ART. XIX.—*Report of the Rotunda Hospital for the Three Years ending 3rd November, 1886.** By JOHN LILLY LANE, B.A. Univ. Dubl.; L.K.Q.C.P. & L.R.C.S.; Ex-Assistant-Physician.

THROUGH the kindness of Dr. Macan, the Master of the Hospital, I have the honour to lay before the Academy the Report of the Rotunda Hospital for the three years ending 3rd November, 1886.

It was after considerable hesitation I accepted his kind offer, feeling keenly how imperfect my efforts to frame a Report worthy of the institution would prove, and how unfavourably my Report would contrast with those brought before you on former occasions by successive Masters of the Hospital.

I have only had the good fortune to hear one of those Reports read—namely, that so ably brought before you by Dr. Macan, the present Master, which I feel certain is still fresh in the memory of many present; and I shall endeavour to inform you of the results since obtained in the hospital by the adoption of the measures and precautions he then advocated.

For the past three years the corrosive sublimate solution for the hands and for intra-uterine injection has been much more freely used, and indeed has almost entirely taken the place of the carbolic acid solution, except in cases of considerable hæmorrhage, suspected renal mischief, or great corpulence, and the reason of the continued use of the carbolic acid solution in these cases is that absorption being so great there is danger of mercurial poisoning manifesting itself by diarrhœa, tenesmus, bloody stools, &c., whereas by using the carbolic acid solution (1 in 80) no bad symptoms have been noticed.

The general use of the evaporation of carbolic acid solution in the wards, mentioned by Dr. Macan in his Report, has been discontinued, although it was had recourse to on one occasion when there were some unsatisfactory cases in the hospital.

Iodoform pessaries have not recently been employed nearly so frequently, and are now used only when the lochial discharge becomes fœtid, and continues so after the first washing out of the uterus.

I may here conveniently allude to the use of the napkins which were introduced by Dr. Macan. At first they did very well, and kept the beds much more cleanly, but after some time the temperature and pulse of some of the patients went up, for which we could not account, unless it were due to the use of the napkins—

* Read before the Obstetrical Section of the Royal Academy of Medicine in Ireland, June 10, 1887.

there being always considerable difficulty in getting them properly washed. It was then decided that the first napkin used in each case should be soaked in corrosive sublimate solution, and wrung out before being applied to the vulva—the napkins, after the first in each case, not being put in the solution. This, at first, seemed successful, but at present only one napkin, soaked in solution, is used for each case.

TABLE A.

—	1883 and 1884	1884 and 1885	1885 and 1886	Total	Average
Forceps - - -	68	65	70	203	1 in 16.75 = 5.96 per cent.
Version { Internal - -	8	8	11	27	} 1 „ 89.5 = 1.1 „
{ External - -	4	5	2	11	
Perforation - - -	5	4	8	17	
Induced labour - -	4	4	3	11	
Accidental hæmorrhage -	24	37	37	98	1 „ 34.71 = 2.88 „
Placenta prævia { Partialis -	2	3	9	14	} 1 „ 226.8 = 0.44 „
{ Centralis -	1	0	0	1	
Post partum hæmorrhage -	52	43	48	143	1 „ 23.72 = 4.2 „
Secondary post partum hæmor- rhage - - -	3	5	6	14	1 „ 243.0 = 0.41 „
Transfusion - - -	0	0	3	3	
Adherent placenta - -	16	13	8	37	1 „ 91.95 = 1.08 „
Breech presentation - -	30	30	20	80	1 „ 42.52 = 2.35 „
Face „ - - -	4	3	6	13	1 „ 261.7 = 0.38 „
Brow „ - - -	0	1	0	1	
Transverse „ - - -	4	5	6	15	1 „ 226.8 = 0.44 „
Footling „ - - -	3	17	12	32	1 „ 106.3 = 0.94 „
Prolapse of funis - - -	8	16	8	32	1 „ 106.3 = 0.94 „
Face to P. - - -	8	14	5	27	
Abortion and premature labour	76	64	63	203	
Threatened abortion - -	2	6	4	12	
Myxoma of chorion - - -	0	0	4	4	
Twins - - -	18	23	13	54	1 „ 63.0 = 1.58 „
Triplets - - -	1	0	1	2	
Umbilical hernia - - -	0	1	0	1	
Convulsions - - -	3	4	6	13	
Mania - - -	5	5	6	16	
Fibroids complicating preg- nancy - - -	0	2	2	4	
Ovarian tumour complicating pregnancy - - -	0	1	0	1	
Occlusion of vagina - - -	0	1	0	1	
Abscess in posterior <i>cul-de-sac</i> with pregnancy - - -	0	0	1	1	
Hydrocephalus - - -	0	0	1	1	
Prolapse of uterus before delivery - - -	0	1	2	3	
Thrombus of labium after delivery	0	1	0	1	
Erythema - - -	12	3	10	25	
Spina bifida - - -	2	2	1	5	
Anencephalous foetus - -	0	3	0	3	
Ophthalmia neonatorum -	14	9	11	34	1 „ 100.05 = 0.99 „

Perchloride of iron injected in 12 cases.

During the three years there were 3,414 patients attended in the hospital, including 12 cases of threatened abortion. The preceding table (A) contains all cases that possessed any unusual interest, and in calculating the percentages I deducted these 12 cases.

There were 43 deaths from various causes, giving a mortality of 1·25 per cent., or 1 patient in 79·39. One of these deaths occurred from supposed acute yellow atrophy of the liver, about a week after the patient left the hospital, which she did contrary to the wishes of the staff; and another from septicæmia, the day after the patient went home, which she also did contrary to the wishes of the staff.

I have not thought proper to include in the list of fatal cases a patient confined in the hospital who had been sent in by Dr. Horne, suffering from a tumour complicating pregnancy. In this case there was at first considerable difficulty in arriving at a diagnosis, but after some time a tumour formed in the posterior *cul-de-sac*, from which, on being opened, a quart of pus escaped. The patient at one time, whilst in hospital, became maniacal, although in this respect she was fairly recovered before she left, which she did at her own and her husband's request. She unfortunately, some time after leaving hospital, got possession of a revolver, and shot herself, with fatal results.

The following is a summary of the fatal cases:—

CASE I.—M. C., aged twenty-four, third pregnancy, admitted 29th November, 1883, in a state of partial collapse from accidental hæmorrhage. Stimulants and beef-tea administered, also ergot; hæmorrhage ceased, and patient improved somewhat; uterine contractions also improved; patient delivered herself a few hours later; placenta expelled in twenty minutes, followed by a gush of blood; uterus relaxed; ergot again given and hot douche used—this not checking the hæmorrhage, uterus injected with perchloride of iron, which stopped the hæmorrhage—but, though every means was tried, the woman gradually sank and died. There was no *post mortem*.

CASE II.—E. M., aged thirty-three, seventh pregnancy, admitted 27th November, 1883, in a very bad state of health, having been an inmate of Stevens' Hospital a few weeks previously with cough and spitting of blood; delivered herself 27th November, but died fourteen days after of phthisis. Dr. James Little had seen the patient and agreed in the diagnosis.

CASE III.—C. C., aged twenty-nine, sixth pregnancy, admitted to hospital 25th January, 1884, but labour not having commenced was

transferred to Auxiliary, as she was suffering from a cough, dyspnœa, dysphagia, and vomiting of ropy mucus and coffee-ground looking stuff; improved somewhat, and was suddenly delivered on night of 30th; the day following there was very little vomiting, but respiration was more difficult, and patient became cyanosed, and died that evening, twenty-four hours after delivery. *Post mortem*.—Acute bronchitis with enlargement of bronchial glands, also an old ulcer of stomach.

CASE IV.—K. H., aged twenty-seven, first pregnancy, admitted 28th January, 1884; delivered with forceps on the 29th of an 8 lbs. child. Liquor amnii had been coming away for five days before admission. Died, 6th February, of septicæmia. No *post mortem*.

CASE V.—A. G., aged nineteen, first pregnancy, admitted 8th March, 1884; delivered same day of a premature child, dead and macerated. Uterus washed out with antiseptic solution. This woman was quite jaundiced when admitted, and had been for a week previously. Died 11th March. *Post mortem*, by Dr. Duffey, verified the diagnosis formed of acute yellow atrophy of liver.

CASE VI.—E. D., aged twenty-five, third pregnancy, sent to Rotunda by Dr. Neary of Howth; when admitted was excited and talkative, speaking about her home and wondering where she was. Delivered 18th April, 1884. Died twenty-four hours after. *Post mortem* by Dr. Duffey.—Tuberculosis of lungs and brain with œdema pulmonum.

CASE VII.—C. K., aged twenty-eight, seventh pregnancy, sent to hospital by the clinical clerk, 30th April, 1884, suffering from accidental hæmorrhage, which first came on two days before admission, but ceased till the day she was seen. The membranes were ruptured at 9 a.m., 30th; child born in twenty minutes after; got rigor at 2 p.m.; greenish vomit, and complained of severe abdominal pain. Died, 1st May, of septic peritonitis.

CASE VIII.—J. S., aged twenty-three, fifth pregnancy, admitted 17th June, 1884; delivered the 18th, after a rather tedious labour; was transferred to Auxiliary 25th; and died, 2nd July, of pyæmia. *Post mortem* by Dr. Duffey.—Acute ulcerative endocarditis.

CASE IX.—M. C., aged twenty-eight, third pregnancy, brought to hospital, night of 8th August, 1884, by the clinical clerk. Patient was very emaciated; had been confined to bed for two and a half months, and dispensary doctor said "both her lungs were gone;" was seven months pregnant. Stimulants administered, and, as she was in labour, membranes were ruptured; delivery effected by natural efforts 9th August, but she died eight hours after of exhaustion from phthisis. No *post mortem*.

CASE X.—R. D., aged twenty-nine, sixth pregnancy, brought to hospital, 20th November, 1884, in a state of coma from convulsions. When undressed, child found born as far as umbilicus; no difficulty in delivering arms and head; premature, eight months. Adherent placenta removed. Died, evening of admission, 15 hours after first convulsion. No *post mortem*.

CASE XI.—B. C., first pregnancy, admitted 24th November, 1884, and delivered same day by natural efforts; face presentation. This patient was examined by a student who had not washed his hands after having examined a labour case with foetid discharge (who also died of septicæmia). Died, 1st December, of asthenia and puerperal peritonitis. No *post mortem*.

CASE XII.—A. W., aged twenty-four, first pregnancy, admitted 24th November, 1884; delivered with forceps same day. Child dead and œdematous. Placenta adherent removed, when it, together with the discharge, was found to have a very foetid smell; slight *post-partum* hæmorrhage. Died, 6th December, of septicæmia. We considered that it was from this case the preceding one was poisoned.

CASE XIII.—B. T., aged thirty, third pregnancy; admitted from Auxiliary, 11th December, 1884, having been sent up from the country. Delivered 12th December. Died 15th December, of septicæmia. No *post mortem*. This woman's child died quite suddenly 24 hours after its birth.

CASE XIV.—W. L., aged twenty, third pregnancy; admitted 4th January, 1885; delivered on 5th of a still-born child, not macerated. Uterus was not washed out. Died 15th January, of asthenia from puerperal peritonitis. No *post mortem*.

CASE XV.—E. R., aged twenty-eight, second pregnancy; admitted 15th January, 1885, at 1 a.m.; delivered a few minutes afterwards. Stated that three days previously she had been attacked with shivering and great pain in back (inferior angle of right scapula), also had troublesome cough. In about seven hours after delivery her pulse was 140, and temperature 103° F. Became maniacal a couple of days later, and died rather suddenly 19th January. *Post mortem*.—Congestion of lungs. This woman, it was afterwards ascertained, had been a great drinker.

CASE XVI.—H. C., aged nineteen, first pregnancy; admitted 13th January, 1885. Hydrocephalic child, diagnosticated by external palpation. Labour had commenced, and in about 20 hours after admission her pulse was found to be 140, and temperature 102·4° F. Membranes were then ruptured, when a large quantity of liquor amnii escaped. A few hours later, child's head was aspirated, and about 40 oz. of fluid drawn off.

Forceps were then applied, and patient delivered. Child was dead, had a spina bifida, and left arm amputated in utero. Died 21st January, having become rather jaundiced. *Post mortem*.—Pleuro-pneumonia.

CASE XVII.—M. A. H., aged thirty-three, fifth pregnancy; admitted 27th January, 1885, suffering from severe accidental hæmorrhage; os rather small; ergot and stimulants given by mouth. The membranes were ruptured, and afterwards version performed. Child extracted, and placenta followed head; slight P. P. H.; iron injected, and, although hæmorrhage ceased, patient gradually sank. *No post mortem*.

CASE XVIII.—M. C., aged thirty-four, second pregnancy; sent to hospital, 13th February, 1885, by Doctor Colgan, of Bagnalstown, Co. Carlow, pregnancy being complicated by an ovarian tumour. Labour induced. Child extracted, March 18th, footling with prolapse of non-pulsating funis; head perforated, as there was some difficulty in its extraction. Patient's abdomen afterwards became greatly distended. Ovariectomy performed on seventh day, but she died 36 hours after of peritonitis. *No post mortem*.

CASE XIX.—M. M., aged twenty-four, first pregnancy; admitted 1st March, 1885, in a bad state of health. Had been under treatment by Dr. Gibson, of Clontarf, for some time, as also her sister, for heart and lung disease. She was very anæmic, with œdema of legs and feet. Delivered day after admission of a premature child. Died six weeks after of pleuro-pneumonia. *No post mortem*.

CASE XX.—M. H., aged twenty-eight, first pregnancy; admitted 2nd May, 1885. Pains commenced last day of April; os small and rigid; anasarca of legs; urine muddy and albuminous. Delivered with forceps, morning of the 5th. Died 17th May. *Post mortem* by Dr. Lentaigne—Pneumonia and Bright's disease.

CASE XXI.—K. F., a nursetender in the hospital, aged twenty-one; first pregnancy. Suddenly got convulsions on evening of 5th June, 1885. Legs and feet were found to be very œdematous. Urine contained blood, and on boiling two-thirds became solid. Was delivered with forceps; no hæmorrhage. Died next morning, never having regained consciousness. *No post mortem*.

CASE XXII.—M. B., aged thirty-three, sixth pregnancy, admitted 25th July, 1885, when she stated she had had hæmorrhage for 14 days, but when examined there appeared to be scarcely any coming; placenta felt partially over os, membranes were therefore ruptured. There being a foetid discharge later on, with rise of temperature and shivering, forceps were applied and delivery effected with ease. Failing to express placenta after a considerable time, it was decided to introduce the hand

into the uterus, for which purpose a few whiffs of chloroform were being given, but before she was under the influence of it she suddenly ceased to breathe, and all efforts failed to revive her. *No post mortem.*

CASE XXIII.—B. C., aged forty, thirteenth pregnancy, admitted 18th Aug., 1885, having a very pendulous abdomen. A large quantity of liquor amnii being diagnosticated the membranes were ruptured. Patient had had bronchitis, and stated she had been unable to turn in bed on account of great tenderness of abdomen. Delivered by natural efforts day of admission, but in three days had green vomit, and in five days more a distinct tumour, dull and elastic, could be felt in middle line of abdomen. She had diarrhoea, with pus and blood in motions. There was considerable œdema of abdominal wall. Skin over tumour sloughed, and as patient was passing water the slough gave way and a quantity of brown, grumous, very fœtid, fluid escaped. Improved after that, and insisted on leaving hospital 3rd September, but sought re-admission after some time, when skin was found to be excoriated from the profuse discharge and want of cleanliness. Died 23rd September. *No post mortem.*

CASE XXIV.—L. S., aged twenty-eight, private patient, third pregnancy, admitted 22nd October, 1885, having had considerable amount of accidental hæmorrhage, which stopped when she was put to bed. Hæmorrhage again set in 23rd, checked by ergot. Vomited on 24th, when there was a little more bleeding, and uterus contracting frequently that night; two fingers passed through os, and foot, which was presenting, brought down; funis, which was not pulsating, prolapsed; child extracted; no hæmorrhage. Some hours after retching came on, and patient sat up, when a gush of blood came and patient fainted; previously had complained of pain in cardiac region. Iron injected. No more hæmorrhage, but patient died of exhaustion on 28th. *No post mortem.*

CASE XXV.—R. B., aged twenty-eight, second pregnancy, admitted 27th October, 1885, with retained placenta, having miscarried two days previously at her own home. Discharge was fœtid, on account of which the uterus was being douched out, when profuse hæmorrhage came on. Fingers were passed into uterus to remove placenta, during which process the patient seemed to faint. Iron injected to stop hæmorrhage, and every means tried to revive her without effect. *Post mortem* by Dr. Lentaigne, who could find nothing wrong. Death supposed to be due to syncope.

CASE XXVI.—A. E., aged twenty-two, first pregnancy, admitted 31st October, 1885; delivered same day; died 9th November, 1885, of puerperal peritonitis. *No post mortem.*

CASE XXVII.—T. L., aged twenty, first pregnancy, admitted 18th October, 1885; delivered 19th; breech presentation. Symptoms of cellulitis developed fifth day, and afterwards inflammation invaded peritoneum; died 10th November of puerperal peritonitis. *No post mortem.*

CASE XXVIII.—M. H., aged twenty-four, first pregnancy, admitted 15th October, 1885; delivered 16th; died of exhaustion from pyæmia 15th November, 1885. No *post mortem*.

CASE XXIX.—M. M., aged twenty one, first pregnancy, admitted 13th November, 1885; delivered 14th; died 25th November of septicæmia.

CASE XXX.—A. M'C., aged twenty-two, first pregnancy; admitted 7th December, 1885. Had been in hospital from 19th November till 23rd, as she had had some hæmorrhage, but as it ceased she would not remain any longer. Placenta prævia lateralis was diagnosticated, and as the hæmorrhage was very bad, child's head was perforated, and delivery accomplished 8th December. There being some *post-partum* hæmorrhage, placenta, which was still attached to uterus, was removed, and iron injected. Died, 30th December, of exhaustion from pyæmia.

CASE XXXI.—A. M'P., aged twenty-five; fifth pregnancy. Patient brought to hospital in a stupid and almost pulseless state, having been attended for fourteen days previously from the hospital for constant vomiting. Labour began evening, 25th December, 1885. There was some hæmorrhage, and placenta was felt at edge of os; membranes were therefore ruptured. Delivered at 1 30 a.m., 26th, of a premature child, and died 30th December, 1885. *Post mortem* by Dr. Lentaigne, who found there was hæmorrhage into stomach.

CASE XXXII.—M. C., aged thirty-five, twelfth pregnancy; sent to Rotunda by Dr. Reede, of Carrickmacross, 2nd January, 1886; patient having had several miscarriages, and also because her legs and abdomen were very œdematous, there was excess of liquor amnii. The membranes were ruptured 7th January, when, with liquor amnii, a considerable amount of blood escaped. Labour accomplished with but very little trouble, though child's head, neck, and body were very œdematous, and abdomen distended with ascitic-like fluid, which was tapped, endeavouring to allow room for expansion of lungs; heart was pulsating, but all efforts failed to establish respiration. There was an enormous fatty placenta. Patient died of asthenia from pyæmia, 20th January. No *post mortem*.

CASE XXXIII.—E. N., aged thirty-nine, ninth pregnancy, admitted 25th March, 1886, having had hæmorrhage for four months. When examined, placenta was felt, and the hæmorrhage being profuse the child was turned and extracted. The placenta, which was still attached, was removed immediately. Although there was not much *post-partum* hæmorrhage, as the woman was sinking, perchloride of iron was injected and transfusion of saline solution, but patient died in a very short time (25th March). No *post mortem*.

CASE XXXIV.—M. D., aged twenty-seven, private patient, second pregnancy; admitted 2nd March, 1886; delivered before she could be

examined or properly undressed. Died of exhaustion, from pyæmia, 9th April, more than five weeks after delivery. No *post mortem*.

CASE XXXV.—M. F., aged forty, fifth pregnancy; admitted 19th May, 1886; delivered 20th. Died of septicæmia, 30th May, 1886. No *post mortem*.

CASE XXXVI.—E. K., aged seventeen, first pregnancy; admitted 30th April, 1886, in an unconscious state, from convulsions; urine, one-fourth albumen. Child born on 1st May. Consciousness returned 2nd May, became maniacal on 5th, and died 10th May, 1886. No *post mortem*.

CASE XXXVII.—E. J., aged twenty-three, first pregnancy; admitted 1st June, 1886; delivered same day. Became maniacal. Died 19th June, 1886, of septicæmia.

CASE XXXVIII.—J. M'K., aged thirty, sixth pregnancy; admitted 30th July, 1886, suffering from accidental hæmorrhage. Labour had commenced. Ergot and stimulants administered and membranes ruptured, but as this did not check the hæmorrhage, and the os being small, and patient very low, the child's head was perforated and delivery effected without much trouble. Placenta, which was still attached, removed immediately, and iron injected, but as patient was evidently sinking she was transfused with saline solution, which had a marked temporary effect; but she died two and a half hours afterwards. No *post mortem*.

CASE XXXIX.—C. K., aged thirty, second pregnancy; admitted 2nd August, 1886; delivered 3rd; was suffering from bronchitis, and stated she had always had a bad chest. Died 12th August, with symptoms of pleuro-pneumonia. No *post mortem*.

CASE XL.—K. K., aged twenty-five, fourth pregnancy; admitted 20th August, 1886, in an almost collapsed state from phthisis. Seen by Dr. Wallace Beatty. Died of acute phthisis, with pneumo-thorax, 14th September, 1886.

CASE XLI.—B. B., aged twenty, first pregnancy; brought to hospital in an unconscious state from hæmorrhage, from which she had suffered during the passage from Liverpool the previous night. When first seen she was lying on the floor of a lodging-house at the North-wall, almost naked, quite insensible and cold. All means tried to produce reaction, when admitted, with some success at first, but hæmorrhage again came on, and when examined a hydatidiform mole found, which was removed without much difficulty or bleeding. Perchloride of iron injected, but as patient was sinking she was transfused with saline solution, without effect.

CASE XLII.—J. K., aged seventeen, first pregnancy; admitted 26th January, 1884; delivered same day of a 4½ lbs. child, which died two

days after its birth. Patient had well-marked venereal rash, and vulva was covered with warts. Became jaundiced two days after delivery. Left hospital on the tenth day after delivery, having signed a declaration that she was doing so contrary to the wishes of the staff, and died at home, 11th February, 1884, of symptoms of acute yellow atrophy of the liver.

CASE XLIII.—B. K., aged eighteen, first pregnancy; admitted 29th June, 1886; delivered same day of a $9\frac{1}{2}$ lbs. child, by natural efforts. Taken out of hospital 11th July by her father, who signed a declaration that he did so contrary to the wishes of the staff. Died 12th July, 1886, of septicæmia.

These 43 cases include all deaths which could in any way be connected with delivery, inquiries being instituted from time to time with respect to any patient who left the hospital in a state not entirely satisfactory. There was no patient transferred to any other hospital during the time. It will be observed, in reading over the particulars of the 43 cases, that two patients died over five weeks, one over four weeks, and three over three weeks after delivery. Such cases are frequently omitted in calculating the puerperal mortality owing to the length of time that had elapsed since their delivery. From these notes it will be seen that seven deaths were due to hæmorrhage, two to acute yellow atrophy of the liver, three to convulsions, one to exhaustion from discharge from encysted peritonitis, one to congestion of the lungs, three to phthisis, one to tuberculosis of lungs and brain, one to acute bronchitis, three to pleuro-pneumonia, one to pneumonia and Bright's disease, one to syncope, one to excessive vomiting, with hæmatemesis, eighteen to septicæmia.

These 18 cases of death from any form of septic infection give a mortality of .52 per cent., or 1 in 189.6; but I consider a better criterion of the health of the hospital is the number of patients who had absolutely normal temperatures and pulses during the puerperal state. I take what is considered by most authorities as the maximum physiological temperature—namely, 100.4° F., or 38° C., and I find that the percentage of cases which did not exceed this maximum at any time during the puerperal state to be for the three years as follows:—In 1884, 74.66; in 1885, 83.54; and in 1886, 85.75. I consider that the above percentages might fairly be increased, for there are many slight causes which might temporarily raise the temperature—as, for instance, constipation, pain from distended breasts, nervous excitement and fretting, which latter are

often observed after a visiting day, owing to the reception of bad news, or such as the case which just occurs to me of a woman whose perinæum I had sutured being told by an adjacent patient that she would die if the stitches gave way. To this alone could be attributed a sudden elevation of temperature, which came down again next morning to normal. Also, it must be borne in mind that for 12 hours after delivery the temperature gradually rises, and if this increase coincides with the evening rise it may exceed the normal maximum, especially if labour had been difficult, with, perhaps, temperature at 102° or 103° F. before delivery, and, therefore, to give a true chart, the temperature for the first 12 hours should not be considered, yet in my records I have done so.

The temperatures are taken in the Rotunda only at stated periods, morning and evening, unless for special reason to the contrary.

I will now give a short table of the cases of abnormal temperatures—*i.e.*, those exceeding 100.4° F., or 38° C.—and in order to simplify it as far as possible, I have tabulated the cases according to centigrade scale. :—

	1883-84	1884-85	1885-86	Total
Number of patients in hospital each year -	1,109	1,112	1,193	3,414
Temperature exceeding 38° C., or 100.4° F., but not exceeding 39° C., or 102.2° F. -	176	94	93	363
Temperature exceeding 39° C., or 102.2° F., but not exceeding 40° C., or 104° F. -	86	68	58	212
Temperature exceeding 40° C., or 104° F., but not exceeding 41° C., or 105.8° F. -	19	21	17	57
Temperature exceeding 41° C., or 105.8° F., but not exceeding 42° C., or 107.6° F. -	—	—	2	2
Sum total for each year of abnormal temperatures -	281	183	170	634

I find there has been a yearly increase in the number of patients in the labour wards during the three years. In Dr. Macan's Report he mentions that the number of women attended during the year ending November, 1883, was 1,090; for the year ending November, 1884, the number, as I make it, was 1,109; in 1885, 1,112; and last year it reached as high as 1,193.

Thus, not only has there been an annual increase in the number

of patients, but, as can be seen by referring to the foregoing table, the general health of the hospital has improved.

I come now to consider the forceps cases. There were 203 women delivered by that means—a percentage of 5·96, or 1 in 16·75. Of these 6 died, only 2, however, of the 6 from septi-cæmia—1 being the patient with a fœtid discharge when admitted, whose case (No. 12) I have already given the particulars of. These 6 cases give a mortality of 2·95 per cent., or 1 in 33·83 in forceps cases. The forceps are not applied unless there are positive indications to warrant their application either on the part of the mother or the child. Those on the part of the mother are, I think, too familiar to require mention, but those on the part of the child which we considered indicated danger to life are either a very quick or very slow fœtal heart, or the escape of meconium per vaginam when the head presented.

Dr. Neville's axis-traction forceps is the one most frequently used of late, and it appears to act very well. It has, I think, many advantages over the axis-traction with rods, being more portable, more easily applied, distends the perinæum less, can be used, if desired, as a simple forceps, can be more thoroughly cleansed, and there is no danger of injuring the vagina, as may sometimes happen when using the other pattern, by the mucous membrane being caught between the blades and rod.

A subject to which I particularly wish to draw the attention of the members is the treatment of retained placenta, and especially when the placenta is adherent. I divide this subject into two classes—1. Cases of simple retained placenta; 2. Cases of retained adherent placenta. The first of these classes I sub-divide into two heads—namely, cases without irregular contraction, and cases of irregular contraction.

The treatment of retained placenta without irregular contraction is very simple, provided the bladder be empty, but simple as the proper treatment is, I am convinced that the hand is often unnecessarily passed into the uterus to remove it.

The instruction formerly given was that the hand should be kept exerting steady pressure on the fundus of the uterus during the third stage of labour. But if this be not properly done it will, instead of doing good, actually do harm, for, as the fundus is occasionally deflected to either side (usually the left), when pressure is made in the mesial line in the hope of expressing the placenta, the lateral flexion is still more increased thereby, folding the uterus as

it were on itself, and pressing the placenta towards the fundus rather than from it through the os. I consider that the present practice of the hospital—*i.e.*, moving the fingers lightly over the uterus—is preferable, and certainly much less tiresome to the hands than the steady pressure.

Of simple retained placenta I have seen some cases where the treatment was very simple—namely, raising the fundus out of its abnormal position, when the placenta was immediately expelled without any pressure being exercised.

Cases of irregular or hour-glass contraction, a well-known expression, are sometimes met with in the third stage, and are said to occasionally occur naturally, but I believe the condition is much more frequently produced artificially by the hand being placed during this stage not on the fundus but somewhat lower down—possibly at the “ring of Bandl,” and pressure and friction there continually used, exciting and causing the circular fibres situated in that particular part of the uterus to contract tonically. If this contraction ring be below the edge of the placenta it will prevent it from getting down into the lower segment of the uterus, or it may be gripped by the ring, in either case, perhaps, necessitating the introduction of the hand for its removal.

In cases of retained placenta due to irregular contraction, whether naturally or artificially produced, the difficulty may, I think, be sometimes overcome by removing the hand from the uterus, especially if not properly applied, and douching it out well, preferably with hot antiseptic solution, but in its absence with plain water.

When the placenta is adherent I believe the proper treatment is to pass the hand or fingers into the uterus and detach it, although I have been informed that some Continental obstetricians allow the placenta in such cases to remain for even a month after delivery (unless there is hæmorrhage or symptoms of septicæmia), especially in the cases where the patients have not come to their full time. I consider, however, that if the operator's hands be not perfectly aseptic, this is the most dangerous of all operations met with in midwifery practice, except the Cæarean section. It has been recommended by some authorities to keep the fingers inside the membranes during the operation, but there are many cases met with where, owing to the friable nature of the placenta, necessitating the removal of small pieces at a time, this is impossible. Should there be any septic infection about the hand, and especially about

the nails, the usual seat of such poison, I fail to see how such a patient can escape becoming infected; for it is analogous to vaccination, except that virulent poison is substituted for healthy lymph, and with unfortunately greater likelihood of its taking effect, owing probably to the prolonged contact. The uterus, except where it has been already douched out with the hope of getting the placenta away, as I have already mentioned, is always douched with antiseptic solution prior to introducing the hand. Although the left hand is recommended by many as being smaller and corresponding more with the pelvic curve, the right hand is the one generally used, for, the patient being in the obstetrical position usual in this country, the fundus of the uterus can be better and more easily supported by the left hand (the operator standing at the patient's back). Nor can an assistant, no matter how experienced he may be, support the uterus so satisfactorily as the operator himself, who knows the exact part of the uterus requiring pressure so as to bring that particular part of the uterine wall nearer to the introduced hand, and who is able to remove it to some other part the moment required.

An anæsthetic, usually chloroform, is nearly always administered, in order that, if necessary, the hand may be passed in a second time where doubt exists whether all the placental tissue has been detached; for if the patient be perfectly conscious of what is being done, the operator must be very resolute to be able to withstand her solicitation not to pass the hand a second time, and I consider that, once the hand is introduced, the operation should be persevered in to entire completion. When satisfied on this point, the uterus should be again douched out with antiseptic solution. I have recorded, in Table A, 37 cases of adherent placenta removed during the three years, giving a percentage of 1·08, or 1 in 91·95. Of these 37 patients 6 died, giving a mortality of 16·2, or 1 in 6·16. This, no doubt, seems a large mortality, but it is not so large as that recorded by the late Dr. M'Clintock, as observed by himself and Dr. Hardy in the Rotunda, where, out of 28 cases 10 died, giving a percentage of 35·7, or 1 in 2·8, fatal cases. Of the 10 deaths 9 were from puerperal fever.

The above six fatal cases cannot, however, all be attributed to the operation, as in three death took place immediately after the children were born—in order that perchloride of iron might be injected owing to severe *ante-partum* hæmorrhage—two of which three died within two and a half hours after delivery; the third (No. 30 in Table of Deaths) died of pyæmia; another was a case

of convulsions, the woman never having recovered consciousness; the fifth was a case of death from syncope (No. 25), death occurring almost before the placenta was removed, which had been retained for two days with considerable hæmorrhage; in the sixth case death resulted from septicæmia (No. 12). The particulars of this case I have already referred to in connection with the forceps cases, but hope I shall be excused for reminding you that the placenta when removed had a very fœtid smell. Thus, of the six deaths only two were due to septicæmia, or 1 in 18·5, or 5·4 per cent.

When the perinæum is lacerated over $\frac{3}{4}$ of an inch in extent, the practice is, having douched out the vagina with antiseptic solution, to suture immediately either with silk or catgut (using in the latter the continuous suture).

The results have been very satisfactory, chiefly owing, I think, to the stitches being inserted deeply so as to bring the whole of the torn surface into apposition. For if this be not done the lochia would probably collect between the edges of the wound, causing them to become unhealthy, especially should the discharge be fœtid, and this unhealthy condition when once produced is very likely to go deeper, until possibly it might invade the whole depth of the perinæum, causing the stitches to slough out, and the wound to gape widely open. I consider that a patient whose perinæum has been lacerated in the first confinement (especially if the child were large), and that it has afterwards united properly, is much less likely to subsequently suffer from prolapse than if the perinæum remained intact, for in the latter case it would show that the parts were very relaxed.

Before concluding I shall briefly refer to some of the subjects to which Dr. Macan alluded at the end of his Report. Concerning the retention of a portion of the membranes, the practice of the hospital is to make gentle traction, having as a rule tied a ligature on it as close to the vulva as possible, and thereby gaining a firm hold so that it can be twisted into a cord or rope-like body, whereby the chance of breakage is reduced. Should, however, the membranes break well inside the vulva, the best course is to allow them to remain there, but the douche may be used, which may possibly cause the piece to come away, and will in any event be beneficial if an antiseptic solution be employed. This course is far preferable to introducing the fingers or hands, whereby air is introduced—a fertile source of fœtid discharge. I cannot recall a case where the adoption of the course I recommend was to be regretted. As to hæmorrhage,

I do not consider it is ever traceable to the retained membrane, but to the imperfect contraction, which is the very cause of the membrane not being expelled.

The prophylactic antiseptic treatment of ophthalmia neonatorum is never adopted until the disease is actually manifest. Both eyes, even though only one shows symptoms, are then treated with nitrate of silver solution, 8 grains to the ounce—pieces of lint dipped in cold water meantime being constantly kept on the affected eye or eyes. Where one eye only is affected, it would be well to have the other bandaged up so as to prevent contamination by the discharge coming in contact with it. Such a bandage is, however, difficult of application. The number of these cases recorded for the three years was 34—possibly there may have been two or three more unrecorded; this is a percentage of .99, or, in round numbers, 1 in 100, which, when compared with other nationalities, is very low.

Infantile asphyxia is treated according to Schultze's method, which, perhaps, I shall be pardoned for endeavouring to describe. First the finger is passed into the child's mouth, and the mucus removed as far as possible. The child is then placed on its back, and the operator's hands are put under its back so that they lie at each side of the spine, the fingers in the direction of the child's lower extremities, and its head resting, or partially resting, between the ulnar side of the operator's hands. The index fingers are then passed underneath the axillæ from behind forwards, the remaining fingers continuing to support the back. The operator now stands up, allowing the child to hang with its feet downwards. The child is now swung upwards so as to cause the legs to fall over the body, and the thorax to be compressed by the thumbs, and then after an interval the legs are swung back to the original position, so that the child will be, as it were, in the vertical or standing position, from whence it is again hoisted to the second position. This movement is repeated eight or ten times, and then the child is placed in a warm bath for a few minutes, during which time any mucus that has collected in the larynx is removed by aspiration through a catheter. Not alone is there compression and expansion of the thorax, but the mucus is frequently ejected into the mouth when the child is swung into the second position. Care should be taken not to jerk the child, lest some of the internal viscera should be thereby injured.

The incubator has, I am satisfied, been the means of saving the lives of many infants, as, notwithstanding the efforts of the mothers

to keep up warmth, I have seen the extremities of the child become scleromatous and frequently assume an almost erysipelatous appearance, feeling quite cold, accompanied with inability to draw the breast, and marked fall of temperature, yet when these infants were placed in the incubator an improvement was visible in 24 hours, and generally after a further 24 hours the child seemed completely restored, with the swelling gone, colour natural, extremities warm, and perfect ability to take the breast. I should mention that such children always get wine-whey. It has been urged against the incubator that when the children are taken out, and especially if taken home, they are liable to die. This I do not admit in the sense in which it is used, as if a child has improved in health it must be better able to meet further attacks and the absence of proper care. The fact that in some cases the incubator fails to save a life will not show that it is inefficient in all cases, and where the incubator fails, in my opinion, the life of the child is fated in any event to be a short one.

For the statistics of the external maternity I am indebted to J. H. Knowles, M.D., ex-Clinical Clerk, who furnished the following. Total number of cases for the three years, 4,766.

TABLE B.

Forceps	-	-	-	-	81, or 1·699 per cent.	=1 in 58·83
Version	-	-	-	-	10 „ 0·209 „	=1 „ 476·6
Accidental hæmorrhage	-	-	-	-	16 „ 0·335 „	=1 „ 297·25
Placenta prævia	-	-	-	-	11 „ 0·230 „	=1 „ 433·27
Post partum hæmorrhage	-	-	-	-	40 „ 0·839 „	=1 „ 119·15
Secondary post partum hæmorrhage	-	-	-	-	5 „	
Adherent placenta	-	-	-	-	11 „ 0·230 „	=1 „ 433·27
Breech	-	-	-	-	75 „ 1·573 „	=1 „ 63·54
Footling	-	-	-	-	20 „ 0·419 „	=1 „ 238·3
Prolapse of funis	-	-	-	-	16 „ 0·335 „	=1 „ 297·87
Face	-	-	-	-	18 „ 0·337 „	=1 „ 264·77
Twins	-	-	-	-	48 „ 1·007 „	=1 „ 99·08
Deaths	-	-	-	-	16 „ 0·33 „	=1 „ 297·87

Six of the deaths were from septicæmia; 2 of the patients died in the Auxiliary Hospital. Perchloride of iron injected in one case of *post-partum* hæmorrhage.