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HINTS IN THE OBSTETRIC PROCEDURE.

THE

19.

ANNUAL ADDRESS

BEFORE THE

Philadelphia County Medical Society.

BY

WILLIAM B. ATKINSON, M.D.,
RETIRING PRESIDENT.

ROYAL COLLEGE OF PHYSICIANS
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PRESIDENT'S ADDRESS.

GENTLEMEN:

IN retiring from the presidency of the Philadelphia County Medical Society, I may be pardoned if I indulge in a few congratulatory remarks—to you, upon the marked evidences of a healthy tone and vigor in your organization; to myself, upon the fact that this has obtained during *my* administration. All of our sessions, but especially those devoted to discussions, have been largely attended by the active working spirits of the Society. Not once have we failed to present for your entertainment subjects of practical value, and in every instance, save when the introductory papers were exhaustive of the subject, has the debate been full, valuable, and interesting.

It is equally satisfactory to me that, during the past year, we have added to our numbers, and that these additions have been such as must prove eminently useful to us in the future—the young, the talented, the energetic. In several instances, also, we have welcomed once more to our ranks our older brothers, who, pleased with our energy and our efforts to deserve success and to make our Society what it was originally intended, the Union or District Medical Society of Philadelphia, have re-united with us, and are again prepared to help us in our support of the dignity of the profession, and to assist our labor in all those matters which the public of right should demand from us, the conservators of their health.

Financially, as well as numerically, we were never in a better condition. I am proud, therefore, that on resigning my office to my honored successor, I can truly say that I leave you improved in every respect. You have given a noble response to the appeal which I made to you when assuming my duties as your presiding officer.

Having entered your ranks very shortly after commencing the practice of my profession, I have grown up with you; I have constantly added to my strength by close association with my learned elder brothers, and have enjoyed much pleasure and benefit from the fraternal relations with those of my own age. Gentlemen, this Society has been to me a perennial spring, from which I have largely drank in the waters of wisdom, which have imparted to me a degree of mental vigor, thus enabling me to battle successfully in the warfare ever to be undertaken by him who takes our profession as his lifetime pursuit, and desires to win his way to fame, if not to fortune.

Hence, I am deeply grateful, and none the less that you so kindly selected me to preside over your deliberations, thus conferring upon me the highest honor in your gift, an honor of which any member of our profession might be proud.

In presenting to you the Annual Address we have, after much deliberation, decided to ask your attention to a brief review of some points in the OBSTETRIC PROCEDURE, which, though apparently small in themselves, we regard as of great practical value in their results, particularly as in those results is bound up the happiness, the welfare of a household. He who assumes the care of a woman in childbirth should never deem any point of too small value to demand his careful and earnest attention. We cannot believe that our experience is singular, or differs greatly from that of our brethren, whose inclination has led them to practise obstetrics as a special branch; but we have been astounded at the utter ignorance and carelessness evinced by so many in the performance of their duty as obstetricians.

We regret to find that very many of our brethren, even of those who have but recently emerged from the care of the "fathers in medicine," still adhere to exploded dogmas and old wives' fables, and are too ready to allow the parturient woman to be guided by the ideas and even follies of those around her, in place of themselves assuming her guidance. They seem content with the formal visit, and inquiry of the nurse, who soon comes (if she has not already) to ignore the doctor, and all goes well, more by good fortune than by good management. We can assure these gentlemen that they would have greater assurance of

a successful termination of their cases if they fully discharged their duty as physicians, as care-takers, and regarded nothing as too small or unimportant in the lying-in chamber.

"The old axiom, 'meddlesome midwifery is bad,' has had great force in obstetric practice, but it is, perhaps, better adapted to ignorance or partial knowledge than to perfect comprehension of the mechanical and motor phenomena of natural labor. I have no doubt the time will come when these will be so well understood that the finger of the accoucheur will be in accordance with every change in the passage of the child during parturition. Proverbs are always one-sided. The phrase quoted has, no doubt, been useful in preventing improper interference, but it has also a tendency to the prevention of interference when this is both useful and necessary."*

We cannot but condemn the practice, more prevalent than would have been anticipated, of allowing the pregnant woman to suffer hour after hour, even days, with useless pains, technically known as "false pains," exhausting her against the final effort culminating in the delivery of her child. In no case should the medical attendant be satisfied to permit the pains to continue, as we have often been assured, days at a time, without interposing and administering some one of the remedies now so readily and usefully employed. We have, on more than one occasion, been informed both by patient and physician that this has been the case before our summons to the consultation. It has been our usual practice, when the pains were severe and the os uteri was rigid and showed no signs of dilatation, to administer anodynes in sufficient doses to quiet completely these inefficient pains. Often they are the result of a rheumatic or neuralgic tendency, and we have especially noticed such a predisposition within the past six or eight months.

Leishman,† in his recent work on Obstetrics, says: "By mistaking false for real pains we may, in our ignorance, allow the woman to go on suffering that which we generally have it in our power to alleviate." Of course a vaginal examination will reveal the true state of affairs, and we should be governed

* Dr. Tyler Smith, Lectures on Obstetrics, p. 367.

† System of Midwifery.

accordingly. But granting that labor has set in, that the os uteri is dilating, yet still rigid, like a band of iron, restraining the advance of the presenting part, even then a full anodyne, by affording rest, refreshes the patient, gives her strength to proceed with her labor, and generally causes the most complete relaxation of the circular fibres of the uterus. We have often had the gratification to find, when our patient again summoned us to her bedside, that a most happy change had taken place, and that the labor had greatly advanced towards its termination.

Soon after the introduction of chloral we were so much pleased with its effects in certain symptoms, that we were induced to employ it in these cases, and the result was so gratifying that we desire nothing better. Schrœder has had a similar experience. He says:* "Chloral appears to act in a similar way. Gerson da Cunha has given it in tardy and exhausting labors. After a few hours' sleep, on awaking, the labor was very rapidly terminated by powerful pains. We have also observed that by the use of chloral in cases where the uterine action was very painful without being efficacious, the labor assumed an instantaneously rapid course, although the intervals between the pains had considerably increased in duration."

When the os is dilatable, but from any cause, as insufficient pains, the progress is slow, much can be done by aiding the dilatation. We do not wish to be regarded in such cases as counselling what may be termed "forcible dilatation," but we are sure that all who have had much experience in obstetrics have seen many instances where, by the gentle but firm sweep of the finger around the advancing part, within the os uteri, the dilatation has been much accelerated, and the part speedily caused to emerge from its grasp.

So *apropos* and valuable are the views of Leishman on this point, that we prefer to give his teachings as presented in the work just quoted.

"So long as the os uteri is not fully dilated, or, in other words, so long as the first stage continues, the patient should be encouraged to believe that this is a stage which is merely preliminary to the act of parturition; and that, therefore, she should

* Manual of Midwifery, p. 167.

not lie in bed, but rather walk about in the intervals between the pains, and take such light food as she would under ordinary circumstances. If she can be induced to occupy her attention, as far as possible, by any familiar occupation, however trivial, it will be to her advantage, by relieving the tedium of her suffering. If this cannot be done, her attendants should try, by cheerful conversation, to beguile the time, and to divert her mind from the gloomy apprehensions which are of frequent occurrence at this period. The accoucheur should not remain in the room at this time unless there be a special necessity for it, although he may visit it occasionally. To do otherwise would encourage her to expect assistance at his hands, which it is not in his power to afford; and, moreover, his presence would to her seem to imply that he expected a speedy termination of her sufferings. During this stage the woman is frequently advised by ignorant attendants to press down, and with this view, foot-stools are placed at the foot of the bed, and towels are tied to the bed-post, by means of which she may fix the trunk, and bring the whole force of the expiratory muscles to bear. This acts most injuriously on the progress of the labor, for the stage is one of dilatation, and not of propulsion; and if the muscles referred to are thus brought prematurely into play, the voluntary expulsive force is fruitlessly expended before the stage arrives at which it may properly be employed."

Just such a picture has on more than one occasion been presented to us, when summoned to a consultation. The patient, her nurse, the doctor, all anxiously expected a speedy release, and yet hours necessarily elapsed before that much-wished-for consummation.

It is frequently the case, that by reason of a malposition of the uterus, the mouth of the womb remains far back, and even high up towards the promontory of the sacrum, while the advancing part of the child is directed forward, and the pains are fruitlessly expended in driving it against the anterior part of the lower segment of the womb. With a finger hooked into the os, and steady traction thus made at every pain, we have frequently soon brought it into the proper line, at the same time rapidly aiding its dilatation, and thus bringing a tedious labor to a con-

clusion. In some instances, the difficulty is not so formidable, but the anterior lip forms a cap or sling over the advancing head, and greatly retards the delivery. Here, the procedure just mentioned removes the obstacle, and quickly terminates the labor. An additional and truly valuable aid in such cases is the vectis, which, acting like a shoe-horn, causes the rim of the os to slip over the head, and permit of its escape.

Where the head is slow to engage, this instrument, the vectis, often proves of great value. Many of you will recall the able and eminently practical essay read before us by our fellow-member, Dr. Wm. Goodell, entitled "A Plea for the Vectis," in which he so graphically depicted the advantages of this instrument. For this reason, I shall content myself with this passing allusion.

But, in behalf of the suffering woman, in deprecation of the evils to which a prolonged labor renders her liable, in behalf of the many infants thus sacrificed, I would earnestly urge every one who practises the obstetric art to provide himself with a proper pair of forceps, and perfect himself by thorough study in their use. I am confident that very many, perhaps a large majority, of cases are permitted to suffer hour after hour without this valuable means of relief, simply because the medical attendant is afraid or unable himself to employ them, or hesitates to summon the aid of a consulting physician, lest he will thus lose credit with the patient and those around her. In nothing is our selfishness so clearly shown as when, trusted with the health, perhaps life of two beings, one whose loss can never be made up, the physician hesitates as to his duty, lest his reputation and pocket may suffer by it. Let me say to such a man, that he is watched by eagle eyes. Every phase of his conduct, every line of his countenance is noted. Much, very much of his future depends upon the report that goes out relative to him from that lying-in chamber. It matters not her condition, her surroundings, her rank in life; she is a woman in the agony of her most sacred duty, her great calling in life, and she demands and should have all that skill, science, and sympathy can do for her.

For the practice of the "divine art of obstetrics," the physician

should be a man of decision. He who wavers is lost. Too often are both mother and child sacrificed to this policy. We are not of those who would counsel a resort to the forceps or other interference when unnecessary, nor would we deem it justifiable to employ this aid for purely selfish purposes. But how often does instrumental aid become an urgent necessity, and, alas, the medical attendant is not prepared to respond to the demands of humanity! Yes, humanity, for every additional unnecessary pang is a crime against humanity!

We believe that yearly this valuable adjunct is being more frequently employed. Accoucheurs are coming to look upon the application of the forceps in a far different light from that in which it was formerly viewed. We are firmly of the opinion that the early application of this instrument would have saved many children now reported as still-born, and also would tend largely to a more speedy and happy recovery of the woman herself. We hope, ere many years, to see the resort to this aid the rule rather than the exception. Perhaps, it would be well in this connection to quote a few brave words that ring out with no uncertain sound from one who has fully shown himself worthy of an audience: "Patience is the watchword of accoucheurs in the management of these positions, and they are told to sit supinely by their suffering patients, watching the throes of labor until the child's head has descended, rotated, and been born. That this will occur in a large majority of instances, no man of any experience can have a shadow of doubt; but there are cases in which the delivery of a living child without injury to either the mother or her offspring is perfectly practicable, and in which, if left to nature, the result may be fatal to one or both. Judicious interference does not jeopardize either, nay, more, the skilful operator had better err in resorting to the forceps or version early, than in postponing either operation too long. We do not hesitate to repeat, that we adhere to a rule adopted several years since, to gravely consider the propriety of interfering when the second stage of labor has continued two hours without any advance. . . . . Thus the physician becomes not the substitute for, but the handmaid and assistant of nature. As such, the intelligent physician goes to the bedside of his suffering patient, in the sore hour of her travail, with a full knowledge of

the extent of his resources. Conscious of his powers, and strong in their possession, he anticipates and prevents danger. 'Meddlesome midwifery is bad!' Delay and timidity in operating are bad."*

We might go further, and quote many excellent authorities, and particularize as to the various evils liable to result from prolonged and tedious labors, but we shall think we have gained our object, if we can but drive from the mind of the medical practitioners that bugbear, "a meddlesome midwifery is bad," which has hovered over this art from its earliest days, and been the cause of untold mischief everywhere that it has been heeded.

Often, after many weary hours of labor, with scarcely any advance of the child, delivery has been speedily accomplished by a change of the position of the woman, as, in her irritable and restless condition, she turns from side to side, or rolls upon her bed, or rises to relieve the bladder or rectum.

Prof. Henry Gibbons, of San Francisco, in a paper read before the Medical Society of that city, says: "Prof. Dewees, of the University of Pennsylvania, was one of the creators of Obstetric Science. His methodical mind subjected everything to strict rule. When I entered the profession, I was fresh from his tutelage, which required that a woman in labor should lie on the left side. One of my first cases kept me at the bedside all night, resisting the importunities of the patient, who was desirous to get on her knees. The pains were severe, but with slow progress. I insisted on the orthodox posture, and did not dare to permit a change. At dawn of day, I ventured to leave the bedside for a few minutes, to breathe the morning air, with the prospect of half a day's imprisonment still before me. I sauntered away about a hundred yards—it was in the country—when the husband came running, with lively gesticulations, and calling for my return. I hurried back to hear, on approaching the door, the discordant music which is often so agreeable both to doctor and mother. The woman, the moment my back was turned, climbed on her knees with her elbows on a chair, and forthwith the baby dropped out."

* Dr. J. S. Parry, American Journal of Obstetrics, Aug. 1873, p. 191.

While we opine that few of our hearers would so strictly follow the *ipse dixit* of any of their teachers, still it is probable that all of you have had a somewhat similar experience on more than one occasion.

Position in labor has not been sufficiently attended to, nor has its importance been recognized. Having for many years held the belief that by adapting the position of the woman so as to favor the descent of the child in the direct line of the axis of the pelvis, that delivery would be correspondingly accelerated, we were agreeably surprised and gratified to receive from Dr. J. W. Smith, of Charles City, Iowa, a copy of his paper upon this subject. It is well known that the position assumed by the woman in labor differs in different countries. Here, and in England, the decubitus is on the left side. In Germany and France, as a general rule, the woman is delivered while lying upon her back. On this point, the history of the obstetric art shows some curious facts. Thus, labor chairs of a peculiar form were formerly, and are even yet in some parts of the world employed. Or, two chairs are strongly fastened together by their adjoining legs, and the woman sits between them, holding on by the backs. Or, the woman sits upon the knees of a friend, or her husband, and is thus delivered, as was once the case in our own experience, in the delivery of a German woman, much to our dismay, being then a neophyte in the lying-in chamber. The Irish people generally prefer the knees. All these customs and methods show, to a marked extent, an instinctive effort on the part of the patient to assume a position which will favor the expulsion of the child.

The limits of this address will not admit of our delving further into these historical points, though they are highly interesting to and will well repay the student who desires the fullest information in his art.

Schrœder* says: "The posture of the parturient woman is to be so arranged that first the direction of the expulsive powers acts as perpendicularly as possible to the plane of the pelvis through which the fœtal head is to be pressed, for thus only the amount of friction will be the least, and, therefore, very little force will be lost; and, secondly, the gravity of the child itself

* Op. cit., p. 90.

will not be prevented from aiding. This last demand is complied with when the plane of the pelvis, through which the head has to be forced, lies horizontally.

"If in each stage of labor these two points are complied with, the posture then is the most perfect.

"The first demand—that the expulsive force should act perpendicularly to the plane of the pelvis through which the head passes—can only be satisfied at the commencement of the pelvic canal, and, as a rule, it is so here as soon as the axis of the uterus and that of the brim have approximately the same direction. But, when the head has passed through the excavation, that is, when the pelvic axis is curved forwards, the axis of the uterus and that of the corresponding plane of the pelvis form an angle. This will be the smallest when the uterus lies as far backwards as possible.

"By accurate measurement, Schultze has shown that the mobility between the lumbar vertebræ and the pelvis is not inconsiderable. The more obtuse the angle is which the lumbar vertebræ form with the brim, the more backwards the uterus comes to be placed and the more the passage will realize our expectations.

"Secondly, it is required that the gravity of the child shall not be impeded in its action. This is obtained if the plane of the pelvis through which the head passes lies horizontally. The woman, therefore, until the head is in the excavation, must be in a half-sitting and half-recumbent position, because then the inlet is horizontal. When the head descends, the back of the woman must be raised still more, so that in the further progress of the delivery she has a sitting posture, and when the head passes through the outlet she must be bent forwards. Since the entrance of the head into the inlet is favored by the half-reclining half-sitting posture, both these demands are perfectly satisfied by it, and that position is, therefore, undoubtedly the most rational at the commencement of labor. The passage of the head through the outlet and the vulva is, most of all, favored by the weight when the woman is bending forwards, and since in that position, through the bending of the sacrum, the lumbar vertebræ form a very obtuse angle with the inlet, that position perfectly corre-

sponds with all rational demands for the last period of the expulsive stage.

"As regards the customary postures, the dorsal position with the trunk somewhat raised is very suitable for the entrance of the head, and the more so the higher the back lies.

"In the expulsive stage, however, the dorsal position is irrational, since in it the head must be forced, opposed to its own gravity, over the ascending inclined plane of the pelvic floor. In the dorsal position, therefore, the expulsion is not only not favored by the weight of the child, but the latter is directly opposed to the expulsive force; the head would have to be pushed over an eminence, so to speak.

"If it is preferred to deliver the woman in the dorsal position, parturition may be facilitated as far as it is possible in that position, if a pillow is placed under the sacrum, so that the angle between the lumbar vertebræ and the inlet becomes as large as possible.

"Lying on the side is unsuitable as long as the head has not yet entered the brim, provided always that there are no definite therapeutic plans connected with this position. For here the head can easily deviate to the opposite side.

"For the delivery of the head the lateral position does not offer the same inconvenience as the dorsal, but it also has no advantages, since the gravity of the child cannot be made use of. To conclude, therefore, it is most suitable to place the woman at the commencement of labor in the dorsal position with her back raised as much as possible. The expulsion of the child is, however, most facilitated if the woman is bending forwards.

"Similar positions can easily be assumed in bed. If the woman is lying on her side, she must turn a little more and kneel on the bed and grasp with her hands the head of the bed, or if she is in the dorsal position she must raise herself and support the upper part of the body by resting on the foot of the bed. By this the sacrum is strongly drawn inwards, and thus the position corresponds with all that may be justly demanded, provided that the abdominal walls are tense.

"If this is not the case, and there be a somewhat pendulous belly, the uterus must be pressed against the lumbar vertebræ by means of a binder. The pressure of the abdominal muscles

can in that position also more powerfully come into play than in a dorsal or lateral."

Leishman* says: "The effect of displacement forwards—anteversion or anterior obliquity of the uterus—must necessarily be to throw the os backwards; and, at the same time, the axis of propulsive action deviates from that which is normal in proportion to the extent of the displacement. If, along with this, there is any contraction of the pelvic brim, the result of the misdivided force may be that the head does not become engaged in the cavity, and that the anterior and inferior part of the uterus is exposed to injurious pressure. This condition of matters—which is recognized by a combined abdominal and vaginal exploration—may best be remedied by raising the depressed fundus, and maintaining it in that position by a bandage. In this way the axis of the uterus is brought more into coincidence with that of the brim—a result which may be still further insured by a supine position."

Prof. Bedford† says: "Let me here remark that, in some instances in which the contractions of the uterus become defective, I have observed great advantage from allowing the woman to place herself for a short time on her knees; this change of position will oftentimes stimulate the organ to renewed effort."

Dr. Gardner,‡ of New York, says: "A change of position during the labor is not unfrequently followed by a renewal of the suspended or flagging pains. Occasionally, as if some obstacle had been removed by the change of posture, a delayed rotation is effected, and the child is speedily delivered."

Dr. Tyler Smith§ himself says: "During the stage of dilatation, and in the early part of the propulsive stage, the direction of the axis of the uterus should receive our attention. It should be as far as possible kept from anteversion, retroversion, or obliquity on either side, as these departures from its proper axis are certain to impede labor."

The late Prof. Charles D. Meigs‖ says: "Where the retardation arises from an improper direction of the expulsive forces, it is of the highest importance to direct the patient as to her atti-

* Op. cit., p. 542.

† Practice of Obstetrics, p. 360.

‡ Tyler Smith on Parturition, p. 358.

§ Op. cit., p. 364.

‖ Treatise on Obstetrics, p. 326.

tude. For example, if a lateral segment of the os uteri can be felt towards the middle of the pelvis, and the other one is either out of reach of the finger, or very high up on the side of the ischium, the fundus uteri is directed to one side of the abdomen, giving more or less obliquity to the long axis of the womb, and of course an oblique line of direction to its forces, which are decomposed, and so nullified. A change of position to the back or the opposite side will bring the plane of the orifice to its proper place in the pelvis."

Dr. Meigs, in this connection, quotes a case which so aptly illustrates our point, that we will be excused for a further quotation.

He says: "I was called to see Mrs.———, and found her lying on her right side. The pains seemed so expulsive, that I expected to receive the child immediately, for she bore down like one in the last throes of labor. I requested her to turn upon her left side, because that position was the most convenient for me. She did so. The pains now became inefficient, and partook in appearance of the character of the grinding pains. I found that the uterus had obliqued far down to the left side as soon as she turned over, which interfered with the due exercise of its power. She was again placed on her right side, which brought the womb into its proper line of direction, and the labor ended after three or four pains. Similar consequences follow from an anterior obliquity of the axis of the uterus; but in this case the anterior segment or lip of the womb seems to hold the head as in a sling or pouch—the anterior part of the cervix being stretched across the head, far behind the middle of the pelvis, while the posterior edge of the circle either cannot be felt at all, or is found high up towards the promontory of the sacrum. It is evident that in such a state of things, a good deal of power must be lost in pushing away the anterior part of the cervix, a power that should be determined in the proper direction. To do this we may draw the os uteri forwards towards the symphysis, and retain it there by the fingers; but there are in many cases a rudeness and violence in this plan, which will be easily appreciated by such as shall make the attempt, and who, moreover, will often find that they cannot retain it in the desirable place without giving pain, and exerting so much force as to expose

the os uteri to contusion or to rupture. If the woman lies on her back, the fundus uteri will retire towards the spine, bringing its axis into the proper range, and of course the plane of the os uteri will take its proper station; if this precaution be taken, the child will, in some instances, be delivered much sooner than if it should be omitted."

Churchill alludes to the subject, but contents himself by enumerating the positions adopted in various countries. Condie, his American editor, speaks of changes of position, but does not seem to appreciate the true usefulness of them and their mode of action.

Moreau* says: "Obliquities of the uterus may impede the progress of labor. When strongly marked, the os uteri does not correspond to the centre of the pelvic excavation, the woman is exhausted by useless efforts, the fœtal head plunges into the cavity of the pelvis, covered by a portion of the neck of the uterus, which it distends, perchance lacerates, and may produce inflammation, gangrene, and death. These disastrous consequences have been chiefly observed in anterior obliquities. Baudelocque was one day called in to see a woman who had been four days in labor, and who was affected with anterior obliquity of the uterus. . . . As the obliquity was very great, the head rested against the promontory of the sacrum, and dilatation could not take place; at last the head descended, covered by the neck of the uterus, . . . death occurred before the termination of labor, and which, certainly, would not have happened if the obliquity had been remedied in the beginning.

"About twenty years ago," says Moreau, "we were desired to see a woman who had already had several children, and in whom there was a very marked anterior obliquity. The fœtal head was in the cavity of the pelvis, covered by the neck of the uterus, whose parietes were so smooth, thin, and tense, that it seemed as if the head were bare; such, indeed, was the opinion of the attending physician, who was preparing to apply the forceps, when the family requested our advice. We immediately ascertained by the sensibility of the part and the pain caused by touching, that the fœtal head was not exposed, and that it was covered by the yet undilated neck of the uterus; we replaced the

* Practice of Obstetrics, Eng. ed., p. 166.

woman on her back with her breech elevated, introduced the extremity of the index finger curved in the shape of a hook, into the os uteri, which was behind and nearly on a level with the promontory of the sacrum, so as to draw the anterior lip gently downward and forward, during the uterine contractions, at the same time, with the other hand on the abdomen, we pushed the fundus uteri upward and backward; this simple plan, continued with great caution and gentleness, effected a rapid dilatation, and in less than two hours the successful and natural termination of a labor, which until our arrival had been considered as excessively difficult, and requiring the use of the forceps. . . . The vaginal Cæsarian operation, mentioned by Lauverjat, was, undoubtedly, performed under similar circumstances. . . . . When an obliquity of the uterus exists, and the fœtus descends into the cavity of the pelvis, we must immediately remedy this accident. If the obliquity is anterior, the woman is to be laid on her back, with a cushion under the breech, in order to establish the parallelism between the axis of the uterus and that of the superior strait; the fundus of the organ is pushed upward, a finger introduced into the vagina, in order, in the interval of the pains, to seek the os uteri, which is found on a level with the promontory of the sacrum, and then the directions given in the preceding case are to be observed, taking care to exert very moderate traction, for fear of lacerating the os uteri. When there is right or left lateral obliquity, the patient is laid on the opposite side, one hand placed on the flank towards which the fundus uteri inclines, the os uteri is acted on with two fingers of the other hand, and thus restored to its natural situation."

Wigand says: "The more completely the os uteri is opposite the fundus, and the more the axis of the uterus corresponds with that of the pelvis, the sooner are the pains, *cæteris paribus*, capable of dilating the os uteri."

In the paper of Dr. J. W. Smith,* which was read before the Iowa State Medical Society, he says: "Text-books and obstetric authors have little that is satisfactory and definite upon this subject. Such fact proves that position is considered of minor importance, or else it is not well understood. . . . . The phi-

* Medical Examiner, July 1, 1873.

losophy of position is based upon gravity and muscular action, including contraction and relaxation. The key-note or axiom, so to speak, of correct position, is the fact that the fundus of the gravid uterus, in its normal state, is movable to a certain extent in nearly all cases, when not obstructed. . . . . Suppose that we cannot tell the exact presentation, or that we can, and in either case that the presenting part is found to impinge or press most strongly upon or towards the *left* side of the pelvis, and even while the os does sometimes point, so to speak, to the *right* side of the median line of the pelvis. These two things occurring together may be said to be contradictory, and they so appear at first observation. . . . . To decide accurately, before or after the full dilatation of the os, a gentle upward pressure of the finger will be necessary. The finger can be passed from side to side, and thus determine *which side of the pelvis is most filled or pressed upon by the presenting part.* If, as supposed, the presenting portion presses most directly upon or to the left side of the pelvis, ... that is the position, the left side, upon which the patient should be placed. . . . . Her head should be low, the thighs and knees flexed, and the arm that is under placed either wholly back of the body, or, which is often easier, the elbow sharply flexed, and only the hand allowed to rest in front of the chest. . . . . In many cases of tedious labor, after the *proper* position is assumed, a single pain or two will bring the fœtus into the proper axis of the pelvis, and complete the labor. . . . . In cases of pendulous abdomen, uterine inertia, etc., a bandage is a valuable aid. This should be about two yards long and from twelve to eighteen inches wide, and of strong material. This should be passed evenly across the abdominal tumor, the ends carried on each side so that they may be firmly grasped behind by the physician or an assistant, and steady pressure can be made across and around the abdomen at every pain. . . . . Posterior obliquity, as in pendulous abdomen, can sometimes be corrected by dorsal position, elevation of the hips or external pressure by the hands; but experience teaches that the side position and bandage is often most effectual in those cases. . . . . For uterine inertia the kneeling or standing posture is preferable, the patient to be supported under the arms by two assistants during each pain."

Dr. Smith illustrates his views by quoting a number of cases; he sums up by claiming the following as some of the advantages for a proper study of this subject by every accoucheur: "Lessening the sufferings of the mother and the risk to mother and child, shortening the duration of labor, the avoidance often of instrumental delivery, there will be a less number of tedious, powerless, and obstructed labors."

Having thus fully demonstrated the value of position in labor, we shall next consider the removal of the placenta. The delivery of the child having been accomplished, our attention should at once be directed to the early and complete removal of the after-birth, which, of course, comprises both the placenta and the membranes attached. Contrary to the teachings of some, my preceptor, the late Dr. Samuel McClellan, invariably insisted upon the immediate removal of the placenta, thus completing the delivery. Such has been my custom during a large obstetric practice, and never have I had occasion to regret it. The uterus, relieved of its burden, without any obstruction, is enabled at once to commence the process of involution, and, by closing firmly its sinuses, hemorrhage is prevented, and the patient is not allowed to waste any more of that vital fluid for which she will have so much need in the performance of her duty as the fountain of life for her offspring. In addition to this, she is greatly in need of repose, which is prevented by a nameless dread of trouble in the removal of the after-birth.

In the management of this, the third stage of labor, I regard the plan of grasping the fundus and body of the womb through the abdominal parietes as the most sure method of accomplishing our whole object. It is quite common for the attendant to pull upon the cord, often separating it from the placenta, or even causing inversion, more or less complete, of the uterus. With the pressure from above by the hand of an intelligent assistant, or the left hand of the accoucheur, while gentle traction is made, in the majority of instances the placenta will readily be delivered. The plan of Prof. C. D. Meigs of reaching up to the edge of the placenta with one or more fingers, and unbuttoning it, rarely fails of success.

But the best and safest method is that now known as Credé's,

though as early as 1853, Dr. Washington L. Atlee, our present president, practised and taught a precisely similar plan. The placenta having failed to come away, by gentle friction over the uterus, it is found to contract, then the fundus and body are grasped, as above remarked, with one or both hands, and generally the after-birth immediately is expelled like the kernel from the fruit-pulp when squeezed in the finger. An additional advantage of this proceeding is that it incites the womb to a tonic contraction, which is much less liable to relax and permit of a subsequent hemorrhage, and also greatly diminishes the liability to severe after-pains, which are often more dreaded by the patient than the pangs of labor. In removing the placenta, it is always best to withdraw the mass by a circular motion, continued so as to twist the membranes into a rope. This secures a clean delivery in place of leaving hanging, in and from the parts, shreds of partially detached secundines, which will speedily putrefy, and give rise to extremely disagreeable odors if not subsequent dangerous results.

In this connection, judging solely from our own experience, the method indicated by Cazeaux and others for removing the placenta would seem to be fraught with great evil. This plan is to draw upon the cord with one hand, while two or three fingers of the other are passed up along in front of the cord pressing it backwards, thus causing it to play over the fingers as over a pulley. His theory is that the traction is thus continuously made in the line of the pelvic and vaginal curve, whereas simple traction would draw the placenta forwards and against the anterior border of the uterus, thus expending much of the traction uselessly. But, how often do we find that the cord is ready to give way and separate even by slight traction! Now, by this method, we give an additional inducement for the attendant to exert strong traction upon the cord, without his hand above outside, following down as the mass is being drawn from the uterine cavity.

It is a too common belief on the part of the attendants, and I regret to say that among these must be included quite frequently the physician, that after-pains are a necessary accompaniment, and must not be interfered with. As we have just remarked,

where, by the proper manipulation, the uterus has been caused to close itself thoroughly, as a general rule the after-pains do not signify. These indicate either a womb obstructed in its involution by the presence of some foreign body, as a clot, a portion of the placenta or membranes, or, as has been known, by the presence of a tumor. In some cases there would appear to exist an abdominal irritability of the organ, which gives rise to the most excruciating pains.

In either case the proper remedial means should be employed. A careful examination of the womb will reveal and enable us to remove any foreign body; and rest, a most important matter to the patient at this juncture, should be obtained by the use of anodynes. Even in first labors it has ever been our habit to leave a prescription of morphia, with the strict injunction that under no circumstances is the patient to be permitted to suffer. We believe most earnestly that such a course conduces greatly to the rapid and safe convalescence of our patient. In repeated instances we have seen these pains of a distinctly neuralgic character; particularly might we expect this in the case of a patient predisposed to this disease.

Leishman* says: "It must be clearly understood that after-pains, although due, in their usual form, to a physiological action, are, when severe, not to be neglected; for not only the want of sleep and constitutional irritation lead to unpleasant results, but the case, if abandoned to nature, may even pass into inflammatory disease, which, at this particular epoch, is, as we shall see, peculiarly disastrous in its effects."

Prof. Dewees particularly urges the necessity for the relief of after-pains, regarding them as an evil of great magnitude.

Belladonna is frequently applied by French accoucheurs in the form of ointment to relieve the after-pains. Dr. Tyler Smith recommends an anodyne liniment to the breasts. Dr. Fordyce Barker prefers Tully's powder, and when the abdomen is tympanitic, the application of turpentine stupes and the employment of turpentine enema. Almost every accoucheur has his favorite prescription for after-pains. Recently, we have in several cases employed a solution of chloral and morphia, and have been

* Op. cit., p. 582.

much pleased with the results. In purely neuralgic cases, Prof. Barker applies chloroform liniment to the abdomen, and administers quinine in five to ten grain doses night and morning.

In more than one case, abdominal pain has been regarded and treated as after-pain, or even the incipient stage of inflammatory action, when it has been solely due to a retention of urine. It requires much care sometimes to ascertain whether the patient has passed the proper quantity of urine, and we are constantly liable to be deceived, though unintentionally, by those who have the care of her. In all cases, the proper abdominal examination will make the diagnosis. In fact, this is a point to which the accoucheur should scrupulously attend, as instances are on record where the patient experienced but slight inconvenience, though her bladder was enormously distended with urine. Of course, the introduction of the catheter speedily relieves this condition, although its repetition at reasonable intervals may be necessary for several days.

This little operation occasionally proves extremely annoying and even embarrassing to both doctor and patient. We have rarely failed in its performance, since we have put in practice a simple manœuvre. Pass the right forefinger within the vagina at its anterior portion, find the urethral canal, then draw the finger down to the opening, and the point is found at which to insert the catheter, which readily slips into the bladder.

We have thought, in order to avoid the wetting of the bed by a slip of the retaining finger, or the employing and replacing of the small vessel in which the urine is commonly allowed to flow for convenience sake, that a better plan would be to affix to the catheter a section of India-rubber tubing of the same calibre, and of sufficient length to reach down to a proper vessel placed below.

The proper nourishment of the child in its first days of extra-uterine life demands the strictest attention of the accoucheur. As soon as the mother is rested from her fatigue, and comfortably fixed, the child should be put to the breast. Unfortunately, in nine cases out of ten, the nurse or some other officious intermeddler has previously administered sugar, or molasses and

water, catnep tea, or some of the many abominations of the lying-in chamber, and the infant, surfeited or sick, is ill prepared to make the proper effort to grasp the nipple and apply its powers of suction. This is entirely contrary to the teachings of nature, and should be absolutely prohibited.

Rigby* says: "It has been, and even still is, a very general practice not to apply the child to the breast until the second or third day, upon the plea that there is no milk; a more erroneous and mischievous plan of treatment could not be devised, for it is a fruitful source of much injury as well as suffering both to the mother and her child. The child should be put to the breast, 'whether there be signs of milk or not!'"

It is eminently the duty of the physician, before leaving his patient, to caution her and her attendants against any such course, and to explain to them carefully and fully the reason why and the necessity for the early application of the child to its mother's breast. Much of its future indigestion, its colics and diarrhœas, its sleepless nights and whining days depend upon the acts of its care-takers in its early hours of life. Nature intended the mother's breast, and nothing else, for the infant, and when the necessity does arise for any other mode of nourishment, it is ever to be regretted, and will, in the vast majority of cases, result in ill-health and early death.

Another and great advantage obtained by attention to this point, is that we thus insure an early secretion of milk, and a less liability to trouble with the nipples, for at this time, when the breasts are rather flaccid, the nipple is more readily drawn out and prepared for the duties it has to perform, whereas, when from any cause the child is kept from the breast until the third day, the breasts then being greatly distended, the nipple is generally retracted, and more difficulty is experienced in causing the infant to seize it, nor does the lacteal fluid flow so rapidly. Hence, the child, finding its efforts fruitless, becomes petulant and too readily relinquishes its attempts, or, by the vigor of its action, soon produces tenderness and even excoriation of the nipples.

Of course due discrimination must be made, as, where the nipples are already in a tender condition, perhaps it would be well

* On Parturition, p. 166.

to wait until the milk begins to make its appearance, and flows readily.

Prof. Fordyce Barker regards this as an important item in the prevention of milk-fever.

Though, under the judicious advice of our profession, improvement has already been shown, still it is yet too frequently seen that the attendants of the patient, even including her physician, are systematically engaged in starving her, regardless of her already exhausted condition. A distinguished professor of obstetrics once remarked to us: "A woman should not be starved because she has had a baby." We fully agreed with him then, and equally so now that a large experience has shown us the benefits to be derived from the proper nourishment of the lying-in woman, and the injury resulting from an opposite course.

Parturition, other things being equal, is a natural physiological process. Hence there is no good reason why the woman who has just been delivered should be starved, or half dieted, on weak gruel, or weak tea and dry toast, for several days, and then cautiously permitted to return to her usual food. On the contrary, the reverse obtains. She rather requires nourishment: even in a perfectly normal labor, there is more or less exhaustion, loss of blood and nerve power, and generally she craves food, her system demands it, and her digestive organs are fully prepared to accept and assimilate it, in order to make good the loss she may have sustained. For these and other reasons, we believe that she should be supplied with nutritious, easily digested food. Perhaps the earliest obstetrician to take this common-sense view was Denman, who immediately adopted for the woman a diet similar in all respects to that used by her previous to delivery.

Leishman* says: "The old method of treatment by starvation during the first few days, when the diet was confined to tea, water gruel, or arrowroot, finds few, if any, supporters at the present time. Nothing, indeed, could be more irrational than such treatment, or more likely to retard recovery, and discourage the lacteal secretion; so that it will be quite proper, after the first day at least, in the great majority of instances in which the

* Op. cit., p. 578.

patient has had some sleep, to give chicken soup, or beef-tea, in addition to the dry toast, gruel, arrowroot, and sago, which are properly given at this stage, as being substances easy of digestion."

Schrœder* says: "Immediately after delivery there is little or no appetite, and, therefore, broths, soups, an egg, and some bread are sufficient. As a beverage, milk is to be recommended. If the woman, however, should have an appetite, she may have sufficient meat, and on the following days also some vegetables."

Graily Hewitt holds sound views on this subject, as do also many of our learned brothers abroad and at home.

We can give but one more quotation, and that will be from Fordyce Barker:† "The theory that a puerperal woman is in an inflammatory condition, or in a state predisposed to inflammation, has in a great measure governed the profession, and has been inculcated by most obstetric authorities, from Celsus down to the present time. They have consequently taught that a puerperal woman should be restricted to what was termed an antiphlogistic diet. . . . . At the present time, a change of practice, more in accordance with sound physiological reasoning and good sense, is rapidly taking place. . . . . Is not the theory a strange one, that the organs connected with parturition will be more rapidly restored to their condition prior to conception; that the metamorphosis of tissue, called involution, will be more easily and effectively accomplished; and that the new function of lactation will be more surely and perfectly established, by depriving the system of its accustomed alimentation! I cannot doubt that in all ages there must have been some whose practice was governed by a sound, intuitive judgment and good sense, and who have therefore freed themselves from the fetters of professional tradition, and followed a rule similar to that inculcated by Denman.

"I should say, in general terms, give the puerperal woman as good nutritious food as she has an appetite for, and can easily digest and assimilate. You will at first find many nurses who will not accept these views, and they may fail to fully carry out your directions in this particular; but my experience has been

* Op. cit., p. 110.

† Puerperal Diseases, p. 26.

that, after a time, the intelligent ones become enthusiastic converts to this course. The woman, exhausted by labor, first needs rest. This gained, as soon as she shows any desire for food, give that which is the most acceptable to her, and which will best sustain her, a cup of good, clear beef-soup, or of chicken or mutton broth. There are those whose instincts or habits lead them to prefer a cup of tea, or gruel, or panada. Very well, only insist that they take enough. Then, as soon as the appetite will permit, guided only by this and the general condition of the woman, and not by the question of time, whether it be the third or the ninth day, gradually give solid food, as birds, poultry, tenderloin of beef, or a mutton-chop. Of course, I only advise such plain, nutritious, and digestible food as good sense would suggest, but give enough of this kind. By following this course of regimen, I believe you will find that your patients rest and sleep better, and their functions are established with less disturbance, than they would be with a spare or insufficient diet. Since I have adopted this method with my puerperal women, I am very sure that I have much less frequently met with those annoying and troublesome nervous phenomena that so commonly follow parturition, as the nervous system is then apt to be in a condition of exalted susceptibility."

Again, Dr. Barker says: "It is certainly more in accordance with sound physiological principles to feed puerperal women upon easily digestible, nutritive articles, than to administer that which contains but little nourishment, and a larger amount of undigestible residue. We shall see, by and by, that there are many puerperal diseases mainly due to exhaustion and inanition. In short, I will say that I have seen much suffering, and many diseases in puerperal women, where one of the chief elements was defective nutrition; but I have never seen the slightest evil result from good, ample, judicious alimentation."*

The binder requires a passing notice. We have not yet arrived at the point of omitting this adjunct in every case. While many women are just as well without it, and indeed all, when we

* See also a valuable paper. "Milk as a Diet during Lactation," by Dr. R. P. Harris, Philada., Amer. Journ. of Obstet., vol. ii. p. 675.

consider the usual condition in which it is found within a very short time after its first application, like a rope high up just beneath the ribs, acting not only as a great source of discomfort, but even as a means of injury to the patient, still, we believe, in very many cases, it is a valuable support to the relaxed abdominal parietes. It makes the patient feel more comfortable to have some such support, though care should always be taken to see that it is properly adjusted. The patient should always have room to fill her lungs to their utmost capacity; otherwise, she is compelled to remain, as it were, in the condition of one with a broken rib, and to employ the diaphragm to a great extent in respiration, a proceeding which cannot fail to affect injuriously the abdominal viscera, and secondarily, those of the pelvis. Rest, the most absolute and entire rest, should be had for the pelvic viscera, to enable them to recover completely from the fatigue, etc. to which they have just been subjected. Hence, we believe that a bandage pinned evenly, and affording a comfortable support to the abdomen, will always be useful, and never injurious.

From time immemorial, a tradition of the lying-in chamber has been "castor oil on the third day." The first two presents to the young wife, after a certain time, were a cradle and a bottle of castor oil. Our own disgust for this article of the materia medica perhaps early induced us to discard this method of "working a passage," and to substitute for it a laxative of a pleasanter kind. This, in common with so many other matters, has been left to the nurse, and she, regardless of the indications, insists on castor oil on the third day. Unless some special necessity occurs, it has not been our habit to employ anything for the bowels. Frequently, they open naturally, or under the use of appropriate food, much to the gratification of the patient at escaping the nauseous dose; though we have more than once known the dose to be given regardless of this fact, solely because that was the rule.

Dr. Goodell* says: "The canonical purge on the third day should be dispensed with; it weakens the body needlessly, and tends to promote the absorption of septic matter."

* Practical Hints for the Treatment and Prevention of Diseases of Women.

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The citrate of magnesia, or some similar pleasant aperient, or better still, an enema, will do all that may be necessary.

On the subject of castor oil, while from our own experience we cannot endorse his belief, we shall give another quotation from Prof. Barker. He says:* "I rarely select castor oil, because to most women it is an exceedingly nauseous, disagreeable medicine, and where there is any tendency to piles, which is frequently the case after labor, it is one of the worst agents that can be selected. I have frequently observed severe suffering from piles, following the evacuation of the bowels from a dose of castor oil. For these reasons, I have almost wholly given up its use as a laxative after confinement."

In conclusion, gentlemen, we would desire you to understand that the hints which we have thus hastily presented for your consideration are the result of a long-cherished desire to bring before our medical brethren some matters which we feel have been too much neglected. If by this mode of presentation we shall secure for them a more careful attention in the future; if we shall thus be the humble instrument in developing even in a slight degree the study of the art, the great art of obstetrics; if thus we shall aid in saving the life of an infant, or in some degree assuaging the pangs and removing some of the perils attending the parturient woman, we shall feel that we have not labored in vain.

Again thanking you for the many courtesies received at your hands, as well as for the kind consideration you have given me on this occasion, I close my official connection with you, and once more resume my position as a laborer in the ranks.

May the Philadelphia County Medical Society continue with increasing vigor its career of usefulness, ever adding to its numbers, and aiding in every matter which will conduce to the health, the happiness, the prosperity of our city, and our whole country!

* Op. cit., p. 29.