Original Articles.

FORTY YEARS' EXPERIENCE IN MIDWIFERY.[1]

BY W. SYMINGTON BROWN, M.D., OF STONEHAM, MASS.

The art of midwifery belongs to prehistoric times; the science of obstetrics is the latest recognized of all the ancient sciences. There is no branch of medicine which demands more skill, presence of mind, or justifiable daring than midwifery. It needs a man who can neither be overwhelmed by disaster nor unduly elated by success, — one who has the courage and honesty to do whatever is best for his patient, irrespective of consequences. Of such men no profession possesses a superfluity.

It is a strange fact, however, that only sixty years ago practitioners in midwifery were not admitted as Fellows to the College of Physicians, London, on the ground of inferiority, and the Royal College of Surgeons did not require candidates for its diploma to undergo an examination in obstetrics. This odium has nearly disappeared in our day, but a single item illustrative of its vestiges may be cited. I refer to the fact that the popular encyclopædias of our own day make no reference to the lives of prominent obstetricians, such as Smellie, Levret, or Naegele. Hundreds of insignificant names are recorded in Appleton's, Chambers's, and Johnson's Encyclopædias, but a profound genius like William Smellie — writer, teacher, inventor, and artist — is not even mentioned.

During a short visit to Scotland, in 1878, I met a lady, thirty-five years old, at whose birth I officiated obstetrically. And I had attended more than a hundred midwifery cases before that one. I wish I possessed a record of them all. While a medical student I served three years as assistant to the late Dr. James Paterson, Professor of Midwifery in the Andersonian University, and delivered many women among the destitute poor of Glasgow. During the last nineteen years I have kept a moderately full record. The whole number, dating from 1840, must exceed 2,000 cases.

In 1842 forceps were rarely used. It was a period of reaction, and many physicians entertained a strong prejudice against their employment, except in extreme cases. Dr. F. H. Ramsbotham, physician to the Royal Maternity Charity, London, in summing up the symptoms warranting recourse to the forceps says: "If the pains have entirely disappeared, if the strength is failing, the spirits sinking, the countenance becoming anxious, if the pulse be 120 or 140 in the minute, the tongue dry, brown, and raspy; if there have been two or three rigors; if there be green discharge; if the head have been locked for four hours, and made no progress for six or eight hours; if the patient be vomiting a dark, coffeeground-like matter; if there be hurried breathing, delirium, or coldness of the extremities," *then* we may use the forceps, — before sending for the undertaker.

I recollect attending one case in Glasgow during a long-drawn-out week. The woman was very poor, and had been compelled during the whole period of gestation to sit from fifteen to eighteen hours a day, winding pirns, in order to earn a bare subsistence. There were no alarming symptoms, but the abdominal muscles seemed to be powerless. I sent for Dr. Paterson, and requested him to help her flagging powers with the forceps, but he declined to do so. The case did not come under any of Ramsbotham's excuses. At last the poor woman got tired of waiting; she sent for a doctor with fewer scruples, and was instrumentally delivered. This case made a deep impression on my mind, and, in fact, converted me to the faith which I hold to-day.

In this paper I propose to state very briefly the principal conclusions I have arrived at under six heads, namely: Forceps, Turning, Ergot, Anæsthetics, Antiseptics, and Craniotomy. Before doing so, however, allow me to make one remark in regard to the language employed. Although what follows may appear like laying down the law in a somewhat curt fashion, such is not my intention. What follows are simply my own opinions on certain obstetrical problems colored by the personal medium. Nobody is more anxious than I am to be set right where I have been wrong. The late Dr. John C. Warren, in his classical work on "Tumors," gives us this good advice: "He [the surgeon] must get the opinion of other surgeons. Even those who have not so much experience as himself may afford him excellent hints, and strike out from his own mind thoughts which without this collision would not have been elicited." Dr. Barnes also truly asserts that "there is no man whose experience is so great that nothing is left for him to learn from the experience of others." Such societies as this one answer that purpose.

FORCEPS.

I prefer curved to straight forceps. They are about as easily applied, and are less liable to slip. If a beginner can only afford one it should be a long pair, either nickel or silver plated. But it is convenient to own a short pair, and I always carry one in my obstetrical bag, along with a No. 6 gum-elastic catheter (male), a Davidson syringe, a hypodermic syringe, a few feet of flat, covered wire (such as milliners use), ether, ergot, chloral, and whiskey.

The short forceps may be used at any time when their employment will benefit the patient or her coming child. We should *not* use them merely to save our own time. But the long forceps (when applied within the uterus) should seldom or never be used without a consultation. Indeed, it is a wise precaution, in most difficult or dangerous cases, to call in a brother practitioner to share the responsibility. I make it an invariable rule to pass a soft catheter into the bladder before applying forceps. In some cases using the catheter helps progress, even when forceps are not needed. If the rectum contains solid fæces I also give an enema of warm soapsuds.

How should the forceps be applied? In Scotland the woman is placed on her left side, with her hips projecting from the bed. In this country the dorsal position is preferred, and it is the one I most frequently use. Lately I have tried a new way, which has certain advantages. The woman lies on her back, in the centre of the bed or anywhere, and is not moved at all. Of course, it is not convenient

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to use long forceps in this position; but, when practicable, it avoids the appearance of preparing for a surgical operation, and I think the less fuss we make the better it is for our patient.

In most cases I insert each blade at the sides of the pelvis, without regard to the position of the child's head. If the vertex presents, you can scarcely go wrong by following this rule, and it saves the patient the annoyance of searching for an ear and other irritating manipulations. I make traction only during a pain, and relax pressure when the pain abates. I think it is advisable to pull with a slight pendulum motion, instead of using direct traction, on the same principle that it is easier to pull down a pair of tight pantaloons by drawing on alternate sides than by pulling on both sides at once.

ERGOT.

As a means of shortening labor ergot is seldom employed nowadays. The forceps have crowded it out of use for that purpose. But as an agent in promoting uterine contraction, after delivery of the placenta, and especially in cases of threatened flooding (some women have a hæmorrhagic idiosyncrasy), it is a valuable remedy. One reason why ergot has fallen into disrepute is the poor quality of many specimens offered for sale. Dr. Squibb's aqueous extract rarely disappoints me. It should be borne in mind, however, that no drug is readily absorbed during extreme depression.

After much blood has been lost our main reliance should be placed on other agencies, such as injections of very hot water and mechanical pressure. The accoucheur's hand inside the womb, with external counter-pressure, is the most reliable method. In milder cases I have succeeded in arresting severe hæmorrhage by injecting hot water and vinegar into the flaccid uterus. But the water must have a temperature of at least 130° F. in the basin, as it cools during its passage along the tube.

TURNING.

As this operation requires no surgical instrument, it obviously antedates the forceps, and, since the days of Ambrose Paré, has been a favorite with many practitioners, and even with skilled midwives. I was acquainted with a physician who, if one might draw an inference from his usual practice, seemed to think that nature had made a mistake in placing the child upside down in the womb. In our own day the late Sir James Simpson, Dr. Barnes, and Dr. Braxton Hicks have done much to bring version into favorable notice. On one occasion, before labor had fairly commenced, while making an external examination, I detected the child's head above the brim, and succeeded in converting a cross presentation into a normal one by the Braxton-Hicks method. I was agreeably surprised at the ease with which the change was effected. But, notwithstanding the plausible arguments advanced by Simpson, Barnes, and others, I have come to the conclusion that turning, after the evacuation of the liquor amnii, is a very dangerous operation for the child, and not much safer for the mother. I admit that cases occur where no other alternative (except Cæsarean section) is left us. If we conclude to turn, the operator's left hand should be used, and, in most cases, it is better to bring down one foot than two feet. The accoucheur's left hand is the obstetrical hand *par excellence*. Physicians should learn to use it adroitly more than they do.

ANÆSTHETICS.

The foremost question under this head is, Do anæsthetics injure the patient? I am pretty sure that they do not. Since 1849 I have used ether, chloroform, or a mixture of the two with alcohol, in every case where the woman was willing to breathe an anæsthetic. Some object; they are afraid to take it, and these I do not urge; but the majority are glad to get it before the labor is over. As a general rule I do not give ether during the first stage.

High authorities tell us that there is a greater tendency to post-partum hæmorrhage after ether or chloroform has been administered. During the last sixteen years I have not employed chloroform in midwifery practice, except as a remedy for convulsions; but I believe that ether, in moderate doses, does not tend to bring on flooding. Ether is seldom given to the extent of unconsciousness. The patient knows what is going on, and can render voluntary assistance when solicited.

A small dose of ether acts beneficially in two ways: it blunts sensibility to pain and allows the abdominal muscles to aid in propulsion. Without ether the patient's will-power is instinctively exerted to delay the labor; with it, the canal is more likely to be relaxed, and the voluntary muscles are not so much restrained. The contractile power of the womb itself is not affected by moderate inhalation of ether.

ANTISEPTICS.

Cleanliness is a good thing in midwifery, and antiseptics are its aides-de-camp. A young doctor who keeps his nails in mourning will eventually have to mourn the absence of a lucrative practice. Still it is possible to have too much of a good thing. Dr. Thomas, of New York, has recently taken a stand on this subject which most physicians would call ultra. The rules and regulations he lays down might possibly be enforced in a hospital, but hardly in private practice. And even if they could be carried out, I question the advantage of trying to surround a physiological process with all the paraphernalia needed in a surgical operation. Carbolic acid has had its flood-tide, and begins to ebb. Corrosive sublimate will probably follow suit at no distant day. Please observe, I do not object to disinfectants or antiseptics in themselves. Both of the chemicals mentioned will, no doubt, be used occasionally with advantage. But I believe that carbolic acid nearly killed Dr. Thomas Keith, and not a few unfortunate patients have suffered from its wholesale reckless employment. I greatly prefer a weak solution of iodine, prepared with iodide of potassium, which may be diluted with water without precipitation, or a hot solution of permanganate of potass. In ordinary cases absolute cleanliness is all that is needed. The routine employment of vaginal injections is likely to do more harm than good. I concur in the opinions expressed by Dr. Adams, of Framingham, in his interesting paper read at your last meeting. Dr. Wm. Goodell's suggestion that lying-in women should be encouraged to

assume the erect posture early, with a view to facilitate the removal of clots and *débris*, is an excellent one.

As already hinted, it is a good plan for the obstetrician to wash his hands, keep his finger-nails pared pretty close, and to fill the small remaining space with softened soap before making a vaginal examination. A Syracuse æsthetic M.D. kindly suggests that no harm would result if he also washed his hands afterward.

CRANIOTOMY.

During the last nineteen years I have performed craniotomy three times, all of the cases occurring in the practice of other physicians. No operation tries a surgeon's nerve more than this one. When we are sure that the child is dead, of course it is plain sailing. But there are cases where the fœtal heart cannot be distinctly heard, and yet the child is alive. To plunge a perforator into a living child's skull, and deliberately take its life, with a view to save that of its mother, is, to say the least, a sad alternative. I hope I shall never feel compelled to do it again. In these days of successful abdominal surgery, would we not be justified in appealing to the patient to allow us to perform the Cæsarean section or laparoëlytrotomy? But we should not wait until the woman is at death's door before operating. In this, as in all other life-saving operations, promptness and decision win the day.

The medical profession is deeply indebted to Dr. Thomas for his efforts to popularize laparoëlytrotomy. I understand that he tried the operation several times on the cadaver before performing it on a patient. Nearly all great surgeons have been in the habit of doing this. In this case the principal difficulty will be to get the consent of the patient and her friends in season to be of any service. We all love to put off the evil day, or even the evil hour, and so the golden opportunity slips through our fingers. But as successful results in this line increase, the dread of the operation itself will decrease, and obstetric surgery may achieve a new triumph in the salvation of human life.

THREE CASES OF PELVIC HÆMATOCELE. —ONE DEATH.[1]

BY M. A. MORRIS, M.D.

On the twenty-third of August, 1876, I first saw Mrs. R., twenty-three years of age, whose previous history was as follows: She had two children, one four, and the other five years of age. In labor she had been attended by an irregular practitioner, and had suffered from "womb trouble" ever since. She first menstruated at the age of thirteen, and had always been regular, the flow continuing three days, and never attended by pain. She had suffered from "inflammation of the bowels."

On the fourth of August her catamenia appeared as usual, but a *watery discharge* had continued up to the time of my visit. On the 17th she had an attack of severe pain in the right iliac region, and soon after, while conversing with a neighbor, she fainted, and fell from her chair to the floor. Afterward she vomited, and noticed a slight show from the vagina. Four days later, although weak, losing color, and suffering some pain, she felt well enough to start on an excursion down the harbor. When the steamer was reached the pain became suddenly worse, and again she fainted and vomited. She was placed on a mattress and sent home, suffering the most terrible agony. On her arrival a physician was sent for, who gave her an opiate, which, with two doses taken on the way from the boat, relieved her.

I found her in bed, looking very pale, with a pulse of 96, and a normal temperature. There was vomiting, thirst, headache, painful micturition, and rumbling of the bowels, — the abdomen was somewhat swollen, tympanitic, and tender to pressure. Pain over the uterus was complained of, and on examination per vaginam the organ was found to be fixed, somewhat retroverted, enlarged, and tender. The os was sufficiently open to admit the tip of the finger. There was an indistinct feeling of fluctuation above, to the left of the uterus, and the fundus could not be felt through the abdominal wall. She thought she could not be pregnant.

Opium in sufficient quantity to quiet pain was given, and a mixture containing dilute sulphuric acid.

September 1st the flowing had stopped for four or five days, and then returned. September 4th there was barely a sign of flowing, and she was so comfortable that a sound was carefully passed into the uterus, showing its depth to be a little over two and a half inches, and that it was retroverted and displaced to the right. The external os and cervix were sufficiently open to easily admit the finger as far as the internal os. September 8th, with the hand on the abdomen and a finger in the vagina, a mass, perhaps as big as a large orange, could be felt to the left of the uterus. Pressure upon it caused pain, which could be felt in the liver and back. There was a scanty serous flow from the vagina, faintly tinged with blood. Micturition and defæcation were still painful. She slowly improved from this time, and the tumor gradually disappeared. She was in bed seven weeks, and was quite well in three months. Four months after the beginning of her illness I made an examination, but found no trace of the tumor, and the uterus was free and movable. I think the hæmorrhage took place into the peritoneal cavity, in this case, as the pain was so severe and the shock so great. The fact that there was no circumscribed tumor at first, and that later on the mass became encysted, and had a well-defined outline, also points to its having been peritoneal. Treatment: Opium, poultices, and dilute sulphuric acid.

The second patient was thirty-three years of age, the mother of three children, the youngest three years old. She had been in good health and regular in her monthly periods up to two months previous, but since that time she had not menstruated. She always suffered from dysmenorrhœa. On the sixteenth of March, 1877, after eating a hearty breakfast, she began work at the washtub, and, soon after lifting a heavy tub, experienced severe pain in the abdomen over the uterus, and then a frequent desire to urinate. There was also a feeling of faint-

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