

occasionally a normal pregnancy may be sacrificed by these means, are preferable to allowing the patient to go through her pregnancy in fancied security when in reality a fatal outcome of the case is never far distant. If, on examination, a placenta previa is discovered, I feel that the pregnancy should be ended at once, except in the rare cases in which a few weeks may mean the delivery of a viable child, and the patient can be put under such conditions as are present in a hospital where delivery can be accomplished at any recurrence of threatening conditions.

In the toxemias of pregnancy the tendency on the part of the profession has been to defer interference until such serious symptoms arise as to force operation. Unquestionably many patients' lives have been sacrificed in a misguided attempt to prolong a pregnancy which has been recognized as definitely pathological. In the hyperemesis of early pregnancy the recovery of many neurotic cases, after a serious condition has been reached, has led to the neglect of many toxemias which should have demanded prompt attention. The diagnosis between the two conditions is often impossible, but it seems to me that the only safe course is to terminate a pregnancy when the condition fails to yield to careful treatment before the patient's condition becomes desperate. There is little chance after a patient shows definite signs of failing power that a normal conclusion of pregnancy can be reached, and the longer operation is deferred the more serious the prognosis of the operation.

In the later months of pregnancy, the toxemia usually takes the form of eclampsia and in the majority of cases the convulsive attacks are preceded by marked prodromal symptoms, usually sufficient to call the patient's attention to the fact that the pregnancy is abnormal. In most cases prompt eliminative treatment will reduce the toxemia and enable the patient to go through pregnancy without further trouble, though an attitude of constant watchfulness on the part of the attendant must be maintained. If, however, the toxemic symptoms do not promptly yield to treatment, if the symptoms increase in spite of treatment, or if when the patient is first seen convulsions have already occurred or the symptoms are threatening, pregnancy should be ended at once for the benefit of the patient, as many lives have been sacrificed in the playing with fire.

In conclusion, I would say that any departure from the normal in pregnancy and labor demands immediate careful investigation and that the earlier the abnormal conditions are recognized and met the better the outcome for the patient. I take exception to the view that any practitioner of medicine is fit to take care of an obstetrical case as has been the custom, my reason being that although trouble so seldom arises that a man may handle many cases without mortality, nevertheless, any case may prove to be one which needs immediate expert attention. My opinion is that no man who is not qualified to recognize abnormalities when they first appear and deal with them promptly, or be willing to call in a consult-

ant to aid him when symptoms first appear, should ever take charge of a case of pregnancy and labor, and if this condition is met, the reproach which has been cast on the profession that the mortality in general, both as regards mother and child, has not improved materially in the last twenty years in spite of the opportunity for improvement made possible by the advances in surgical technic, will be removed. Many practitioners are, however, trusting to luck in the handling of obstetric cases who would never dare to handle a serious medical or surgical case without consultation, and consultation at the least suspicion of trouble, and to this attitude we owe most of our bad results.

OBSTETRICAL PROGRESS.*

BY STANLEY F. WARREN, M.D., PORTLAND, ME.

I AM highly honored by your invitation to discuss these valuable papers. Their underlying topic is the same, "Recent Progress in Obstetrics," and the one is complimentary to the other. It has been said that this is the only department in medicine which has made no decided advance in the last twenty-five years. The truth of such a statement hangs by a very thin filament of fact. Is it not true that as much as fifty years ago, in this very city, the longest single stride in the progress of obstetrics, or in any of the other departments of medicine, was taken by Dr. Oliver Wendell Holmes, when he published and defended his thesis, "On the Contagiousness of Childbed Fever"? Three years afterwards, and still more than fifty years ago, Semelweis independently demonstrated the same infectious character of the disease. With its cornerstone laid in America and cemented in Europe, these great architects laid the foundations of the temple of scientific obstetrics, and never has a day passed since without decided growth in the palace beautiful as the craftsmen of the world have labored upon it.

Perhaps I may be too pessimistic, but I am inclined to believe that in a simple, spontaneous childbirth the ordinary general practitioner of medicine is a needless bill of expense to the family. He is only a man-midwife, doing the work of a nurse, but taking the pay of an expert. In fact, his work is oftentimes not so good as that of the nurse, because his technic is not so good as hers. He "plays to the gallery" in fervent exhortations to "bear down," and by a spectacular tying of the cord. Just so soon as he interferes with the sequences of physiological labor, he thereby changes the character of the process from one of health to one of disease. Now he must drop the mantle of Sairy Gamp and take on the work and responsibilities of the skilled surgeon. That the capital operations of obstetrics are now not so often attempted by the general practitioner is one of the most obvious signs of modern obstetrical progress.

I shall not essay to discuss the scientific side of these papers, but rather their more practical

* Read in discussion of papers by Drs. Reynolds and Newell before the Suffolk District Medical Society, Feb. 17, 1909.

aspects, with which I am better acquainted. The method of presentation of the argument of Dr. Reynolds is particularly delightful to me, because of its originality. It is evident that the nucleus of his contention is the term, "prophylactic obstetrics." The adjective has no hard and fast limitations. Each obstetrician may prescribe for himself, and for his patient, the characteristics which make this one's labor physiological and that one's pathological. Undoubtedly in prehistoric times woman gave birth to her offspring like other plantigrade mammals, without pain, just as her other functions, respiration and digestion, were painless. But when in the cycles of evolution the genus homo sapiens assumed the erect posture, and the historic birth canal developed, as described, from lower types, then childbirth began, and has continued, to be not physiological, but pathological. For primeval woman, painful labor was not contemplated; now-a-days it has become one of the deterrent factors in over production of the race.

From personal experience, I heartily agree in the truth of Dr. Reynolds's three propositions. The first, that "mechanical obstacles of clinical importance are far more common than formerly taught," may be illustrated by the present relative frequency of posterior positions of the occiput, a fact now made possible by the modern methods of studying fetal attitude. A second illustration might be the knowledge which the present-day obstetrician has of the effects of social and family habits upon childbearing, as such habits are productive of massive children due to excessive nitrogenous diet, or to prolonged gestation, etc.

The second proposition, that "excessive pain in labor is a serious evil," is demonstrable by the fact that our women, in increasing number, require an anesthetic in delivery. The popular idea of the laity, that labor must be necessarily painful, is appreciably less noticeable than in my younger days of practice. Professional aid in shortening this period of suffering is certainly accepted more often by the city patient than by her country cousin. The former has been taught by experience and observation that artificial delivery is to her advantage, both in the relief of actual pain and because it leaves her in better anatomical condition than does natural labor.

For evidence of the third proposition, that "careful and skilled study before term is the most important technical element in the management of difficult labor," permit me to offer the following very brief notes of twenty-six deliveries in consultation, all included within my last series of one hundred confinements.

1. Long first stage, third cephalic position, forceps extraction by Scanzoni method.
2. Obstructed labor, third position, Scanzoni.
3. Four days labor, unrecognized fourth position, moderately contracted conjugate, high Tarnier.
4. Aged primipara, fourth position, Scanzoni.
5. Placenta marginalis, narrowed pelvis, *accouchement forcé*, Tarnier.
6. Eclampsia, *accouchement forcé*, low forceps.
7. Third position, manual rotation forward, high forceps.

8. Twins, third position and breech, Tarnier and podalic version.

9. Third position, contracted pelvis, Cesarean section.

10. Third position, Scanzoni.

11. Seventy-two hours first stage, first position, disproportion, Tarnier.

12. *Accouchement forcé* for progressive toxemia, podalic version and paracentesis of fetal abdomen, dystocia due to fetal ascites.

13. Eclampsia, *accouchement forcé*, podalic version.

14. Primipara, left mento-anterior position, placenta marginalis and prolapse of cord.

15. Eclampsia, five convulsions, manual dilatation, child stillborn, mother died in coma on third day.

16. Medium forceps for delay.

17. Rheumatic arthritis, phlebitis, bed sore sixth month, manual dilatation with bad cervical tear, podalic version.

18. Pernicious vomiting, uterus emptied.

19. Third position, easy Scanzoni.

20. Cervix rigid due to former trachelorrhaphy, manual dilatation after twelve hours, easy Scanzoni.

21. Primipara, forty hours first stage, generally contracted male pelvis, very difficult extraction with Tarnier.

22. Hydrocephalus, head emptied, cranioclast.

23. Primipara weighing 220 lb., four days first stage, forceps and craniotomy failed, Cesarean section, child dead in utero, mother died third day of sepsis, true conjugate measured under ether 3 inches.

24. Long first stage, third position, firm contraction ring in dry uterus, Tarnier.

25. Previous manual dilatation with bad cervical tears, requiring immediate suture, third position, Tarnier.

26. Pendulous abdomen, no engagement after eighteen hours, easy podalic version.

Most of these cases show by their clinical history that there was a failure to recognize early the immediate cause of the arrest of labor. Per contra, the fact that consultation was desired shows that the general practitioner is becoming educated, by the stern logic of events, to value and seek the aid of his more experienced brother obstetrician rather than to attempt to do the work himself, with the prospect of failure and loss of professional prestige as his "portion of labor."

The paper of Dr. Newell is of just such a character as his great clinical experience and critical bent of mind would lead him to present. It is full of the most valuable conclusions, valuable because tested by common sense and sound reasoning. The argument rests upon the principle that any irregularity, in the course of pregnancy or labor, calls for an immediate examination for the cause. Such an examination is to be made methodically, and with the best degree of technical skill which the immediate attendant possesses. Primiparae should be encouraged to place themselves early under the tutelage of their selected obstetrician, who is not necessarily the family physician. No question referring to her condition which she may ask him should be thought trivial, for in no department of medicine is prophylaxis so essential as in midwifery. And when labor begins, any delay in its orderly progress beyond classical limits warrants and demands a thorough intra-uterine examination, even at the expense of manual dilatation of the birth canal and full anesthesia. To the neglect of this apparently obvious rule must be attributed nearly all the dystocias for which the expert is consulted. The general practitioner must understand that a long first stage means, in the vast majority of patients, trouble somewhere, and if he has not the courage

nor skill to find it, then it is his bounden duty to get some one who can.

There is no time remaining for me to discuss the paper *in extenso*. The reasoning is self-convincing and needs no arguments. It is as useless to attempt to prove axioms as it is to fight windmills. Certain sentences have caught my ear with their clear, honest ring, and may be emphasized by repetition.

"Any permanent change in the rate of the fetal heart calls for interference on the part of the child." "The course of wisdom, even in cases of normal labor, is to interfere as soon as progress has reached the point when the element of risk in operation is less than the strain of labor." "The teaching, never to interfere with a breech case until maternal power begins to fail or fetal heart flag, is decidedly wrong." "The earlier that indication (for interference) is met, the easier the operation and the better the prognosis for both patients."

In cases of both early and late puerperal toxemia, the almost universal post-mortem findings of acute destructive hepatitis give much weight to the recent claims of Ewing and others that all these pathological conditions are simply links in a single chain. It is metabolism gone wrong. Depending upon a known cause, pregnancy, it is the task of the obstetrician to determine whether anything within the reach of his professional skill except the crucial experiment of emptying the uterus can avail against the hydra-headed disease. The method of urinalysis, thus far advised, for determining the coefficient of ammonium is still experimental and subject to obvious limitations for the general practitioner. It is strictly a laboratory analysis, requires much time to make, and, therefore, it is doubtful if it can ever become generally useful. Most of us must still rely for the diagnosis of hepatic insufficiency in the pregnant woman upon the familiar clinical symptoms of continuous, increasing, systemic poisoning, malaise, anorexia, uncontrollable vomiting, degraded pulse, heightened temperature, obscured mentality, coma and death. True organic toxemia is so insidious in its onset, the early differentiation between benign and malignant cases so difficult, the moment of interference so evasive, that any aids to solve the problem are welcome. Recent studies to that end are certainly worthy of careful examination and unprejudiced trial.

Two cases of apparent pernicious vomiting in pregnancy have been received into my service at the Maine General Hospital, and I have seen another in consultation. In both of the hospital patients, specimens of the urine were sent to a laboratory for determination of the ammonium content. Long before the urinary report for the first patient could have been received, symptoms became so urgent that the uterus was promptly emptied. Two days after operation the urinalysis was returned, showing a high rate of ammonium, and the woman was then convalescent. The specimen from the second patient was lost in transmission; meantime she rallied under appropriate treatment and carried the child to

a successful term delivery. The third patient was *in extremis* when I reached her; as a forlorn hope, the uterus was emptied, but she died soon afterwards. In this case no analysis for ammonium was made.

In connection with the general subject of these papers, I wish to repeat my personal experience with Cesarean section for obstructed labor. I do this partly to show this presence that we obstetricians in the back woods are alive, and partly to add my testimony to the contention of Dr. Reynolds that the rate of mortality, and, I submit, of morbidity in Cesarean section depends largely upon the fact whether the section is elective or compulsory. The cases are six in number, and are mentioned in outline.

1. Two stillborn children after forceps delivery at term. One induced labor at thirty-sixth week, child stillborn; elective Cesarean section four days before term, successful for both mother and child. Flat pelvis and large children. Operation in tenement.

2. Two-hundred-pound woman. First child at term with forceps, stillborn; second child at eighth months by induced labor and forceps, stillborn. Elective section four days before term, successful for both. Obstruction due to large children. Operation at residence.

3. Primipara; distorted pelvis from early hip-joint disease; under my care before and after section, but the operation was made in this city (Boston). Compulsory section for labor on the morning set for operation; successful for both.

4. Multipara; extosis on ramus closing the outlet; section made at hospital after six hours of labor; successful for both.

5. Multipara; successive births increasingly difficult, last two children stillborn; flat pelvis, true conjugate three and one-half inches; after five hours' labor, tentative trial made of forceps; section at hospital successful for both, with ten-pound child; moderate temperature during first week due to sepsis from slight lacerations by instruments.

6. Primipara, weighing two hundred and twenty pounds; four days in labor; forceps failed and head could not be perforated owing to degree of ossification; true conjugate three inches; difficult section from extreme fat, and extraction of dead child weighing thirteen pounds; biparietal diameter five inches, and head one solid bone. Mother died seventy-two hours after operation from sepsis. The only death in the series, and was not due to the operation *per se*.

I congratulate this society that it has two members able to present such papers; I congratulate myself that I have had the privilege of hearing them.

—•—

TYPHOID FEVER EPIDEMIC. — Over thirty cases of typhoid fever are reported from Winsted, Conn., with three deaths, up to June 9. The health officers consider that contamination of a well on one of the dairy farms is responsible for the outbreak, and the Borough Board has created a new office of milk inspector to investigate all dairies. — *Med. Rec.*