Address in obstetrics and diseases of women and children : delivered at the twenty-eighth annual meeting of the American Medical Association / by James P. White.

Contributors

White, James P. 1811-1881.
Boston Medical Library Association
Royal College of Surgeons of England

Publication/Creation

Philadelphia : Collins, printer, 1877.

Persistent URL

https://wellcomecollection.org/works/jb8gv6ya

Provider

Royal College of Surgeons

License and attribution

Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
https://wellcomecollection.org

ADDRESS

BY

Prof. JAMES P. WHITE, M. D.

AT THE

AMERICAN MEDICAL ASSOCIATION,

CHICAGO,

1877.

With Compliments

James O. White

ADDRESS IN OBSTETRICS

AND

DISEASES OF WOMEN AND CHILDREN.

DELIVERED AT THE

TWENTY-EIGHTH ANNUAL MEETING

OF THE

AMERICAN MEDICAL ASSOCIATION.

BY

JAMES P. WHITE, M.D.,

PROFESSOR OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN IN THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF BUFFALO, FELLOW OF THE AMERICAN GYNÆCOLOGICAL SOCIETY, ETC. ETC. ETC.

CHAIRMAN OF THE SECTION ON OBSTETRICS.

(Reprinted from the Transactions of the Association.)

PHILADELPHIA:
COLLINS, PRINTER, 705 JAYNE STREET.
1877.

ADDRESS IN OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN.

Mr. President and Gentlemen of the American Medical Association:

Having done me the honor, which I trust is duly appreciated, at the last meeting of this Association, of electing me Chairman of the Section on "Obstetrics and Diseases of Women and Children," I ask your indulgence whilst, in compliance with the by-laws, I refer to some of the "advances and discoveries of the past year" in this important department of Medical Science. The spirit of this regulation is proper, and this process of annually "posting up," in the several departments, wise, and if judiciously performed, will be eminently useful to the great body of the profession. It would have been better had this task been allotted to abler hands, but as I was not present to decline the unmerited honor, it seemed incumbent on me to discharge its duties to the best of my ability, however much I might fall below the ideal standard.

During the last year much has been accomplished in the departments of Obstetrics and Gynæcology, and the progress was duly reported a few months since at the great "International Congress" and at the meeting of the Gynæcological Society in New York in September last. The proceedings of the former remain unpublished, and I cannot therefore have recourse to the stores of information contained in the able papers and debates which I am sure will be found therein. It is true I attended both these gatherings of distinguished men, and to some extent participated in their transactions and discussions, and was throughout an attentive listener, but so much occurred during that great centennial period that memory does not enable me to enumerate all the important subjects which received the atten-

tion of these learned bodies. Besides many of the members of this Association were present at those meetings. And I shall therefore confine my remarks as far as may be to such subjects as have received attention since their adjournment, or that were not brought prominently forward for discussion at any of the meetings of those bodies.

The most notable event which has occurred, pertaining to this department during the last memorable year, is the organization of a society having for its object "the promotion of knowledge in all that relates to the diseases of women and to obstetrics." After a brief notice there assembled in the rooms of the Academy of Medicine in New York, in September last, many of the best and most progressive men in this department of medical science, and held the first meeting of a society to be called the American Gynæcological Society, under the most favorable auspices. The papers submitted, considering the limited time for preparation, were remarkable in number and for their originality, and were ably and critically discussed. The volume of *Transactions* which has just made its appearance is highly creditable and augurs well for the future of the Society.

The members of this Society hope through its agency to accomplish for the profession in America all that has been done in London, Dublin, and Edinburgh by similar organizations in those cities. Even more than that, it contemplates the union, for scientific purposes, of all the representative men in the several obstetrical and gynæcological societies of the different cities in this country. In the admirable address of Prof. Fordyce Barker, its first President, he justly remarks that "the status of the Society in the scientific world will be determined by the character and value of the papers published in its *Transactions*, and by the tone and ability of its discussions." He also very properly adds that "there is a large class of topics which it should be the province of this Society to examine that cannot be properly treated in a forensic discussion." The profession in America therefore, and this Association as its legitimate representative, have great reason for congratulation in the formation of the American Gynæcological Society, so auspiciously inaugurated for the furtherance of investigations in one of its most important fields.[1]

[1] I am pleased to be able to state that the Gynæcological Society has promised to furnish in its next volume of *Transactions* an "Index of current gynæcological

The Gynæcological Society will I am sure be found in no sense antagonistic to this great catholic Association, but a hearty and successful co-worker in its peculiar sphere, and will result in placing a department, which in its present scope and grasp had no existence in this country a few years since, in the front rank among its co-ordinate sisters.

The work of the late Dr. John S. Parry on Extra-Uterine Pregnancy deserves more than a passing notice. The monograph is the most comprehensive one upon the subject that has been written, and aside from the memoir of Dr. Campbell (Edinburgh, 1840) is the only attempt at any extended examination of this important subject. Based upon five hundred cases, collected from all sources, a number greater than ever before analyzed, the teachings of the work should be carefully weighed in their bearing upon methods of procedure which are still *sub judice*.

Dr. Parry adopts in his classification three main species of extra-uterine pregnancy : ovarian, tubal, and abdominal. Other forms he regards as varieties of these, as for instance the interstitial, to which the more definite title of tubo-uterine is given.

The author cites several indubitable examples of ovarian pregnancy, the occurrence of which has been hitherto denied by Farre, Velpeau, Thomas, and others. Churchill, Tanner, Rogers, Tait, Barnes, Rokitansky, and others have contradicted the occurrence of primary abdominal pregnancy, but that the ovum may receive nourishment from a peritoneal surface is conclusively shown by the well-known case of Lecluyse, in which the fecundated ovum escaped through a utero-abdominal fistula, the placenta becoming attached to the small intestines, and also by the case reported by Braxton Hicks, in which the ovum was found attached to and deriving nourishment from the retro-uterine pouch.

Dr. Parry believes that the decidual membrane is developed in the uterus alone and not in the cyst, even when the pregnancy is tubal. He, therefore, regards the placenta as being formed from fœtal tissue alone. There are very many important and interesting points advanced by Dr. Parry, which lack of time forbids us

and obstetric literature." It has secured the co-operation of Dr. J. S. Billings, U.S.A , in charge of the National Medical Library at Washington, and if complete, as it doubtless will be, this catalogue will be found very useful to my successors in furnishing material for their annual addresses.

to mention. We desire, however, to briefly notice what he has to say in regard to palliative and operative measures.

The plan of puncturing the cyst and evacuating the liquor amnii during the earlier months, and thus destroying the life of the fœtus, has not yielded the results which were anticipated. Out of seven cases treated in this way, but two recovered, and one was not benefited. In one case the fœtal heart was heard until the patient's death.

The palliative treatment during the early period of pregnancy consists in relieving the colicky pains, for which purpose opium is best calculated. The employment of anæsthetics to relieve the pains, presents the objection of perhaps hastening the very thing which it is sought to prevent—rupture of the cyst during the period of excitement induced by the anæsthetic, or during the vomiting which so often follows its use. The author does not recommend any attempt to destroy the fœtus through the system of the mother.

Of extirpation of the fœtal sac, Dr. Parry says that if the diagnosis of tubal or ovarian pregnancy could be perfectly certain, the operation would be perfectly justifiable. Abdominal pregnancy, he thinks, might be allowed to progress to term, since it is known frequently to recover. He would, if called to a case when the life of the fœtus could be destroyed, attempt to do so by electricity, without puncture of the sac, or, failing in that, would use the galvano-caustic knife, as employed by Dr. Thomas, with the exception of leaving the placenta *in situ*, deeming the risks of septicæmia, or subsequent secondary hemorrhage, less than those of primary hemorrhage, and the means necessary to its control.

When rupture of the sac has taken place, the number of recoveries is so small, that the author strongly urges the immediate performance of gastrotomy, the removal of the fœtus, and the control of hemorrhage by ligature, cautery, or otherwise. He says: "It appears simply criminal to sit idly by and see a woman die from rupture of an extra-uterine fœtal cyst without attempting to save her." It certainly seems that the advice of Dr. Parry is judicious, for the woman's life cannot be more in danger from the operation than from the internal hemorrhage, which cannot be controlled without making it. The author arrives at the conclusion in reference to operations when the fœtus has been re-

tained to or beyond term that primary gastrotomy should never be performed. He recommends that the only interference should be the enlargement of any openings made by nature, the treatment of symptoms as they arise, and that gastrotomy be deferred until the condition of the patient makes it imperative. The placenta, he thinks, should be left to separate spontaneously, the funis being fixed in the opening, whereby the placenta can be removed when separated. Dr. Parry's deductions are abundantly supported by statistics, and his conclusions carefully drawn. His book will long remain a monument to a member of our profession, whose early demise has left a vacancy not easily filled.

Prof. Maxon[1] has recently directed the attention of the profession to the *breast-knee* position as an important means of correcting mal-positions of the fœtus. Any part of the lateral aspect of the child may present at the brim, at the commencement of labor. The present accepted treatment in all presentations of the arm or side, when detected early in labor, consists in podalic version, introducing the hand of the accoucheur into the uterus and bringing down the feet.

This operation is always attended with some risk to the mother, and all the dangers to the child incident to a footling presentation. It is plain that if the cephalic could be easily and safely substituted for the transverse position, it would be safer for both than bringing down the feet, podalic version. Dr. Maxon proposes, by aid of gravitation, placing the woman in the knee-breast position, thus elongating the uterus, and making the fœtal ovoid conform to the long diameter of the uterus, to bring the head to correspond to the pelvic brim. The knees of the woman are elevated by folded quilts, whilst the chest rests upon the bed and thus the fundus of the uterus is made to ascend high up into the cavity of the abdomen occupied by the pelvic extremity of the fœtus, the lateral aspect of the child is removed from the superior strait and the head made to take its place.

The hand of the accoucheur is then introduced into the vagina, the head of the child seized and placed in the uterine outlet with its diameters in their proper relations to the diameters of the superior strait. Time does not permit us to follow the Dr. through a minute description of the manipulations necessary to rectify all

[1] Shoulder and other more Transverse Presentations. By Edwin R. Maxon, Esq., A.M., M.D., L.S.—*American Practitioner* for March, 1877.

transverse positions; we can only indicate the principle upon which he proceeds. The idea seems to possess value, and should be carefully studied by every obstetric practitioner. May it not be useful combined with "version by external manipulation;" a procedure which has been recently revived by the German accoucheurs? The originator of this principle, Dr. Maxon, is very sanguine in his belief in its utility, and in his "conclusion" uses the following language: "The principle is sound, and the procedure entirely void of danger to mother or child, being scarcely an inconvenience; that it is so easy of execution any competent obstetrician may avail himself of its advantages without fear; that it has been, so far as known, and therefore is likely to continue to be, successful in every case in which it has been or may be hereafter understandingly put in practice, when the capacity of the pelvis will admit of delivery under any circumstances." It would seem that the problem of combining the influence of gravity with external manipulation offers a tempting field for further observation in all cases of transverse or lateral presentations.

In this connection it should be stated that J. H. Aveling, Physician to the Chelsea Hospital for Women, is publishing in the *Obstetrical Journal of Great Britain and Ireland* a series of articles on the "Influence of Posture on Women." Dr. A. seems to be making an exhaustive report on this subject. He describes the influence of posture upon the performance of the normal functions as well as upon the diseases of the female organs of generation. Thus he gives its effects in ovulation, nidation, anomalous de-nidation, menstruation, and its anomalies, impregnation, gestation, fœtal position, etc. etc. In a succeeding chapter he very carefully considers the effect of posture on parturition. He minutely details the present and ancient positions—standing, sitting, kneeling, knee-head ascending, knee-head descending, dorsal reclination, supine recumbency, right lateral recumbency, left lateral recumbency, and many others which we cannot find space to enumerate. He then describes the effect of posture on obstructed parturition, in pelvic deformities and anomalies, in hemorrhages and convulsions, and in many other complications incident to labor. He also dwells upon the importance of posture during convalescence from parturition, lochiation, defecation, urination, and involution, all of which makes entertaining reading, and is certainly very suggestive.

Before dismissing this subject it should be stated that Profs. Henry and A. Sibley Campbell, of Augusta, Georgia, have published very interesting articles on "Pneumatic Pressure and the Genu-pectoral Posture in the Reduction of Uterine Luxations." In their articles the utilization of air pressure as an instrumentality to effect uterine replacement by gravity is well described, accompanied with illustrative diagrams.[1] The various articles to which we can merely refer, without attempting any discussion of their merits, show the importance which the question of posture has assumed in gynæcology and obstetrics.

Two papers by Prof. Isaac E. Taylor, M.D., of New York, although read prior to the last meeting of this Association, have but recently been published in full.[2] The first of these, "What is the best Treatment in Cases of Labor in Contracted or Deformed Pelves, ranging from two and one-half to four inches?" was read before the Academy, Sept. 16, 1875. The second paper, "Is Craniotomy, Cephalotripsy, or Cranioclasm, preferable to the Cæsarean Section in Pelves ranging from one and one-half to two and one-half inches?" was presented March 2, 1876.

These papers are upon subjects of such vital importance in the practice of the obstetric art, and carry with their teaching so much weight derived from their author's experience, position, and scholarly attainments that some notice of them will be expected in this address.

Prof. Taylor lays down the following propositions in his first paper, as guides to action in these cases:—

"1. To select such operations as may conduce to the safety of the mother and child, and avoid craniotomy if possible.

"2. To deliver the patient with as much ease and safety, and as early as correct and judicious treatment to her pelvic structures and her future health may require."

In this paper, after relating the histories of two cases of contracted pelves—one delivered by version, the other, after a trial with forceps, by embryotomy—Dr. Taylor takes occasion to differ

[1] Gynæcological Transactions, vol. i. page 198. Pneumatic Self-replacement in Dislocations of the Gravid and Non-gravid Uterus. By Henry F. Campbell, M.D. Pneumatic Pressure and the Genu-pectoral Posture in the Reduction of Uterine Luxations. By A. Sibley Campbell, M.D.—*Amer. Journ. of Obstetrics*, January 1, 1877.

[2] Transactions of the New York Academy of Medicine. Second series, vol. ii. N. Y., 1876, pp. 173–200, 200–234.

with many writers as to the proper time to apply the forceps. His practice seems to be to apply them as soon as the os is sufficiently dilated to admit of their introduction; using them to "retain the head in contact with the os uteri during and after a pain, and in some cases aid in flexing the head when the vertex presents, so that the occiput may be put in apposition with the os tincæ, and thus become the natural dilator of the cervix." The practice of the early introduction of the forceps, when necessary, is one which we have followed and taught for many years, believing that in skilful hands they can be introduced with perfect safety when the os is sufficiently dilated and is dilatable. Dr. Taylor in this paper speaks of two different deformities—the generally contracted pelvis and the simple flat pelvis. In the former, with the diameter ranging from three and one-quarter to three and three-quarters inches, he prefers the forceps, as, should version be performed, embryotomy would have to be adopted in some instances. It certainly seems to us that the forceps should have the first trial, for, if failure after careful and persistent trial occurs, it is certainly evident that it would be equally impossible to deliver by version; the only remaining course would be craniotomy. In the simple flat pelvis, after a short trial with the forceps has failed to deliver the head, Prof. Taylor would use version, under the expectation that by traction on the body of the child the head could be delivered, assisted by propulsion from above, without resorting to embryotomy. We cannot agree with Dr. Taylor's teaching as to the kind of forceps to apply. We have not found that difficulty which he seems to anticipate in applying the long curved forceps to the biparietal portions of the head. The long straight forceps which he recommends possess moreover this disadvantage, they cannot be applied to the head as high up in the pelvic cavity, as we shall attempt to show further on, as can the long curved ones. Dr. Taylor's oft-repeated injunction to avoid waiting in these cases we most heartily indorse: the practitioner should early make up his mind what course to adopt, and proceed *at once* to carefully and intelligently put it into operation. With regard to version in the flat pelvis, of two and three-quarters to three and three-quarters inches, it does not seem to us to offer any more chances of success than the forceps, except, perhaps, in the greater of these diameters, and then we doubt if it more than equals the forceps. Certainly the increased

mortality in head-last over vertex presentations, in normal pelves, would seem to indicate that the infant's life would very probably be sacrificed; and there seems to be more chance of injury to the mother's pelvic structures in an attempt to drag the head through by traction on the body, than in a careful but determined trial with the forceps and, these failing, the employment of craniotomy.

We now pass to Prof. Taylor's second paper.

Dr. Taylor's second paper, upon the comparative merits of craniotomy, cephalotripsy, cranioclasm, or Cæsarean section in pelves of from one and one-half to two and one-half inches, enters into a learned and careful analysis of these various methods. The question involved in a discussion of this character is one of great gravity. To quote Prof. Taylor's language: "In the whole range of surgical and obstetrical practice, there is no occasion which calls for more deliberation, more precise knowledge and a clearer judgment, than are required to enable the obstetrician to determine in difficult cases of labor, in deformed pelves, how long he may trust to nature without compromising the life of the mother, or entailing upon her an existence of misery worse than death itself; or, on the other hand, to fix the precise time when he is unfortunately importuned to sacrifice the life of the child for that of the mother, or, by the performance of the Cæsarean section, perchance save the child, and possibly the mother."

From his observations Prof. Taylor deduces the following:—

"1. That a mutilated fœtus can be delivered with safety to the mother through a space of one and three-fourths inch antero-posterior, and two and a half inches transverse, by craniotomy, cephalotripsy, or cranioclasm, provided the vault has been destroyed and the face made to present edgewise or delivering the head sidewise.

"2. That after cephalotripsy or cranioclasm, if necessary, version, early performed, with propulsion from above the pubes afterward, and before the uterine forces are exhausted, is preferable to the first proposition and I believe more available.

"3. The cephalotribe or cranioclast cannot be considered sufficiently available as tractors after cephalotripsy, to deliver the patient in extreme contraction, and that other instruments as tractors are necessary to aid the delivery.

"4. That the Cæsarean section should not be performed when

the contraction or deformity is as stated above, unless some other complications or circumstances exist or presents."

Dr. Taylor has invented and figures with this paper a new cranioclast, by means of which the head can be more effectually crushed, and with greater safety to the mother.

A modification of Meigs's embryotomy forceps is also presented, together with the right-angle blunt hook which the author uses in preference to the crochet.

The increasing frequency of operations for ovarian tumor and other intra-abdominal growths has we think caused those who have made the operation to have less hesitancy in making Cæsarean section than is exhibited by Dr. Taylor. With a small child and a prompt and careful operator the operations proposed by Dr. Taylor could be made with greater safety to the mother, probably, than Cæsarean section; but it seems that the dragging of the body of a large child, one weighing from eight to twelve pounds, for example, through a pelvis whose antero-posterior diameter is but an inch and a half cannot but be attended with extreme risk to the mother. We are of the opinion that it is not so much the nature of the operation, in Cæsarean section, as the condition of the patient, that tends to an unfavorable result. Too frequently it is adopted, as Dr. Taylor calls it a *dernier resort*, every other known procedure being tried and the patient being completely exhausted and even moribund previous to making the operation. While we therefore can only express our admiration for Dr. Taylor's valuable papers and recommend their careful study by all practitioners of the obstetric art, we are inclined to differ somewhat from his condemnation of Cæsarean section.

There is in this country a growing tendency to overcome the hypercaution inculcated by the older British and American writers and practitioners in the use of the forceps. It seems to your reporter wise to encourage this sentiment, and to bring the influence of this learned and representative body to bear in support of the more frequent resort to that most humane of instruments, the obstetric forceps. As long ago as 1857, my friend, the late Dr. Quackenbush, of Albany, read a paper before the State Medical Society of New York, urging the "more frequent resort to the forceps to facilitate the *last stage* of labor." Dr. Newman, of Denver, formerly of Lousviille, also wrote a paper on the subject a few years ago, and invented a special instrument for the pur-

pose. Indeed, the progressive members of the profession are inclined to favor a much more frequent resort to the forceps than the teaching of our preceptors would warrant.

In the belief that this instrument, as we find it in the hands of practitioners in this country, is exceedingly defective, the speaker made an effort more than a quarter of a century since to improve its construction. Subsequent experience in the application of the forceps then devised, and careful observation of other forms of the instrument, have confirmed the conviction of its superiority. Confirmation of this opinion has also been afforded by the testimony of many intelligent accoucheurs who have used it in this country and in Europe.

Some alterations in conformation have been made from time to time, suggested by carefully observing its defects, in the many opportunities afforded for its application in hospital, consultation, and private practice, since its adoption in 1847. I trust the instrument, as now recommended, will be found to combine all the advantages separately possessed by many of the various instruments used by accoucheurs in this country and in Europe.

There can be little doubt that much of the discredit cast upon its application in suitable cases has arisen from the fact that the instrument used was not adapted to fulfil all the purposes for which it was designed. Either it was too heavy and thick; it did not possess the requisite length and curves to seize the head at the superior strait; or it could not be locked without difficulty, which rendered it useless; and the operator, after a fruitless attempt to apply it, has thrown it by in despair, and condemned the instrument altogether. There can be as little doubt, also, that partiality for the short forceps, which can be used only when the head is at the inferior pelvic strait, has greatly contributed to the infrequency with which it has been resorted to by English practitioners. National prejudice has seldom manifested itself more strongly than in the tenacity with which they cling to the short forceps. All the forceps used by British accoucheurs, until quite lately, are very much alike, differing only in an endless variety of slight deviations. It is also worthy of remark that the French and German practitioners are nearly unanimous in their preference for the long forceps. In France, as has been well remarked, they all bear a "family likeness to the forceps of Levret," possessing in greater or less degree the second curve, which corresponds to the general axis of the pelvis,

and which, with their greater length, renders them suitable for penetrating the parturient passages and seizing the head at the brim, if necessary. Does not this difference account, in part at least, for the greater partiality for the instrument, and the greater frequency of its use on the continent than in England?

Whilst in France and Germany they are resorted to by some as often as one in every seven, and, by those obstetricians who use them least, as often as once in "250" labors; in England and Ireland only one in six or eight hundred has until recently been thought suitable for their application. Thus we find Dr. Seibold, of Berlin, who uses a long instrument, according to the valuable tables furnished by the American edition of Churchill's Midwifery, had recourse to forceps once in every seven cases—and *craniotomy* only once in 2093 cases. Dr. Collins, of Dublin, who recommends the short forceps, employed it only once in 617 labors, and resorted to the graver operation of *perforation* once in 141 cases, being nearly 4½ times as often as he used the forceps. These men were among the very first practitioners in their respective countries; and yet we find the celebrated Irish accoucheur resorted to craniotomy more than 14 times as often as the no less distinguished continental physician, whilst the latter delivered by forceps 88 times as often as the former.

Nor are these by any means rare examples. Drs. Clarke, Ramsbotham, and in short almost all the older English writers, advised that the forceps be used *only* when the head has descended resting on the floor of the pelvis, so "that an ear can be felt," etc., deeming it proper to resort to their aid but once in 700 labors, or thereabouts; whilst the best French accoucheurs apply the forceps many times in the same number of cases, and with a corresponding infrequency in the number of cases of embryotomy. Is not this wonderful difference in the frequency of using this instrument to be ascribed in a great measure to the difference in its form as used by these gentlemen? That the highest proportional frequency may not claim imitation we will admit. But is it not apparent that there may be danger of falling into the opposite extreme, and that hypercaution and delay may beget the necessity, often, for a more frequent resort to craniotomy?

In this country, we find both the long and short forceps in use, as the practitioner chanced to adopt as his text-book and guide a French or an English author. As the long forceps only can be applied when the head is high in the pelvis, and may be used by

skilful hands equally well at the inferior strait, I am inclined to recommend, with most practitioners at least, its exclusive use. By confining himself to one instrument, the operator acquires greater familiarity with it, and becomes more expert in its application. Besides, as the short forceps is in no respect better for seizing the head, even in the inferior strait, it is entirely unnecessary, and motives of economy would induce many persons to dispense with it altogether.

The form of the long forceps, as we find it scattered through the country, varies greatly, as does also its weight. Most of those which I have examined are bungling modifications of Dewees's improvement of Baudelocques', or of Seibold's. Many of them, made by indifferent mechanics, are much more exceptionable than the original patterns. It is not a matter of surprise that most prudent practitioners are disinclined to resort to this degenerate unmechanical instrument, or that its use should so often be followed by injury to the structures of the mother, or that the operator should be baffled in his efforts to secure the presenting part of the child between its thick and ill-shapen blades, and finally perhaps utterly fail to close and lock them.

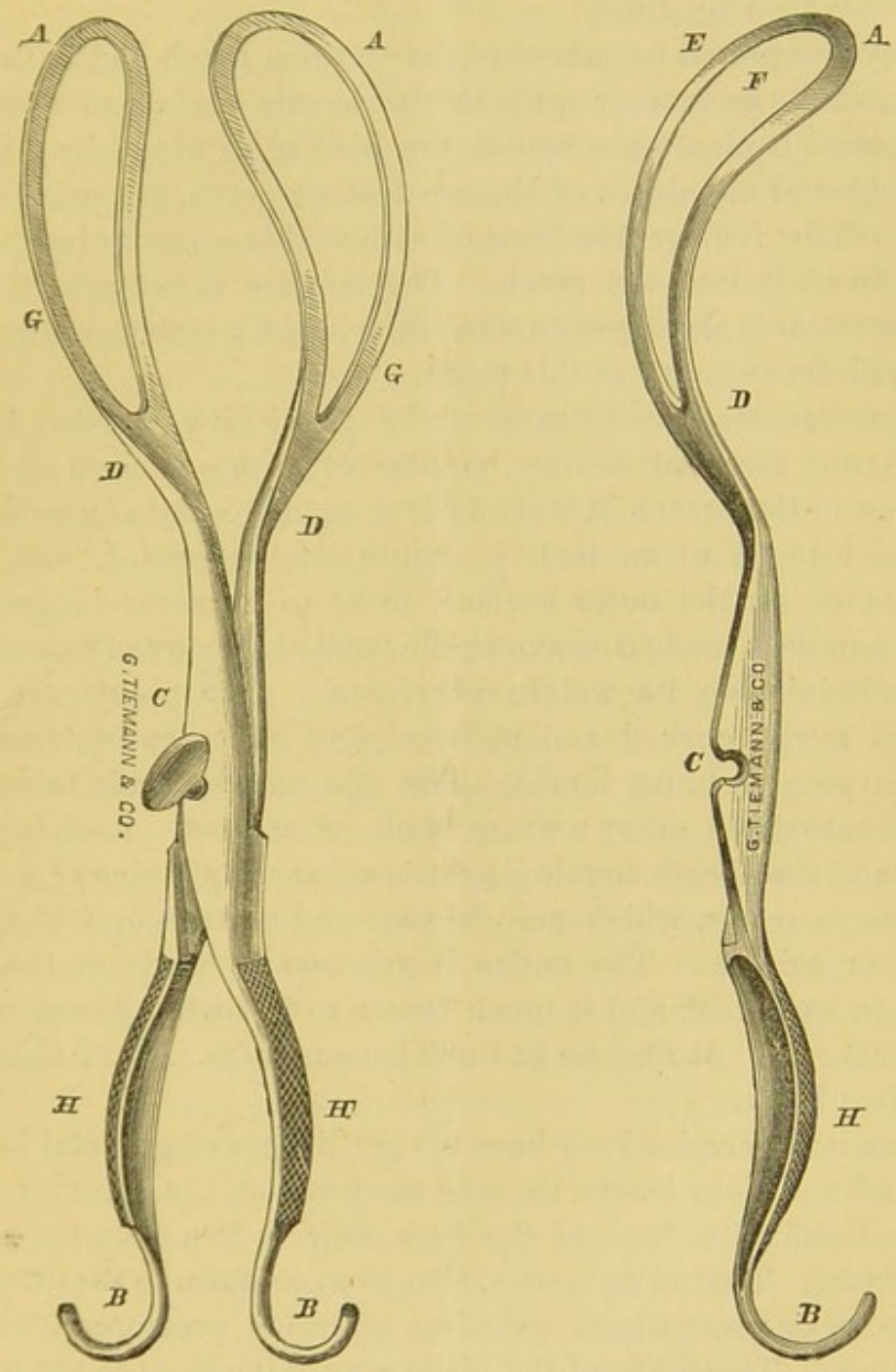
It is true, there is no apparent want of variety in the form of this instrument, as may be seen by examining the numerous plates furnished by the modern obstetrical publications. The difficulty seems rather to have been, that each man, conscious of its general defects, has fastened upon some one point, and losing sight of everything else, has strenuously urged the adoption of his fancied or real improvement upon that particular portion of the instrument, attaching this improvement, or modification, very likely to one otherwise so imperfect as to preclude its use. Others, again, have recommended an instrument, the general form of which was admirably adapted to fulfil the end in view, and then rendered its application difficult by leaving, through want of observation, or national prejudice, some important point defective. Thus, Moreau, who gives the cut of an instrument combining in my opinion more excellences than any other, unites the blades by means of a "*pivot*," which requires that they should be adjusted with the utmost accuracy before they can be locked, thus making it exceedingly difficult of application.

Prof. Hodge has pursued a different course, and one which must, by persevering observation, eventuate in the perfection of the instrument. He places before him all the different forceps in

use, selecting from each its peculiar merits, then combining them all in one. But in an effort to improve his "eclectic forceps," and continue the shafts of the blades in contact, and prevent the vulva from being put upon the stretch unnecessarily early, he has made the angle between the blade and the shaft so acute, when the blades are closed, as to require that its weight should be greatly increased in order to secure the proper power at the distal extremity of the blade. His instrument has also other defects which are susceptible of improvement. The blade is too wide, more especially at the heel of the fenestrum, the inner edge of the fenestrum is unnecessarily thick, the shoulders of the notch in the female or mortise blade are too abrupt, thus making it difficult to lock; the handles are smooth and not sufficiently separated, and cannot be securely grasped, etc. etc. It is, however, the least exceptionable, in my humble judgment, of any American instrument. Indeed, were the profession generally in possession of an instrument combining as many useful qualities, and as well adapted to administer relief to the suffering female, as the one recommended by the late Professor of Obstetrics in the University of Pennsylvania, I should not deem it necessary to obtrude this notice upon the Association. But, unfortunately, this is by no means the case. Many of the pupils of the late Dr. Meigs, of Philadelphia, still insist on using the long forceps, without the second or lateral curve, which must seriously impair its usefulness for application at the superior strait, as it cannot conform to the natural curvature in the passages, and must endanger the perineum from pressure.

The instrument which I have used during the last few years is a long forceps, and is considerably curved upon its lateral aspect. It measures in its entire length (A to B), conforming the line measured to the curvature of the blades, 17 inches. The blades and their shafts to the pivot being about $9\frac{1}{2}$ or 10, the handles about 7 inches. The blade (A to D) is $6\frac{1}{2}$ inches in length, and 7 lines at its narrowest point (D), and $2\frac{1}{8}$ inches at its broadest point (E). The fenestrum is one and three-eighths ($1\frac{3}{8}$) at the widest part (F), and gradually diminishes to less than one-half of an inch at the heel. The inner or fenestral margin of the blades is ground down so as not to exceed one-sixteenth of an inch in thickness, the width (E to F) being scarcely $5\frac{1}{2}$ lines, and not exceeding one line in thickness at its periphery (E), being considerably thicker in the centre (midway between E and F).

The shaft of the blade is scalloped out considerably toward the pivot, upon its inner surface, beyond the termination of the fenestrum, thus diminishing weight without lessening the strength.



The points of the blades when the instrument is closed (A to A) are but 8 or 9 lines apart, and at the widest point (G to G) they are 2 inches and 9 lines apart, on the upper or concave surface; whilst on the lower or convex surface, they are slightly more expanded.

The shafts of the blades (from D to C) approach each other rapidly, but not abruptly.

The blades at the centre of their points (A) deviate 3½ inches from the straight line in forming their second or pelvic curve. The entire thickness of the closed instrument at their point of junction (C) is less than six lines.

They are united by means of the German notch and button, or screw, which is counter-sunk in the female blade, and when the instrument is closed the blades are held as firmly as by a pivot. The edges or shoulders of the mortise, or notch, are rounded, or pared off for four or five lines on either side, so as to incline the pivot to slide into the notch. The mortise is not carried very deeply towards the opposite side of the blade, which would greatly diminish its strength at this point.

The handles, unencumbered by the heavy wooden beams which are attached to the handles of many modern forceps, diverge in the centre (H H) to 1¾ inches, and each is expanded or flattened to 1⅛ of an inch in width at that point, and well roughened on the outer surface, so as to be securely grasped. Each handle is made concave on the inside and convex externally, thus diminishing its weight very much. The points are contracted again, curved and polished, and will separately answer the purpose of blunt hooks. The one may be made to inclose a perforator, and other a sharp hook or crochet. Each is made oval, and the sheath enveloping it is secured by means of a small transverse screw, which may be removed by the point of a penknife or scissors. The entire instrument is made of the best German cast-steel, and is much better to be nickel plated which prevents rust. It may be had of Tiemann & Co., No. 67 Chatham St., New York.

Here it is perceived we have a very light and graceful instrument of sufficient length to seize the head at the superior strait without difficulty, leaving the lock entirely free from the external organs. The curve is such, also, as to conform to the direction of the passages, without exerting injurious pressure upon the perineum. The shafts of the blade approximate so as not to distend the vulva before the descent of the head. They incline, however, so gradually as not to diminish their power, as is the case with the instrument of Dr. Hodge. By the politeness of a pupil of Prof. Hodge's, having an instrument approved by his preceptor the inventor, I am enabled to compare the instruments, and I find that although the forceps of Prof. H. are four and a half ounces heavier, they spring or yield more, being more dilated, by

the same amount of force applied at the distal extremity of the blade, than those described. Besides, the blade of the latter is nearly an inch narrower, and hence it is introduced with much greater facility. It will be found that the concavity of the fenestrum, *bevelling* off the inner edges of the blades, will render it better adapted to fit accurately the parietal protuberances, and prevent those salient points from being injured or indented by the sharp angles usually found on the inner border or edge of the fenestrum. Moreover, this is the widest part of the fœtal head, and the surface to which the fenestrum is ordinarily applied, and if this margin of each blade be two or two and a half lines in thickness, as is the case in many instruments, the pelvic space which will be requisite for delivery will be three lines less in using one than the other form; or, which is equivalent to the same thing, the amount of compression of the fœtal head must be three lines more in consequence of unnecessary thickness of this edge of the instrument.

One of the difficulties in the application of the forceps consists in uniting the blades, after they have been carried to the requisite height. In the instrument represented, this end is greatly facilitated, slightly lessening the weight at the same time, by cutting away the abrupt shoulders to the mortise, into which the screw easily glides, whenever it gets within these inclined planes.

Again, whoever has been compelled to hold on to well polished round steel handles for any considerable time, will readily appeciate the comfort, as well as sense of security which a roughened and expanded surface must afford. It adds but slightly to the weight of the instrument to increase the length of the handle, and bend it so as to form a blunt hook, and may be a source of considerable convenience. A very good perforator may be inserted into the extremity of one handle, and a sharp hook into the other, and though they may not be of the most approved patterns, they answer very well, should the work of destruction become unavoidable. This arrangement is more important in country than city practice, as one instrument is much more portable as well as more economical than four.[1]

[1] The weight of the different forceps most frequently found in use, is as follows:—

White's,	13 ounces.	Eliot's,	19½ ounces.
Hodge's,	17½ "	Suer, Paris,	23 "
Bedford's,	18½ "	Seibold, Berlin,	27 "

The last four having their weight greatly increased by the heavy wooden handles, which are entirely dispensed with in the instrument here recommended.

I do not suppose that the instrument as represented is insusceptible of improvement. But it is claimed that it can be used with much greater ease and safety than those to be found in the shops of the cutlers in this country. It is very light, may be applied at the brim, in the cavity, or at the outlet of the pelvis, by simply varying the direction of the handles. It is less likely to do injury to the child and maternal organs than those in common use, and were it, or some better form than those now in use, generally introduced, much of the repugnance on the part of the profession to the early employment of this instrument would be overcome; the delay and suffering of the mother would be thereby lessened, with increased safety to her structures, and far fewer children would be subjected to destructive operations. Indeed, I am pleased to add that the prejudice of British and American practitioners to the more frequent use of this most beneficent of all obstetric instruments is rapidly giving place to a more intelligent appreciation of its powers and utility.

As indicative of the great change which British opinion is undergoing, it may be stated that at a meeting of the Obstetrical Society of London, in March of this year, Dr. Edis read a paper upon the use of forceps in modern midwifery, in which the point attempted to be elucidated was "the highest rate of frequency of application of the forceps coincident with the lowest rate of mortality to mother and child." Among his conclusions formulated we find his sixth reading: "The use of forceps, at least as often as in one case in ten, was desirable." The prevailing sentiment at the meeting, as expressed by Barnes, Playfair, Hicks, Aveling, and other celebrated obstetricians present, showed that a change, amounting to a revolution, was taking place in the opinions and practice of our London brethren in the use of the forceps.

An important improvement in the treatment of placenta prævia has been recently suggested and adopted by some of the most progressive practitioners in the department of obstetrics. Aware of the danger of hemorrhage incident to the commencement of labor, and that it may proceed to a fatal degree before the accoucheur can reach the patient; when not summoned until after the pains and flow have commenced, it is recommended always to induce labor a short time before the completion of the full period of gestation. Dr. Thomas[1] thinks premature labor should

[1] Amer. Journ. of Obstetrics, Feb. 1876. American Practitioner for May, 1877.

always be induced. The same method of treatment is also advocated by Greenhalgh,[1] Playfair,[2] Parvin,[3] and others. Some years since the speaker was associated with Prof. Thomas F. Rochester, of Buffalo, in the treatment of a case in which hemorrhage, to an extent which proved fatal, occurred before our arrival. We found the woman so exsanguinated that, although little blood was lost after visiting her, and although she was rapidly delivered of a large child, almost without hemorrhage, she died, as it seemed to us, from the loss already sustained. Since that time, now some years ago, I have been in the habit of teaching and pursuing the course of anticipating the full period, and inducing labor, when the attendant could be present, from the commencement of the dilatation of the os, and control the accompanying hemorrhage. By so doing, the labor is from its inception completely under our direction, instead of having it occur at night, or during our absence. If delivery is not undertaken until after the child is viable, its safety is also promoted, rather than by waiting until it is debilitated by the repeated hemorrhages which are almost certain to occur from delay. Confident that this course of practice will, upon reflection, commend itself to the good judgment of all, it is merely necessary to add that delivery is accomplished in the same manner, and governed by the same rules of practice, as when the os becomes dilatable without artificial interference.

Much attention has also been bestowed during the past year upon the important subject of post-partum hemorrhage. Preventive measures have been especially insisted upon: securing the tonic contraction of the uterus at the conclusion of the second stage, by manipulations over the hypogastrium, the administration of ergot just before its termination, preventing the rapid expulsion of the shoulders and hips, and thus leaving the uterus patulous and atonic; depressing the head of the patient, and profiting by the influence of gravitation; and, in short, pursuing Crede's method of concluding the labor. It is unnecessary to recite the received plan of treatment of hemorrhage by compression, manipulation, cold, position, ergot, hypodermic injections of ergotine, anodynes, stimulants, etc. etc. In relation to the use of injections of persulphate of iron into the uterine cavity, although the subject has recently received a large share of atten-

[1] Obstet. Transactions, vol. vi. p. 188. [2] Obstet., p. 365.

[3] American Practitioner, 1875 and 1876.

tion in the obstetrical societies of Great Britain and in this country, no conclusion has been reached. Barnes and his followers are very sanguine in the belief that iron may be safely injected into the organ, and that it will control the hemorrhage; whilst others are of opinion that by its use hard coagula are formed in the cavity, the hemorrhage by no means always arrested, and the patient exposed to the danger of thrombus and septicæmia. The matter is still *subjudice*, and we will not engage in its discussion.

In this connection it should be mentioned that Prof. Trask, with others, has recently called attention to the use of tincture of iodine, as being more safe and quite as efficient, used as an injection into the bleeding cavity, as the preparations of iron in this form of hemorrhage.

The "after treatment" of parturient women has, under the leadership of such men as Goodell, Barker, Thomas, and others, undergone a great change within the last few years. Regarding childbirth as a physiological and not a pathological act, and treating the patient upon that hypothesis; giving her nutritious and digestible food in abundance, pure air, and improving her hygiene generally, is becoming the accepted doctrine of the day. She is no longer required to fast or live on slops and ptisans; to preserve the horizontal posture for the arbitrary nine days; and take the traditional dose of castor oil every second day, as demanded by our forefathers; but is allowed to be made comfortable notwithstanding her sin of child-bearing. Numerous articles have been published during the last year, all tending to the same salutary and rational reform in the treatment of the parturient during convalescence.

Prof. Montrose A. Pallen recently read a paper before the New York Obstetrical Society, which is published in the *American Journal of Obstetrics* for April, making some valuable "suggestions in regard to the insanities of females." He calls attention to the "existing ignorance concerning the neuroses attendant on female pelvic lesions," and the "entire absence of records of the pathological condition of the generative organs of women incarcerated in asylums for the insane." Every practitioner of moderate experience must have seen cases of insanity in females where treatment addressed to the genito-urinary lesions alone could be relied upon to cure the mental alienation. Prof. Pallen dwells upon the importance of such treatment, and

insists that many more might be restored if a due appreciation were given to the "intimate relationship of gynæcology and neurology."

Menstruation, pregnancy, parturition, or lactation often exert a controlling influence upon the psychological symptoms present, and must be carefully estimated before we can intelligently adopt the hygienic and therapeutic measures appropriate to overcome the delusions arising from derangement of these functions. So again, sub-involution and every form of metric inflammation and ulceration may, either of them, produce by reflex action mental symptoms of an anomalous and alarming character, and which can only be overcome by remedies addressed to the uterine disease. The large number of cases in the female wards of all asylums who require special treatment of the sexual organs, renders it essential that alienists having them in charge should make themselves thoroughly acquainted with this class of diseases, or else that the medical staff of each institution should have among its number an accomplished gynæcologist. Time is not permitted on this occasion to do more than commend this subject to the careful consideration of all reflecting men in the profession.

The subject of "chronic inversion of the uterus" was again brought to the attention of the profession by a paper read by Prof. James P. White, in June last, before the Medical Society of the State of New York, giving his twelfth case; by another, before the International Medical Congress, giving a *résumé* of twelve cases, all of which had been successfully reduced. The cases referred to by Dr. White vary in duration from a short time after the accident to seven, fifteen, and twenty-two years. He takes the position that inversion can *always* be reduced by gentle, persevering, uninterrupted pressure upon the fundus. The os is dilated and reflected down over the neck, and the mechanism of reduction is precisely the reverse of inversion, the fundus finally passing up and disappearing through the os, and neck, and body of the organ.

A plate, showing an instrument called the "uterine repositor," is given accompanying the paper. Through pressure upon the wire coil at the outer extremity, elastic force is applied and continued indefinitely on the fundus, which is received into the concave or disk-shaped India-rubber cup or cavity at the distal or uterine extremity of the instrument. The two ends are connected

by a long stem of hard rubber, conforming in shape to the general axis of the pelvis.

It would seem that the large number of cases, all of which have been, by him, reported from time to time in the medical journals, or at the meetings of the New York State Medical Society as the reductions were made, and all these reductions successfully performed in the presence of intelligent witnesses, ought to establish the practicability of this operation in the manner described. Still so rooted and confirmed is the habit of regarding and treating chronic inversion as irreducible, and seeking for some unheard-of method of treatment, that the simple procedure now recommended has been almost entirely disregarded or overlooked. Thus, during the last thirteen months no less than fifteen cases of inversion have, by different writers, been reported in the pages of the *Obstetrical Journal of Great Britain and Ireland*, without mentioning in a single instance the improvements suggested in the publications here referred to. In four of these cases, death was the result. In three the uterus was removed by the ecraseur or different kinds of ligatures. Six were recent or acute, and were easily reduced soon after the accident. One was reposited at the end of two years and ten months, after repeated trials, by taxis. This case was reported to the London Obstetrical Society, giving rise to a protracted debate participated in by many celebrated gynæcologists; among the number, Storer, of Boston, and yet no allusion is made to the "uterine repositor" and elastic, long-continued pressure by it, or to the "modus operandi" of reposition described by Dr. White, nor of the success in the treatment of that accident by his method. In the April number of the same leading journal, Dr. Matthews Duncan relates five of the fifteen cases just referred to. Two of these died; one chronic, one acute. Two were reduced, one soon after delivery, the other later, by *incisions* into the substance of the organ; and one was *excised* after fruitless efforts to reposit, terminating in the death of the woman. Although considerable debate followed the report of these cases by Dr. Duncan in the Obstetrical Society of Edinburgh, no reference is made to views advanced by Prof. White, although his opinions are sustained by a larger number of cases than has ever been reported as occurring in the experience of any other individual. This incredulity or ignorance, this blind adherence to authority, is extraordinary. These views were given to the world in the *American Journal of*

the Medical Sciences as long ago as July, 1858, with a full description of the process of reduction in a successful case of six months' duration. This publication was accompanied with plates illustrating the whole process. The opinion is now maintained, based upon reduction in the twelve cases described, that the uterus may *always* be reposited unless bound down by firm adhesions; and that reduction is accomplished at the longest time (22 years) with the same certainty and facility as at any intervening period after complete involution.

This practice has been successfully adopted by several American gynæcologists, but has as yet received little attention in Great Britain or on the continent. Your reporter is very sanguine in the belief that this advance is certain at no distant day to be adopted by all reflecting progressive men, and the opprobrium consequent upon the confession of irreducibility, and permanent and loathsome invalidism as its consequence, removed from our profession.

In June last, Prof. E. R. Peaslee read before the New York Academy of Medicine a very valuable paper, which he entitles "Incision and Discision of the Cervix Uteri." All doubtless are familiar with the fact that the late Prof. Simpson, of Edinburgh, in 1844, or thereabouts, recommended the free division of the cervex uteri as a means of curing stenosis of the canal of the neck, often present in dysmenorrhœa and sterility. He devised an instrument, the metrotome, for the performance of this operation, which, with its modifications, has been extensively used both in Europe and America. A few years since Drs. Sims and Emmet varied this operation by using scissors instead of the metrotome, and in flexions of the uterus dividing completely the lip throughout its entire vaginal portion. These operations were for some years resorted to without much discrimination, became very *fashionable*, and, it is to be feared, many practitioners resorted to them recklessly or as a matter of routine, without much reference to the indications or requirements of the individual case under treatment.[1] Careful observers were not long in ascertaining that they were frequently followed by profuse hemorrhages,

[1] Indeed, when I visited Edinburgh, in 1851, I saw Prof. Simpson operate frequently, without any precautions against hemorrhage. Sometimes as many as four or five in his rooms in a day, the patient returning to her home as best she could, without any apprehension on his part of danger, and sanguine in the belief that all would be cured by it.

pelvic cellulitis, septicemia, sterility, or leaving a tendency to miscarriage, and that they sometimes resulted fatally. Instead of uniformly affording relief to the painful flow, unless pursued with appropriate after-treatment, the dysmenorrhœa was often increased. These operations also signally failed as a means of curing sterility, the stricture returning increased in degree leaving the canal still narrower than before these deep cuttings were made. These operations were therefore to a great degree abandoned both as a means of curing dysmenorrhœa and relieving sterility. As often occurs in medicine the operation was falling into disrepute or becoming *unfashionable*, when Dr. Peaslee came forward with a proposition to substitute superficial or slight incisions in the lining membrane for the deep cuttings already described. Dr. Peaslee believes these delicate incisions may be made without danger, and that by subsequent dilatation are more certain to accomplish the object than the deep incisions of Simpson and Greenhalgh or the discisions of Sims. He also states that these superficial incisions followed by suitable dilatations leave the canal in a more normal shape than the deeper incisions, or the divisions of the lip as practised by Sims and Emmet, which latter leave the orifice patulous and gaping. Hence he thinks conception and retention of the fecundated ovum much more likely to result after this operation than where complete division of the lip has been resorted to. Dr. Peaslee gives a minute description of his method of operating with diagrams of the canal of the neck in the normal condition, after the deep incisions, and after his procedure. It may be found by careful observation that hypercaution has induced the doctor to make his incisions too slight or superficial, thus going to the opposite extreme. He gives the cut of an instrument by means of which these delicate incisions can be made without danger even by the unskilful or inexperienced. In my opinion, in skilful hands, and none other should venture upon its use, the best instrument for this and similar operations is a small, narrow-bladed, long-handled knife. This tenotome-like blade can be passed up beside a small probe or sound into the narrowest canal, and such divisions of substance can be made as shall in any case be necessary to render it easily dilatable to the required size. Indeed whether the incisions be made deep or superficial entirely through the tissues of the organ or to any intermediate degree, they should always be made by the knife of the operator and be

guided by his skill and not made to depend upon the mechanical and arbitrary arrangement of a metrotome. In this way only can the sensible views of Dr. Peaslee be carried out. He says "my method consists in incising the internal os if the stenosis exists of that part, and the external if at the latter, to such an extent as to give to both their precise average dimensions, also overcoming any other point of stenosis existing anywhere else in the cervical canal." Dr. Peaslee taking the canal in the neck of the parous uterus as his model, endeavors to make the one operated on conform to it in every respect. By this modified operation the dangers of hemorrhage are avoided as the larger vessels are not divided; by it, also, the danger of septic peritonitis is greatly lessened, and the neck left in condition less likely to part with the product of conception than when the tissues are completely divided and the part left gaping.

The first volume of the *Gynæcological Transactions* contains a long and able paper read before the Society, in September last, by Thomas Addis Emmet, on "The Etiology of Uterine Flexures." Whilst Dr. Emmet has modified his views on the question of the frequency and necessity of this operation, he still advises it for the relief of flexures at the vaginal junction. "I always," says Dr. Emmet, "divide with scissors the posterior lip backward in the median line." It would do great injustice to the monograph of Dr. Emmet for me, in the limited space permitted on this occasion, to attempt any analysis of it. It should be carefully read by all especially pursuing this department. In the discussion which followed its reading in the Society, a diversity of opinion on the subject of the proper treatment of stenosis, whether arising from contraction of the calibre of the canal, or depending upon flexion of the cervix, was manifest. Drs. Peaslee, Barnes, of London, White, Howard Taylor, Wilson, and Chadwick expressing their views and describing their peculiar methods of operation. Suffice it to say that the prevailing sentiment was opposed to the free divisions, either by the bilateral operation, or the complete severing of the tissues of the lips, as practised by Sims and Emmet a few years since.

But time fails; I have already trespassed upon your kindness by occupying more than the prescribed limit, and cannot refer to many subjects which would claim attention did space permit.

In conclusion, I beg to call the attention of this Association to the great neglect on the part of schools in clinical teaching in

obstetrics, and in the diseases of the generative organs. There is no subject in the whole college curriculum which so imperatively demands bedside observation as the process of parturition. The relations of the parts vary with each successive pain, from the commencement to the conclusion of the process. These variations, with the duties devolving upon the accoucheur during the process, can only be learned in the presence of the parturient. Nearly thirty years since, the reporter introduced his graduating class into the parturient chamber, and taught the young men their duties in the presence of the woman in labor. A great storm of popular indignation succeeded this effort to initiate this important advance in medical teaching, which soon exhausted itself and subsided. The practice of clinical teaching in midwifery was indorsed by nearly every medical journal in the country; it was adopted, in some form, by many of the medical schools, and continued, notwithstanding the opposition of the ignorant and prejudiced, which it encountered in no measured degree, to be triumphantly pursued in the University of Buffalo, in a lying-in hospital established for that purpose. I regret to be compelled to add, however, that from a variety of opposing circumstances, and from a lack of appreciation of its importance on the part of the profession, it is by no means uniformly adopted by teachers in this department at the present day, and the neophyte is still obliged to gain his first experience at the bedside of his own patient, without the guidance of a preceptor, and where a false step may result in ruin to his reputation. Simply commending the subject of clinical teaching in this department to your careful consideration, I should deem it unnecessary, even did time permit, to enlarge upon its importance.