CLINICAL REPORTS OF THE ROTUNDA HOSPITAL
FOR YEAR ENDING OCTOBER 31st, 1909.

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AND

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DURING the year 1908–9 there were 2,369 admissions to the maternity wards and 2,045 deliveries, which is 15 less than the previous year.

The hospital has been improved by the installation of electric light, the planing down of the greatly worn floors, the uniform painting with white enamel of the wood-work of all the convalescent wards, and the modernising of the labour wards by rounding off angles, replastering ceilings and walls, and painting with rippoline enamel.

These labour wards are too small for our present requirements, and will soon have to be reconstructed. The corridors of the hospital and the nurses' home stand badly in need of painting. This deficiency has been commented on in the Government Board of Inspectors' Report, and it is a matter of no surprise to read this comment, for many of our corridors have not been painted for twenty years.

In previous reports I have referred to special points of obstetrical interest which have attracted our attention. This year I desire to refer to eclampsia, contracted pelvis, and the treatment of premature children.

My cases of eclampsia up to date number 73. This is not only the largest series of cases published by one observer

in Ireland, but surpasses the combined number of my two predecessors. It would be of interest to know if the other Dublin maternity hospitals show a like increase. Six of these patients died, a percentage mortality which compares favourably with the results obtained in other clinics (8.22 per cent.).

The close attention given to statistical records of eclampsia make it imperative that a common standard for diagnosis should be established. That this is necessary is evidenced by the fact that some authors classify as eclampsia convulsive seizures unaccompanied by albuminuria, and thus open the way for inaccurate compilation.

The rules we have acted on in classification are as follow :—

(1) All deaths associated with convulsions, occurring after the sixth month of pregnancy, have been considered as due to eclampsia. Before the sixth month the diagnosis rests on the pathological findings. If there is obvious chronic renal disease it should not be classed as a case of eclampsia.

(2) No woman who gives a history of previous fits unconnected with pregnancy or labour should be included, nor has such a case been included in our list.

(3) We have not included any case of convulsions free from albuminuria. This limitation is of the utmost importance, for there are many conditions which simulate eclampsia, such as epilepsy, heat-stroke, &c.

(4) An unconscious pregnant woman, who shows marked toxic symptoms after the sixth month, with albuminuria, is considered to have eclampsia, whether or not she has had convulsions.

It is possible that some cases of true eclampsia may pass unrecorded, but, on the other hand, if a less stringent definition is accepted, it is absolutely certain that many spurious cases will be included in a statistical table.

A close inspection of former reports will demonstrate the fact, which has been repeatedly noted by other observers, that the incidence of eclampsia is apparently in the nature of an epidemic. Thus we have gone months without a case, and then have had four cases in the house at once. This fact is

worthy of more than a passing notice, for it is possible that it may serve as a clue to the recognition of the cause of the disease.

It seems to me that we have five possible explanations to account for its epidemic character :—

(1) The disease is due to a specific micro-organism. This may be dismissed because of its inherent improbability.

(2) Some chance infection by an indifferent organism, such as the influenza bacillus, may determine the onset in a pre-disposed woman. That eclampsia is the culmination of a high degree of auto-intoxication is now almost universally accepted. I have often thought that certain mild epidemics of influenza or coryza might be its exciting cause in patients predisposed to the attack by toxæmia. The great congestion of the nasal mucous membrane during the attack suggests the disease coryza. I confess, however, that investigations in this direction have led me to no definite results.

(3) Meteorological conditions and seasonal changes affecting a woman with a system saturated with toxins. This is a plausible explanation, but I have never been able to suggest any connection between weather conditions and the actual epidemic. They do not accompany dampness, great heat, great cold, or rapid changes of temperature.

(4) The disease is due to insufficient fluid in the system. In this connection the undoubted fact should be remembered that eclamptics suffer from a thirstiness of the tissues. A great number of pregnant women do not drink sufficient fluid for their wants. It is amongst this class that the toxæmias of pregnancy will be found. It is possible that this lack of fluid may account for the great prevalence of eclampsia in tropical climates, where the natives have schooled themselves to exist on a minimum of fluid. Here again we have attempted to associate seasonal changes with lessened intake of water, but our investigations have led to negative results.

(5) The disease is due to intestinal disturbances. Our final source of inquiry may possibly lead to more definite results. An extensive experience of the disease has convinced us that

intestinal irritation is closely associated with the onset of convulsions. It is rare to see an eclamptic patient with good teeth. A frequent history is that a large meal has been bolted shortly before the attack. In nearly every case efforts to empty the stomach and the bowel have been rewarded by the removal of large quantities of undigested and indigestible material, frequently of a vegetable nature. Thus, potato skins, lumps of apparently raw cabbage, currants and orange pulp have been removed by gastric and rectal lavage. Their removal is usually associated with benefit. Is it not possible that a connection exists between these indigestible masses and the epidemic nature of the disease? Thus, seasons when raw vegetables are likely to constitute the popular articles of diet, or in the early spring, when the old vegetables have become tough and diseased, would be likely periods for epidemics of eclampsia. The raw meats and vegetables so popular in Continental countries, and the almost exclusive vegetable diet of the tropics, could in this way be made accountable for the greater prevalence of eclampsia there as compared to Ireland.

We think we have gradually evolved a better technique in the treatment of these cases. We have not had a death in our last twenty-six cases. We now insist on greater watchfulness throughout the illness, and seldom permit the nurse to take the entire responsibility. If the breathing becomes impeded and marked signs of obstruction appear, the attendants are instructed to rapidly turn the patient on to her chest, making her head hang over the side of the bed. This allows the fluid which is the cause of the obstruction to pour from the nose and mouth, and free the embarrassed breathing. If necessary this manœuvre is followed by artificial respiration and administration of oxygen. More than one patient has, we think, thus been saved from asphyxia, and one of our recent patients was resuscitated by a night student from what promised to be a fatal attack.

We do not leave as large a quantity of fluid in the stomach as formerly, for we have noticed that it is apt to regurgitate and embarrass the respiration. A full stomach has also a

tendency to press on the weakened heart. To avoid such pressure we keep our patients for the most part on the right side, and only occasionally turn them on to the left side.

In respect to contracted pelves, I would like to enter a plea for their estimation in inches rather than in centimetres. Whatever disadvantage the English method has in other respects it certainly lends itself to a very simple and satisfactory division of pelvic contractions. Thus, if we start with $4\frac{1}{4}$ inches as the normal conjugate, we can divide the different contractions into five degrees, the first four separated from each other by half-inch measurements, the fifth degree comprising all pelves with a true conjugate less than $2\frac{1}{4}$ inches. This presupposes that a simple flat pelvis is being dealt with ; in the presence of general contraction the condition must be considered worse by half an inch.

Children of abnormally large size can be delivered through the normal sized pelvis, and this labour is comparable to unaided delivery in a contracted pelvis. Therefore rules of treatment for contracted pelvis should be based on the supposition that a child certainly of normal size has to be delivered. That this supposition is justifiable is evidenced by our last sixty-one cases of contracted pelvis, with a true conjugate of $3\frac{1}{4}$ inches or less. In these cases the children averaged $7\frac{1}{2}$ lbs. in weight.

I desire to state in an emphatic manner that precision in pelvic measurement is a necessity, in carrying out scientific methods of treatment ; that this precision can be obtained only by Skutsch's pelvimeter, the use of which requires considerable practice ; that treatment based on the known size of the pelvis will yield better results than that obtained by any other single method. Of other methods, the most important is Professor Müller's, which is of immense utility, but not of universal application. It often fails in obese women, or when the child lies in the third or fourth position with the head extended. To carry it out thoroughly an anæsthetic is necessary.

I no longer consider it justifiable in a well-appointed hospital

to induce premature labour or to perform prophylactic version as a treatment for contraction without complication.

These women may be allowed to fall into labour and deliver themselves naturally, provided that the narrowing is not greater than the first or second degree. In such cases the application of a tight binder after rupture of the membranes and the persistent employment of Walcher's position are of immense help.

Delivery by forceps or by enlargement of the pelvis should not be delayed when once maternal or infantile symptoms of distress have appeared, and for these a careful and continuous watch should be kept.

Walcher's position may be maintained indefinitely by placing the patient in the cross-bed position, with her hips elevated by raising the legs of the bed on blocks. This enables the patient's legs to hang down without permitting the feet to touch the floor. Two chairs are placed by the side of the bed, and the patient, covered with blankets, is instructed to let her feet rest on them in the intervals between pains. During the uterine contractions the legs hang down. One of our patients was kept in this position from 11 30 a.m. until 8 30 p.m. without undue discomfort.

In contractions of the third degree the patient's powers should not be wasted by a prolonged second stage, for an enlarging operation will nearly always be necessary for delivery.

In the fourth degree of contraction Cæsarean section, intra- or extra-peritoneal, is the operation of necessity, if the child is alive, whilst craniotomy with cleidotomy, if necessary, can be relied upon for delivery if the child is dead.

In the fifth degree, whether the child is dead or alive, it is best extracted by Cæsarean section.

Of the enlarging operations, sub-cutaneous pubiotomy appears to offer most advantages, both in regard to simplicity and freedom from complication. The one case in which I have performed it will appear in the next Annual Report.

I will again refer to extra-peritoneal Cæsarean section.

To sum up, my views on the treatment of contracted pelvis are :—

- (1) Induction of premature labour is never advisable.
- (2) Perforation is not permissible unless the child is dead.
- (3) Turning should never be employed as a treatment for contracted pelvis, but may still be performed for complications of labour, such as prolapse of the cord, when associated with contractions of the first or second degree.
- (4) In the greater degrees of contraction time should not be wasted in an endeavour to obtain natural delivery.
- (5) On the other hand, in the lesser degrees ample time should be given the woman to enable her to deliver herself, if possible. Eight or ten hours may be necessary for the moulding of the head, and interference should not be considered until there are evidences of foetal or maternal distress. Once foetal symptoms of distress are manifested there should be no delay in delivery. Walcher's position should not be forgotten as an aid to fixation of the head.
- (6) High forceps should never be applied until all arrangements are perfected for an operation to enlarge the pelvis. It is, in my opinion, a pity to proceed to the latter expedient until forceps have been tried tentatively. It must be confessed they occasionally accomplish their purpose under the most unexpected circumstances.

Finally, in these, as in all other obstetrical operations, the best results cannot possibly be obtained if rubber gloves are not worn.

The treatment of premature children is, to say the least, disappointing. I have over and over again remarked that these infants do apparently well for about a week. They then become very withered, with a dry, parched skin, and gradually die from asthenia. The change is sudden in its onset, and seems to be closely associated with dryness of the tissues due to lack of fluid. This is not surprising when we remember the hot atmosphere in which the child is kept, the constant loss of fluid through the skin, lungs, kidneys and bowel, and the extraordinarily deficient means at our disposal to make good

this waste. Thus it is often impossible to give such an infant more than a teaspoonful of fluid at a time, and our resources are taxed to the utmost to compensate for the loss. I have tried subcutaneous injections of saline, but the paucity of subcutaneous tissue makes this quite impracticable.

Rectal injections provide the only means whereby a sufficient quantity of fluid may be absorbed. To make this means effective it is necessary to hold the child up by the heels. In this way, and only in this way, can an appreciable amount of fluid be retained. These injections should be very slowly administered, three or four times a day. Success depends on whether the fluid is retained in sufficient amount, and it should not be less than half an ounce.

Of course I do not under-estimate the importance of heat and of colostrum, the latter of which excites the formation of the anti-bodies that are considered necessary for assimilation. Neither do I forget that such children require warmth and nourishment in its most digestible form, such as small quantities of peptonised whey, until the mother's milk is established.

The morbidity shows a further improvement, 3.85 per cent., as compared with 5.30 per cent. by the B. M. A. standard—*i.e.*, a temperature reaching 100° Fahr. on any two occasions between the second and eighth day, by bi-daily taking, the mouth temperature to be recorded, abortion cases to be excluded, and deaths to be included in the morbidity list, regardless of temperature. By our own estimate it is 2.49 per cent., as compared with 3.64 per cent. last year.

Our method of estimating morbidity is as follows:—A patient is considered morbid if her temperature and pulse, taken twice daily, rise above 99° F. and 90 respectively on three consecutive occasions, counting from the beginning of the second day to the time of her discharge, which in normal cases is noon of the eighth day. Abortion cases are included, but deaths without fever are excluded. If the patient's temperature and pulse are above the lines indicated she is not permitted to leave the hospital until they fall to normal for

three consecutive takings, and should a patient be kept in the hospital after the eighth day, and then show any morbidity, our statistics will show it. Temperatures are always taken in the mouth.

We have to record four deaths, which is the smallest number that has occurred during any year of my mastership. Of these four, two were due to sepsis, one to shock, and one to pulmonary tuberculosis.

Two Cæsarean sections were performed during the year; the first calls for no comment, the other was the first of three hysterotomies that I have performed up to date. So far as I know it was the first performed in Great Britain. The steps of the operation were as follow :—

A transverse incision from one anterior superior spine to the other, passing about one inch above the pubes, was carried down to and through the sheath of the rectus. The sheath was separated upwards. The muscles were divided from each other vertically in the middle line. The transversalis fascia and peritoneum were incised transversely. The bladder was raised, putting the vesico-uterine fold on the stretch. This was opened transversely, a finger beneath the fold guarding the uterus from injury. The upper edge of this fold was separated upwards from the uterus and stitched to the upper edge of the wound in the parietal peritoneum, shutting off the general peritoneal cavity. This union was carried all the way around the peritoneal edges, but it is not necessary to continue it any further than just beyond the angles of the wound. Interrupted sutures were used to prevent the closing in of the orifice of the opening which a continuous suture causes.

The lower uterine segment and cervix were opened longitudinally in the middle line. The head was extracted with the lower blade of the forceps and one hand. After removal of the placenta the uterus did not contract well, and hæmorrhage was free. The uterine cavity was douched with hot saline, and plugged with iodoform gauze, the end of which was pushed into the vagina. The uterine incision was closed with interrupted catgut sutures. The free edge of the peritoneum

above the bladder was united by interrupted catgut sutures to the edge of the peritoneum, from which it was originally severed. The aponeurosis was closed with continuous silk sutures, and the skin with Michel's clamps.

My case of symphysiotomy was performed under most unfavourable circumstances for foetal distress in a woman with contracted pelvis complicated by a brow presentation. The membranes were ruptured, the liquor amnii drained off, and solid meconium coming away. The os was the size of a shilling. After the patient was anæsthetised considerable delay ensued while the os was being opened with Frommer's dilators. The death of the foetus, though much to be regretted, was not unexpected. The only interest in respect to the operation was its ease of performance and completeness of subsequent recovery. The woman walked from the seventeenth day, and in this respect showed no difference to convalescence after pubiotomy.

L. J., with a conjugate diameter of $9\frac{3}{4}$ cm., delivered herself naturally of twins. The first, weighing 5 lbs., had a large depressed fracture on the right frontal bone. This was quickly and successfully raised by the plan which I introduced in 1904, and have employed on many similar occasions. This method has proved efficient in raising a depression in a child fifteen months old. That it raises both plates without injuring the brain was demonstrated by *post-mortem* on the baby, which was shown to this Section recently.

The sharp point of one blade of a bullet forceps was bored through the bone at the centre of the fracture. The point must be sharp, else the depression is increased. The shank was then turned at right angles to the bone, and the depressed fracture pulled steadily into position.

The case of C. D. raises the question of correct treatment in pregnancy complicated by myoma. These cases are at all times uncertain in their results, but when, as in this case, the tumours grow very rapidly before the child is viable, the uncertainty is intensified. With rest in bed we were able to allow pregnancy to advance to the thirty-fourth week. Then

delivery became imperative, and labour was induced by Krause's method.

The reasons for selecting induction and not Cæsarean section were as follow :—

The tumours were so situated that they did not obstruct delivery. The patient was a primigravida, and one felt that Cæsarean section would probably end in hysterectomy and deprive her of the possibility of further offspring. This conservatism was not warranted by the results. The foetus lay transversely, the cord prolapsed, and the child died before extraction. The tumours underwent red degeneration, and the patient ran a high temperature for ten days, causing us much anxiety. Subsequent hysterectomy resulted in complete recovery.

We had two cases of spontaneous delivery with brow presentations. One in a primipara requires no special mention. The second case was a primipara, and the baby weighed $6\frac{3}{4}$ lbs. It is remarkable in that the head was born neither flexed nor extended, with the chin posterior. It was simply driven out as a brow, and caused extensive laceration of the perinæum. Such a mechanism in brow presentation is rare.

Having been urged to employ iodoform gauze wrung out in izal as a uterine drain in cases of fever after child-birth, we gave it a very extended trial. We found that it clogged the gauze, did not drain as well as gauze in salt solution or weak carbolic solution, and that it had no compensatory advantages. We have given it up.

We first started to use scopolamin in maternity work in September, 1908, and have used it freely throughout the year.

We have given it to about 100 cases, all primiparæ. There was no maternal mortality, but two children were born dead. Personally we do not think these deaths had any direct connection with the administration of scopolamin. What we particularly want to call attention to is that scopolamin given by the mouth acts as well as when given by hypodermic injection. Cases in which scopolamin has been administered do not require any greater personal supervision than normal

cases, though this supervision is, of course, most desirable when collecting statistics. My assistants purpose dealing with this subject in a special paper.

My assistant, Dr. Freeland, has been anxious to ascertain practically if any better results can be obtained in labour cases by the addition of shaving to our present methods. To demonstrate this he has selected ruptured perinæums requiring repair, and the application of forceps as eminently suited for the comparison, every other one of these cases being shaved. This investigation promises most interesting results, but until a very much larger number of cases is forthcoming it will serve no good purpose to publish them.

Labour was induced eleven times—for a dead child four times, for albuminuria and œdema once, for hydramnios once, for myoma once, and for *ante-partum* hæmorrhage once. There remain three cases in which labour was induced at full term because of foetal death on former occasions from unexplained causes when labour occurred spontaneously. Live children resulted in these cases.

There were thirty-four cases of *post-partum* hæmorrhage during the year. In five cases the pulse rate remained below 100 ; in nine it was between 100 and 120 ; in ten it was between 140 and 160 ; and in six it was over 160. Twenty-two cases occurred before the placenta left. In twelve of these the placenta was expressed directly from the uterus ; in the other ten, a portion or all of the placenta was adherent, necessitating manual removal—three times, of pieces of placenta left after expression ; seven times, of the whole placenta. Twelve cases occurred after the expression of the placenta, two and a half hours being the longest interval between the end of labour and the occurrence of hæmorrhage. Six of the thirty-four cases followed operative delivery, necessitating an anæsthetic. The treatment was as follows :—Intra-uterine douche followed by a gauze plug, eleven cases ; intra-uterine douche, eight cases ; repair of cervical tears, two cases. The others were checked by catheterisation, expression of the placenta, massage, manual control, and the administration of ergotin.

For the accurate compilation of these Reports I am indebted to my Assistant Masters, Drs. Solomons and Freeland.

MATERNAL MORTALITY.

B. K., aged thirty-eight, 12-para ; admitted Nov. 17 ; delivered Nov. 18; died Dec., 1909. Hydramnios; anencephalus; rupture of membranes; sepsis. Admitted Nov. 17, two weeks beyond full term, no foetal heart heard, membranes ruptured, and fifteen pints of liquor amnii withdrawn ; five and a half hours later she delivered herself naturally of a 5½ lb. macerated anencephalic foetus. Temperature remained normal until the seventh evening, from which time it gradually rose until death. She received four intra-uterine douches. The uterus was explored manually, and considerable decidual debris was removed from the placental site. There was a diplococcus in the smear and pure culture. She developed mania a few days before death.

See Pathological Report for *post-mortem* findings.

M. M., aged twenty-four, 1-para ; admitted July 31 ; delivered August 3 ; died August 5, 1909. Pulmonary tuberculosis ; prolapse of cord ; forceps. Admitted in the last stages of phthisis. When she entered the second stage the membranes ruptured, cord prolapsed, and a living child 7 lbs. weight was easily extracted with forceps. She died two and a half days later.

See Pathological Report for *post-mortem* findings.

E. M., aged twenty-one, 2-para ; admitted August 3 ; delivered August 4 ; died August 4, 1909. Miscarriage ; rupture of the uterus ; sepsis. On admission severe abdominal pain ; foetid discharge ; a history of four months' pregnancy. Abdomen very tender. Foetus half way through the os. Foetus removed. In removing placenta, uterus was found ruptured on right side ; the uterine cavity and rent were plugged with iodoform gauze. Patient at this time showed signs of general peritonitis, and died within ten hours.

See Pathological Report for *post-mortem* findings.

M. M., aged nineteen, 1-para ; admitted August 20 ; delivered August 20 ; died August 20. Twins ; labour shock. Admitted in normal labour. Membranes artificially ruptured when they

appeared at vulva, and patient immediately collapsed after the discharge of a large amount of liquor amnii. She shortly afterwards delivered herself of twins ; there was very little hæmorrhage, but despite free stimulation the patient never rallied, and died three hours after delivery.

See Pathological Report for *post-mortem* findings.

CASES MENTIONED ABOVE.

A. W., aged twenty-five, 5-para ; admitted April 6 ; delivered April 8 ; discharged April 28, 1909. Classical Cæsarean section. Operation performed before the onset of labour.. No difficulty. Uninterrupted recovery. Child weighed $7\frac{1}{4}$ lbs. Left the hospital alive. All previous children dead born with fractured skulls.

See table of Contracted Pelves.

M. G., aged thirty-five, 1-para ; admitted October 22 ; delivered October 25 ; discharged Nov. 14. Extra-peritoneal Cæsarean section. In labour fourteen and a half hours, with membranes ruptured when operation performed. Child alive ; $5\frac{3}{4}$ lbs. ; about four weeks premature. Uninterrupted recovery.

See table of Contracted Pelves.

M.D ., aged twenty-three, 1-para ; admitted July 9 ; delivered July 11 ; discharged August 7. Symphysiotomy ; brow presentation ; internal version. In labour ten hours when operation performed.

For details of case, see body of Report.

M. C., aged twenty, 1-para ; admitted August 24 ; delivered August 25 ; discharged Sept. 2, 1909. Twins ; fractured skull. Normal delivery. Children weighed 5 and $4\frac{3}{4}$ lbs. respectively. True conjugate $9\frac{5}{8}$ cms.

For details, see body of the Report.

C. D., aged thirty-seven, 1-para, admitted Jan. 16 ; delivered Feb. 13 ; discharged March 31. Myoma ; induction of premature labour ; transverse presentation ; prolapse of cord ; version ; subsequent hysterectomy. Thirty-two weeks pregnant, multiple

290 *Clinical Reports of the Rotunda Hospital.*

myomata, growing rapidly. Labour induced by Krause's method. Child dead. Transferred to Gynæcological Ward on the twenty-second day. Hysterectomy performed on the twenty-fourth day. Uninterrupted recovery.

S. E., aged twenty-nine, 1-para ; admitted Sept. 14 ; delivered Sept. 14 ; discharged Sept. 22, 1909. Brow presentation ; spontaneous delivery ; chin posterior. Nine hours in labour. No difficulty. Child alive ; $6\frac{3}{4}$ lbs. weight. Circumference of head ; chin to occiput, 14 inches. Extensive laceration of both levators.

This patient was to have returned for internal pelvimetry, but has not done so.

TABLE NO. I.—*Maternity Department.*

—	Nov.	Dec.	Jan	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Total
Total deliveries -	165	152	137	149	178	171	171	169	182	204	166	129	1,973
Total abortions -	4	1	3	5	5	6	5	11	11	8	9	4	72
Not in labour -	26	24	20	27	32	25	32	41	26	32	19	20	324
Total	195	177	160	181	215	202	208	221	219	244	194	153	2,369

TABLE NO. II.—*Nature and Number of Cases Treated in the Extern Maternity.*

Total number of Labours -	2,200	Hæmorrhage—	
Abortions -	230	Accidental -	5
Hydramnios -	11	Unavoidable -	6
Myxoma chorii -	1	Post-partum -	37
Presentations—		Rupture of uterus -	1
Face to pubes -	24	Operations—	
Face -	5	Forceps -	34
Brow -	1	Version -	18
Breech -	75	Manual removal -	19
Transverse -	8	Eclampsia -	1
Twins -	21	Mortality, maternal -	8
Triplets -	1	Infantile Conditions—	
Prolapse of funis -	11	Anencephalus -	2
		Hydrocephalus -	3
		Spina bifid -	1

TABLE NO. III.—*Extern Mortality.*

Name	Age and Para	Date of Delivery.	Cause of Death	Time Ill	REMARKS
S. U.	40 years, XI.	Nov. 9, 1908	<i>Post-partum</i> hæmorrhage	Died almost immediately	Dead when extern assistant arrived
M. N.	— II.	Nov. 27, 1908	Pulmonary embolus	Died 9th day of puerperium; pleurisy for 5 days before death	Got out of bed against orders; collapsed and died
A. M.	44 years, XXV.	Dec. 10, 1908	Acute dilatation of the heart	Died suddenly, 2nd day of puerperium	Patient had chronic endocarditis. Placenta manually removed
M. L.	24 years, I.	Jan. 10, 1909	Septicæmia	41 days	Sapremia first; membranes and placenta complete
A. T.	— IX.	Feb. 7, 1909	<i>Ante-partum</i> hæmorrhage	—	Moribund when friends sent into hospital; dead when extern assistant arrived
E. C.	24 years, II.	May 4, 1909	Shock; <i>post-partum</i> hæmorrhage	3 hours	Adherent placenta; manual removal
C. M.	32 years, V.	June 6, 1909	Pernicious anæmia	Died 5th day of puerperium	Was in labour when seen first; hæmoglobin, 10 per cent.; R.B.C., 350,000
L. M.	31 years, II.	Aug. 8, 1909	Septicæmia	14 days	Lacerated perineum; membranes and placenta complete

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

Total admissions	-	2,369	Mortality—		
„ deliveries	-	2,045	Maternal	-	4
Primiparæ	-	723	Infantile, died in hospital		36
Abortions and miscarriages	-	72			
Hyperemesis	-	1	Stillborn—		
Hydramnios	-	5	Recent	-	29
Myxoma chorii	-	2	Macerated	-	43
			Putrid	-	4
Presentations—					
Face to pubes	-	20	Infantile conditions—		
Face	-	6	Anencephalus	-	1
Brow	-	4	Anencephalus and spina		
Breech	-	46	bifida	-	1
Transverse	-	4	Hydrocephalus	-	4
Twins	-	29	Hydrocephalus and spina		
Impacted shoulders	-	1	bifida	-	1
Prolapse of funis	-	16	Spina bifida	-	1
			Encephalocele	-	1
Hæmorrhage—			Encephalocele, talipes,		
Accidental	-	6	supernumerary fin-		
Unavoidable	-	2	gers and toes	-	1
Post-partum	-	34	Cephalhæmatoma	-	7
Laceration of cervix (operative)	-	7	Fractured humerus	-	1
			Fractured clavicle	-	3
Lacerated perineum—			Ophthalmia	-	4
Primiparæ	-	345	Talipes	-	5
Multiparæ	-	137	Imperforate anus	-	2
Failure of primary union	-	18	Umbilical hernia (large)	-	1
Atresia of vagina	-	1	Hare-lip	-	2
Rupture of uterus	-	1	Cleft palate	-	1
Hæmatoma of vulva	-	2	Absence of hand	-	1
Adherent placenta	-	15	Depressed fracture of		
Contracted pelvis	-	14	skull	-	1
			Dislocation of clavicle	-	1
Operations—			Fibroma of finger	-	1
Induction of labour	-	11	Genu varum	-	1
Episiotomy for central tear	-	3	Hæmophilia	-	1
Cæsarean section	-	1	Hæmatoma of cheek	-	1
Hysterotomy	-	1	Icterus neonatorum	-	2
Symphysiotomy	-		Melæna	-	3
Perforation after coming			Nævus	-	2
head	-	1	Rupture of funis	-	1
Forceps	-	81	Imperforate anus, ab-		
Version	-	17	sence of ext. genitals	-	1
Eclampsia	-	7	Monster with teeth, un-		
Mania	-	4	descended testicles,		
Phlegmasia	-	1	five fingers and toes,		
Puerperal ulcer	-	5	hygroma, &c.	-	1
Morbidity—					
B. M. A. estimation	-	3.75			
Rotunda estimation	-	2.49			

TABLE NO. V.—*Accidental Hæmorrhage.*

Name	Age and Para	Variety	Period	Result to Mother	Result to Child	Presentation	Treatment and Remarks
E. H.	48, XIV.	External	Term	Recovery	Dead	Vertex	Plugged and tight binder; removed in 5 hours; good pains; delivered 1½ hours later
W. D.	24, I.	"	8 months	"	Alive	"	Forceps when os fully open.
T. W.	26, I.	"	Term	"	"	"	Membranes ruptured.
G. V.	28, V.	"	"	"	"	"	Plugs and tight binder; removed 6 hours; good pains; delivered 5 hours later.
W. C.	31, XII.	"	"	"	Macerated	"	Plugged and tight binder; removed in 6 hours; almost unaided delivery.
E. S.	33, VIII.	"	"	"	Alive	"	Forceps when os fully open.

TABLE NO. VI.—*Placenta Prævia.*

(Includes Extern Cases).

Name	Age and Para	Variety	Period	Result to Mother	Result to Child	Presentation	Treatment and Remarks
M. J.	42, VIII.	Lateral	7 months	Recovered	A.	Vertex	Spontaneous delivery.
R. S.	23, III.	Central	"	"	D.	"	Bi-polar version.
M. S.	25, V.	Marginal	Term	"	"	Transverse	Bi-polar version.
E. K.	30, IX.	Lateral	8 months	"	A.	Vertex	Bi-polar version.
M. R.	36, X.	Central	7 months	"	D.	"	Bi-polar version.
B. O'R.	33, VII.	Marginal	Term	"	A.	Breech	Foot brought down.
M. B.	38, VIII.	Central	"	"	"	Transverse	Bi-polar version.
M. D.	24, II.	Marginal	"	"	"	Vertex	Internal version.

TABLE NO. VII.—*Contracted Pelves.*

All internal measurements made with Skutsch Pelvimeter.

Name	Age	Para.	Pelvic Measurements					Mode of Delivery	Result to Child	Weight of Child	Result to Mother	REMARKS
			C. V.	Trans.	Ext. C.	I.-C.	I.-S.					
J. N.	30	I.	8	10	17	26	25½	Breech normal Vertex	Alive	3½	Alive	Premature, 7 months. Baby died in 2½ hours.
B. G.	19	I.	8	11	17	25	23½	normal Vertex	Alive	7	Alive	—
E. D.	22	I.	8	10	18½	26	22	normal Vertex	Alive	5¼	Alive	Head fixed late in labour. Walcher's position. Scopolamin and morphin.
A. N.	25	V.	8	11	18½	27	25	Cæsarean Section	Alive	7¼	Alive	Previous children dead born. One prolapse cord and fractured skull. Others forceps and fractured skulls.
M.A.K.	22	I.	7.5	—	17½	26½	25	Brow, bipolar version, perforation	Dead	9	Alive	Prolapse of cord. After-coming head stuck. Perforated.
E. G.	26	II.	8½	10½	18	26½	24	Internal version	Dead	5½	Alive	Prolapsed cord, stopped pulsating when version started. Membranes ruptured some hours and liquor amni drained away
J. M.	19	I.	8	12	16	28	26	Breech extraction	Alive	7¾	Alive	Prolapse of cord. Breech unfixed. Great difficulty with aftercoming head.
L. B.	35	I.	6	10¾	17½	27½	25¼	Version	Dead	5¾	Alive	Head presenting, cord prolapsed.
M. D.	23	I.	8	12¾	19	28	26	Symphysiotomy. Version	Dead	6¼	Alive	Membranes ruptured with onset of labour.
C. K.	23	I.	8	11½	20	26	25	Normal	Alive	8	Alive	—
C. S.	33	II.	9	12¼	20½	28	25½	Induction of labour, forceps	Alive	9	Alive	First child normally delivered dead.
A. T.	25	I.	7	11½	16	27	26	Breech	Dead	5½	Alive	Macerated.
M. S.	24	III.	8½	—	18	26	24	Version	Dead	6¼	Alive	Transverse. Macerated.
M. G.	35	I.	6	—	16	26	25½	Hysterotomy	Alive	5¾	Alive	—

TABLE NO. VIII.—*Forceps.*

Indication	No.	Dead Children	REMARKS
Delayed second stage -	63	6	3 macerated : one twins ; for- ceps on both.
Delayed second stage.	4	0	
Persistent occipito- posterior.			
Accidental hæmorrhage	2	0	
Eclampsia - -	1	0	Macerated.
Mania - - -	1	1	
Œdema and albuminuria	1	0	
Pendulous abdomen -	1	0	
Phthisis - -	1	0	1 putrid.
Primary inertia. Fœtal indications.	2	0	
Prolapse of cord -	2	0	
Sepsis - - -	2	2	
Threatened rupture of uterus.	1	1	5 macerated.
Total - -	81	10	

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

I.-para - - - -	65
II.-para - - - -	12
III.-para - - - -	0
IV.-para - - - -	1
V.-para and over - -	3
Total - -	81

SUB-TABLE B.—*Showing Ages of Patients.*

17-25 - -	27
26-30 - -	27
31-35 - -	18
36 and over - -	9
Total - -	81

TABLE No. IX.--*Eclampsia*.

Name	Age and Para	Condition on Admission	Urine	No. of Fits			Treatment	Result to Mother	Result to Child	REMARKS
				Before Labour	During Labour	After Labour				
C. D., admitted Feb. 2, '09	20 years I.	Conscious	Albumen abundant	-	-	6	Morphin; bowel washed out (2); purgatives; infusion under breasts; poultices to loins	Rec.	A D	Delivered Feb. 2. First fit 9 hours later
C. M., admitted Feb. 18, '09	23 years II.	Conscious	Albumen abundant	-	-	1	Morphin; stomach washed out; purgatives	Rec.	A	Delivered Feb. 18. Fit 1½ hours later
T. K., admitted June 10, '09	46 years I.	Unconscious	Albumen abundant	8	1	-	Morphin; stomach washed out; bowel washed out; poultices to loins; purgatives	Rec.	D	Delivered June 11
B. I., admitted June 14, '09	34 years I.	Conscious	Albumen abundant	-	-	5	Morphin; bowel washed out (2); purgation	Rec.	A	Delivered June 14. First fit 2 hours after delivery
E. H., admitted June 15, '09	29 years I.	Unconscious	Albumen abundant	8	1	1	Morphin; stomach washed out; bowel washed out; purgatives; poultices to loins; stimulation; oxygen; artificial respiration (3 times)	Rec.	D	Chloral gr. xx. before admission; pulse very poor; cyanosis on admission; three times during day respiration ceased altogether. Delivered June 15
M. N., admitted July 29, '09	40 years II. 1st preg. abortion	Œdema of legs; conscious	Albumen abundant	-	1	-	Morphin; bowel washed out; forceps	Rec.	A	Fit during second stage. Delivered June 29
M. McK., admitted Sept. 30, '09	29 years I.	Unconscious	Albumen abundant	4	-	-	Morphin; bowel washed out; poultices to loins; purgatives	Rec.	D	Child macerated. Delivered Oct. 5

TABLE No X.—*Prolapse of Cord.*

Name	Age and Para	Size of Pelvis.	Result to Child	Weight	Result to Mother	Presenta-tion	Treatment	REMARKS
K. M.	35 years—X.	Not measured*	A.	10½	Rec.	Vertex	Replaced ; forceps	Delivered 2 hrs. after replacement
C. D.	37 years—I.	Not measured	D.	6¼	Rec.	Trans-verse Breech	Bi-polar version	Afterwards had hysterectomy for myoma
M. K.	30 years—V.	Not measured*	A.	8	Rec.	Breech	Traction	
B. D.	19 years—I.	Not measured	A.	6½	Rec.	Breech	Traction	First of twins
K. T.	30 years—VI.	Not measured*	A.	7½	Rec.	Vertex	None	
M. K.	22 years—I.	7.5 cm. C. V.	D.	9	Rec.	Brow	Bi-polar version ; perforation.	Cord prolapsed with os size of a shilling
E. G.	26 years—II.	8½ cm. C. V. 10½ cm. trans.	D.	5½	Rec.	Vertex	Int. version	Membranes ruptured some hours on admission
J. M.	19 years—I.	8 cm. C. V. 12 cm. trans.	A.	7¾	Rec.	Breech	Traction	Dislocation of clavicle
L. B.	35 years—I.	6 cm. C. V. 10¾ trans.	D.	5¾	Rec.	Vertex	Int. version	Membranes ruptured some hours on admission
C. B.	30 years—VII.	Not measured*	A.	5¾	Rec.	Breech	Traction	
M. D.	22 years—I.	Not measured	A.	6½	Rec.	Breech	Traction	
E. K.	27 years I.	Not measured	D.	9	Rec.	Vertex	None	Pulseless ; cord prolapsed when membranes ruptured
A. M.	30 years—VI.	Not measured*	A.	8¾	Rec.	Vertex	Int. version	Fractured clavicle
M. M.	34 years—I.	Not measured	A.	7	Died	Vertex	Forceps	Phthisis. See Mortality Table
M. P.	28 years—I.	Not measured	A.	7	Rec.	Vertex	Forceps	
K. R.	23 years—I.	Not measured	A.	8	Rec.	Breech	Traction	

* Five of the cases in primiparæ were not measured because of laceration of the perineum.

TABLE No. XI.—*Breach Presentations.*

Para	Total	Dead Children	REMARKS						
Primiparæ	16	<table><tr><td>Fresh</td><td>1</td></tr><tr><td>Macerated</td><td>2</td></tr><tr><td>Total</td><td>3</td></tr></table>	Fresh	1	Macerated	2	Total	3	Four associated with prolapse of the cord. Two premature, one of which was one of twins. Death during labour was due to primary inertia. Six were one of twins.
Fresh	1								
Macerated	2								
Total	3								
Multiparæ	30	<table><tr><td>Fresh</td><td>0</td></tr><tr><td>Macerated</td><td>2</td></tr><tr><td>Total</td><td>2</td></tr></table>	Fresh	0	Macerated	2	Total	2	
Fresh	0								
Macerated	2								
Total	2								
Totals	46	5	4 macerated.						

TABLE No. XII.—*Twins.*

Both males	-	-	-	7
Both females	-	-	-	12
One male and one female	-	-	-	10
Total	-	-	-	29

TABLE No. XIII. A.—*Morbidity.*

[illegible]

TABLE NO. XIII. B.

Rotunda Estimation	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Total
Total Cases -	169	153	140	154	183	177	176	180	193	212	175	133	2045
Cases Morbid -	5	2	3	3	9	4	2	4	4	8	5	2	51
Percentage -	2.96	1.31	2.14	1.95	4.92	2.26	1.14	2.22	2.07	3.77	2.86	1.50	2.49
Total number - 51													
Total percentage - 2.49													

TABLE NO. XIII. C.—*Comparison of Morbidities.*

PRIMIPARÆ.

British Medical Association Estimation	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Total
Total Cases -	59	49	50	46	65	62	69	73	72	80	54	44	723
Cases Morbid	2	3	2	1	6	3	3	4	2	4	3	3	36
Percentage -	3.39	6.12	4.00	2.17	9.23	4.84	4.35	5.48	2.78	5.00	5.56	6.82	4.98

Total cases - 36

Percentage - 4.98

MULTIPARÆ.

Total Cases -	106	103	87	103	113	109	102	96	110	124	112	85	1250
Cases Morbid -	3	0	2	3	3	3	2	3	5	7	5	4	40
Percentage -	2.83	0	2.30	2.91	2.65	2.75	1.96	3.13	4.55	5.65	4.46	4.71	3.20

Total cases morbid - 40

Total percentage - 3.20

TABLE NO. XIV.—*Causes of Morbidity other than Uterine.*

Alveolar abscess	...	...	...	1
Bronchitis	...	...	...	1
Constipation	...	...	...	4
Eclampsia	...	..	...	1
Influenza	...	...	...	3
Mastitis	...	...	...	2
Puerperal ulcer	...	...	...	5
Pulmonary tuberculosis		...	...	1
Septic thumb	...	...	...	1
Superficial symphysiotomy		...	...	1
Suppuration of wound	...	...	...	1
Syphilis	...	...	...	1
White leg	...	...	...	1
Total				23

TABLE NO. XV.—*Operative Cases, showing Morbidity.*

Forceps (both, 4; B.M.A., 4)	.	.	.	.	.	8
Induction of Labour (B.M.A., 2)	.	.	.	.	.	2
Manual removal of placenta (both, 2; B.M.A., 3)	.	.	.	.	.	5
Rupture of membranes for hydramnios (both, 1)	.	.	.	.	.	1
<i>Post-partum</i> hæmorrhage (both, 1)	.	.	.	.	.	1
Symphysiotomy (B.M.A., 1)	.	.	.	.	.	1
Version (B.M.A., 2)	.	.	.	.	.	2
						20

TABLE NO. XV. A.—*Percentage Operative Morbidity, B. M. A. Estimation.*

Forceps	9.88 per cent.
Manual Removals	33.33 per cent.

TABLE NO. XV. B.—*Rotunda Estimation.*

Forceps	4.94 per cent
Manual Removals	13.33 per cent.

TABLE NO. XVI.—*Lacerated Perineums showing Morbidity.*

B.M.A., estimation alone	4
Rotunda „ „	0
Both estimations	8
Total	12

5 of these associated with forceps.

The following Tables are based on those cases morbid by the B. M. A. Estimation :—

TABLE NO. XVII.—*Duration of stay in House of Morbid Cases.*

Under 10 days	33, including 3 deaths.
10-19 days	34
20-29 days	9, including 1 death.
Total	76

TABLE No. XVIII.—*Duration of Temperature.*

Under 5 days	.	57, including 3 deaths.
5-9 days	.	12
10-19 days	.	7, including 1 death.
Total,		76

TABLE No. XIX.—*Highest Temperature Recorded.*

100°-100.9°	28, including 3 deaths.
101°-101.9°	25
102°-102.9°	11
103°-103.9°	11
104°-104.9°	1, including 1 death.
	<hr/>
Total,	76

TABLE No. XX.—*Treatment of Morbid Cases.*

No treatment	.	.	.	21
Vaginal douche only	.	.	.	3
Uterine douche	.	.	.	39
Quinine only	.	.	.	7
Local treatment (suppurations)	.	.	.	6
Total,				76

TABLE No. XX. A.—*Uterine Douches.*

20 patients had 1 douche.
9 patients had 2 douches.
7 patients had 3 douches.
2 patients had 4 douches.
1 patient had 6 douches.

Total, 39

Izal was used to soak gauze drains before insertion instead of 2 per cent. carbolic for from 4-6 months, and then given up. Of these 76 morbid cases 23 had incomplete membranes.

For report of uterine cultures see Pathological Report.

TABLE No. XXI.—*Maternal Mortality.*

Name and Age	Admitted	Delivered	Died	Cause of Death	REMARKS
B. K., 38 yrs.	1908 Nov. 17	1908 Nov. 18	1908 Dec. 8	Sepsis	Hydramnios; anencephalus. See P. M. report
M. M., 24 yrs.	1909 July 31	1909 Aug. 3	1909 Aug. 5	Pulmonary tuberculosis	—
E. M., 21 yrs.	Aug. 3	Aug. 4	Aug. 4	Miscarriage; rupture of uterus; sepsis	Delivered just after midnight; died before midday
M. M., 19 yrs.	Aug. 20	Aug. 20	Aug. 20	Labour shock	—

STATISTICAL RETURNS OF THE GYNÆCOLOGICAL DEPARTMENT.

TABLE I.—*Showing nature and number of Operations.**

<p>VULVA AND PERINEUM— Carcinoma of vulva (2)— Adenocarcinoma - 1 Epithelioma - 1 Hymenectomy - 2 Lacerations of Perineum (86)— Complete - 6 Incomplete - 80</p> <p>URETHRA AND BLADDER— Prolapse of urethral mucous membrane - 1 Urethral caruncle - 3</p> <p>VAGINA— Cicatrix - 1 Cyst - 2 Fistula, vesico-vaginal - 1 Anterior colporrhaphy - 17 Anterior colpotomy - 8 Posterior colpotomy - 5</p> <p>RECTUM— Fissure of rectum cured - 1 Hæmorrhoids - 5 Prolapse of rectum - 1</p> <p>CERVIX— Trachelorrhaphies and am- putations (75)— Schroeder - 57 Sanger - 14 Emmet - 3 Circular amputation - 1 Posterior division - 27 Pozzi's operation - 2 Carcinoma - 6</p> <p>UTERUS— Curettage - 254 Polypus (fibroid) - 13</p>	<p>Ventro-suspension - 82† Vaginal suspension - 8 Ventro-fixation - 4 Alexander Adams - 4 Myomectomy (12)— • Abdominal - 11 Vaginal - 1 Hysterectomy (31)— Supra-vaginal - 19 Wertheim - 7 Complete - 5 Cæsarean section - 1</p> <p>TUBES AND OVARIES— Ovariotomy - 14 Resection of ovary with other operations - 19 Resection of ovary - 2 Resection of tube with other operations - 25 Salpingo oöphorectomy with other operations - 13 Salpingectomy - 2 Salpingo-oöphorectomy - 12 Tubal pregnancy - 7 Parovarian cyst - 4</p> <p>MISCELLANEOUS— Herniotomy (4)— Inguinal - 2 Umbilical - 2 Appendicectomy - 1 Appendix abscess - 1 Nephrectomy - 1 Pylorotomy - 1 Gastroenterostomy - 1 Laparotomy - 6 Parametritis - 1 Talma-Morison - 1</p>
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* 168 Abdominal Sections were performed.

† Of the Ventro-suspensions 35 were unaccompanied by any other Abdominal Operation.

TABLE NO. II. A.—*Abdominal Hysterectomies.*

No.	Name	Date	Age	Disease	Operation	Result	REMARKS
1	E. D.	7/1/'09	39	Degenerate pyosalpinx	Supravaginal hysterectomy	Recovered	Married, multipara; plugged
2	M. W.	5/1/'09	38	Fibroid uterus	"	"	Married, nullipara; both ovaries left
3	C. D.	16/2/'09	37	"	"	"	Married, nullipara; left tube and ovary removed
4	M. O.	16/2/'09	37	General disease of uterus and adnexa	"	"	Both tubes and ovaries removed; married, 2-para
5	M. A.	19/2/'09	23	Pyosalpinx	Complete hysterectomy	"	Married, nullipara; both tubes and ovaries removed; plugged
6	C. D.	26/2/'09	28	"	"	"	Married, nullipara
7	J. W.	5/3/'09	48	Fibroid uterus	Supravaginal hysterectomy	"	Married, 4-para; both tubes and ovaries left
8	M. S.	1/6/'09	34	"	"	"	Unmarried
9	M. M.	6/4/'09	40	"	"	"	Both tubes and ovaries removed
10	A. B.	4/6/'09	43	Intraligamentary myoma	"	"	Unmarried; tubes and ovaries left
11	L. B.	12/6/'09	44	Fibroid uterus	"	"	Married, multipara; tubes and ovaries removed
12	M. G.	22/6/'09	43	"	"	"	Married, nullipara; tubes and ovaries left
13	K. M.	15/6/'09	49	Ovarian cyst malignant; secondary deposits in uterus and ovariectomy	Complete hysterectomy	"	Married, nullipara; other ovary removed for cyst 1½ years previously

TABLE NO. II. A.—continued.

No.	Name	Date	Age	Disease	Operation	Result	REMARKS
14	C. C.	25/6/'09	42	Fibroid uterus	-	Recovered	Unmarried; one ovary removed
15	C. M.	18/6/'09	44	"	"	"	Unmarried; both tubes and ovaries left
16	B. H.	19/7/'09	44	"	"	"	Married, nullipara; both tubes and ovaries left; adhesions
17	J. R.	22/7/'09	50	Fibroid uterus	"	"	Unmarried; both tubes and ovaries removed
18	A. M.	23/7/'09	45	"	"	"	Married, nullipara; tubes and ovaries left
19	M. B.	—	36	Retro-peritoneal tumour	Complete hysterectomy	"	Unmarried; operation to reach tumour
20	J. C.	10/9/'09	42	Fibroid uterus	-	"	Married, multipara; double sal-pingo-oöphorectomy
21	D. B.	25/9/'09	38	Bilateral pus tubes	-	"	Very ill, with symptoms of peritonitis for 48 hours after operation; plugged
22	E. G.	21/9/'09	40	Fibroid uterus	"	"	Unmarried
23	G. N.	2/10/'09	40	"	"	"	Two children last pregnancy; abortion 8 years ago
24	M. F.	15/10/'09	36	Double pyosalpinx	Panhysterectomy	"	Last pregnancy 5 years ago; plugged

TABLE NO. II. B.—*Abdominal Hysterectomies*—MALIGNANT DISEASE.

No.	Name	Date	Age	Disease	Operation	Result	REMARKS
1	J. D.	12/2/09	60	Adeno-carcinoma of body	Wertheim's	Recovered	Menopause 9 years ago; 4-para, last 27 years ago
2	M. R.	27/4/09	45	Epithelioma of cervix	"	"	6-para, last 6 years ago; recurrence in 5 months
3	M. R.	25/5/09	49	"	"	"	4-para, last 5 years ago
4	L. R.	28/5/09	60	"	"	"	1-para, 31 years ago
5	M. R.	8/6/09	38	"	"	Died 11/7/09. See Table VI., No. 6	Nullipara, 15 years married
6	B. O'C.	13/7/09	44	"	"	Died in 3 hours; shock	6-para, last 5 years ago
7	K. W.	13/10/09	26	"	"	Recovered	6-para, last one year ago

TABLE NO. III.—*Myomectomies (Abdominal).*

No.	Name	Age	Date	Disease	Result	REMARKS
1	B. M.	35	13/11/'08	Multiple myomata (8)	Died 18/11/'09	Operated in 12 hours for secondary hæmorrhage; died 5 days later; symptoms of pulmonary embolus; <i>post mortem</i> , see Pathological Report. One abortion Nullipara; 11 years married; ventro-suspension followed myomectomy
2	M. O'S.	20	20/11/'08	Myomata, $2\frac{1}{2} \times 3\frac{1}{2}$ in. on anterior wall	Recovered	4-para; last 20 months ago
3	M. N.	40	11/12/'08	Pedunculated myoma, 12×10 in., on right side	"	
4	T. B.	32	29/12/'08	One large submucous and three small subserous myomata	"	Uterus split in two and then sewn up again; nullipara; married 6 months
5	M. H.	40	29/1/'09	Myoma, 2×1 in., on fundus	"	Unmarried; ventrosuspension and amputation of cervix also performed
6	C. B.	38	5/2/'09	Myoma, 3×3 in., on anterior wall	"	One abortion 3 years ago, followed by ventro-suspension
7	M. M.	34	12/3/'09	3 myomata; subserous right cornu 5 in. in diam., another $\frac{1}{2}$ in. diam., left cornu; third interstitial anterior wall, 1 in. diam.	"	Unmarried; followed by ventro-suspension.
8	B. K.	36	16/4/'09	One large and 4 small myomata	"	1-para, 10 months ago
9	C. H.	36	20/4/'09	One myoma, 8×6 in.; 6 myomata, ranging from $\frac{1}{2}$ to 2 in. in diam	"	Married one year; nullipara
10	M. H.	29	26/7/'09	One submucous myoma, 5×4 in.	"	Unmarried; uterus split in two; repaired; then suspended
11	K. H.	35	29/10/'09	One subserous myoma, 1 in. diam.	"	Unmarried; followed by ventro-suspension

TABLE No. IV.—*Ovariectomies and Salpingectomies (Abdominal).**

No.	Name	Age	Date	Disease	Operation	Result	REMARKS
1	L. M.	27	27/11/08	Tubal pregnancy	Left salpingo-oöphrec- tomy	Recovered	1-para
2	J. B.	26	4/12/08	Salpingo-oöphoritis	Right oöphorectomy; partial double sal- pingectomy	"	3-para; plug for hæmorrhage
3	M. B.	22	8/12/08	"	Partial right salpingo- oöphorectomy	"	2-para; ventro-suspension per- formed
4	M. K.	42	17/12/08	Double pyo-salpinx	Right salpingo-oöphor- ectomy; partial left salpingo-o ö p h o r - ectomy	"	12-para; drained
5	C. L.	37	8/1/09	Right ovarian cyst	Right ovariectomy	"	2-para; patient was 4 months pregnant, and later was de- livered of a 7½ lb. child; a year after this died of generalised carcinoma. The cyst was benign.
6	M. F.	41	19/1/09	Double ovarian cyst	Partial double oöphor- ectomy	"	11-para; ventro-suspension per- formed
7	R. H.	26	9/2/09	Right ovarian cyst	Right ovariectomy	"	1-para; patient was nearly 3 months pregnant, and aborted 12 days after the operation
8	A. M.	24	5/2/09	"	"	"	Nullipara; simple cyst removed in its entirety
9	M. B.	30	9/2/09	Ruptured tubal preg- nancy	Double salpingectomy (partial)	"	6-para; ruptured tubal pregnancy on one side; thickened tube on other
10	A. T.	30	19/2/09	Right ovarian cyst	Right ovariectomy	"	Nullipara; simple cyst

* See Footnote to Table I.

TABLE NO. IV.—continued.*

No.	Name	Age	Date	Disease	Operation	Result	REMARKS
11	B. M. Q.	29	2/4/'09	Ruptured tubal pregnancy	Right salpingectomy -	Recovered	5-para; wound suppurated
12	A. D.	39	19/3/'09	Left ovarian cyst	Left ovariectomy -	"	3-para; right ovariectomy 3 years previously
13	M. H.	38	26/3/'09	Right ovarian cyst; left parovarian cyst	Right ovariectomy; removal of left parovarian cyst	"	Nullipara
14	M. C.	46	23/4/'09	Left pyosalpinx; appendicitis	Left salpingectomy; appendicectomy	"	5-para; drained
15	M. C.	23	23/4/'09	Tubal pregnancy	Right salpingectomy -	"	2-para; right ovary resected
16	B. F.	51	21/5/'09	Fibroma of ovary	Right oöphrectomy -	"	Single
17	J. M.	30	16/5/'09	Tubal pregnancy	Right salpingectomy -	"	4-para
18	J. M.	22	1/6/'09	Double salpingo-oöphritis	Left salpingo-oöphorectomy; partial right salpingo-oöphorectomy	"	Single
19	M. H.	40	7/5/'09	Ovarian cyst	Right ovariectomy -	Died	Papillary cyst undergoing septic change. See Mortality Table VI., No. 5
20	M. C.	51	19/6/'09	Salpingo-oöphritis	Left salpingo-oöphorectomy	"	10-para
21	L. J.	25	12/6/'09	Tubal pregnancy	Partial right salpingectomy	"	1-para; drained
22	L. B.	34	9/7/'09	"	Left salpingectomy -	"	9-para; drained

* See Footnote to Table I.

TABLE NO. IV.—continued.*

No.	Name	Age	Date	Disease	Operation	Result	REMARKS
23	A. M.	33	2/7/09	Left ovarian cyst -	Left ovariectomy	Recovered	Single; simple cyst
24	E. C.	52	19/7/09	"	"	Died (from perforated gastric ulcer after uneventful convalescence)	A large tumour, evidently carcinoma of stomach, discovered during operation; patient died 9 days after ovariectomy; <i>post mortem</i> showed perforated gastric (carcinomatous) ulcer. See Table VI., No. 9.
25	B. O'D.	24	20/8/09	Right salpingo-oöphoritis	Right salpingo-oöphorectomy	Recovered	1-para
26	J. M.	26	20/8/09	Right ovarian cyst -	Right ovariectomy	"	Single
27	A. D.	22	31/8/09	Right salpingo-oöphoritis	Right salpingo-oöphorectomy	"	Single
28	R. M.	28	31/8/09	Left pyosalpinx -	Left salpingo-oöphorectomy	"	Married, nullipara; drained
29	A. D.	44	3/9/09	Cyst adenoma, right side	Right salpingo-oöphorectomy	"	5-para
30	J. H.	37	28/9/09	Left ovarian cyst; right salpingitis	Left salpingo-oöphorectomy; right salpingectomy	"	2-para
31	M. L.	20	2/10/09	Left ovarian cyst -	Left ovariectomy	"	Single; simple cyst

* See Footnote to Table I.

TABLE No. V.—*Miscellaneous Operations.**

No.	Name	Date	Age	Disease	Operation	Result	REMARKS
1	M. B.	12/1/'09	32	Inguinal hernia	Herniotomy	Recovered	Alexander Adams operation performed also.
2	E. B.	29/1/'09	43	Gastric carcinoma	Pylorectomy	Recovered	Cholecystectomy performed 12 months previously.
3	M. L.	4/2/'09	47	Hypernephroma	Gastro-enterostomy Nephrectomy	Died (suppression of urine)	<i>Post mortem</i> showed other kidney in a state of chronic intestinal nephritis, also secondary nodule in lung.
4	K. M.	10/4/'09	39	Inguinal hernia	Herniotomy	Recovered	
5	M. F.	4/5/'09	33	Umbilical hernia	"	"	
6	M. C	23/4/'09	46	Appendicitis	Appendicectomy	"	Salpingectomy performed also.
7	M. E.	14/5/'09	30	Tubercular peritonitis	Laparotomy	Relieved	Abdomen studded with tubercle.
8	M. M'L	14/5/'09	27	Cirrhosis of liver, &c.	Talma-Morison	"	
9	J. R.	16/7/'09	48	Pelvic carcinoma	Laparotomy	Died	See Mortality Table VI., No. 8.
10	L. W.	14/9/'09	46	Umbilical hernia	Herniotomy	Recovered	

* This only includes important major miscellaneous operations.

TABLE No. VI.—Mortality.

No.	Name	Age	Date of Operation	Died	Cause of Death	REMARKS
1	B. M.	35	13/11/'08	18/11/'08	Pulmonary embolism	See Table III., No. 1.
2	M. L.	47	4/2/'09	5/2/'09	Hypernephroma	See Table V., No. 2.
3	M. K.	36	—	10/3/'09	General purulent peritonitis, empyema right side	Came to the Hospital moribund, and was admitted.
4	C. B.	47	22/3/'09	23/3/'09	Purulent peritonitis	Patient was very septic on admission. A submucous myoma was removed after splitting the posterior lip, but patient died on the following day. <i>Post mortem</i> showed abdomen full of pus; abscess in right broad ligament.
5	M. H.	40	7/5/'09	8/5/'09	Acute purulent peritonitis	See Table IV., No. 19.
6	M. R.	38	8/6/'09	11/7/'09	Sepsis	A very advanced case of carcinoma. See Table IIb., No. 5.
7	B. O'C.	44	13/7/'09	13/7/'09	Shock	See Table IIb., No. 6. <i>Post mortem</i> showed no evident carcinoma anywhere. Patient died shortly after operation was completed.
8	M. O'R	48	16/7/'09	23/7/'09	Purulent peritonitis	Pelvis found completely involved in carcinoma; abscess cavities broken into at operation. See Table V., No. 9.
9	E. C.	52	19/7/'09	28/7/'09	Perforated gastric ulcer	Ovariectomy performed nine days previously when carcinoma in stomach was discovered, but operation was deferred. Patient, however, suddenly died. See Table IV., No. 24.