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PARTURITION AS A FACTOR IN GYNECOLOGIC PRACTICE.*

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To convince gynecologists that parturition is not only a factor, but the principal factor, in producing morbidity which calls for their interference, no other argument is needed but the statistics of their own practice.

Not having any special statistics at my command, I can not give the percentage of the cases of gynecic practice due directly or indirectly to parturition. They, of course, vary in different communities, as well as in the practice of different gynecologists. From what I can cull from general statistics, and from my own, as well as some statistics kindly furnished me by several gentlemen of large experience, I feel justified in saying that considerably over 50 per cent. of all gynecologic cases can be charged to parturition. The statistics furnished me vary very materially; the lowest are 55 per cent., and the highest 90 per cent., the average being about 66 per cent. The percentage of those working in large general hospitals is much smaller than those having private hospitals. In my own practice, if I eliminate the cases of gonococci infection treated in the general hospital, the percentage of cases following parturition is increased over 20 per cent. In speaking of parturition, I, of course, include the large number resulting from abortions. It would certainly be very interesting, and perhaps startling, to know just what percentage of parturient women become subjects for the gynecologist. This can not even be approximated, nevertheless our observation leads us to believe that it is quite large.

Aside from inversion of the uterus and fistulas due to pressure, nearly all the morbid conditions following parturition which come to the notice of the gynecologist are primarily due to sepsis, to lacerations, or to both combined.

Having these undisputed facts before us, it behooves us to make earnest, energetic inquiry as to: 1, the best means of avoiding these primary causes; and 2, when they do occur, what measures will be the most effective in preventing the secondary morbid conditions which are liable to follow in their train. Modern aseptic and surgical obstetric practice has already done wonders in this direction. I believe the principal object of the chairman and secretary of this Section in placing this subject in the symposium, was to elicit a discussion which would show in no uncertain tones, not only the great work already accomplished along this line, but

the immense possibilities it affords. I do not want to show an enthusiasm which facts do not warrant, but I believe a rigid enforcement of the rules of obstetric practice, as laid down by our best teachers and writers of to-day, would eliminate more than 50 per cent. of the gynecic cases resulting from parturition, if we except those resulting from abortion. What other proof do I need to sustain me in this than the records of cases confined in the maternity hospitals, where nowadays a case of septic infection very rarely occurs, and from which hospitals a woman is not allowed to depart with a ruptured perineum unrepaired.

In my enthusiasm in this matter I do not want to be unjust to the general medical profession, by making rash statements. At the risk, therefore, of apparently making an apology for ignorant and careless midwifery, I do not claim that we have arrived at that degree of perfection that we can, in every instance and under all circumstances, prevent septic infection. This concession does not neutralize the assertion that in almost all, if not all, cases of "septic infection," there has been a failure in the technique either by omission or commission. The assertion made by a member of our profession some time ago, that "the obstetrician who has a case of septic infection to occur in his practice is guilty of malpractice," was entirely too radical. Our sense of justice as a profession forbids our endorsing such an extravagant sentiment.

The obstetrician can not always control the general environment of his patient, nor can he be held responsible for her ignorance, carelessness, or obstreperousness. He can not make up for the imperfections of an incapable nurse, neither can he be held accountable for the sometimes dangerous interference of ignorant and superstitious neighbors and friends. This being conceded, and the fact acknowledged that septic infection may occasionally occur in the hands of the most skillful and careful practitioner, it does not militate against our claims for the effectiveness of asepsis, nor is it an excuse for the careless or indolent who fail to carry out its requirements.

There is a false idea among a large portion of the laity that a laceration is always significant of a lack of skill on the part of the attendant. This notion is ratified by that class of accoucheurs who never have a laceration to occur in their practice, and who never have a morbidity or mortality to occur after a confinement attended by them—a class with whom I have no patience. They help bring unmerited odium upon able and conscientious fellow practitioners. I can not speak more kindly of such than to say that their practice is either very limited, or they fail to search for lacerations. It is certainly no disgrace, and ordinarily no reflection, on the ability of the accoucheur, to have a laceration of the cervix or perineum to occur. Of course, complete lacerations of the perineum, though sometimes unavoidable, are comparatively rare; but I

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believe that, even in the practice of the most accomplished obstetricians, at least slight lacerations in primiparæ are the rule rather than the exception.

I am convinced from my observations that men frequently allow a lacerated perineum to pass unannounced, and without repair, because of the fear that a knowledge of it would cause a reflection on their skill. To such I say: "Their reputation is liable to suffer subsequently tenfold more by a failure to attempt a repair." I use the word "attempt" advisedly, for it is not always possible to secure prompt and perfect union. While a woman has no right to chide her attendant for a laceration where he has used ordinary care and skill, she has a right to condemn him if he wilfully leaves her to endure the manifold evils which are liable to result from an unrepaired lacerated perineum. The instances are very rare indeed where he is justified in neglecting an immediate repair of the perineum, and just as rare where he should fail to advise the repair of a lacerated cervix at the earliest possible period after the puerperium.

Notwithstanding all of the excuses or concessions I have already made, it is certainly an undeniable fact, that very many more women are doomed to a life of morbidity than should be, with our present resources. This may, to a certain extent, be the result of incapability or carelessness on the part of the practitioner, but as a rule the skill and honesty of the physician is beyond reproach. Methods of practice and ignorance on the part of the laity are largely responsible. The general notion that the obstetrician is a mere midwife, whose duties begin with the onset of labor, and end with the delivery of the placenta, is preposterous. It is as much his duty to care for her during her pregnancy, and prepare her for the trying ordeal of labor, as it is to conduct her through that important event. Again, it is equally as necessary for him to follow her through the puerperium and to the completion of involution.

Upon a subject now so well understood as asepsis, it is unnecessary for me to go into minutæ, and yet there are a few points in this connection, to which I wish to call attention. First, the day of antiseptic midwifery is past. Notwithstanding its many defects, it was necessary in the course of evolution to a more perfect technique. To-day we know its principles are not only directly harmful, but a neglect of asepsis, with a dependence upon antiseptics to right wrongs, is not only unscientific, but cruel and murderous. The true antiseptics are the normal and healthy secretions of the body, and especially that greatest of all germicides, the blood. Hence the necessity of due attention to the secretions and to the condition of the blood previous to the onset of labor. In instituting aseptic precautions before labor, the douching of the vagina with antiseptics is not only useless, but harmful in a healthy woman. And in an unhealthy vagina, with pernicious secretions, it is not effective. Where it is necessary at all to cleanse the vagina, it should be scrubbed and prepared as carefully as if one was about to do a vaginal hysterectomy. The normal secretions of the vagina ordinarily make it uninhabitable for septic germs. The normal and safe habitat for them is the vulva, and it should undergo the most careful cleansing possible.

A cause of infection, through putrefaction, is a failure to remove all placental tissue and membranes. For this reason, a careful examination of the placenta should be made on all occasions to determine its complete removal. In this connection, I want, in the most emphatic manner possible, to call attention to a matter

of the gravest importance, which I am led to believe does not receive that consideration it deserves by the profession. I refer to the placenta succenturiata and placenta spuria. I am convinced that they not only exist very much more frequently than is generally believed, but that they are frequently the direct cause of sepsis that can not be accounted for. In two autopsies with which I am acquainted, one of them being in one of the most prominent women of our city, a spurious placenta was found. On at least five occasions I have found them.

Comparatively little has been written on this subject, and I hope I have said enough to awaken a spirit of investigation upon it. While I have not time to discuss the matter at length, notwithstanding the very able paper maintaining the other side of the question, read by my worthy friend from Philadelphia, at the Milwaukee meeting in 1894, I am still of the opinion that "the routine practice of administering ergot after the third stage of labor," as set forth in a paper read by me before the Pittsburg South Side Medical Society, and published in the *Therapeutic Gazette* of July 15, 1892, is pernicious, and is frequently the cause of the woman being placed in the gynecologist's chair.

The too early resumption of household cares and duties after labor and before involution is complete is, I think, accountable for many of the malpositions and their concomitant disorders which we encounter. This matter, however, is elucidated in the paper of Dr. Vineberg, and I will not dwell upon it.

Inasmuch as I have performed the duty assigned me of opening the discussion, I shall leave it for others more worthy to discuss it. In conclusion, I have only to say that by a rational midwifery such as I have suggested, with careful asepsis and proper and timely repair of lacerations, salpingitis, ovarian abscess, and endometritis would be less frequent, and prolapsus uteri, vesicocele and rectocele, with all their accompanying phenomena, would be comparatively rare.

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DISCUSSION.

DR. MORCEDAI PRICE, Philadelphia.—I wish to endorse the Doctor's method of treatment. He is the only man in this state who has always advocated good obstetrics. I wish to say that nine out of ten cases of puerperal fever referred to me have been caused by the useless, worthless and dangerous use of antiseptics. The condition of the medical men to-day, in regard to obstetrics, is that they have microbes in mind all the time. They need to be washed and cleaned. I have seen temperatures of 103 and 104 from intrauterine irrigation after labor and from the use of the curette. These two things have come to be the fashion in all cases of labor. The mortality and the danger following such procedures is probably the result of at least 50 per cent. of the deaths from puerperal fever. I have in many instances asked the attending physician to discontinue with antiseptics and washings and the result has been all that could be asked for. In one case I was persuaded by an overwhelming majority, in a consultation, to use a douche. They had irrigated the vagina and asked me to irrigate the uterus. I asked them to give a twentieth of a grain of strychnin, but they insisted on my using the douche. As a consequence we spent the night with that woman trying to save her from the effects of the douche. It is the cause of more disastrous results than any other practice.

I endorse the Doctor's paper without hesitation and believe that if the profession will read and adopt the methods recommended by him, the mortality in obstetric cases would be lessened. It is greater to-day than at any other time in the course of my professional career of thirty odd years. The profession must unlearn all the nonsense taught them in the past, and it will take just such papers as that of Dr. Duff to teach them the proper method.

DR. L. H. DUNNING, Indianapolis—I most heartily endorse the paper. Dr. Duff has stated his point forcibly, although not too strongly. I have often seen what he has pointed out, especially the disastrous results following the use of too strong bichlorid douches. I recall a case seen a few days ago, in which the patient had a temperature of 101. The doctor became alarmed, gave a bichlorid douche, which was followed by shock and an almost fatal issue. Withholding the douche, on my advice, resulted in the recovery of the patient.

The point I specially wish to mention, and which is of considerable importance, is the fact that a large percentage of the cases coming into the hands of the gynecologists are the result of parturition. There is one class of cases which comes to use which could readily be prevented, cases of displacement due to subinvolution. We have all been taught that every case of laceration of the perineum should be attended to at once. While we all believe in treating lacerations conservatively, many general practitioners ignore this point. I do not suppose that immediate repair of a laceration of the cervix has always been satisfactory, but I do believe that the case ought to be examined six weeks after the delivery, and if a laceration is found it should be promptly attended to. If allowed to go on it will in many instances result in imperfect involution, displacements, marked congestion of the pelvic organs and chronic invalidism. The care of the woman delivered should not end until the cervix has been attended to and until involution has properly taken place.

DR. JOSEPH PRICE, Philadelphia—The practice of midwifery in private and public differs more or less. The practice in private has degenerated tremendously. We are not as enthusiastic as we were a few years ago. I remember the time when obstetricians entered into all of our discussions with considerable enthusiasm. To-day the reading of an obstetric paper is the excuse for men to leave the session. The professor of obstetrics sits on two stools. Every obstetrician in America seeks an appointment in school to teach obstetrics while he is practicing gynecology. Nothing is more unfortunate for women than the fact that we have no enthusiastic specialists in obstetrics. You can not very well follow the same methods in public which you do in private. Very few households will permit the practice of well-organized and disciplined maternity work. The syringes commonly used in private houses ought never to be used by the obstetrician. Unless the physician has his own syringe he should never use the one hanging behind the bath-tub. That syringe is used by everybody and is sometimes the source of infection of the entire household. While the wife or mother is down-town shopping the maid or cook will surely use it. I have tried to educate my patients to the importance of locking up their syringes just as they do their jewels. In the maternity the vaginal douche, ante-partum or postpartum, is good practice, as these patients are usually much dirtier than private patients, who take better care of themselves.

The indiscriminate use of the curette is little short of being criminal. A woman sometimes develops a little temperature and the doctor thinks he must use the curette. After having done so he is no better off than before and really does not know what he has done it for. Nearly all the cases which I have seen a few days after curettement, still have some pieces of membrane left in the uterus. Dr. Duff fortunately presents such valuable papers at nearly every meeting of our Association, and we owe him a debt of gratitude for pounding away at obstetrics at such an opportune time as the present.

DR. C. A. RITTER, Kansas City—The science and art of obstetrics, implying in its broadest sense the care of woman during gestation, labor and the puerperium, has, until the recent past, been sadly neglected. The numerous papers on the program of this section dealing with gynecologic subjects, the few on obstetric, indicate to some degree the tendency of the medical mind of to-day. More scientific and careful obstetric work means fewer invalids, and lessens the necessity of gynecologic interference. The frequent practice, on the part of the young graduate—unless thoroughly trained in clinical work, and not altogether absent among the older members of the profession—of frequent vaginal examination, and other useless interference during normal labor; the use of the ante-partum

and post-partum douche in the absence of pathological conditions; the failure in immediate repair of injuries to the vagina and pelvic floor, are fruitful sources of infection. Hence many mothers endure a mild or more severe attack of sepsis, have an unsatisfactory puerperium, a "bad getting up," and at no distant date, consult the gynecologist for surgical relief. With temperature and increased pulse-rate during the puerperium we should interrogate other organs besides the uterus for source of trouble.

Frequently the thorough evacuation of the contents of the alimentary canal by the free use of saline cathartics will be followed by normal temperature and pulse. I agree with the author in his statement that there is danger of using too strong germicidal remedies about the parturient canal. To be clean, to be aseptic, should be the alpha and omega in the care of the parturient patient.

DR. A. B. MILLER, Syracuse—I regret that I was not present when Dr. Duff read his paper, but from the discussion it seems to me that we are not treating the subject under discussion as we should. For us to deal with the sky parlor in obstetrics, instead of coming down to the real facts, is not going to diminish or decrease the mortality in obstetrics. The fact that everybody uses the syringe is not the source of the infection in cases of obstetrics; the infection is carried usually by the physician in attendance. If he has been attending a pus case, a streptococcus infection, our patient will in all probability be infected and is surely going to die. If we practice bacteriology and recognize that these infections are based on specific poisons, then we shall know of the possibility of our patient's recovering. If we have a staphylococcus infection the larger percentage of cases will recover, but if we have a streptococcus infection the case will in the majority of instances die. Cases of mixed infection will also die. In my practice, instead of resorting to the curette or irrigating the vagina or uterus, I determine as soon as possible the source and kind of infection with which I am dealing. If due to the presence of putrefactive material in the uterus, irrigation and the curette will do good because we are removing the products of infection and we are overcoming the progress of the infection. If we have septicemia, due to a streptococcus infection, the majority of patients will die; and if due to the bacillus coli communis, it is of little consequence.

As to the silver ointment I regret to say that while several cases have come under my care, I have seen but little benefit from its use. It is all important to ascertain the source and kind of infection with which we are dealing. If we have a pus tube from an old infection, that patient is not going to be benefited by the use of the douche or the curette. It requires something more than that.

DR. ALBERT H. TUTTLE, Cambridge, Mass.—If we consider parturition as one of the most important factors in the production of diseases of women, we must study how we should treat cases of parturition so that we will avoid as much as possible the complications which may result. It resolves itself into two stages. The first stage should be the preparation of our patient before the delivery, and we must consider that almost every case of parturition will be attended with the production of lesions of the parturient canal. This will, in many instances, mean large tears, complicating the deeper structures of the pelvis. In other cases there will only be moderate abrasion, but still capable of carrying infection. Consequently, we should prepare a patient for parturition in as careful a manner as we would for an abdominal section or a vaginal hysterectomy; that is an important factor. I know of no obstetrician in my immediate vicinity who makes any preparation of his patient more than to use a vaginal douche. Many of them object to that, saying that a douche before delivery interferes with the normal secretions of the vagina and also interferes with delivery itself.

The other consideration is the careful examination and repair of the parts immediately at the close of labor. It is almost an impossibility to find a primipara who goes through labor without more or less of a tear. There may be only a little gash, which appears as nothing, but when we examine the vagina and look in we may find deep lacerations in the vault extending up to the cervix or opening up the subperitoneal

space. Others may start at the cervix and from a similar lesion. These injuries are generally productive of severe infection with adhesions and fixation of the uterus. The infection in other cases may be mild or severe, depending on the character of the germ present. If the infection is due to the streptococcus you are almost sure to lose your patient. There are two things which should be borne in mind, namely, make a careful preparation of your patient beforehand and carefully examine the vagina and uterus after parturition, cleaning out all clots in the uterus and making a complete surgical repair of the injured parts. If the obstetrician is not able to do this himself, he should call in a neighboring physician who can do it.

The complete surgical repair of the injuries of parturition is of the utmost importance for the health of our women and the prevention of severe pelvic disease.

DR. E. G. ZINKE, Cincinnati—I have no doubt that the majority of those present know how to prevent sepsis during and after labor. I do not doubt that the majority of us thoroughly understand when and when not to irrigate, before, during or after labor; when and when not to use the curette, when to use the sharp and when the dull curette. The trouble lies elsewhere and it was pointedly stated by my friend Dr. Price, of Philadelphia. The obstetrician of the present day does not hold the position he should and there is a very good reason for it, because it does not pay to be a specialist of obstetrics. There is not money enough in it to pay a man to devote his attention exclusively to the practice of obstetrics and there lies the fault.

Everybody who has graduated, who has received a course of study as we now have it, thinks he knows all about obstetrics. I have seen men who have told me that they never saw a fatal case. They do not know what it is to have a case of puerperal sepsis or a badly torn perineum. In my part of the country, men attend cases of confinement for from \$5 to \$20. A man who charges \$25 is looked upon as a robber, and the man who charges \$50 is left strictly alone.

I hold the chair of obstetrics in our college and I am bound to practice gynecology in order to pay my debts. It is well to look these things in the face. The chair of obstetrics ought to be endowed. A good college ought to pay a man \$5000 a year to teach such a branch. Then they could demand of him that he give the subject his entire attention, and I, for my part, would be willing to do it.

The profession, too, is largely to blame, because every effort that men have made, with the view of establishing maternities or out-door clinics have been damned by the profession abroad and in their immediate vicinity. I remember years ago when I started an out-door clinic in Cincinnati. I had great difficulty in obtaining the permission of the faculty to do so for fear the college would receive unpleasant notoriety, and not without good cause. The first obstetric clinic was established in Boston, and the founder of it had to leave the city in order to save his life. The first attempt to deliver a woman before a class was served in the same way. To-day, a man connected with a maternity or out-door clinic is looked down upon by his brethren. If you want to teach obstetrics thoroughly and practice it as it should be, all these things must be taken into consideration. Every man is doing the best he can, and you can not blame him if he practices other things which he understands just as well, and does not limit himself to the department he occupies simply because it does not seem right to some.

DR. DUFF (closing the discussion)—I would like to say much on this subject and would like to have said it in my paper, but I had to make it short, simply striking the notes and giving you the tune. You all know that the subject of obstetrics has not been a popular one. I have found this out for several years. I teach obstetrics and try to do so to the best of my ability, but I have to practice gynecology to make a living. I am sometimes called out fifty miles into the country to help a man out in a case. I lose much time and money in making this call, and when I meet the doctor at the depot he will probably tell me that "this is a poor man and he can not pay anything," and all I get for my time is my expenses paid. A man can not practice obstetrics alone; he can not

take the necessary time; he can not have the armamentarium.

As to infection, we are coming to the day when we will consider septic infection as I have discussed it in my paper. The days of aseptic obstetrics are coming. We must use prevention in obstetrics as we do in other operations. We should not be careless beforehand and then try to remedy it afterward. Neither should we invade the territory in order to defend it, when there is no infection present in it.

A short time ago, I saw a case of septicemia in consultation with two other gentlemen. The lady had a temperature of 107, and the pulse I could not count. I made a digital examination and found placental tissue in her uterus. I called the attending physician aside and asked him whether he had all of the placenta. He said "yes" and even exhumed the placenta in order to prove it. On examination, I found that there was a placenta succenturiata as large as my hand. The case I refer to in my paper had sepsis. The doctor said he had taken the pieces all out, but on the autopsy we found a placenta succenturiata. I have seen five cases of this myself, and I have met others who have found them as well. There is very little in the literature on the subject, and I hope it will be considered more carefully next year so that all cases of this kind may be recorded.

I should like to talk along this line for a long time, but I hope that the spirit engendered here this morning will grow, and that the obstetrician will come here, read his paper and become popular instead of being an excuse for a man to slip out of the room.

ANTEFLEXION OF THE UTERUS; ITS CAUSES AND TREATMENT.*

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Anteflexion of the uterus may not infrequently be regarded as a symptom of an undeveloped condition of the genitalia. The state is, no doubt, in many cases, congenital in its manifestation, or is early superinduced by exposure of the subject to faulty hygienic surroundings. Improper modes of dressing during the years of childhood and before puberty have been ascribed as an important factor entering into its causation, but it is often difficult to appreciate how the normal intra-abdominal pressure can be so modified as to cause, to any great extent, before the vulvovaginal introitus has been affected by the influences of parturient processes, displacement of so small an organ as the uterus, which, for the most part scarcely measures by the sound two and one-half inches in depth.

The uterus, including its cervix, sustained in its proper position by the uterosacral ligaments, with the axis of the corpus assuming with that of the cervix an obtuse angle, can not be said to present a condition manifesting pathologic phases, unless there is an accompanying dysmenorrhea or there are marked vesical symptoms. Such a condition of the uterus does not require treatment, unless there has been exhibited a tendency to a greater displacement of the organ, or there is an associated inflammation, or a morbid process in adjacent structures. When the axis of the body of the uterus forms with the axis of the cervix an acute or a right angle, pathologic symptoms, more or less severe, are almost always present.

Cervical anteflexion is largely due to habitual constipation; this is more apt to occur in girls at the beginning of their menstrual period, when the lower portions of the uterosacral ligaments are in a soft and yielding condition. For this reason, treatment for healthful regularity of the bowels in such subjects

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