(4) Gall-stones are a possible exciting cause, especially in a person predisposed to carcinoma.

(5) The organ is not generally much enlarged, save occasionally by the secondary process of dilatation.

(6) Metastasis is not widespread, and by continuity of structure neighboring organs are involved.

(7) Adhesions to adjacent organs, and ulceration and perforation are not common.

(8) Pain, jaundice, emaciation, cachexia and tumor are present in the largest number of cases, while indigestion, vomiting, constipation or diarrhoea and ascites are of more frequent occurrence than most persons think, and are important associate phenomena by means of which the disease is recognized.

(9) Pain occurs in about sixty-two per cent. of the cases, at first ill defined, it soon becomes localized to the right hypochondrium, and is lancinating in character.

(10) Jaundice in about sixty-nine per cent. of the cases. Gradually increases in intensity.

(11) Tumor in about sixty-eight per cent. of the cases. (a) Situated in (1) the gall-bladder region, (2) to the right of the umbilicus (when it is in the latter location the liver is usually enlarged). (b) Character (1) hard or firm, (2) painful and tender.

(12) The progress of the disease is almost always progressive, and toward a fatal termination.

(13) Complications are due to (1) occlusion of the ducts, and secondary effects on the liver and gall-bladder; (2) ulceration and perforation of gall-bladder; (3) the symptoms that arise by metastasis in other organs.

(14) Duration is short, the average being six and two-thirds months.

(15) Death due to (1) Exhaustion; (2) Peritonitis; (3) Metastasis to other organs; (4) Biliary obstruction.

(To be continued.)

REPORT OF ONE HUNDRED AND EIGHTY-SEVEN CASES OF MIDWIFERY IN PRIVATE PRACTICE.

BY MARIE E. ZAKRZEWSKA, M.D., BOSTON.

I PRESENT here the summary report of these 187 cases in my private practice, recorded in the succession in which they occurred at the beginning of my obstetrical career. My object in so doing is to encourage the young practitioner, who is entering on a field of work, the importance of which is so variously described in the different medical journals. To explain my meaning, let me refer to sentences like these:—"When I am called to a case of child-birth, I prepare myself as if I were going to perform a capital operation"; or, "No physician ought to follow an obstetrical call without taking with him a well-equipped bag, containing instruments, disinfectants, drugs, etc."; then follows a full, and minute list of articles, the expense of which would look like a small fortune to a young practitioner, who is warned to prepare thus, for a normal case of labor.

Such remarks in our journals are evidently intended to instruct and caution, yet must necessarily alarm the young practitioner, in regard to the most natural process in a woman's life. It is within the last decade, that in all the medical journals, East and West, may be found similar paragraphs of caution, more necessary perhaps to the country practitioner who must depend

upon self, than to those in towns and cities; but the effect is to engender in the beginner an anxiety, a fear, which finds expression in manners and words towards the patients before, during, and after the lying-in period, and still more, transmitting, as it were, the same anxiety, or creating the same fear among our otherwise most sensible and courageous classes of women.

There already exists a feeling of fear and anxiety about this natural phenomena of child-birth, in just that social grade who possess the best qualifications for propagating the race by raising a number of children.

Thus the fear of losing health by child-bearing and the increase of expenditures for costly preparations, supposed to be essential, make many a couple of moderate wealth consider it beyond their means to have children born to them. If, however, such fears have not been created as yet in all classes of people, still the young practitioner himself suffers an undue anxiety concerning the possible result, when meeting neither the willingness, nor the means to carry out such preparations as he has been taught to think absolutely necessary in modern midwifery. Meanwhile, the richer woman who can provide all the costly luxuries demanded, is victimized by being over-nursed, and petted into a delicate state of health, which she did not experience before child-bearing, which thus seems the cause; but this condition would never have existed, had she been led with confidence and courage towards the great event of a woman's life, the birth of her first babe, and if she had been guided during the lying-in period with that kind of rational treatment, which is called common-sense, and had not been regarded as a sick person who was hovering between life and death, until her full recovery.

Propagation of the race is a mere process of nature, as is proved by the thousands of children who swarm the streets inhabited by our healthy working classes, where neither indifference nor neglect, yet no "preparation as for a capital operation," is practised, where cleanliness is sufficient and disinfectants are unknown. The woman, not the physician, brings the child into the world. The presence of the doctor is simply desirable in exceptional cases when abnormal conditions may occur, and when obstetrical art will assist or supplement nature.

It is for this reason that I maintain that the young obstetrician is preferable to the old, if he is not disturbed by the admonitions of which I have spoken. The younger practitioner has much more patience to wait quietly for the natural process to take its course, the lessons received concerning the action of a normal labor are fresh in his remembrance, and are applied while watching over the case. The desire to establish a reputation of success, of having "everything go well," will prevent meddlesome interference, and will encourage the woman, and strengthen the patience of both doctor and patient; and the young mother will recover far better than with the "experienced" old practitioner, whose patience is worn out, and who understands better how to shorten the healthful suffering of a woman, by using forceps, and hastening the removal of the placenta, and afterwards has to sow up consequent tears, and perform all sorts of "scientific" measures "to bring a woman through."

When I studied clinical midwifery, in 1851-52, in the Royal Charité, of Berlin, the male students remarked that the clinics were rather tedious during the winter

months from November to April, as there were so few instrumental labors. The "*accoucheuse-en-chef*" consoled by telling them to wait until summer, and she would provide them plenty of chances to see forceps used. I asked her how this could be; she simply said, "I *make* these cases then." And so it was. During the winter months, when the students in midwifery were young women, they were thoroughly instructed in the course of a normal labor, and in patiently letting nature do the work; consequently we seldom used forceps, and had very little child-bed fever. When the summer came, and young men students took the place of the young women, every third case was made a forceps-case, by untimely rupturing the membranes, or by other meddlesome interference with nature, which consisted chiefly in yielding to the *woman's* wish to put an end to her suffering. Of course, we now had plenty of interesting work, and were removed by whole wards to the isolating building, in order to stop the spreading of fevers, purulent ophthalmia, and peritonitis. When, in 1853, I took the place *accoucheuse-en-chef*, for which I had studied, I followed a different course, teaching the young men minutely the mechanism of normal labor, showing them when and how to assist nature in case of an abnormal deviation, using for this purpose the manikin, instead of the living woman; and not one single time, were we removed to the isolating building during that summer, and the young men were as well, even better satisfied with the knowledge gained thus, than in witnessing the use of forceps by the *accoucheur-en-chef*.

Of the three branches which constitute our profession — Surgery, General Diseases and Obstetrics — the latter is the only department in which we can approach to something like science. A diagnosis of pregnancy can almost always be made from the time a woman is six weeks' pregnant, and the prognosis can be deduced in advanced pregnancy with much more probability of certainty than in any condition belonging to the two other departments.

The position of the child in the uterus can be ascertained; with a little practice, the size of the pelvis can be correctly measured simply by the hand, provided the practitioner knows the size of the span of his fingers, and has paid attention to measuring the small pelvis when for whatever purpose, an internal pelvic examination is made of the condition and relations of the bones of the small pelvis.

During labor, if possible at its very early stages, the presentation of the child ought to be correctly ascertained, and this can be done, even before the os uteri is open, if the hand has been well trained; but it *must always* be ascertained before the membranes break, and therefore examinations should take place only between the pains when the membranes are soft and no danger exists of an untimely rupture; this must be repeated until the practitioner has obtained knowledge of the exact presentation. Then a prognosis, so far as the birth is concerned, can be given, provided the dynamic conditions are normal. Yet here, again, we often meet with new difficulties in the power of perception in the attendant. What are the normal dynamic forces? They are different in every woman independent of her size or appearance. It is far oftener the physician's patience gives out than the strength of the patient, and instrumental interference is resorted to, less for the benefit of the woman than for the relief of the physician from the tedious watch-

ing and constant work of encouraging the woman during the passage of the child through the pelvis.

It is a marvellous process, and every time I witness it, it is as new as at the first time when I stood by and watched a woman working to bring forth her babe. I know from experience that the older I grow the less faith I have that the woman will accomplish the task, when I hear her declare that all her strength is gone. I am even obliged to recall to my own mind, the rules I laid down to the students, that patient waiting will teach me and her better, and that she will have the strength needed, that she will accomplish the work far safer than I can do for her artificially, and with less danger of injury to the child.

It is for these various reasons that I have made the statistics of these cases in order to prove by number what cannot otherwise be affirmed. In order to simplify the records, I call all first positions, when the diameter avoiding the rectum is covered and the dorsal side of the child is against the abdominal walls of the mother. The second positions when the diameter in which the rectum lies is covered with the dorsal side of the child against the abdomen of the mother. The third and fourth positions when the dorsal side of the child lies in the dorsal side of the mother in the first or second diameter.

If such a correct diagnosis is obtained, the pelvis is well measured inside with the fingers from promontory to lower edge of pubic symphysis, and the relation of the latter to the os coccyx and the position of child is ascertained, then the physician's work is done. If the dynamic forces should now fail, easy and correct assistance can be rendered to bring forth the child; otherwise simply patience has to be exercised in order to avoid all artificial stretching of the os uteri and adjacent parts thus preventing the frequent tears of these delicate organs.

The active part of the physician's work begins only after the woman has done her work and brought the child where it can be fully seen. Then support of the perineum is to be given, and given with such understanding as to again imitate nature, preventing, if possible, the tearing of this so thinly stretched organ.

After the child is fairly in the world comes the real test of the physician's good sense, namely, in the delivery of the placenta. Here again, in most cases, nature will do the work. I always advise my students to place the woman on her back if not delivered in that position, as soon as the child is removed, thus causing a natural return of the abdomen and its contents and its walls to their place, before I even touch the placental portion of the cord. In this position the uterus will soon regain its tone, contractions will recommence and thus will be expelled what no longer belongs there, namely, the placenta. An occasional gentle touch of the abdomen under the bed-clothing will convince a practised hand whether the uterus has resumed its activity or not. If the placenta is entirely detached, the uterus will appear hard under the abdominal wall and the expulsion of the placenta into the vagina will take place within fifteen minutes in the case of a primipara, with but few pains. If it is not entirely detached as is most frequently the case in the multipara, or in premature births, then provided there is no hæmorrhage, I teach to wait quietly for an hour or more thus leaving nature to perform its task, and never interfere by putting the hand into the uterus; such interference being, I have no doubt, often the

cause of inflammation and fevers. Only in case of hæmorrhage or appearance of abnormal pains do I interfere with nature.

As soon as the placenta is felt in the vagina, and is not expelled by the muscular contraction of this organ, then a moderate pull on the placental cord will assist in ejecting it from the vulva, and with it will be brought the membranes and such clots of blood as may have been formed in the process of loosening. This simple method I call self-expulsion; and you will find that my statistics prove this to be the most frequent form.

During the last four months of my holding the position as *accoucheuse-en-chef* in the Royal Charité, of Berlin, Professor Credé held the office of clinical professor, to which he was appointed after the death of Prof. J. H. Schmidt, my steadfast friend and teacher. Dr. Credé was ambitious for success *à tout prix*. During the winter preceding his appointment he acquired some notoriety in his efforts to gain renown by inventing a new — his own — method for delivering the placenta — the Credé Method. As soon as he had the direction of the *clinique*, he taught practically, during *his hour* of attendance, what he had before taught theoretically; while I, during the other twenty-three hours of the day, very unwisely perhaps, not only discouraged the young men from following his method, but when teaching the midwives, actually opposed his method.

The Credé method has been followed by many of his pupils, and even gained some reputation in this country; but now Dr. Credé is making an effort to add to his fame and this time it is by renouncing lately his "method," acknowledging it to be an error, and admitting that it may have been practised to the detriment of many a woman.

I have recorded these 187 cases on a paper which I had lined and printed for the purpose; they are selected from my private practice in preference to that of the hospital; the latter can never give a criterion for the former, because the conditions and surroundings of the patients, are so utterly different in their homes from those in institutions. Also, I have collected these cases from my general records commencing in 1855, and giving them in just the succession in which they occurred, not making intervals of years between. They are, therefore, really a record, consequently include all classes and conditions, from the mechanic's wife, who could not even afford the attendance of a nurse, to the wife of the wealthiest man in the best of surroundings, who employed a nurse for months. But no dispensary patient is recorded among them.

Although I tried to make a record of all my practice, even of the slightest consultation and prescriptions ordered, yet I did not in the earlier years keep it as minutely as I might have done, had I supposed I should ever write about it, or wish to make use of it scientifically. I keep my records chiefly for my own instruction and satisfaction, in order that I may from time to time test thus the clearness of my perceptions.

I will commence by giving statistics relating to the age of the patients. The youngest primipara was 18 years old; the oldest was 41 years old; 75 primiparae are recorded, the ages varying between 20 and 30 years. The ages of the multiparae varied up to nearly 50 years; and the eleventh child-birth was the highest number in an individual.

The hours of birth I have not strictly kept; 60% of those whom I recorded were born between midnight and noon.

There were, with two pairs of twins, 183 infants in all, 99 boys and 84 girls; 4 were miscarriages under 16 weeks.

I had almost every infant weighed; the smallest living child was in a multipara, weight 2 lbs.; another one was 4 lbs. One pair of twins weighed 5½ lbs. and 4½ lbs., each; one pair, 6 lbs. and 7 lbs., each.

10 infants weighed		6 lbs. net
56 "		7 "
74 "		8 "
31 "		9 and 9½ "
1 "		10 "
2 "		11 "
1 "		12½ "

Duration of labor from first pain to birth of child: 70 from 1 to 10 hours, 64 from 10 to 20 hours, 32 from 20 to 30 hours, 12 from 30 to 40 hours. Of these 12 cases 7 were 36 hours. There were besides these, one each of 48, 54, 60 and 70; and two of 72 hours.

These 187 cases also include 4 miscarriages, of from 12 to 16 weeks' pregnancy, and 20 premature births, of from 20 to 36 weeks' pregnancy, leaving 163 cases of full time.

POSITION OF CHILD PRESENTING AT TIME OF LABOR.

Vertex presentation, I.		130
" " II.		34
" " III.		3
" " IV.		8
Breech presentations (3 times I., 1 case IV.)		4
Foot " (2 times III., 1 case I.)		3
Knees " (IV. position)		1
Face " (IV. position)		1
Transverse position, with prolapsed cord		1
Vertex position, high in large pelvis, because the brim of pelvis contracted		1

I am sorry that I did not always keep record of the time when the membranes ruptured. I marked it only in extraordinary cases; namely, in case of the 4 pounds' infant; membranes ruptured 8 days, that is 8 times 24 hours before labor; in the case just mentioned of contracted pelvis, rupture 47 hours before labor; in a case of completely adhered placenta, rupture 26 hours before labor.

Among the normal yet protracted cases of labor, there is a multipara, where the membranes ruptured 48 hours before there was a sign of labor. I find four others recorded, rupture at 15, 22, 22 and 25 hours before birth; the latter case was a primipara, labor lasted 6½ hours, during which she took eleven dollars' worth of sulphuric ether, yet recovered well, and was strong in four weeks. Several times I have noted down that membranes ruptured with the passing head of the child, and a number, rupture from 15 to 60 minutes before passage of head from vulva.

I have explained my use of term, "self-expulsion of placenta"; this occurred unassisted in 173 cases; in 10 cases a partially loosening placenta, requiring introducing of the hand and artificial removal on account of hæmorrhage; in three cases, there were completely adhered placenta requiring forcible removal, after waiting two hours or more; only one case of partial placenta prævia occurred. All these cases made a speedy and good recovery.

I may here add that most of the hæmorrhagic cases were among the miscarriages, that is less than 20 weeks time of pregnancy; but few occurred in normal labor.

The normal labors were 142; that is, in every respect, birth of child and delivery of placenta requiring no assistance.

Among the infants born, were four stillborn, so decomposed that the skin peeled off; two died from application of forceps, heads above brim of pelvis. Forceps were used in five other cases; in one, because of unyielding os coccyx, head of child having been on the perineum for nine hours; the whole labor was 36 hours. The recovery of all these patients took place within six weeks.

One case suffered from hæmorrhage from the beginning of labor until the placenta expelled itself.

There were three cases of convulsions, but all after delivery; in one, coming when the head was passing through the vulva, and continuing at intervals for four hours; in the second, beginning one hour after labor and lasting 36 hours; in the third, beginning 72 hours after labor, and lasting 24 hours, yet the patient retained her milk to nurse twins. All three cases recovered well within seven weeks.

One case of pregnancy of 32 weeks only; a multipara; there were irregular, spasmodic pains; child born with a large umbilical hernia. One case was rather formidable; primipara 34 weeks pregnant; 1 breech presentation; completely adhered placenta; hour-glass contraction of uterus, and hæmorrhage in consequence of this irregular contraction; catheter had to be used upwards of eight days.

Two cases are recorded where the contractions were perfectly painless, pressure alone indicating the approach of labor.

In one case labor was induced after 32 weeks' pregnancy, on account of contracted pelvis, craniotomy having been twice previously performed.

The majority of these 187 patients recovered health and strength within four weeks; a few within seven weeks, and three within three months, these latter having complications of inflamed breasts and hæmorrhoids.

One remarkable case was that of a patient whom I attended with typhoid fever when three months' pregnant; and when 34 weeks' pregnant, she had an attack of pneumonia which brought on labor, and a dead child was born. Patient recovered in six weeks.

Clinical Department.

A CASE OF ABDOMINAL NEPHRECTOMY FOR PYONEPHROSIS.

BY J. C. IRISH, M.D., LOWELL.

In September, 1889, I saw, with Dr. Hodgdon of Peterboro, Mrs. T., of Dublin, N. H., who was suffering from an abdominal tumor. She gave the following history: Age fifty-nine. Menstruation ceased about ten years before. Had one child, now twenty-five years old. Soon after her confinement, her abdomen became very large. Several physicians, who examined her at this time decided that she had an ovarian cystoma, and advised its removal. Subsequently, however, the tumor suddenly disappeared, and the abdomen, in a few days, became reduced to its usual size. Ever after, Mrs. T. remained perfectly well, until in the past spring, she noticed a growth occupying the left side of the abdomen. When Dr. Hodgdon saw her in August, he found a tumor extending from the pelvis to the thoracic walls, and filling completely the left half of the abdominal cavity.

Its size at the time of my examination, a month

later, had slightly increased. No fluctuation could be detected. Resonance was found over portions of the tumor, especially at the upper part. Still the growth could be distinctly felt beneath the overlying intestines. It was entirely immovable and its superior outline beneath the left thoracic wall could not be traced.

By vaginal examination the tumor could not be reached, nor could anything abnormal be found in the pelvis. Yet the history of a probable ruptured parovarian cyst, although it had remained quiescent twenty-four years, lent great probability to the belief, that the present growth took its origin from this old sac — possibly with an added element of malignancy. On the other hand the immovability of the tumor, especially beneath the anterior thorax and the intestines in front, strongly suggested an origin from the left kidney. The patient, we learned by inquiry, passed a very small amount of urine and had had attacks of renal colic. She had never passed a calculus nor had any irritation of the bladder. The urine contained no pus.

From all these facts, the conclusion was reached, that we had to deal, probably, with a tumor from the kidney. The possibility that this diagnosis might require a very radical revision did not escape our minds.

The patient's general health, during the past few weeks, had failed rapidly. She was confined to the bed a large portion of each day; was somewhat emaciated and anæmic; pulse 100; tongue red; vomited often, and unable to take only small quantities of food. Her general look and condition was that which is always seen in patients in whom degenerative changes of an abdominal tumor, notably an ovarian, are actively progressing.

September 21st, with assistance of Drs. Hodgdon, Cutter, Chase and Allen, I removed the tumor through a long abdominal incision in the median line. Intestines and omentum were extensively and closely adherent to the cyst, and were separated only with great difficulty. The sac contained seven quarts of pus. Its walls were about one-third of an inch in thickness, except over the anterior and lower portion, where they were thinned by a degeneration, that was indicated by a yellowish-white color of the surface and entire lack of blood supply. At this place rupture of the cyst would have soon occurred. The renal vessels, much dilated, together with the surrounding tissues, made a pedicle somewhat difficult to ligate, both on account of its size and position. A drainage-tube extending to the site of the kidney was inserted. Abdominal wound was closed in the usual manner. The patient went on through an uneventful convalescence to a complete recovery. The average amount of urine that she now passes daily is thirty-two ounces.

A microscopical examination of the cyst, by Dr. Whitney, demonstrated malpighian bodies and urinary tubules at various points within its walls, showing that it was formed of the dilated kidney. In short the case was one of pyonephrosis, due probably to obstruction of the ureter by a calculus.

In the way of an exact diagnosis, before the abdominal cavity was opened, were these difficulties: (1) the shape, size and position of the tumor, made it possible that it might have grown either from the left kidney or left ovary; (2) the past history of a ruptured parovarian cyst, and the present condition of the patient, strongly indicative of a degenerating ovarian cystoma; (3) the absence of any fluctuation that we