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OBSTETRICAL EXPERIENCES IN GENERAL PRACTICE.* WITH SUMMARY OF 800 DELIVERIES.

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WE will begin with the proposition that the *sine qua non* of obstetrics is *cleanliness*; that the parturient woman can stand much trauma, amazing hardship, but little sepsis; that the operator who will not approach his maternity work in the spirit of supercilious caution and cleanly endeavor, strikes a foul and a cruel blow which is bound to tell in the end results.

And yet our caution must be relative and our cleanliness must be practicable. The writer's experience would forbid him to recede from his previously expressed opinion that the receptivity of the patient is an important and always variable quantity in many of our dire and distressing results, and is ever obtruding itself upon the field of the accomplished and painstaking accoucheur's work, quite as insidiously as upon that of his less skilful and less careful brother's.

It is altogether possible that some men's experiences may be atypical, or that they deduce erroneous conclusions from vitiated premises.

Whilst the author's field of earnest endeavor has been anything but ideal, whilst the very nature of his environment in many of the homes of the lowly, the poor and the careless, leaves much to be desired in all that makes for safety, prevention of danger, and

competent after-care of lives resignedly committed to his care, he has neither been confronted by the frequency of a perilous septicemia nor, on the other hand, fortified by the confident self-assurance that his patient *shall* not die of sepsis—an assurance possessed by our eminent and gifted Jewett, such is his faith in aseptic and antiseptic midwifery.

In the broad scope which I hope to cursorily cover, all that time allows will be epigrammatic, disconnected statements, more prolific of debate, it is to be hoped, than any formal essay upon a set topic.

The writer may be said to have been confronted by one thousand opportunities for septicemia, inasmuch as his experience covers a range of eight hundred deliveries and more than two hundred abortions and miscarriages, the latter often more fraught with danger, it is conceded, than the former. Two fatal cases of sepsis have been his quota, or a mortality of one-fifth of one per cent.

Garrigues says (*American Text Book of Obstet.*), that since 1875 the tide has turned. They then believed the hospital a menace to life: now it is considered infinitely safer than the home. He further says that the mortality in private practice is twice as large as in hospital practice, or larger: that out of every 100, 95, or even 89 women delivered in New York or other large cities in private practice, one dies—i. e., up to 1.12 per cent., as

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against 0.6 per cent., 0.5 per cent., or even 0.4 per cent. in the best lying-in establishments; that country practitioners are still greater opponents of asepsis and antisepsis than city practitioners.

The writer (and he may acknowledge himself a countryman, perhaps, though he will not agree that he is an opponent of asepsis) proudly, but not vainly or boastfully begs to report a mortality in private practice of three cases in eight hundred deliveries, or 0.37 per cent.—a lower per cent. than the vaunted New York Maternity Hospital statistics.

If the writer would be expected to add to his mortality statistics three deaths in cases with which he has been more or less closely identified in hospital practice—one from general peritonitis following operation for peri-nephritic abscess on the ninth day post-partum, in which it is thought that transportation at that time played some part; one from eclampsia, moribund on admission and attended with a temperature of 106 degrees; and one further death from eclampsia upon the table in the last of many seizures and a few moments before the extraction, after version, of a dead child—he would still be confronted by the creditable mortality of 0.75 per cent. He can recall but one death from miscarriage, by any cause—an exsanguinated patient—and in this he begs to modestly aver that no human agency could have spared this life, called, as he was, but a few hours before the death of said patient.

Bearing upon the practical point of the treatment of puerperal septicemia, and after rehearsing the standard articles of Lusk, written fifteen years ago, of Garrigues, written twelve years ago, of Jewett, written nine years ago, and since, and the able exposition of the subject given to this Society by Polak, three years ago, I think we are warranted in saying that we know little more now than then. We know more and think less, perhaps, of silver and the serums.

Upon this we can all agree, that, as dealing with a germ poison the really efficient treatment must be ger-

micidal, specific, and antidotal; that reconstructive, tonic, supportive treatment, valuable as it may be, and responsible for about all the lives we manage to save in this dread affliction, only *indirectly* impresses the inroads of the poison by improving resistive power, does not shatter or destroy the already existing germs to any appreciable extent, nor eradicate their baneful and destructive influences, and reasoning by analogy with kindred conditions, e. g., malarial, syphilitic poisons and the like, we know how comparatively futile are the reconstructive tonics when not preceded by the effects of quinine, mercury, iodides, etc.

We are still fondly hoping, then, for just such positive remedies as these last-named, and diphtheria antitoxin. Until we find the unfailing conqueror of the streptococcic foe, we are going to continue to view sad and distressing deaths, humiliated, crest-fallen, and dejected over our helplessness to aid.

Gallant has recently made an earnest plea for utero-vaginal drainage in puerperal fever, and cites cases successfully treated by a silver bivalve cervical drain, coupled with permanganate uterine douches and gauze packing of the vagina, to thwart the tendency of the weighty uterus to settle down upon the floor of the pelvis, and to flex and obstruct the cervical canal. He soaks gauze in ichthyol and glycerine, and this, to the writer's mind, would destroy its absorptive and drain property.

The valve of the opsonic index as a guide in the treatment of bacterial infection (Chas. Bolduan, *L. I. Med. Journal*, Oct., 1907), and its development in 1903 by Wright of England, whilst it lays claims to results in *local*, practically acknowledges defeat in *systemic* infections.

A summary of the aforesaid 800 deliveries, almost entirely in private practice, would show the following noteworthy incidents:

Forceps. Used but twice in the first sixty cases.

Occipito Anterior. Thirty-eight cases.

Occipito Posterior. Fifteen cases. Rotation occurring eight times; not occurring, seven times. Brow presentation, four cases, including two anencephalous cases. Face presentation, five cases. Transverse or oblique presentations, nine cases.

Version. Thirteen cases; for twins, four cases; for transverse presentation, three cases; for shoulder presentation, four cases; for face presentation, two cases. (Prolapsed cord in four cases. Rupture of vagina in one case.)

Breech Presentation. Twenty cases. Knee or footling, three cases; occipital posterior in after-coming head, one case.

Eclampsia. Fourteen cases; eleven private cases, three hospital cases. Recovery in all the mothers; surprisingly good results in infants; two died—one was moribund on admission, and one recovered. Spontaneous delivery of premature dead infant.

Twins. Fifteen cases; only four pairs lived to any reasonable age.

Transverse and Shoulder presentations. Seven cases; five podalic versions, two cephalic versions, three attended before labor.

Prolapsed Cord. Six cases; two with shoulder, one with face, one with vertex and two with breech presentation; has proven quite a jeopardy to life of babes.

Induction of Premature Delivery. Six cases; one for twins (one lived one minute and one lived thirty-six hours in incubator); one for incessant vomiting—dead child; one for hydatidiform mole; two for eclampsia; one for hemorrhage from marginal placenta prævia.

Hydatidiform Mole. Patient in dangerous condition at time of evacuating uterus.

Post-partum hemorrhage. Six cases—three typical.

Placenta prævia. Four cases, atypical.

Mild sepsis. Eight cases.

Severe sepsis. Six cases.

Fatal sepsis. Two cases.

Rupture of Vagina. One fatal case; forceps-version laparotomy.

Puerperal nephritis. Six cases.

Adherent Placenta. Six cases; two very grievous.

Erysipelas. One very trying and worrisome case, with all the symptoms of a grave sepsis.

Phlebitis. Seven cases; pulmonary infarction, one case.

Anencephalous. Two cases in the same mother.

Craniotomy. One case, after knowledge of infant's death, and after ineffectual attempts at forceps and version in a persistent face presentation.

Symphyseotomy. One case; sepsis post-partum; recovery. Death in subsequent confinement at Sloane Maternity Hospital.

Labor Complicated by Fibroid. Four cases; three in the same mother; one suggestive of a remaining twin.

Shock. Three cases; one in case of rupture of vagina; one attended by nausea from ergot.

Successful Use of Suprapubic Compress. Two brow cases righted; one hand case averted which threatened to complicate vertex presentation.

Perinephritic Abscess. Easy delivery in case; operation fatal.

Fracture of Child's Humerus. Three cases; two cases of clavicle.

Puerperal Mania. Three cases.

Goitre in Mother. One notable case; amazing improvement, post-partum.

In the remaining few moments of my time, permit me to call attention to my large proportion of occipito-posterior, and eclampsia cases:

In the latter condition, I have been peculiarly fortunate—have had no maternal death in private practice, and infant mortality has been extremely low. The cases have been, on the whole, of more than average gravity. The treatment has been by catheterism, chloroform, accouchement forcé hurried extraction, morphia to the point of narcosis, the opening of the three avenues of waste—the kidneys, the bowels, and the skin—the last, not the least important:—in two cases, blood letting—coma for twenty-four hours post-partum in one.

The writer has recently seen a case where a five-hour seance of seizures supervened six weeks after delivery,

resulting in blindness on August 20th ult.—still unchanged—strongly advised the hospital—advice spurned. Had a remote notion of urging decapsulation of the kidney. Also in a recent case at St. John's L. I. City Hospital, admitted in coma—after relief of symptoms, for which frequent vapor baths were mainly responsible, spontaneous and premature delivery of a dead foetus resulted in prompt improvement and ultimate recovery of the mother.

Schoekart* writes thus upon eclampsia:

Treatment: Rapid delivery by forceps or version when cervix is dilatable; when cervix is closed and labor not begun—must interfere in multiparae—manual dilatation; in primiparae manual dilatation impossible. He uses Bossi's dilator—it dilates rapidly, and safely; rejects Caesarean and Dührssen's incisions in private practice; he reports three cases of exceptional gravity; he dilates cautiously, and feels the progress with the hand.

Fry, of Washington, reports three cases of vaginal caesarean section for eclampsia.

Pier† advances these late ideas on eclampsia: decapsulation of kidney, lumbar punctures, delivery by Bossi's dilator.

Decapsulation is said to reduce congestion, eliminate the changed epithelium obstructing the canaliculi, and to modify vaso-motor conditions.

It must be done before anuria comes on; it is indicated in the renal forms of eclampsia, after the failure of medical treatment, when urine is very meagre (as well as urea and extractives) and when casts are frequent.

Gauss‡ finds several successful cases reported of decapsulation and nephrotomy, where patients would have died save for it.

In 75 per cent. of cases convulsions are controlled by delivery.

In 25 per cent. of cases life is sacrificed if no further relief is obtained.

Krönig, at Freiberg, reports two cases of successful decapsulation in eclampsia.

In forceps cases my experience in occipito posterior, and most difficult extractions has been fairly broad and certainly strenuous. I have had, I believe, amazing fortune. I have never had occasion to feel warrantable regret over their use; I have never had a maternal death due to them, and my infant mortality has been much in their favor, I believe, as contrasted with versions of similar or proportionate difficulty.

That the forceps present grave dangers can scarcely be gainsaid, and that these dangers depend in the main upon (1st) the rarity of the occasions which permit the blades to be applied to the sides of head (2d), imperfect cervical dilatation, and (3) traction in improper axes—is equally incontestable.

Let me say a word of caution about damaged perineal. Let the stitching and ablation of the wound area be first attended to, and a compress put in place. Do not make unconscious efforts at inoculating patients with stale blood, faeces, etc., from buttocks and thighs, by giving the wound area later attention—in fact the last rub with the one swab—as is so commonly the practice.

In conclusion, the writer must make an honest confession, which, though humiliating, is, he hopes, nevertheless, honorable.

He has had a deplorable dearth of experience in the art and practice of pelvimetry, without the pursuit of which, he believes, there is no scientific midwifery, nor expert accoucheur.

I may be permitted to wonder over my escape from the absolute, or even relative indications for caesarean section in the list of cases cited. The astounding improvements in caesarean results of later years robs the condition of much of its former danger, and fear and trembling are not so ready to stay the otherwise willing hand.

*Bull. de la Soc. Belge de Gyn. et d' Obstetr. Vol. 18, No. 1—1907.

†Annals de Gyn. et Obstetr., May, 1907.

‡Zent. fur Gyn. June 6, 1907.

The claims for the preference of Gigli's operation of pubiotomy would appear to be founded upon an appeal to the skill of the *average* surgeon.

In conditions of grave peril, and of refinements of obstetrical art such as

delivery in severe pelvic contraction present, the *average* surgeon should be gracious enough to call upon *celebrities* who, recompense or no recompense, are eager and willing to be commanded.