make out exactly its position. Though the patient's pulse had become somewhat quicker, the foetal heart was the same as before, and between the pains the uterus was quite relaxed. At 3 o'clock p.m., just before the administration of chloroform, I palpated the belly, and was shocked to find that the foetal parts could be felt with startling distinctness, and on again listening for the foetal heart it could not be heard. No complaint of unusual pain had been made, and nothing in her aspect suggested the terrible lesion which had thus so suddenly occurred. Internal examination showed that the head was on the perineum. Delivery was immediately effected with the forceps, and was followed by moderate bleeding ; the uterus became perfectly contracted. As the placenta did not come away, the hand was passed into the vagina, when it was found that the right and anterior vaginal fornices were torn through, and the hand passed up between the layers of the

broad ligament. When the left side was explored it was found that the peritoneal cavity was opened, and the placenta was lying in it. After its removal iodoform gauze was passed into the rent and some left in the vagina. At this time the pulse was good, but before long it became much diminished in force and increased in frequency; the temperature did not fall. The child weighed ten pounds; and the promontory was observed to be very sharp. On the following day the pulse was still more rapid and feeble, the temperature had risen to 101° , and the poor woman died about forty-eight hours from the time the rupture took place.

There are many points of great interest and importance illustrated by this case:—

1. The need for careful watching, and often for early interference in cases, especially multiparæ, where the presenting part fails to engage in the pelvis soon after the advent of labour pains and the escape of the liquor amnii.

2. The difficulty which may for a time attend the diagnosis of rupture. In this instance I was guided to this conclusion by the results of palpation and the sudden cessation of the foetal heart.

The ordinary signs and symptoms of collapse were absent till some time after delivery. In Dr. M'Clintock's admirable paper on rupture of the vagina he points out (*a*) that it occurs most frequently with head presentations; (*b*) when the head is in the pelvis; (*c*) where some bony projection is present in the pelvis; (*d*) the vomiting of dark coloured fluid is generally absent; (*e*) the foetus generally escapes into the peritoneal cavity.

The *post-mortem* conditions showed that coeliotomy would have been unavailing.

Dr. Neville made a *post-mortem* to the extent of ascertaining the exact nature of the local lesions. He found that both vaginal and uterine ruptures were more extensive than was anticipated. For the greater part of its course the uterine

rupture, occupying the cervical and lower uterine regions, simply opened into the folds of the right broad ligament, into which had escaped a small amount of blood. But at its highest point this rupture somewhat altered its direction and was here complete—*i.e.*, had opened into the peritoneal cavity posteriorly. The vault of the vagina laterally and partly through Douglas' space was deeply torn, to the extent of opening through the latter into the peritoneal cavity, while the vaginal wall in its upper and posterior third was deeply fissured. The resulting hæmorrhage, as evidenced *post mortem*, was slight in extent, and Dr. Neville did not think that the lesions revealed were such as could have been efficiently dealt with by any operation. Signs of commencing peritonitis also existed.

Decidual endometritis was observed in two cases, both 1-paræ, aged respectively seventeen and twenty-two years. In both a somewhat firm growth on inner surface of uterus could be felt with finger and curette; if handled roughly it bled, and its connection with uterus was too firm to allow of its removal. A high range of temperature prevailed in both patients, but steady improvement followed douches and draining with gauze. In the case of L. S., though the uterus became healthy, the pulmonary phthisis from which she was suffering ended fatally six weeks after her confinement.

PHLEBITIS.

This affection was present in four patients, but in only one was attended with any rise of temperature, and then only for three days. She was a very delicate 1-para, aged twenty-five, admitted April 8 from Mercer's Hospital, suffering from ascites, caused by chronic kidney disease. Labour came on when pregnancy had lasted only 8½ months; the child was very small, and natural efforts effected delivery. Owing to the dropsy, manual removal of placenta became necessary.

MITRAL DISEASE, BRONCHITIS—FORCED DELIVERY.

M. C., aged twenty-five, 1-para, admitted May 14th at 7 a.m. She had been confined to bed for some months owing to mitral valve disease and bronchitis; the pulse was quick, feeble and irregular; there was great distress in breathing and orthopnoea. Pains were fairly regular; os about the size of a five-shilling piece, and head low in pelvis; her face was pallid and lips cyanosed. The dyspnoea and heart's action grew steadily worse, and at 10 o'clock it was manifestly impossible for her to continue the struggle much longer. Though she could not lie down, I succeeded in passing the forceps through the still very imperfectly dilated os, and applied gentle traction; but while doing so matters became so much worse that the patient was at the point of death, so I perforated the head, and delivery was speedily completed. The presentation was occipito-posterior. With the emptying of the uterus a marvellous degree of relief was obtained; in half an hour afterwards the patient was able to lie down, and a favourable puerperium followed, delayed a little by phlebitis in the right leg.

In some of my previous Reports will be found notes of cases in which pregnancy was complicated with organic cardiac disease, in which compensation was so imperfect that even so early as the sixth month the patient was unable to lie down in bed, her sufferings having become steadily aggravated in each pregnancy. In all of these premature labour was induced with the best results. With my knowledge of these facts I am at a loss to understand how good, practical obstetricians, such as Winckel, can advise against this mode of treatment.

CASES OF APHONIA.

CASE I.—S. D., aged twenty-eight, 3-para. Without any apparent cause patient lost her voice shortly after labour began; and the condition was even more marked some hours later. Aphonia had occurred during a former confinement also, beginning about the same time, and persisting for some days. On this

occasion the voice became more audible on the second day of the puerperium, and was almost of its ordinary strength on the fourth day.

CASE II.—E. L., aged twenty-nine, 5-para; became quite aphonic on the day following her delivery, and remained so for several days. She had a similar experience on several former occasions at the conclusion of pregnancy.

CASE III.—K. B., aged thirty-two, 7-para. Patient was conscious of her voice becoming weak a few days previous to her admission to hospital. After delivery she could only speak in a whisper. She has had a similar experience on two former occasions.

ENLARGEMENT OF THYROID (?) GLAND IN AN INFANT.

CASE—M. K., 2-para, gave birth to an infant which presented marked enlargement of thyroid, involving isthmus and both lobes; respiration was difficult, owing, apparently, to the pressure caused by the enlargement. Patient states her first infant suffered similarly, but the trouble disappeared in a short time.

CUTANEOUS AFFECTIONS.

Cases of the above observed during the year were few in number and not of any special interest. Two examples occurred of extensive pigmentation of the abdomen, such as sometimes follows the use of arsenic. As in former years, two forms of erythema were observed, and two very trifling cases of pemphigus in infants. In six instances patients were affected with troublesome acne on the chin and nose. This had occurred in successive pregnancies, and generally subsided after delivery. One infant presented a copious papular syphilide on arms, but not on face; and one mother was admitted suffering from general psoriasis.

DECIDUAL ENDOMETRITIS.

CASE I.—C. P., 1-para, aged seventeen, stated she was in good health during pregnancy; gave birth to a living infant after an

easy labour. On the third and following days there was a considerable rise of temperature and pulse, and on exploring the uterus a firm growth was found, especially developed at the fundus and right cornu. It was not possible to detach it thoroughly with either finger or curette, and any attempt to do so was followed by bleeding. Copious douching of the cavity was practised, and it was then packed with iodoform gauze. This proceeding was repeated on several occasions; and convalescence though tardy was satisfactory.

CASE II.—L. S., 1-para, aged twenty-two; labour was natural; child alive; a few days afterwards there was considerable pyrexia, and on examination the cavity of the uterus was found occupied by a firm growth, closely adherent to the uterine wall, from which it could not be detached without violence, except in small fragments. Douching and packing with iodoform gauze were tried, but without any appreciable effect on the temperature and pulse. These latter, however, were no doubt aggravated by pulmonary phthisis, of which signs became observable during the first week of the puerperium, and which proved fatal in six weeks from the birth of her infant.