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### PART I.

#### ORIGINAL COMMUNICATIONS.

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ART. XXIV.—*Report of the Rotunda Hospital for the Year ending November 3rd, 1883.*\* By ARTHUR V. MACAN, M.B. ; Master of the Hospital.

THE Report of the Rotunda Hospital, which I have the honour of bringing before the Academy to-night, will deal chiefly with the application of Listerism, or, if anyone likes the term better, of antiseptics, to midwifery.

It is now many years since I became a believer in the theory—first enunciated by Semmelweis, in 1847—that puerperal fever is caused by the absorption of animal matter in a state of decomposition. Such a belief makes the position of Master of a large Lying-in Hospital like the Rotunda a most anxious one. For if puerperal fever be due to the absorption of septic matter, it is preventable; and, should it occur, one must be ready to acknowledge that its presence is due either to ignorance of the precautions necessary to prevent such an occurrence, or to failure in seeing that such precautions are rigorously carried out.

Hence, though thoroughly aware that antiseptics had been successfully introduced into many of the Lying-in Hospitals on the Continent, with the result of greatly decreasing the puerperal mortality, I was doubtful, when first appointed to the hospital, whether I was myself thorough master of the process, and, granted even that I were, whether I should be able to see that the necessary precautions were rigorously carried out.

\* Read before the Obstetrical Section of the Academy of Medicine, Friday, April 25, 1884.

Before proceeding further, however, I will first enumerate the antiseptic precautions which had been introduced into the hospital by my immediate predecessor, Dr. Atthill. These consisted chiefly in a request to the pupils and nurses in training to wash their hands with carbolic soap before examining patients. More recently a vessel of carbolic solution (1 in 40) was left beside the wash-hand basins, and pupils were expected to dip their hands into it after washing them with carbolic soap. Prophylactic antiseptic vaginal injections had also been extensively tried, but finally abandoned, as they did not seem to give any better results than the purely expectant treatment. These measures, though excellent, as far as they went, were not, in my opinion, sufficient.

Now, in considering the precautions which should be taken for the prevention of puerperal fever, it is absolutely essential that we should keep quite separate in our minds the two great classes—auto-infection, where the poison is generated within the woman, and hetero-infection, where the poison is introduced from without. The latter class is, under ordinary circumstances, by far the more numerous and the more dangerous, and is generally, one might almost say always, due to inoculation with septic matter introduced by the hands of those examining, or by instruments used in operations. Our first efforts should therefore be directed to the thorough disinfection of every hand and instrument likely to come in contact with the genitals of a woman during pregnancy, labour, or the puerperal state. Whether the septic poison is ever conveyed by the air, is by no means certain; but, till it is proved that it is not, we should endeavour to disinfect it also. Even when the woman has escaped being infected during labour, she may subsequently be so by the introduction of septic poison by the nurse while washing her, or by contact with imperfectly washed bed-clothes or napkins.

Hence, to a believer in the theory of Semmelweis, the first and most essential precaution necessary in a lying-in hospital is to refuse to allow students who are dissecting to examine lying-in women. Hereafter, when the nature of the septic poison and the proper and most powerful method of disinfection are more thoroughly understood, this may, and I trust will, become an unnecessary precaution. But with our present knowledge, and with the endless proofs that are at our disposal that puerperal fever has frequently had such an origin, I look upon it as little short of criminal to allow a student to walk from the dissecting-room to the lying-in

chamber. The first rule I made, after being appointed Master of the Rotunda, was, therefore, that no student who was dissecting would be allowed to attend the hospital. But further, in order to make it as easy as possible for students and nurses thoroughly to disinfect their hands before examining any case of labour, vessels containing a 1 in 40 solution of carbolic acid were placed over every wash-hand basin, and I personally instructed every student who entered the hospital as to the way I thought it necessary to wash the hands. The notice that I now show you was also put up in every ward:—

“NOTICE.—Rule—No one shall make a vaginal examination without having first washed the hands in carbolic acid solution, using a nail brush carefully. By order, Arthur V. Macan, Master of the Hospital. November, 1882. The Master feels confident that the Pupils of the Hospital will assist him in seeing that this rule is strictly carried out.”<sup>a</sup>

Moreover, to lessen the necessity of making vaginal examinations, and thereby also the risk of conveying septic infection, each student is taught to palpate the abdomen, and soon recognises, without difficulty except in exceptional cases, not only what the presentation is, but also the exact position of the child's head, back, and limbs. Also every student or nurse who examines a woman *per vaginam* has to write his or her name down on her card, so that if she should afterwards prove to be infected the origin of the infection may be traced. This can readily be done, as only four students are allowed to examine any given case. It has, I think, another very important good result—giving each student a sense of personal responsibility for the cases which he examines. If I or my assistants make a vaginal examination, we also enter our names on the patient's card, in order that we may share the responsibility should any symptoms of septic poisoning afterwards show themselves. As soon as the child is born, the woman is made to lie slightly on the back to prevent the entrance of air into the vagina or uterus, and there is an absolute rule against touching the woman's genitals with the fingers after delivery, except in cases of post partum hæmorrhage, ruptured perinæum, or retained placenta, and then only by the Assistant Master. Before stitching up a ruptured perinæum, the vagina is injected with carbolic acid solution (1 in 40), and, should it be found necessary to introduce the hand, the

<sup>a</sup> After the hands have been thoroughly washed in carbolic acid solution, they are now dipped for half a minute in the corrosive sublimate solution, 1 in 1,000.

uterus is always washed out with a similar solution.<sup>a</sup> In like manner the vagina is irrigated and the external genitals are carefully washed before every operation, and the uterus is syringed out afterwards, and recently a pessary containing ʒiss. of iodoform has then been passed to the fundus and left there.

To prevent the possibility of infection being carried by a vaginal or uterine tube, they are all made of glass, and a separate vaginal tube, such as I now exhibit, is provided for every bed in the hospital. These, when in use, are kept in carbolic acid solution, and are boiled in the same solution before being again used for another patient. To guard against the injection of air into the vagina or uterus, which, besides being in itself very dangerous, is a fertile source of fœtid lochia and consequent auto-infection, the old india-rubber syphon syringes have been entirely replaced by irrigators, which act by gravity; and in order to render the air, if it should enter the vagina, as innocuous as possible, carbolic acid solution is constantly evaporated in the wards day and night. This latter precaution I do not, however, look on as very essential, and I intend very shortly to try if we cannot get as good results without it. The old gum-elastic catheters have also been banished and their places filled by silver instruments, which, both before and after being used, are placed for a considerable time in the hot evaporating carbolic solution.

Now, if every person's fingers who examines a woman during labour, and every instrument that touches her, is quite free from septic poison, we must look on such a person as having so far escaped hetero-infection. Hence, if the prophylactic precautions adopted during labour are sufficient, there can be no necessity for any prophylactic antiseptic injections, whether vaginal or uterine, in the puerperal state, and, as a fact, I never allow them to be used either in hospital or private practice. Indeed I do not even consider it necessary to use an antiseptic solution for washing the external genitals, which is done twice daily with plain warm water, a piece of oakum taking the place of a sponge, a substitution the credit of which belongs to Dr. Atthill. Since, however, it is a well-ascertained fact that even healthy lochia, if brought in contact with the genitals of a recently-delivered woman, may produce fever, the nurses are taught to avoid, as far as possible, any contact with the genitals of puerperal women.

<sup>a</sup> For some months past a solution of corrosive sublimate, 1 in 2,000, has been substituted for the carbolic acid, with most satisfactory results.

Finally, in order to lessen the chance of infection through the bed-clothes, napkins were for the first time introduced into the hospital. Formerly a sheet was placed under the woman's buttocks, folded in such a way that the four loose corners were hanging over the edge of the bed. As soon as the woman, after being delivered on the couch, was put into her own bed, the uppermost corner of this sheet was placed between her legs to receive the lochial discharge. As soon as this was dirty, the second corner took its place, and so on. The washing, too, was so badly done that the stains left by the lochia on the four corners could often be clearly seen when the sheets came back from the wash. That such a condition of affairs must have been a frequent cause of fœtid discharge and subsequent auto-infection is obvious. Since the introduction of napkins and a more strict supervision of the clothes returned from the wash, this source of danger has, I am happy to say, been eliminated.

Such are the precautions looked on as necessary to guard patients who come into the Rotunda from inoculation with septic matter, or so-called hetero-infection.

Before I pass on to consider the measures taken to prevent auto-infection, I would like once more to emphasise the clinical distinctions between auto- and hetero-infection. In the latter case the labour has been most probably quite normal—the patient a fine, healthy primipara. The symptoms come on suddenly, within about thirty-six hours of delivery, and at the onset the discharge is not fœtid. In this case the poison has been inoculated into the blood in the same manner as the vaccine virus is in vaccination, and like it also has a very constant period of incubation. In cases of auto-infection, on the contrary, the woman is most frequently a multipara, the labour long, and perhaps complicated with a dead and putrid fœtus, or with fibrous tumour or cancer of the uterus, or there has been post partum hæmorrhage from a badly-contracted uterus, followed by the formation of clots, or the retention of portions of the membranes or placenta. The uterus being badly contracted, and the abdominal walls very relaxed, air enters the vagina, and decomposition of the contents of the uterus is the result. If the fœtid discharge thus occasioned finds a free escape—if the drainage is, in other words, perfect, no absorption takes place into the system, and we have the well-known clinical phenomenon of a fœtid discharge without either a high pulse or fever. But if, as is more generally the case, the

escape of the fluid is in any way obstructed, it becomes more and more fœtid from the delay, and, being absorbed into the system, causes fever—so-called autogenetic puerperal fever. This condition, called sapræmia, or putrid absorption, by Dr. Matthews Duncan, differs *in toto* from the hetero-genetic puerperal fever, or that due to inoculation with septic matter. For, while the former corresponds to fever due to absorption from a badly-drained wound, which disappears as soon as the fœtid accumulation has been removed, the wound itself disinfected, and free drainage established, hetero-infection, on the other hand, more nearly resembles the effects of a snake-bite, subsequent death or recovery being determined by the amount and virulence of the poison primarily introduced through the wound into the system. Nor in this case can we hope for any benefit to result from the subsequent application of antiseptics to the wound, as the poison has already infected the whole system.

Since, then, auto-infection depends on the absorption of putrid matter from the interior of the uterus, there are two conditions essential before it can occur—first, a fœtid discharge, and, second, retention of this discharge within the uterus. Now, in order that the discharge should become fœtid, I think air must have been allowed to enter the uterus. Hence the prophylaxis of auto-infection consists, first of all, in preventing the entrance of air into the uterus; and, secondly, in removing quickly any fœtid accumulation that may have taken place within the uterus, disinfecting its cavity, and providing for free drainage. One point of great importance, in order to prevent the entrance of air into the uterus during the third stage of labour, is to make the woman lie somewhat on her back as soon as the child is born. If this be not done, and the pressure of the hand is removed for a moment from the fundus, the uterus falls downwards, a vacuum is formed, into which, if the sides of the vulva from any cause, such as ruptured perinæum, are not in close apposition, air rushes. There can be no doubt, I think, that for a similar reason the position on the back, or nearly on the back, should be maintained as much as possible for some days after delivery, and the proper application of the binder, as preventing a negative pressure in the abdomen, insisted on. The great laxity of the abdominal walls in multiparæ and the tendency there is to imperfect contraction of the uterus will, I think, account in great measure for the increased liability to putrid absorption which has long been noticed in women who have had many children; while the excessive mortality in first cases is readily explained by the danger

of septic inoculation into the os during the long dilating stage, and into the ruptured perinæum during the third stage. Hence auto-infection is more common in pluriparæ, hetero-infection in first cases.

As a means of preventing an accumulation taking place within the uterus the position on the back is also of importance, as the intra-abdominal pressure is then greater than when the woman is on her side, and gravity acts more thoroughly. A distended bladder, which prevents the uterus contracting properly, should also be avoided—in fact, anything that is known to prevent uterine contraction should be removed. If the uterus be badly contracted ergot should be given, and should the discharge become fœtid *hot* antiseptic vaginal injections are indicated, which not only remove the discharge, but cause the uterus to contract. If the discharge be fœtid and the temperature not only becomes high, but remains so for twenty-four or thirty-six hours, then intra-uterine antiseptic injections should be made,<sup>a</sup> and an iodoform pessary introduced. Also, in all cases where the child is dead, and there is the slightest smell, the uterus should be washed out with corrosive sublimate solution, and an iodoform pessary introduced. When there has been a fœtid discharge, accompanied by a high temperature, but without any symptoms of inflammation being present, the patient is encouraged to get up on the sixth day, as usual. The erect position, by aiding gravity, and putting increased pressure on the fundus, causes the drainage to be more perfect, and the result is, as a rule, that the temperature quickly sinks to normal.

Here I would like to draw your attention to the suitability of iodoform as a means of rendering, and keeping, the interior of the uterus aseptic, and thus preventing the possibility of putrid absorption. It has been extensively used for some time past in the Rotunda for this purpose, with the most gratifying results. It is introduced into the uterus in the form of a pessary, the amount of the drug in each being  $\mathfrak{z}i.$  or  $\mathfrak{z}iiss.$  This decomposes very slowly, and exerts its antiseptic action for three or four days, at the least. I have also noticed that it has a powerful effect in lessening the temperature, quite apart from its antiseptic action. Thus there is a case in the Rotunda at the present moment in which we induced premature labour. It took three days, however, to bring on efficient pains, and some time before delivery the pulse was 130 and the temperature  $103\cdot6^{\circ}$ . As soon as the child was born the uterus was washed out with corrosive sublimate (1 in

<sup>a</sup>The solution now used is corrosive sublimate, 1 in 2,000.

2,000) and 3iss. of iodoform introduced. The result was that the temperature on the following day had fallen to 96·4°, or over 7°. I have brought down some of the pessaries that we use, that the members of the Academy may see them.

As to the treatment of hetero-genetic infection I have very little to say, as I know of nothing that quickens the elimination of the poison from the system. If the continuous high temperature is beginning to show its effect on the nervous system the treatment should be antipyretic. For this purpose we give quinine in large single doses of from 10 to 20 grains, or the bath at 90° cooled down to 60°, both combined with large quantities of alcohol. I am happy to say, however, that I have only once been obliged to resort to the cold bath, and that was in a patient who was delivered before I took charge of the hospital. In future I shall not hesitate in these cases to try the antipyretic effect of a pessary of 3iss. of iodoform introduced into the uterus.

Let us now pass on to consider the results obtained by these measures during the past year.

The number of women confined in the hospital during the year was 1,090. The following is a list of the abnormal cases:—

Forceps	-	-	-	62, or 1 in 17·58—5·68 per cent.
Version	-	-	-	5, „ 1 „ 218 —
Post partum hæmorrhage	25,	„	1 „	43·6 —
Breech	-	-	-	29, — — — 2·66 per cent.
Adherent placenta	-	8,	„ 1 „	37·5 —
Secondary hæmorrhage	-	1,	- - -	— —
Placenta prævia	-	8,	„ 1 „	136·25 —
Accidental hæmorrhage	16,	„	1 „	68 —
Face	-	-	-	4, - - - — —
Face to P.	-	-	-	2 (?), - - - — —
Prolapse of funis	-	-	-	5, „ 1 „ 218 —
Convulsions	-	-	-	5, „ 1 „ 218 —
Abortions	-	-	-	16, „ 1 „ 68 —
Mania	-	-	-	2, - - - — —
Perforation	-	-	-	2, „ - „ — —
Hydatids	-	-	-	1, - - - — —
Induction of premature labor	1,	-	- - -	— —
Twins	-	-	-	14, „ 1 „ 77·8 —
Scarlatina	-	-	-	1, - - - — —
Erysipelas	-	-	-	1, - - - — —



Of the 1,090 patients 6 died, giving a mortality of 0·55 per cent., or 1 patient in 181·6. The particulars of these 6 cases are as follows:—

CASE I.—J. B., aged forty, eleventh pregnancy; admitted Dec. 19th, 1882, having had convulsions for more than 30 hours previously. Comatose when admitted. Membranes were ruptured artificially, and after a time the head was perforated, and the child was born by the natural efforts two hours after. Woman died on 21st, having never regained consciousness. There was no *post mortem* examination.

CASE II.—M. J. W., aged twenty-seven, fourth pregnancy; admitted Dec. 24th, delivered Dec. 24th, 1882. Partial placenta prævia. The membranes were ruptured artificially, the hæmorrhage then ceased, and the child was born without assistance. Patient had been twice in hospital lately for hæmorrhage. She was transferred to the Auxiliary Hospital, and died there on Jan. 16th of pleuro-pneumonia. No *post mortem*.

CASE III.—E. F., aged thirty-five, ninth pregnancy; admitted Feb. 27th, delivered Feb. 28th. Fœtus premature at 6½ months, dead and putrid. *Uterus was not washed out*. Woman died on ninth day, with symptoms of pleuro-pneumonia.

*Post mortem by Dr. Duffey.*—“Double pleurisy, which must have been present before admission. No symptoms of septic infection.”

I was quite prepared to look on this case as one of auto-infection from a dead and putrid fœtus, the uterus not having been washed out, but Dr. Duffey said there were no evidences of septicæmia.

CASE IV.—B. S., aged twenty-two, first pregnancy; admitted April 29th, 1883, delivered same day. Immediately after delivery a large tumour, the size of a fœtal head, was discovered attached to the side of the fundus. This was diagnosed to be a fibroid. Patient died very quickly on eleventh day, with symptoms of œdema pulmonum.

*Post mortem by Dr. Duffey.*—“Mitral stenosis; œdema pulmonum; fibroma uteri.”

CASE V.—M. R., aged twenty-three, second pregnancy; admitted June 14th with accidental hæmorrhage; delivered same day, and died of post partum hæmorrhage.

*Post mortem.*—Uterus studded over with fibroid tumours of various sizes; liver enlarged, and amyloid.

This was the only case in which the perchloride of iron was injected during the year.

CASE VI.—S. A. S., aged thirty-four, first pregnancy; sent up by Dr. M'Ewan, of the A. M. D., from the Curragh Camp, on account of a large abdominal tumour complicating pregnancy. Was delivered by turning, on account of partial placenta prævia, on August 20th. Went on well for a few days, but then showed symptoms of putrid absorption, and died on twenty-fourth day.

*Post mortem by Dr. Duffey.*—"Large sub-peritoneal fibroid, weighing  $6\frac{1}{2}$  lbs., which was gangrenous and adherent to the abdominal walls and intestines. Fundus uteri ulcerated through, and giving passage to fœtid debris of tumour."

If this case were to come before me again, I would certainly recommend Porro's operation.

Now, in order thoroughly to appreciate these figures, I would wish it to be distinctly understood that these six deaths comprise the total mortality, *from all causes*, of these 1,090 women during the entire time they were under our care. Furthermore, I did not, during the year, transfer a single puerperal patient to any other hospital, and only one woman left in such a condition as to lead us to fear for the result, and I have since ascertained that she was alive six months afterwards. Hence, this mortality of 0·55 per cent., or 1 in 181·6 patients, represents not only the puerperal mortality, but also the total mortality of the puerperal state, which is a very different thing. When such competent authorities as Dr. Matthews Duncan and the late Dr. M'Clintock estimate the puerperal mortality of private practice as not less than 1 in 120 cases, we may, I think, safely conclude that a patient delivered in the Rotunda Hospital during the past year ran far less chance of dying than if she had been delivered in her own home by a private practitioner.

All the women who died were married women, and only two of them were primiparæ—which two facts, if we consider the much greater liability shown by unmarried women, and especially primiparæ, to infection, are in themselves sufficient to show that septic infection was very rare. All the deaths followed more or less complicated labours, and not a single woman died who had a natural labour. Of the 64 cases of forceps delivery, many of which were difficult extractions, and some undertaken before the full dilatation of the os, not one died.

These results I attribute entirely to the antiseptic precautions already described at length, but these precautions would have been useless had I not had the hearty coöperation of everyone connected

with the hospital; and I would take this opportunity of publicly thanking the students of the Rotunda for the willing and conscientious manner in which they have carried out whatever measures were thought necessary for the safety of the patients placed under their charge.

The forceps most commonly in use during the year was Barnes'. For though always a believer in the theoretical advantages of an axis-traction forceps, I found Tarnier's instrument so large that it filled the vagina, and prevented any control being exerted by the fingers during extraction. Recently, however, I have frequently used Simpson's modification of Tarnier's forceps, and have found them most manageable and efficient. They are, however, a little too short, and the angle at which the traction bar is fastened on to the traction rods is very faulty. I therefore got over a pair of Hegar's modification of Simpson's instrument, which I now exhibit to the Academy. They are longer than Simpson's, and the mechanism of the locking of the traction rods into the handle is improved. From a recent paper which Prof. Simpson has kindly sent me, I see that he has himself already introduced these improvements, so that his latest model is the same in all essential particulars as Hegar's. The position of the screw in the latter instrument on the right handle instead of the left is, however, a further improvement, as it cannot then fall down between the handles in the act of locking. Prof. Simpson recommends us to introduce the left or lower blade with the left hand, and quotes Pajot in support of this method. But Pajot's observations refer to the position on the back, which is the usual one on the Continent, under which condition the left blade must be introduced with the left hand, and *vice versâ*. But they do not in the least apply to the ordinary obstetric position in this country—viz., on the left side, or else the lower blade of Barnes' forceps should also be introduced with the left hand, a plan which no one, as far as I am aware, has as yet recommended.

It would take too long to enter at present into a discussion on the merits of the axis-traction forceps, but I am myself convinced that they are a much more powerful instrument than the ordinary double-curved forceps, and will soon entirely supersede them, except in cases where delivery has to be undertaken while the occiput, in third or fourth vertex presentations, or the chin in face presentations, has not as yet rotated forwards.

Post partum hæmorrhage has been very rare, the ordinary time

allowed between the birth of the child and the expression of the placenta being at least fifteen minutes. During this time the hand is not merely placed on the uterus, but gentle friction and kneading is made with the tips of the fingers over the whole fundus, which stimulate it to contract. Accurate statistics were not kept of the number of cases in which the perinæum was ruptured, but whenever it extends nearly or quite as far as the sphincter, sutures are introduced, and, as a rule, with very good results; nor, as a rule, can any rise of temperature be traced to this accident or its remedy.

Version was performed in five cases—one case, in which the labour was complicated with large fibrous tumour, died, and has been already given at length.

There were eight cases of placenta prævia, in none of which was the presentation complete. The treatment consisted in bipolar turning when the hæmorrhage called for early interference, and merely rupture of the membranes where the pains were good, the head presenting, and the hæmorrhage not excessive. Two patients died, and their cases will be found recorded among the fatal cases.

Five women had puerperal convulsions, one of them being brought into hospital in a state of profound coma. She died, having been previously delivered by craniotomy. Our treatment of puerperal convulsions consists in the immediate use of chloroform, followed either by large doses of morphia subcutaneously, or by enemata of 30 grains of hydrate of chloral, the latter repeated after each convulsion. The hot steam bath and pilocarpine subcutaneously ( $\frac{1}{3}$  grain, repeated if necessary) are also used in cases where the urine is albuminous and œdema is present.

Sixteen women were admitted for abortion, in none of whom was plugging of the vagina practised. The treatment is expectant as long as possible. If the hæmorrhage be excessive before the cervix is large enough to allow of the removal of the ovum, the cervix is either plugged with a tupelo tent, or dilated with Hegar's dilator, and the ovum then removed. If there are symptoms of any portion being retained, and causing either putrid absorption or hæmorrhage, the uterus is first washed out with a solution of corrosive sublimate, 1 in 2,000, and the interior of the uterus then curetted, after which the cavity is again thoroughly disinfected with corrosive sublimate, and, in septic cases, an iodoform pessary (3i.—3iss.) introduced.

There were only two cases of perforation during the year. One has been already mentioned when speaking of convulsions. In the second case, N. P., Feb. 13th, 1883, the woman was in hard labour for four days, and the forceps were twice applied vigorously, for half an hour each time. This woman never had a serious symptom after delivery, though unable to use the lower limbs for some time in consequence of the pressure exerted on the nerves and soft parts by the head. She left hospital quite well in less than three weeks.<sup>a</sup>

The best instrument for delivering the head after perforation is, I think, Braun's cranioclast, which I now exhibit to the Academy, and which is not as well known nor as much used in this country as it deserves to be. It is very like Dr. Barnes' craniotomy forceps. It is essentially a traction, not a crushing, instrument. One blade is passed through the hole made by the perforator, the other is passed outside the cranium. The instrument is then locked and screwed up, and affords a most powerful means of applying traction. The great advantage it possesses over the cephalotribe is that it allows the head to accommodate itself to the pelvis, no matter how irregular this may be, whereas the cephalotribe, while diminishing one diameter of the head, increases the opposite one. In a case of perforation that occurred this year I used Breiskey's cephalotribe, which I now exhibit, and which is strongly recommended by Schroeder, and found it very efficient and easy to apply.

Since September last the temperature of every case has been taken regularly twice daily, and I have not been able to recognise any constant rise of temperature, even to the extent of one degree, accompanying the first secretion of the milk. The results of these observations would rather tend to prove that the temperature curve of the puerperal state, in a typical normal case, does not differ in the slightest degree from that in the non-puerperal state; and I am inclined to believe that any temperature above 100° F., except immediately after delivery, indicates that something abnormal is taking place, though it may not always be possible to say what the exact cause of the rise may be.

The statistics of the external maternity for the year, which were furnished by the clinical clerk, Reginald L. Mosley, M.B., were as follow:—

<sup>a</sup> Since this paper was read this patient has again been delivered by perforation, and was up and walking about on the eighth day.

Total number of cases - - - -	1,335
Forceps ( $\frac{1}{48}$ ) - - - -	29
Face - - - -	8
Abortions - - - -	100
Lower extremity and breech - - -	42
Upper extremity and hand - - -	6
Accidental hæmorrhage - - -	1
Placenta prævia - - - -	7
Adherent placenta - - - -	7
Twins - - - -	19
Prolapse of funis - - - -	5
Convulsions - - - -	2
Thrombus - - - -	1
Anencephalous fœtus - - - -	2
Post partum hæmorrhage - - -	17
Mortality { Septicæmia - - - 3 } { Placenta prævia, &c. - 1 }	4

Before closing this Report, which has already far exceeded the usual limits of papers read before the Academy, I would venture to call your attention to the great importance of a careful palpation of the uterus through the abdominal walls, in every case, both during labour and in the puerperal state. The condition of the bladder is at once known, and if the waters have not already escaped we can tell with accuracy the exact position of the child, and in cases of breech or transverse presentation we can bring down the head by external manipulation. During the puerperal state palpation of the abdomen will at once inform us of the condition of the uterus as to contraction or relaxation, of fulness or emptiness of the bladder, and of the necessity of passing a catheter.

There are many other subjects—such as the danger or innocuity of retention of the membranes or portions of the placenta; the prophylactic antiseptic treatment of ophthalmia neonatorum, lately introduced by Professor Credé; the treatment of infantile asphyxia by Professor Schultze’s method; the use of Tarnier’s incubator, &c., &c.—which I have been unable to include in this Report, but which I hope to have the opportunity of bringing under the notice of the Academy on some future occasion.