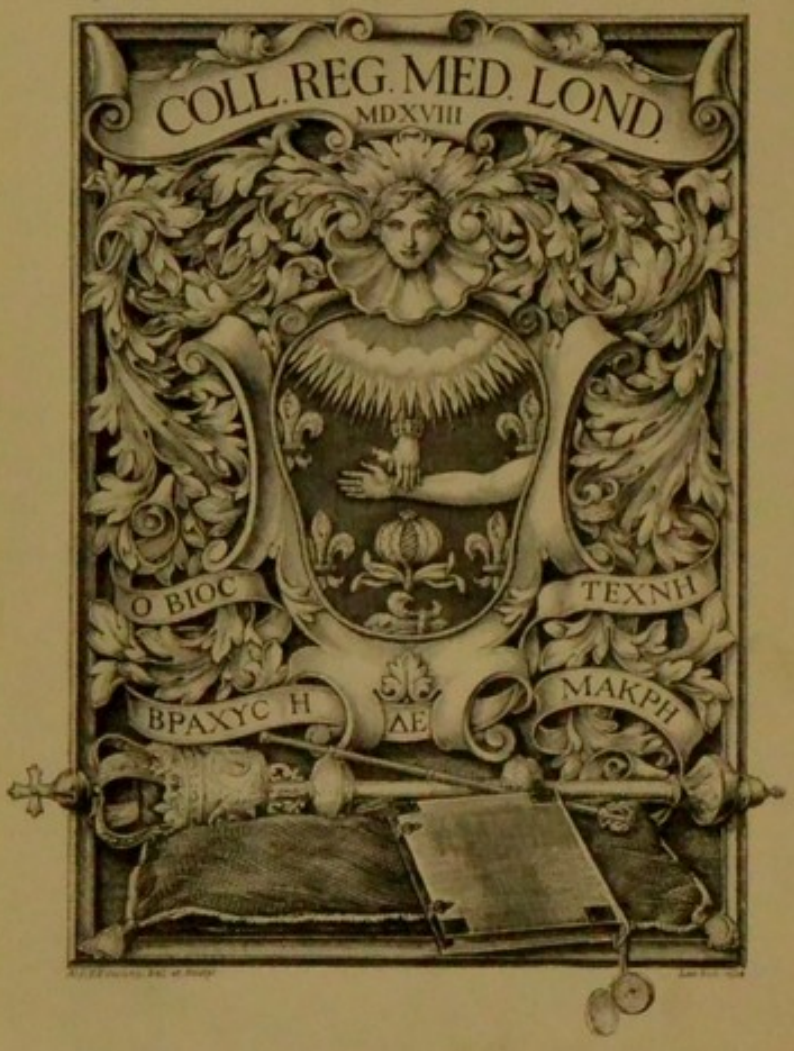
Caesarean section in Great Britain and Ireland : with tables of 1282 cases of caesarean section by over 100 living obstetricians and gynaecologists in Great Britain and Ireland / by Amand Routh.



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CÆSAREAN SECTION

IN

GREAT BRITAIN AND IRELAND

With Tables

Of 1282 Cases of Cæsarean Section by over 100 Living Obstetricians and Gynæcologists in Great Britain and Ireland

BY

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Being a Report

Upon the subject read at the V-me Congrès International d'Obstetrique et de Gynécologie at St. Petersburg in September, 1910.

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On Cæsarean Section in the United Kingdom.*

WITH

Tables of 1282 Cases of Cæsarean Section by over 100 Obstetricians and Gynæcologists of the United Kingdom, who were living on June 1, 1910.

BY

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In this paper I have added somewhat to the Report read at St. Petersburg, for it is evident that some details which would be out of place in an International Report might prove interesting to those more closely concerned.

I would like here cordially to thank my colleagues, over 100 of whom have sent in their cases of Cæsarean section, for their replies to my numerous questions, and for helping me to make a list of 1282 cases, the study of which cannot fail to be useful and interesting.

The subject of Cæsarean Section is a fascinating one. The operation has been known and practised in isolated cases in many parts of the world—civilized and uncivilized—for centuries, but till the last 30 or 40 years had been mainly employed to prevent women from dying undelivered when obstruction was due to extreme pelvic contraction or to the presence of a pelvic tumour. During recent years the comparative safety of the operation has led to wide extension of its indications, which may be enumerated as follows:—

A. *Obstructions to labour.*

1. Pelvic contractions. Induction of Premature Labour. Craniotomy. Symphysiotomy and Pubiotomy. Cæsarean Section. C.S. in Septic cases. Sterilization. Extra-peritoneal Cæsarean Section. Summary.

* Being a Report read at the V-me Congrès International d'Obstetrique et de Gynécologie at St. Petersburg in September, 1910.

2. Fibro-myomata.
3. Cancer of cervix or vagina.
4. Ovarian tumours.
5. Other pelvic tumours (osteomata, enchondromata, cancer of rectum, etc., subperitoneal tumours). Hydatids. Bicornute uterus.
6. Stenosis of cervix or vagina.
7. Miscellaneous. (Previous ventrifixation. Tonic contraction of the uterus. Hour-glass contraction. Prolonged gestation).

B. *Uterine Hæmorrhage.*
1. Concealed accidental Hæmorrhage.
2. Placenta Prævia.

C. *Constitutional Crises.*
1. Eclampsia.
2. Miscellaneous. (Chorea. Advanced Heart Disease. Obesity and anasarca, etc. Myasthenia gravis).

The subject will be dealt with under each of these indications, and will conclude with some remarks upon vaginal Cæsarean Section and some statistics derived from the tables of 1,282 cases of abdominal Cæsarean Section. These cases are appended in chronological tables.

A. I. Contracted Pelvis.

In 1826 Professor Hamilton, of Edinburgh, described four methods of delivery in contracted pelvis:—

1. Induction of Premature labour when seen before full time.
2. "Lessening the size of the child's head" which he called "embryotomy."
3. "Cutting through the parietes into the uterus," which he called "hysterotomy or Cæsarean Section."
4. "Dividing the bones of the pelvis at the Symphysis Pubis," an operation then called the "Sigaultian Operation."

The induction of premature labour was only applicable to cases seen during pregnancy and discovered then to have a moderately contracted pelvis, and before the introduction of antiseptics the induction was not without risk. The mortality of Cæsarean Section in the United Kingdom, then looked upon as a forlorn hope, was 95 per cent., only 1 case, according to Blundell,[2] having survived out of 23 cases up to 1821, and the Sigaultian operation was entirely discountenanced. Practically, therefore, the only real chance of delivery with moderate pelvic contraction was craniotomy, which had a mortality of at least 20 per cent. (Churchill),[3] whilst patients with a conjugata vera of less than $2\frac{1}{2}$ in. (6·2 cm.) had only a 5 per cent. chance of survival.

In the present day for all practical purposes these four operations, improved and extended as regards technique, facilitated by anæsthesia and rendered safer by asepsis, are still the only means at our disposal.

It is necessary to discuss first the three alternative methods for dealing with cases of contracted pelvis:—Induction of Premature Labour, Craniotomy, and Pelviotomy before discussing Cæsarean Section.

Induction of Premature Labour.

This is essentially a British procedure and was established as ethically correct in the treatment of contracted pelvis at a consultation of London Obstetricians in 1756, and the first case came under the care of Dr. Macauley who induced labour by rupturing the membranes, the woman recovering.

It was not till 1809 that it was adopted in Germany by Wenzel, and in 1831 in France by Stoltz.

In 1862 Robert Barnes stated that "English Midwifery, pre-eminently conservative, claims the honour of introducing and establishing an operation which has probably been the means of saving more lives of mothers and children than any other operation we know of." This method of dealing with pregnancy in cases of contracted pelvis is now a favourite one in the United Kingdom when the case is seen early enough, as an alternative to any other method when the conjugata vera is over $3\frac{1}{4}$ inches (8·1 cm.) in a flat, and $3\frac{1}{2}$ (8·7 cm.) in a generally contracted pelvis, or where in previous labours the child or the child's head was found to be relatively too large for the pelvis.

I know of only one British obstetrician (Dr. Hastings Tweedy)[5] who takes the view, held also by Pinard and Whitridge Williams, and others abroad, that induction of premature labour is never advisable. He considers that "Induction of premature labour, prophylactic turning, high forceps and perforation are obsolete procedures."

The advantages of induction of premature labour are its *ease* of performance, its *safety* to the mother, the mortality and morbidity being practically nil; and, if done at or after the 35th week, with the vertex presenting, the small fœtal mortality.

Ease. The simplicity of Krause's[6] method (1855) of inducing labour by the introduction of one or two sterilized No. 12 gum elastic bougies between the membranes makes the proceeding easy.

Safety. (*a*) *The maternal mortality* is less than 1 in 200. *The fœtal mortality* is extremely small after the 35th week, especially if delivery of the child is able to be spontaneously accomplished, the head being encouraged to enter the brim by Walcher's position, and if labour be only induced when the head presents. In this connexion

it may be mentioned that the fœtal head is very compressible at this stage, allowing extensive moulding.

If the head does not present, and cannot be made to engage in the brim by external cephalic version, labour should not be induced, but the case allowed to go to full term with the consent of the patient, and be dealt with by Cæsarean Section.

In transverse or breech presentations, or after podalic version, the immature child will very probably die during or soon after delivery as a result of the manipulations required.

Thus at Queen Charlotte's Hospital between 1890 and 1899, Dr. J. B. Banister[14a] tells me that podalic version was resorted to as a means of delivery or the child presented by the breech after induction of labour in 22 cases of contracted pelvis, and out of these there were 17 fœtal deaths during or within 3 days of delivery, giving a fœtal mortality of 77·2 per cent.

In the next ten years, 1899 to 1909, 27 cases either of breech presentation or of podalic version to effect delivery were met with. In these 27 cases the child perished in 11, thus giving a fœtal mortality of 40·7 per cent. This diminished mortality is due to a narrowing of the indications under which version was attempted, and to the generally later date at which induction was performed in this decade.

This mortality is 15·8 per cent. higher than the mortality under identical circumstances attending delivery per vias naturales with cephalic lies during the same period.

According to Bar[7] the fœtal mortality after induction of labour in pelves with a conjugata vera of $2\frac{3}{4}$ in. to $3\frac{1}{4}$in. (7-8 cm.) is 53 per cent., whilst with a conjugata vera of $3^1/_5$ to $3^3/_5$ in. (8-9 cm.) the mortality is 12 per cent. and 8·6 per cent. where the diameter is over that size. In practice, however, the relation of the size of the head to the size of the pelvis is far more important than the pelvic measurements even when ascertained by such instruments as Skutsch's pelvimeter. As Barbour concisely states "the fœtal head is the best pelvimeter," and probably the best method of arriving at the exact date when labour should be induced is by Müller's[8] (1885) manœuvre associated with the modification suggested by Munro Kerr of applying the thumb of the hand which is examining *per vaginam* to the top of the symphysis pubis to estimate the amount of overlapping of the head. Griffith[10] adopts a somewhat different method. The patient is placed in an armchair in such a position that the uterus is vertical. The difference in weight of the fœtus (a few ounces) and the liquor amnii is sufficient to cause the head to descend into the brim. So long as this happens induction is unnecessary, but when the head can no longer enter the brim induction should be performed.

In multiparæ the history of previous confinements, the weight

of the children and the size and shape and bone development of their heads at birth are further indications of value.

Eden[11] gives the statistics of induction of premature labour at Queen Charlotte's Hospital, and states "that out of 309 cases of pelvic contraction during the four years 1905—1908, 101 had had premature labour induced by Krause's method at a date of gestation which was found by Müller's manœuvre to be indicated. The maternal mortality was *nil*, and the fœtal was 13 per cent. In 84 cases labour had been induced at or after the 36th week. The average weight of the infants was from 5 to 5½ lb."

Treub of Amsterdam[12a] induced labour prematurely in 36 women, 2 of which had a conjugata vera of 8-8·5 cm., 13 between 8·5 and 9 cm., 14 between 9 and 9·5 cm., and 7 between 9·5 and 10 cm. The previous experience of these 36 women was 49 dead children, and 38 living (43·6 per cent.). As a result of the induction of labour these same women had 14 dead children and 49 living (77·7 per cent), the children only being considered living if they left the hospital with their mothers.

At a recent discussion Spencer[12] states that "he has induced labour in 33 cases of contracted pelvis in the last 5 years at University College Hospital with 4 fœtal deaths (12 per cent.). He has induced labour in a woman six times, and she has, as a result, five healthy living children. In a patient who recently left the hospital the first pregnancy was terminated by craniotomy; the other three labours had been induced. In the last of these he discovered twins, and therefore postponed induction to the 37th week. This patient had as a consequence of these three inductions four living children. Next week he would induce labour in a lady with a 3½ inch conjugate, who had two of the healthiest children he ever saw, both induced at the 35th week." He (Spencer) rightly regarded individual cases of this kind as of more importance in deciding the real value of induction of premature labour than any amount of statistics in which this important information was not forthcoming.

Where the C.V. is *over* 3·5 inches (8·7 cm.) in flat pelves or 3·8 inches (9·5 cm.) in generally-contracted pelves spontaneous or forceps delivery may be reasonably expected at full term if time be given for moulding of the fœtal head and the head be of normal size.

It is also equally desirable that spontaneous delivery should be encouraged to take place after induction of premature labour. Thus Banister[14a] states that at Charing Cross Hospital and at Queen Charlotte's, 1906 to 1909, the fœtal mortality up to the end of the first month, in 99 cases of spontaneous delivery after induction of labour in pelves of 3¼ inches and over, was 5, *i.e.*, 5·05 per cent., as compared with a mortality of 10 in 28 similar cases, 35·7 per cent.,

where forceps (21 cases) or version (7 cases) had to be subsequently adopted.

Prof. von Herff[11a] of Basle, in a communication to the Meeting of the British Medical Association held in London in 1910, spoke strongly in favour of the induction of premature labour by all accoucheurs who estimated the life of the mother higher than that of the child, and states that at his own Clinic spontaneous delivery occurred in 86·5 per cent. of his cases of contracted pelvis after induction of labour.

To sum up it may therefore be stated that if the conjugata vera be less than $3\frac{1}{4}$ inches (8·1 cm.) the patient should be allowed to go to full term and have Cæsarean Section performed. If the C.V. be over $3\frac{1}{4}$ inches (8·1 cm.) and the head present labour may be induced at the 35th week; if the C.V. be $3\frac{1}{2}$ inches (8·7 cm.), at the 36th week. Delivery after induction should be encouraged to take place spontaneously whenever possible.

Craniotomy.

Craniotomy has never been a favourite operation in the United Kingdom, but owing to the terrible mortality of Cæsarean Section up to 30 years ago (89 per cent. in 1866 and 84 per cent. up to 1876) and to the absolute disapproval of Sigault's original symphysiotomy (1777 to 1858) there was no other method of dealing with contracted pelves when the patients were seen for the first time during labour, and as a matter of fact Churchill,[3] who wrote in 1842, said that craniotomy "was the only safe operation in cases of moderately contracted pelves and had been performed:—

In the United Kingdom 218 times in 47,851 cases (1 in 219).
In France 30 times in 36,169 cases (1 in 1,205).
In Germany 132 times in 256,655 cases (1 in 1,944).

Taking all these cases together the maternal mortality was 20 per cent. whilst the mortality of Cæsarean Section in the three countries was at least 60 per cent. and in the United Kingdom over 80 per cent."

Obstetricians, however, viewed the destruction of the child with keen dislike, and in 1859 the first paper read at the newly-formed Obstetrical Society of London was by Dr. Tyler Smith[13] (Physician-Accoucheur at St. Mary's Hospital, London) on "Abolition of Craniotomy in all cases where the fœtus is living and viable." Tyler-Smith stated that "the maternal mortality of the operation was still about 20 per cent." It was realised, however, then and now, that it may be necessary in the interests of the mother to destroy the child especially in cases known or thought to be septic in order to save the mother, in preference to performing pelviotomy or Cæsarean section. In such cases, as Galabin said in 1902, "the

perforation of a living child may conduce to the interest even of fœtal life, if it saves the mother to bear more children."

Treub[12a] of Amsterdam, after stating that in certain septic cases craniotomy is inevitable, deals with the argument advanced by Pinard against craniotomy "that the rôle of the physician is not to kill." Treub says "that a single case where after a craniotomy, a woman has survived to have living children by some other method, is sufficient to prove the impossibility of sustaining such a view." He adds that he knows of many such instances.

The mortality of craniotomy is very high, even in the present day with all the advantages of anæsthesia and asepsis, as the following statistics, collected by Munro Kerr[41] and Blacker,[15] show:—

	Mortality.
Munro Kerr's (1901—1906) (63 cases) - -	12·6 per cent.
Galabin's (1891–1901 (Guy's Hospital) (33 cases)	9·0 „
Rotunda Hospital (1896—1900) (6 cases) -	16·6 „
Pinard (1892—1899) - - - - -	11·5 „
Gusserow (1902) (47 cases) - - - -	6·3 „
Chrobak's Clinic in Vienna - - - -	7·7 „
Zweifel's Clinic in Leipzig - - - -	7·0 „

The morbidity also (20–30 per cent.) is very large as compared with that of Cæsarean section, though considerably less than after pelviotomy (40–60 per cent.).

Such mortality and morbidity is largely due to the fact that in most cases fruitless attempts had been made to deliver by forceps or version and the parts were already bruised and often also infected.

The size of the pelvis which admits of a child being delivered after cephalotripsy or cranioclasm is differently given by different obstetricians, but it may be roughly stated that it should not be attempted if the conjugata vera is less than 2½ inches (6·2 cm.) in an equally contracted pelvis or less than 2 inches by 4 inches (5 by 10 cm.) (Herman[21] and Eden[22]) in a flat pelvis.

With a conjugata vera of 2½ inches (6·2 cm.) craniotomy has a maternal mortality of over 10 per cent. and a morbidity of 20 per cent. and is a difficult and tedious operation.

In the absence of previous attempts at delivery and in skilled hands where the conjugata vera is above 2½ inches (6.2 cm.) the mortality of craniotomy may be far less than this, thus Donald gives 18 consecutive cases, Lewers 6, Spencer 11, John Phillips 16, all without a death, whilst Leopold gives 71 cases with only 2 deaths, both from eclampsia.

Still the average mortality of craniotomy in general practice is about 8 per cent., distinctly less than that of Cæsarean section for contracted pelvis done under similar circumstances, *i.e.*, where other

attempts at delivery had been made. (See under Cæsarean Section and Table IV., p. 48.) As craniotomy, however, necessarily involves fœtal death, it is to be hoped that the time is not far distant when (as Matthews Duncan[16] said in 1889) the increasing safety of Cæsarean section and its substitutes will lead to its abolition when the child is alive.

In general practice where facilities for Cæsarean section or pelviotomy may not exist, it will still be advisable in a few rare cases to do craniotomy in the interests of the mother when the child is alive and the conjugata vera over 2½ inches.

By the courtesy of Sir Arthur Downes, of the Local Government Board, I have been able to ascertain the statistics of the last three years (1907-8-9) in the Poor Law Maternity Wards of the Metropolitan District (Workhouses and Infirmaries), where the very worst and poorest cases are admitted. Out of 8,991 total deliveries, 395 cases required surgical assistance. Of these, 59 were cases of contracted pelves, in 18 of which (1 in 500 of total deliveries) craniotomy had to be performed, with 2 maternal deaths (11 per cent.). Five of the children were alive at the time of the operation, one of the mothers refusing to have Cæsarean section performed.

In obstetric clinics or at special hospitals in the hands of experts, craniotomy is now very rarely performed when the child is known to be alive, and it is only indicated if the child is thought to be deformed (hydrocephalus, etc.) or moribund, or where the patient is presumed to be infected, or where the risk to the mother of craniotomy is distinctly less than by any other method of delivery.

Thus at Queen Charlotte's Hospital, London, in 1909, out of 1,734 cases attended, including 67 cases of contracted pelvis, craniotomy was not once performed upon a living child, but was done 9 times upon dead children (1 in 193 cases), viz., once upon a hydrocephalic child, 4 times in contracted pelvis, and 4 times as a convenience with macerated infants. There was no maternal mortality.

The object of performing craniotomy in septic cases is that it enables the uterus to be emptied of its contents with antiseptic precautions, and at the same time the uterine wound of a Cæsarean section is obviated and a septic peritonitis is thereby prevented.

In performing craniotomy it is almost inevitable that abrasion will be produced in the cervix or vagina. In infected cases the risk is obvious, and it is probable that local tissue infection and perhaps a general infection may be prevented by some such method as Maxwell's intra-amniotic irrigation (see p. 19), before the operation, followed by a further intra-amniotic irrigation after the child is extracted, and by an intra-uterine irrigation of iodine and water at the end of the third stage.

In all cases where craniotomy is contemplated, and the child

alive, the wishes of the parents should be consulted, as it may happen not infrequently that a child is so much desired that some form of pelviotomy or Cæsarean section would be preferred to craniotomy even if the maternal risk were thereby increased.

Pelviotomy.

Pelviotomy (symphysiotomy and pubiotomy) are operations recommended for obstructed labour in contracted pelves with a C.V. between $2\frac{3}{4}$ inches and $3\frac{1}{2}$ inches (6·9 cm. and 8·7 cm.).

Pelviotomy has had a curious history. The first recorded operation was a symphysiotomy performed by Jean Claude de la Courvée in 1655 on a patient dying during labour.

Symphysiotomy was, however, definitely introduced by the French obstetricians in 1777 after a successful operation by Sigault, and up to 1830, according to Baudelocque, there had been 41 operations with 14 maternal and 28 fœtal deaths—a maternal mortality considerably less than that of Cæsarean section at that date. In Italy and Germany also the operation was cordially received. In Great Britain symphysiotomy was at first considered to be a possible substitute for craniotomy in cases of moderate pelvic contraction not seen early enough for the induction of labour, but it soon fell into disrepute, and Churchill,[17] writing in 1842, speaks strongly against it and remarks that it was performed in the year 1782 "for the *first and last time* in this country by Mr. Welchman, of Kingston, Warwickshire."

Symphysiotomy was still entirely unpractised in Great Britain in 1865 according to Hall Davis[18] and Murphy.[19] In 1866 it was revived by Morisani and Novi in Naples, and since 1885, owing mainly to the introduction of antiseptics, far better results have been obtained, both as regards maternal and fœtal mortality and maternal morbidity.

These operators also combined symphysiotomy with induction of premature labour, thus being able to induce labour at a later date than would be otherwise required.

Since 1892 symphysiotomy has been widely practised over Europe and America, but has made smaller progress in Great Britain than elsewhere.

Recent statistics are those collected by Munro Kerr,[20] who in 1908 collected from all countries 275 cases of *symphysiotomy* with a maternal mortality of 6·5 per cent. and a fœtal of 10 per cent. Others give the fœtal mortality as 6·6 per cent.

Pinard states that in symphysiotomy the pubic bones can be safely separated 6 cm. (2·4 inches), much more than was at first thought desirable. This maximum separation means an antero-posterior gain of 15 mm. ($^3/_8$ inch) and the total gain by the projection of the head through the gap is 22 mm. or $\frac{7}{8}$ inch (Blacker[23]).

The gain transversely is clearly greater still, so that the operation is more useful in generally contracted, or in generally contracted flat pelves than in flat pelves.

Subcutaneous symphysiotomy was successfully practised by Herman[24] in 1899 in 8 cases. He prefers to divide the symphysis with a tenotomy knife from below upwards. Ayres[31] cuts from above downwards. No sutures are required. These subcutaneous operations are considered to be more adapted to "suspect cases," cases probably infected.

Pubiotomy was performed in Italy for the first time by Professor Catolica and M. Galbiati in 1819, though pubiotomy or rather ischio-pubiotomy had been suggested in 1784 by Aitken,[25] of Edinburgh. It was not, however, fully described till 1844 when Stoltz again performed it.

Pubiotomy, as performed by Döderlein, has lately been preferred to symphysiotomy, as being easier and safer. Walcher's modification of dividing the bone at the level of the outer limit of the labium majus, or Pinard's (*Annales de Gynéc.*, 1892) ischio-pubiotomy seem good substitutes, as by their incisions the connective tissue is less extensively exposed. The open method has been largely superseded by the subcutaneous one as advised by Bumm, a Gigli's saw being used to divide the bone.

The mortality of subcutaneous pubiotomy in 217 cases was, according to Döderlein, 4·1 per cent., whilst it was 10·1 per cent. in 77 cases done by the open method, or 5·9 per cent. in the 294 cases combined.

Leopold[27] (60 cases), Bumm[28] (53) and Bürgers (30) show a mortality of only one case and a fœtal mortality of 6·6 per cent. Such results have not been equalled by others.

There have been recently two valuable discussions in London on pelviotomy in contracted pelves, following papers by Dr. Hastings Tweedy[5] of Dublin, and Dr. Blacker[29] of London.

During the discussion stress was laid upon the need for full dilatation of the soft parts before any form of pelviotomy was adopted, and because of the difficulty in insuring this some of those who have performed the operation, such as Munro Kerr, only recognise its justifiability in multiparæ. It was recognized by practically all speakers that there is no place for any form of pelviotomy for cases where the conjugata vera is under 3 inches, when Cæsarean section or craniotomy would be performed. Nor for cases where the conjugata vera is over 3·5 inches in flat pelves and 3·8 inches in generally contracted pelves when spontaneous delivery may confidently be expected at or near full term, except when the head is abnormally large. According to Blacker, Kronig has found that with a conjugata vera of 3·4 to 3·8 inches (8·5—9·5 cm.) 86·5 per cent. of the labours were terminated spontaneously, or 94 per cent. with the

assistance of forceps, and Schauta has proved that such spontaneous deliveries have a maternal mortality of 0·09 per cent. and a fœtal mortality of 4·1 per cent. Munro Kerr quotes Boenninghausen as giving the fœtal mortality for spontaneous delivery in generally contracted pelves as 2·2 per cent. and for flat rachitic pelves as 2·7 per cent., while in artificially terminated labours in similar pelves the mortality was 41 per cent. and 47 per cent. respectively. Such results as these cannot be improved upon by any form of operative interference.

English statistics point in the same direction, thus Eden[11] states that at Queen Charlotte's Hospital in the years 1905-8, out of 309 cases of contracted pelvis 42 went to full term and were delivered spontaneously with a fœtal mortality of 4·7 per cent., and 74 cases in which the conjugata vera was 3½ inches or more were delivered by forceps with a mortality of 18·7 per cent.

The discussions mainly turned on cases with pelves having a conjugate of 3-3·6 inches (7·5—8·5 cm.) which, in the absence of pelviotomy or spontaneous delivery, would largely be treated by induction of premature labour if seen early enough in pregnancy, or by craniotomy or Cæsarean section if actually in labour. No speaker was in favour of substituting pelviotomy for these cases as a routine practice.

It has already been shown that the maternal mortality of induction of premature labour is less than 1 per cent., whilst that of pelviotomy may be taken as between 4 per cent. and 6 per cent. according to various statistics; while the infantile mortality of the former is from 8—12 per cent. in suitable cases as against 6 to 10 per cent. in pelviotomy. The chief objection to either symphysiotomy or pubiotomy is not so much the maternal mortality but the high degree of morbidity which follows the operations, especially where infection has already occurred.

Herbert Spencer[32] gives the following data of morbidity:—"In the 510 cases of pubiotomy collected by Schläfli hæmatoma was observed in 17 per cent.; severe tears in 15·4 per cent. (of these 12·6 per cent. died), injuries to the bladder in 12 per cent., thrombophlebitis in 8 per cent. Of 120 cases investigated later, hernia through the gap of the bone was found in 7·5 per cent., prolapse of the vagina in 24 per cent., chronic incontinence of urine in 4 per cent. Of the mothers 4·9 per cent. and of the children 9·6 per cent. died. In 117 cases of induction of premature labour von Herff had had one maternal death and 80 per cent. of the children left the clinic alive. The results of 53 cases of pubiotomy in Bumm's clinic given by Krämer showed that in over 3 per cent. the bleeding was profuse, and in five cases hæmatoma, œdema and thrombi occurred. In 12 spontaneous deliveries there were three unimportant injuries to the soft parts, and the bladder was injured three times by the

needle and healed spontaneously, while in the remaining 41 women delivered artificially there were seven injuries of the bladder or urethra, and in 19 cases the soft parts were extensively torn; only one mother died, but 54 per cent. had fever in the puerperium, and 13·4 per cent. of the children died."

It must be remembered that in Döderlein's open pubiotomy a compound fracture is practically produced, and if sepsis be present the risk is necessarily great. Much the same risk applies to symphysiotomy by the open method.

Even subcutaneous symphysiotomy, as practised in 1899 by Herman, and subcutaneous pubiotomy as introduced by Bumm in Germany and recommended in this country by Hastings Tweedy, are not perfectly safe if the patient be already infected.

In a paper read at the British Medical Association Meeting in London this year, Professor von Herff,[11a] of Basle, said that the mortality of the mother was increased by symphysiotomy by 8 per cent., by subcutaneous hebosteotomy and subcutaneous symphysiotomy by 4 per cent., and the maternal morbidity was disproportionately great—whilst 8 or 9 per cent. of the children died. He considered pelviotomy should only be employed as a last resource.

In the United Kingdom neither symphysiotomy nor pubiotomy have been much practised. Cases have been done by Buist, Donald, FitzGibbon, Griffith, Herman, Johnstone, Munro Kerr, Lewers, Russell, Hastings Tweedy, Wallace, Walls, and others. Even by most of these, however, pelviotomy would rarely be advised if the women were seen early enough during pregnancy for premature labour to be induced, unless previous inductions had resulted in stillborn deliveries and Cæsarean section was for some reason inadvisable. Very few of these obstetricians would operate if the case was probably infected.

A few (Hastings Tweedy) consider 2¾ inches the smallest conjugata vera for any pelviotomy. Most prefer not to operate under 3 inches. Munro Kerr, who has done 18 cases, considers 3¼ inches (8·1 cm.) the lowest pelvic deformity, and he would never operate on a primipara.

Many operators,* however, would give pelviotomy a possible place, as an alternative mainly to craniotomy, in some such cases as the following, viz., where labour is advanced, the child alive, the head impacted in the pelvis, and unable to be delivered by forceps, where very little more room is apparently needed, and where the case is probably aseptic, and in a suitable environment (hospital).

* Russell Andrews, Barbour, Halliday Croom, Eden, Haig Fergusson, FitzGibbon, Gibson, Griffith, Hewetson, Jardine, Jellett, Johnstone, Munro Kerr, Kynoch, Lea, McCann, Playfair, Purefoy, Russell, Darwall Smith, Stevens, Swayne, F. E. Taylor, Hastings Tweedy and H. Williamson, Spencer and Blacker would only do pubiotomy, if the patient refused Cæsarean section, supposing those two were the alternatives.

If the case were probably infected the choice would lie between Cæsarean hysterectomy and craniotomy, putting aside for the moment extra-peritoneal Cæsarean section. Craniotomy would give the patient the chance of a child at a subsequent pregnancy and would by most operators be preferred to Cæsarean hysterectomy which would sterilize her. Here, however, the patient and her husband would be consulted and their decision accepted. (See p. 18 Cæsarean section in septic cases.)

The majority of operators in the United Kingdom* consider that induction of premature labour, Cæsarean section with or without hysterectomy, and craniotomy cover all cases of pregnancy in contracted pelvis, and their main reason against pelviotomy is the very large morbidity which at present follows the operation.

The choice between Pubiotomy and Symphysiotomy.

Pubiotomy is preferred by Barbour, Blacker, Haig Fergusson, FitzGibbon, Gibson, Hewetson, F. E. Holland, Johnstone, Munro Kerr, McCann, Playfair, Purefoy, and Wilson. Blacker gives the following reason for the preference:—It does not open a joint; there appears to be less risk of immediate and remote complications, and both the maternal and the fœtal mortality are less than after symphysiotomy. Hastings Tweedy who has performed two symphysiotomies and five pubiotomies according to Döderlein's method, prefers subcutaneous pubiotomy as advocated by Bumm, which he has performed once, but urges specially that the vagina should be thoroughly dilated by wool pledgets to facilitate subsequent delivery.

Buist, Eden, Griffith and Malins prefer symphysiotomy to pubiotomy owing to its simplicity, whilst Russell Andrews and Lea prefer the subcutaneous form of that operation.

If the morbidity following pelviotomy could be materially lessened, the time may come when obstetricians in the United Kingdom will adopt the operation when the head is impacted in the pelvis and very little more room is apparently required to deliver it, and will further in many instances advise women with contracted pelves with a conjugata vera of 3 inches to 3¼ inches (7·5—8 cm.) to go to full term instead of having premature labour induced before the 35th week. If the child be alive it will then be a question whether some form of Cæsarean section will be adopted, or some form of pelviotomy. Probably if the woman is a primipara and has never been delivered of a child, dead or alive, she will be treated by

* Blair Bell, Stanmore Bishop, Cameron, Champneys, Croft, Dakin, Donald, William Duncan, Fairbairn, Favell, Haig Fergusson, Fothergill, Gow, Grimsdale, Haultain, Hellier, Herman, Handfield-Jones, Lewers, Lockyer, Lyle, Maclean, Mansell Moullin, Newnham, Pearson, John Phillips, Phillips (Sheffield), Purslow, Rayner, Robinson, Routh, Scharlieb, Spencer, Stabb, Stookes, Tate, Bellingham-Smith, Walls and Willett of Liverpool.

Cæsarean section, but if she has previously had her soft parts dilated and labour is advanced, pelviotomy may be selected. With, however, a morbidity of 40 per cent. British operators are at present, speaking generally, averse to the operation.

The question of subsequent pregnancies in connection with pelviotomy is also important. Cæsarean section can be repeated with small risk to the mother, or if need be the patient can at the same time be sterilized. There is not yet sufficient evidence as to the course of repeated labours after pelviotomy. If the pelvis were found to be permanently enlarged by the first operation and the woman's chances improved in subsequent labours, it would be a strong point in favour of the operation, but apparently any permanent enlargement of the pelvis means some dyskinesia, some lessening in the activity and mobility of the patient.

Meanwhile Zweifel and Pinard both consider that symphysiotomy does actually lead to a permanent enlargement of the pelvis, and Thies says that spontaneous delivery occurs more frequently by 50 per cent. after symphysiotomy than before it. Can the same be said after pubiotomy? *

G. Schickele[33] of Strasburg with a view to permanent enlargement of the pelvis has described a mode of pubiotomy by sawing through the bone so as to form a series of steps. Complete bony union does not take place, connective tissue filling in the gaps.

Further evidence on these points is awaited with interest.

Cæsarean Section.

In France the operation was much in favour duringthe first half of the 19th century, and according to Dufeillay it was sometimes done as a pre-arranged selection in cases of contracted pelves without other efforts at delivery having been made. Such cases must however have been few for Godson[41a] and Budin[33a] have stated that there had been no successful case in Paris between 1787 and 1879, when Tarnier performed his first "Porro."

In Great Britain at all events the results were very bad owing to the operation being only adopted as a last resort.

The teaching of Mauriceau[34] of Paris, whose work on the "Diseases of Women with Child" was translated into English by Hugh Chamberlen in 1752, had greatly influenced British Obstetricians. Mauriceau considered Cæsarean section "a damnable policy martyring and killing the mother to save the child and advised that it should never be done till the mother was dead," and although he was no doubt largely influenced by Roman Catholic doctrine he

* Cova of Rome, at the recent International Congress of Obstetrics at St. Petersburg, stated that he had observed subsequent labours after hebosteotomy in 13 cases, in 7 of which he found that the pelvis had remained dilated.

advised that a living child should be destroyed by embryotomy "rather than resolve upon that cruelty and barbariousness of the Cæsarean section in which it is absolutely impossible that a woman should ever escape."

This teaching seems to have held sway in Great Britain for the next 70 years, only very few cases of Cæsarean section being performed. Blundell[2] gives a list of 23 cases,* the only cases that had been performed up to 1821, but always with fatal results except one by Barlow[35] published in 1793.

Cæsarean section was in fact looked upon as so certainly fatal that it was only done as a forlorn hope after every other means had been adopted to deliver the child, to prevent the woman dying undelivered.

In 1866 Playfair[36] stated at the Obstetrical Society of London that the mortality was 89 per cent. Up to 1882 Greenhalgh of St. Bartholomew's Hospital had had 10 cases with 9 deaths. Spencer Wells's[91] mortality after ovariotomy was 28 per cent in 1866, and only 11 per cent in 1882.

The use of chloroform anæsthesia by Simpson of Edinburgh in 1847, the introduction into Great Britain of Semmelweiss's views of the septic origin of puerperal fever by C. H. F. Routh[39] in 1848, Pasteur's discoveries of the causes of putrescence, fermentation and sepsis, the improved details in technique suggested by Spencer Wells[40] in 1864 (uterine sutures), by Porro (1876), Sanger[51] (1882), Leopold[52] and others, and the introduction of antiseptics (1867—1893) through the genius of Lord Lister have made the operation of Cæsarean section relatively safe.

In 1876, Porro introduced the alternative operation of supra-vaginal hysterectomy, and for a time it seemed as if that operation would take the place of the conservative Cæsarean section.

In January 1884, Dr. Clement Godson's[41a] paper in the *British Medical Journal* drew attention to Porro's operation, giving a case of his own (Case 4), the first successful one in Great Britain, together with a list of 137 similar operations by others, with a total maternal mortality of 55·8 per cent., and for a time this operation was regularly adopted in England. Thus in the table of cases collected in this paper, it will be seen that between 1882 and 1888 inclusive 7 out of the 9 cases there recorded were dealt with by supra-vaginal hysterectomy with extra-peritoneal treatment of the stump.

In February 1889 Dr. (now Sir Francis) Champneys[41b] of London,

* The operation had also been performed successfully by an illiterate woman, named Mary Dunally, in Tyrone, Ireland, in 1737. She operated with a razor, extracted the infant and held the wound while a messenger was despatched a mile away for some silk and tailors' needles. She smeared the wound with the whites of eggs.

drew attention to the value of Sanger's improved technique of the conservative Cæsarean section (1882), and described a successful case of his own performed in March 1888 (Case 9), emphasizing particularly Sanger's musculo-muscular and sero-serous sutures. This paper was definitely epoch-marking, and stemmed the tide which had set in in favour of Porro's sterilizing and more radical operation. Thus in the collected cases during the following 3 years the "Porro" operation was done 9 times (with 1 death), and Cæsarean section 18 times (with 4 deaths). Dr. Champneys showed that the increasing success of Cæsarean section had put an end to its limitations to cases of absolute contraction where a child could not be delivered *per vias naturales*, and that its limits should now extend upwards into the class of relative contraction, and he considered that if it could be shown in a given case that Cæsarean section was not more dangerous to the mother than craniotomy the former should be the operation performed.

In the following month, April 1888, Dr. Murdoch Cameron of Glasgow had another successful case of Sanger's Conservative Cæsarean section (Case 10), and in March 1891 he was able to publish a list of ten consecutive cases, nine of which recovered, stamping himself as the pioneer with Sir Francis Champneys of the modern operation in the United Kingdom.

The advantages of conservative Cæsarean section over the more radical operation became so well established, that in a few years the latter operation was rarely performed. Thus in 1902 out of 45 operations for contracted pelvis in the Tables 43 were treated by Cæsarean section alone: the other two being dealt with by supravaginal hysterectomy, with intra-peritoneal treatment of the stump. The operation of sub-total hysterectomy with extra-peritoneal treatment of the stump (Porro) had practically ceased to be an alternative to conservative Cæsarean section by 1899 or 1900.

The mortality of Cæsarean section has steadily diminished; thus it was 38 per cent. in Glasgow in 1891—1896, 20 per cent. in 1902, about 12 per cent. in 1904, and it may now be said that Cæsarean section in the United Kingdom has become an operation with hardly any morbidity, and with a mortality when performed for contracted pelvis under "favourable" circumstances of 2·9 per cent. (see Table IV. and other statistics at end of paper), which certainly does not exceed that of other gynæcological cœliotomies.

In this connection it may be noticed that in 1906, 90 cases of Cæsarean section for contracted pelvis are recorded in the tables, with 2 deaths, or 2·2 per cent., and in 1908, 154 cases with 7 deaths, a mortality of 4·5 per cent.

I have endeavoured to ascertain the saving of life in cases of contracted pelvis which has resulted from the present extended performance of Cæsarean section for relative indications, as com-

pared with the results following the performance of Cæsarean section when done almost solely for absolute indications, *i.e.*, where the conjugata vera is under $2\frac{1}{4}$ inches (5·6 cm.).

For this purpose Dr. J. B. Banister has worked out for me the statistics at Queen Charlotte's Hospital during the two decades 1890—1899 and 1900—1909. Roughly speaking these decades at that hospital represent the periods before Cæsarean section was generally practised, and the period when it was adopted according to modern indications.

In the first decade (1890—99) 10,529 women were attended in labour. Of these 135 had contracted pelves with a conjugata vera of $3\frac{1}{2}$ inches or under. Delivery was effected by Cæsarean section in 7 cases with one maternal and one fœtal death; by symphysiotomy in 2 cases, both children dying; by craniotomy in 28 cases, with 2 maternal deaths. The total fœtal mortality of this decade in these 135 cases was 58·5 per cent. The total maternal mortality was 2·96 per cent.

In the second decade (1900—1909) 15,222 cases were attended in their confinements. Of these, 259 were cases of contracted pelvis. Delivery was effected by Cæsarean section in 74 cases with 3 maternal and 8 fœtal deaths; by 1 symphysiotomy, both mother and child living; by craniotomy in 13 cases in only three of which the child was alive, with a maternal mortality of one. The total fœtal mortality of this decade in the 259 cases of contracted pelvis was 22·4 per cent. The total maternal mortality was 2·31 per cent.

It will thus be seen that whilst there was only a saving of the lives of mothers in 0·65 per cent., the saving of fœtal life was 36 per cent., a practical result of enormous value and significance.

Amongst the cases of contracted pelvis collected for the purpose of this paper from living obstetricians, the first recorded case of Cæsarean section was performed by Lloyd Roberts in 1867 (Case 1), the first successful ones by Champneys and Murdoch Cameron in 1888 (Cases 9 and 10). The first supra-vaginal hysterectomy with intra-peritoneal treatment of the stump was by A. R. Simpson in 1881 (Case 3), the uterine stump being ligatured in three divisions and dropped into the abdomen without covering it with peritoneum. The first successful supra-vaginal hysterectomy with external treatment of the stump was by Clement Godson in 1882 (Case 4). The first successful supra-vaginal hysterectomy with intra-peritoneal treatment of the stump was by Sinclair in 1892 (Case 50)—the stump being covered by peritoneum. The first Cæsarean-pan-hysterectomy for contracted pelvis was performed successfully by Donald in 1897 (Case 129).

Indications for Cæsarean Section in cases of Pelvic Contraction.

Conjugata vera up to $2\frac{1}{2}$ inches (6·2 cm.). The patient at full term or in labour. It is an absolute indication to perform Cæsarean

section if a woman cannot be delivered *per vias naturales* of a child living or dead. An alternative operation, extra-peritoneal Cæsarean section, introduced in Germany in 1907 is discussed elsewhere.

Conjugata vera 2½ *inches*—3 *inches.*

It is agreed that there is a strong relative indication that Cæsarean section should be performed if the child be living when the conjugata vera is between 2½ inches and 3 inches; but if infection is feared, other steps should be taken (see p. 20).

Conjugata vera 3 *inches*—3½ *inches.*

The main discussion will turn upon the relative values of Cæsarean section and pelviotomy with a conjugata vera between 3 inches and 3½ inches. If the child be dead, craniotomy should certainly be done. If the child be living, and the case aseptic, conservative Cæsarean section should be performed.

If the child be living and the head has partly entered the brim and there appears to be very little more room needed for delivery to take place, and yet forceps have failed, it becomes as already stated the ideal place for some form of pelviotomy, if it should ever become free from its present post-operative morbidity.

When the conjugata vera is more than 3½ inches delivery is usually effected by the natural efforts or by axis-traction forceps or version, but here again further assistance by Cæsarean section or pelviotomy may be required if the head be found to be relatively too large.

CÆSAREAN SECTION IN "SEPTIC CASES."

If as a matter of routine women were examined during the course of their pregnancies, their contracted pelves would be discovered and appropriate treatment would be recommended at suitable dates, and "suspect" and "infected" cases would not arise.

If, however, a woman is in labour and has been examined, or attempts have been made to deliver her before admission she may be infected.

It must, however, be remembered that the infection is very recent, and that the uterus is largely protected by the membranes from direct contact with the infecting organisms. Only the cervix and vagina are exposed, and if they are not injured or abraded the risk of general infection at the time when the patient is usually seen is small.

It is this which makes craniotomy safer than Cæsarean section, for immediately after extraction of the child the amniotic cavity can be freely irrigated, and at the end of the third stage the uterus can also be irrigated, with 3 or 4 pints of iodised water. Whereas

if Cæsarean section is performed, the uterine incised wound is exposed to the infecting germs, which would probably prevent primary union and if so would cause a fatal peritonitis. This is probably true even if they were only putrefactive organisms and not virulent pathogenic germs.

The mortality of Cæsarean section is largely in these septic cases.

In the mortality statistics of the cases collected in this paper (see Table IV, p. 48), it is seen that in cases of Cæsarean section where *attempts had been made to deliver by forceps, etc., or where repeated examination had been made* the mortality was 22 out of 64 cases = 34·3 per cent., and in 166 cases where it is stated that the patient was *in labour and the membranes were ruptured but no attempts had been made to deliver*, the mortality was 18 = 10·8 per cent. On the other hand in 224 cases where the patient was *in labour with membranes unruptured* the mortality was only 5 = 2·2 per cent., and in 245 cases "*not in labour*" the mortality was 9 or 3·6 per cent.

From these data it seems clear that if frequent examination and attempts at delivery have been made the case is almost certainly septic and should be treated at such. It is probable also that infection may be present if the membranes have been ruptured for some time and examinations made before admission, but the experience and reliability of those who have previously dealt with the case must be taken into consideration.

If cases "not in labour" are combined with cases at the "beginning of labour with the membranes intact," and with cases "kept in hospital some days before operation," in all 469 cases, the mortality is only 2·9 per cent. (see Table IV, p. 48), whereas in the 230 cases where the membranes were ruptured, or where frequent examinations or attempts at delivery had been made, the mortality was 17·3 per cent.

The difficulty is to be sure that the patient is infected and nothing but a reliable bacteriological investigation of the liquor amnii remaining in the uterus can make this point clear. Such symptoms as feverishness, offensive discharge, or tender uterus would clearly indicate infection.

In the presence of such symptoms and in the absence of a reliable bacteriological report these cases will be "suspect" and most will be rightly treated as definitely "infected."

In doubtful cases of infection where the membranes are ruptured R. D. Maxwell of the London Hospital has recommended and adopted in one case (No. 1275) an excellent prophlactic measure of irrigating the uterine (amniotic) cavity per vaginam before performing Cæsarean section. A soft pewter or other pliable tube is passed up to the fundus uteri, and the amniotic cavity, and incidentally the fœtus, is freely irrigated with normal saline

solution at 100° F. Possibly a saturated boric acid solution would be more useful if micro-organisms were present. The method is of course available in all degrees of pelvic contraction.

It is possible that this method might have been useful in cases 341, 811, 946, 1045, and many others. Such cases as 946, 1090, 1121 show however that cases which appear most unfavourable may recover without such aid.

Whether it is possible to so thoroughly irrigate the amniotic cavity that all putrefactive organisms can be washed away or rendered harmless is only a question which can be settled by experience.

If most of the liquor amnii had drained away, and especially if the uterine muscle were contracted down on the child, such irrigation could only be very partial. The difficulty too of dislodging germs from fœtal apertures and irregularities, or those luxuriating in a vernix caseosa is evident. Still it is an additional method at our disposal and may prove of great value. In any case the irrigation must "lessen the dose," for it dilutes the poison present.

If Maxwell's method, or some modification of it, should prove serviceable it would largely prevent craniotomy with living children, in cases where there was no virulent infection present. Such rapidly multiplying and invading pathogenic germs as streptococci, etc., could hardly be successfully dealt with even in a case very recently infected, by any irrigating fluid which was not so powerfully antiseptic as to cause serious injury to the fœtus.

The line of treatment in "suspect cases" then seems to be somewhat as follows:

All forms of symphysiotomy, hebeosteotomy, and extra-peritoneal Cæsarean section are at present not considered suitable for these septic cases, owing to the very large post-operative morbidity which would then attend them.

In all cases the uterus should be eventrated before incision and the abdominal cavity carefully guarded.

In contracted pelves with C.V. under $2\frac{1}{2}''$ (6·2 *cm.*) hysterectomy should follow the Cæsarean section in cases where Maxwell's irrigation is not thought a possible means of enabling a conservative Cæsarean section to be done.

With a C.V. of over $2\frac{1}{2}''$ *with a dead child* craniotomy (with such precautions as stated on p. 8) is indicated, although if virulent infection is present hysterectomy would probably be the better treatment.

With a C.V. of over $2\frac{1}{2}''$ (6·2 *cm.*) *the child being alive.* Here the alternatives are clearly craniotomy and Cæsarean hysterectomy.

If the parturient canal be probably infected when the patient is first seen, and the fœtal heart indicates weakness, or the child is hydrocephalic or probably injured, the majority of British

obstetricians would prefer to do craniotomy with previous and subsequent intra-uterine irrigation, in the interests of the mother, believing that it would give her a better chance than Cæsarean hysterectomy which is necessarily also a sterilizing operation.

If the patient were feverish and ill and the uterus tender, indicating that the infection had probably spread into the uterine tissue or even into the patient's blood, and especially if pathogenic germs were found in the uterus or vagina by bacteriological examination hysterectomy should be performed to prevent further infection.

If hysterectomy were done most operators would prefer supra-vaginal amputation of the uterus with intra-peritoneal treatment of the stump.

In the 230 cases of C.S. for contracted pelvis here collected where the membranes had been ruptured before admission, or where frequent examinations or attempts at delivery had been made, Cæsarean section was performed in 216 cases with 40 deaths, a mortality of 27·7%, whereas in the other 14 cases which were further treated by supra-vaginal hysterectomy with intra-peritoneal treatment of the stump, there was no mortality, all the women recovering. (See note †, Table IV., p. 48).

Some would possibly prefer the original (1876) Porro-hysterectomy with extra-peritoneal treatment of the stump.[1] There is no doubt that this method more effectively shuts off the peritoneal cavity from the infected cervix and vagina than where intra-peritoneal treatment of the stump or panhysterectomy is adopted. Thus it seems particularly indicated in such cases as acute gonorrhœa (Case 441 and possibly 496). An increasing number will prefer to perform panhysterectomy—the theoretically ideal operation—with the idea that the cervix being septic might prove to be a source of infection. (See Tables IV. and V., pp. 48 and 49 and their footnotes.)

Addendum. November, 1910.

As a result of suggestions made by foreign speakers at the Congress, I am not without hope that a rapid bacteriological examination of films prepared from the liquor amnii or from the cervix or upper vagina in "suspect cases" when the membranes are ruptured will enable the treatment of these cases to be put on a more scientific basis. It is evident that if frequent examinations have been made

1. In connection with the question of sub-total hysterectomy for septic cases it is interesting to note that in Blundell's (2) Lectures given at Guy's Hospital in 1830–31, he suggested that such an operation might save many lives. He performed the operation four times on rabbits, firmly suturing the uterine stump to the anterior abdominal wall, bringing the ligatures through the abdominal wound. A ligature slipped in one case, but the other three rabbits recovered. He adds: "Perhaps this method of operating may hereafter prove an eminent and valuable improvement."

or forceps used, and the upper vagina is found infected, the amniotic cavity will also be infected.

It is not necessary, therefore, in such cases to obtain intra-uterine swabbings.

Mr. A. N. Leathem, bacteriologist at Charing Cross Hospital, has very kindly replied to my enquiry as to whether it is possible to make a satisfactory and *reliable* bacteriological examination of such swabbings by means of stained films, and to give a reliable report within an hour as to the presence or absence of pathogenic or saprophytic organisms. His reply is "that films could be made and stained from uterine swabbings and, if the organisms were present in considerable numbers, a reliable report as to the presence of streptococci, staphylococci, or pneumococci could be given *within half an hour*. If bacilli were present it would be more difficult to decide as to the presence of B. coli, although in some cases it would probably be possible to say that the bacilli present in the films were all saprophytic."

I hope at a later date to ascertain whether reports from the examination of films prepared rapidly can be relied upon, by having cultures made from the same swabbings and seeing whether the culture results coincide with the reported results of the film tests.

If reliable bacteriological data can be thus forthcoming within an hour of the patient's admission, and the presence or absence of infection certified, and the variety of the germs present identified, it seems to me that the exact form of the operation required would be indicated with much greater scientific accuracy than is now possible. Thus classical Cæsarean section would be performed with perfect security if the fluid were sterile; Cæsarean section, preceded by some variety or some evolution of Maxwell's intra-uterine irrigation and by eventration of the uterus, might be considered safe if only putrefactive germs were found; and a radical hysterectomy would probably be considered desirable if pathogenic micro-organisms were discovered.

It is possible that some such scientific basis may do away with the need for craniotomy with living children in well-organised obstetrics clinics, but craniotomy with irrigation safeguards would still be required in general practice where prompt bacteriological investigation and special technical experience might not be forthcoming.

THE OPERATION OF CÆSAREAN SECTION AS PERFORMED IN THE UNITED KINGDOM.

The most suitable date for performing C.S. appears to be at the onset of labour (see Table IV., p. 48), if the patient is already in hospital, and next to that before labour has commenced.

The technique of the operation is not different from that used abroad. As the operation has often to be done promptly the skin should be prepared, at all events in emergency operations, by the iodine method, 2% solution. The uterus is not turned out of the abdomen before being incised except in cases where the membranes are ruptured and there is a possibility of the remaining liquor amnii being infected.

The incision is made longitudinally in the midline anteriorly, or posteriorly if there be a fibroid in the anterior wall, avoiding the lower uterine segment. Fritsch's transverse[42] fundal incision has been given a fair trial, Munro Kerr[43] having used it 9 times, but he "did not find it any great advantage" and has now discontinued it. A sagittal fundal incision as proposed by Müller, Caruso, and Morisani is not liked. Munro Kerr draws attention to one objection to a fundal incision, viz., that the placenta is more often cut into. He gives 40% in his own case, 35% in Schroeder's, 41% in Hubl's, and 54% in Braum von Fernwald's.

The elastic ligature is not used. The child is extracted by first lifting out the head to prevent it being gripped by the contracting uterus. Some prefer to extract the child by the feet. After extraction of the child and placenta and membranes the patency of the cervix is ascertained and hot sterile water may be poured into the uterus. The uterus is then grasped bilaterally by the two hands of the assistant, and the cut surfaces everted till they are flat. The deep and superficial sutures[1] can then be inserted by curved, or, as I prefer, by long straight needles. The deep interrupted sutures should be sero-muscular and must take up the the whole of the muscle tissue; the superficial suture (of fine silk or catgut) may be continuous and should be serous only, and should take up sufficient peritoneum to completely cover in the knots of the deep sutures.

Of the 81 operators in the United Kingdom who have sent particulars, 41[2] use silk for the deep sutures, 27[3] catgut, 8[4] silk-worm gut, and 4[5] linen thread.

1. No uterine sutures were used in Great Britain up to 1865, at all events during the previous few decades, but in 1863 Spencer Wells[44] advised their use, and he first sutured the uterus in 1865, the patient surviving. He used a continuous silk suture, one end of which he passed into the vagina to be withdrawn thence some days afterwards. At that date sutures were strongly opposed by Greenhalgh, Robert Barnes[45] and many others.

In 1870 Braxton Hicks[45] and Robert Barnes[46] used silver wire, passing through both uterus and abdominal wall. In 1876 carbolized catgut was used for the uterine wound by Galabin, Meadows and C. H. F. Routh,[47] and fishing gut by Galabin,[48] but all these patients died.

In 1879 Braxton Hicks[49] first used interrupted silk sutures, and this is now mainly used for the deep sutures.

2. Barbour, Berkeley, Bishop, Blacker, Bonney, Braithwaite, Cameron, Champneys, Croft, Dodd, Duncan, Edge, Fairbairn, FitzGibbon, Fothergill, Giles, Grimsdale, Haultain, Handfield-Jones, Jellett, Kynoch, Lea, Malins, Newnham, Phillips (London), Playfair, Purefoy, Purslow, Rayner, Routh, Savage, Mrs. Scharlieb, Sinclair, Spencer, Stark, Stevens, Tate, Taylor, Tweedy, and Mrs. Willey.

3. Russell Andrews, Buist, Donald, Favell, Haig Ferguson, Gemmell, Hellier, Hewetson, Jardine, Johnstone, Munro Kerr, Lackie, Lyle, Martin (Sheffield), Mansell Moullin, Pearson, Russell, Heywood Smith, B. Smith, Stookes, Swayne, Targett, Wallace, Wilson, Willett (Liverpool).

4. Gow, Holland, Lewers, Lockyer, McCann, Robinson, D. Smith, Stabb, and Williamson.

5. Barber, Dakin, Griffith, and Phillips (Sheffield).

STERILIZATION.

Historical.

The first mention of Sterilization[53] in cases of contracted pelvis that I can find is Blundell's advice (given in 1819 when Cæsarean section had a mortality of 95%) that every woman upon whom Cæsarean section was performed should have a portion of each Fallopian tube removed. He further made the suggestion in 1830 that all women known to have contracted pelves should be sterilized before marriage in a similar way.

Under what circumstances is an operator now justified in sterilizing a patient whilst performing Cæsarean section for contracted pelvis?

The Ethics of the question.

I know of no subject connected with the Ethics of Surgery upon which opinion more varies than the question of Sterilization in Cæsarean section.

I exclude from consideration hysterectomy performed for fibromyomata, carcinoma, infection, or uncontrollable hæmorrhage, and also oöphorectomy in cases of osteomalacia, inasmuch as the object of the operations is in such cases entirely outside the question of Sterilization. Most obstetricians consider that the patient (and her husband) should be consulted and be given the opportunity, after hearing the risks of another pregnancy, of deciding whether she should be sterilized or not. In some cases the patient would leave it to the operator to decide at the operation according as to whether the child seemed likely to survive or was stillborn or maldeveloped. The question must be fairly represented to the patient and the risks of rupture of the uterus in a future pregnancy told her. That rupture through or adjacent to the scar is a real, though relatively a small risk is clear from 120 cases of such rupture collected by Olhausen[54], and others by Brodhead,[56] Munro Kerr,[55] and Wallace,[57] and quite recently by Singer[57a]. On the

other hand the operator would explain that the chief argument in favour of sterilization has been largely removed owing to the reduced maternal mortality in the operation, and that the risk of a second Cæsarean section is probably less than that of the primary one.

Thus in 150 cases of repeated Cæsarean section collected by Polak[58] of Brooklyn, N.Y. (see also Wallace[57]) the mortality was less than 5 per cent., and in the Table of 1,282 cases in the United Kingdom here given, there were 108 cases with 7 deaths, a mortality of 6·4 per cent. (see footnote *a*), a smaller death rate than the average mortality 8·1 per cent of all cases of Cæsarean section in contracted pelvis, done during the last 10 years, and about the same as the 6·1 per cent. mortality of the last 5 years (Table III, p. 47). Only 4 of the children died before leaving the hospital. Ten women had Cæsarean section performed three times (*b*), and one (*c*) four times by Professor Sinclair, all these 11 women surviving.

The following British obstetricians, whether for or against sterilization, hold that the decision as to whether a woman should or should not be sterilized, must ultimately and ethically rest with the patient and her husband after having had the subject put fairly before them:—Barber, Barbour, Berkeley, Stanmore Bishop, Bonney, Cameron, Halliday Croom, Champneys, Edge, Favell, FitzGibbon, Haig Ferguson, Gibson, Giles, Gow, Haultain, Hellier, Herman, E. Holland, Jardine, Jellett, Johnstone, Munro Kerr, Lewers, Lockyer, Maclean, Newnham, John Phillips, Playfair, Purslow, Rayner, Routh, Savage, Mrs. Scharlieb, Darwall Smith, Heywood Smith, Stabb, Stevens, Stookes, F. E. Taylor, Wallace, Walls, Herbert Williamson, Wilson.

Others, like Spencer[59] and Lyle, consider that the patient need not be consulted and that the operator alone should decide, that his surgery should be strictly conservative and that sterilization should only be done when it is involved in the performance of hysterectomy or oöphorectomy for other conditions.

Grimsdale sees no reason to sterilize after Cæsarean section any more than after natural labour, and Gemmell, Hewetson, Lea and Willett (Liverpool) think sterilization is unjustifiable.

At the opposite extreme Buist, Tennison Collins, Duncan, Newn-

(*a*) Up to the end of 1909 there had been 88 cases of repeated Cæsarean section, with 4 deaths, a mortality of 4·5 per cent. Unfortunately three deaths occurred in the first 6 months of 1910 out of 20 cases. The causes of death in these 7 cases were tuberculosis, peritonitis (2), acute intestinal obstruction, shock, pyelo-nephritis and bowel injury.

(*b*) Briggs, Grimsdale, Haultain, Hewetson, Sinclair, Spencer, Wallace (3), Walls.

(*c*) Sir W. Sinclair's 4 Cæsarean sections on the same woman were performed on April 10, 1896, August 22, 1901, June 23, 1903, and August 1, 1907. I am informed that she is again pregnant.

ham, Rayner, Nigel Stark and Swayne consider that it is not justifiable to allow a patient to be subjected to the risk of another pregnancy, and that she should always be sterilized, unless forbidden by the patient or her husband.

Desirability.

As regards the *desirability* apart from the ethics of sterilization, I have endeavoured to place in three groups the views of those who have expressed decided opinions on the subject.

1. Those operators who consider that a patient should be sterilized to avoid the risk of another pregnancy and another Cæsarean section:—Malcolm Black, Buist, Murdoch Cameron, Tennison Collins, Duncan, Lackie, Mansell Moullin, Martin (Sheffield), Newnham, Rayner, Nigel Stark, and Swayne.

This view was very largely held by many obstetricians, including Champneys, Cullingworth and myself, but the diminishing risk of Cæsarean section and the still smaller risk of repeated operation made these and many others change their views.

2. Those who would more or less strongly advise against sterilization, in most cases however, being willing to sterilize if the patient insisted upon it after hearing the pros and cons :—Russell Andrews, Barbour, Beckett-Overy, Berkeley, Stanmore Bishop, Blacker, Blair-Bell, Bonney, Champneys, Croft, Donald, Fairbairn, Favell, Haig Fergusson, Gemmell, Gibson, Gow, Griffith, Grimsdale, Handfield-Jones, Hewetson, Holland, Jardine, Johnstone, Munro Kerr, Lockyer, Lyle, Maclean, Malins, Pearson, Playfair, Purefoy, Lloyd Roberts, Routh, Russell, Savage, Sinclair, Bellingham Smith, Darwall Smith, Spencer, Stabb, Stevens, Stookes, Targett, Tate, Hastings Tweedy, Wallace, Walls, Willett (Liverpool), Williamson, Wilson and others.

3. Amongst these some would sterilize under certain conditions in cases of contracted pelvis:—

(*a*) Russell Andrews, Barbour, Berkeley, Gow, E. Holland, Russell, Bellingham-Smith, Darwall-Smith, Targett, Tate would be willing to sterilize at the second Cæsarean section, if the child of the first pregnancy were alive and well.

(*b*) Blacker, Bonney, FitzGibbon, Gibson, Grimsdale, Munro Kerr, Phillips of Sheffield, Stookes, Wallace and Herbert Williamson would prefer not to sterilize till the third Cæsarean section and only then if both the previous children survived.

(*c*) Targett would sterilize if the pelvic contraction were associated with severe spinal curvature or ankylosis from old hip disease.

Hastings Tweedy considers sterilization "unnecessary and undesirable," unless the patient has organic disease superadded to pelvic contraction.

Beckett-Overy, Maclean and Mrs. Willey consider that the type

and character of the parents, such as imbecility, might be considered by the operator.

(*d*) Jellett, McCann and Heywood-Smith would prefer to sterilize if the pelvic contraction were so extreme that premature labour could not be induced at a subsequent pregnancy.

The consensus of opinion seems to be that the operator has no right to sterilize a woman without her consent and approval, and on the other hand he should consent to sterilize her if after the situation is fully explained to her, she and her husband demand it. In other words, as Champneys says, "the patient has the ultimate right to choose."

The method of sterilization most in favour is removal of the Fallopian Tubes in whole or part.

1. The tubes may be either simply *ligatured and divided*, a proceeding which Cameron, Munro Kerr, Kynoch and Stookes consider sufficient, but which Horrocks, Griffith (Case 150) and others have shown has not always prevented fertilization.

2.* Or a loop may be picked up and ligatured and the loop cut away as Gow recommends.

3.* The whole of both Fallopian Tubes may be removed.

4.*Removal or division of tubes, sewing peritoneum over the stumps by burying them in the Broad Ligaments.

5.*Excision of the uterine end of the Fallopian Tubes by an elliptical incision into the uterine cornu and closing the incised muscle by catgut sutures.

6. Crushing the tubes, with or without ligature (Edge).

7.* Hysterectomy.

8. Removal of the ovaries.

Extra-Peritoneal or Supra-symphysary Cæsarean Section.

Historical. Parvin[68] states that extra-peritoneal section of the uterus, now re-introduced, was proposed by Jorg in 1806 and by Ritgen in 1821. In 1823 Baudelocque described the operation as gastro-elytrotomy and Gaillard Thomas (1870) and Skene (1874) and

2.* Barber, Barbour, Braithwaite, Buist, Favell, Ferguson, Gow, Grimsdale, Haultain, Hellier, Jardine, Lackie, Lea, Lewers, Maclean, Martin, (Sheffield), Newnham, Phillips (London), Purslow, Rayner, Scharlieb, Stabb, Stark, Taylor, Tweedy, Walls, Williamson.

3.* Berkeley, Bonney, Collins, Croom, Dodd, Eden, Gibson, Griffith, Herman, Pearson, Scharlieb, Bellingham Smith, Heywood Smith (cautery to uterine end), Stevens, Stookes.

4.* Andrews, Bell, Blacker, Briggs, Champneys, Croft, Fitzgibbon, Handfield-Jones, Johnstone, Lockyer, Malins, Phillips (Sheffield), Darwall Smith, Swayne, Targett, Tate, Wallace, Wilson.

5.* Fairbairn, Holland, Jellett, McCann, Playfair, Robinson, Routh, Russell.

7.* Dakin, Duncan, Giles, Mansell Moullin (if over 40), Mrs. Willey.

8.* Stanmore Bishop (and tubes), Hewetson.

others in U.S.A. performed it on ten occasions as a substitute for Cæsarean section. Whiteside Hime of Sheffield and Edis of London were the first to perform it in England in 1880.

More recently a large number of operators abroad have been anxious to find some operation which would do away with the necessity for perforating a living child, and be applicable for those marked cases of pelvic contraction unsuitable to pelviotomy or craniotomy, especially in cases supposed to be septic and therefore unsuited to classical Cæsarean section.

It was felt by many that pubiotomy or symphysiotomy, however, suitable for moderate degrees of pelvic contraction when the patient was aseptic, became dangerous to life, or accompanied by enormous morbidity during convalescence if the patient were septic. In addition there are numerous cases with a smaller conjugata vera than $2\frac{3}{4}$ inches (7 cm.) where pubiotomy is impracticable at term. To avoid therefore the alternatives of craniotomy or Cæsarean hysterectomy they have endeavoured to extract the child without the peritoneal cavity being involved in the operation. It was realized that eventration of the uterus before incision was not sufficient to prevent septic peritonitis in cases where apparently only saprophytic germs were present, and quite useless when virulent streptococci were the cause of the infection.

Some operators endeavour to strip off the peritoneum from the lower uterine segment without opening the peritoneum—true extra-peritoneal Cæsarean section. Others realizing that that is frequently impossible, or if practicable, causes much injury to the peritoneum, prefer to open the peritoneal cavity, and then incise the visceral peritoneum where it is loosely applied—usually at the point of over-lapping of bladder and uterus—strip off some of the peritoneum and stitch it temporarily to the parietal peritoneum at the margins of the abdominal wound. This is usually called the trans-peritoneal Cæsarean section.

Any such operation would in infected cases compete mainly with Cæsarean hysterectomy.

Frank[60] of Cologne in 1907, was the first in recent years to advise that for possibly septic cases the uterus should be opened whilst the peritoneal cavity was shut off. The pelvis being raised he made a transverse supra-pubic incision through all the tissues down to the peritoneum. The recti muscles are then widely separated and the retro-pubic cellular tissue opened up. The peritoneum is then stripped from below upwards off the superior surface of the bladder and the anterior wall of the uterus. The child is then extracted through a transverse uterine incision by traction, forceps or version. In septic cases abdominal drainage is employed. Baumm[61] of Breslau, Sellheim[62] and others have modified Frank's technique into a transperitoneal operation. After a modified Pfannenstiel supra-

pubic incision through skin and fat, the fascia and muscles and peritoneum are divided longitudinally along the linea alba. The peritoneum at the point where it passes from the bladder on to the anterior wall of the uterus is then divided transversely, stripped off and turned up, and the flap temporarily united by interrupted sutures to the parietal peritoneum at the upper end of the abdominal incision. If necessary the bladder with its covering of peritoneum can also be stripped off and turned down. The child is then extracted extra-peritoneally through a longitudinal or transverse uterine incision.

Probably the Latzko-Döderlein operation is now the favourite extra-peritoneal Cæsarean section abroad, and this is described by Döderlein as follows:—

"A Pfannenstiel transverse incision is first made followed by separation of the recti with very slight notching of the right rectus at its point of insertion and partial detachment of its base. The bladder is so far filled that its contours are plainly visible, in the way that Sellheim and others have also done, and then the hand is squeezed between the anterior and lateral pelvic wall to the right, so that the loose cellular tissue here is divided, in the same way that the finger divides it in subcutaneous "hebosteotomy" only more extensively. In doing this there is scarcely any loss of blood so that it is not necessary to do anything to arrest hæmorrhage. By means of this single manipulation such a large piece of the genital tube is exposed that it can be laid open at once. If necessary the right side of the moderately filled bladder is pushed flatly over towards the middle line, and there is then always space to make a large enough longitudinal incision into the lower uterine segment for the extraction of the child. The head which projects at the pelvic inlet pouches the lower uterine segment and the wall of the uterus so far forward that it greatly facilitates the incision. Very great care is necessary in order not to injure the child. An incision is then made at the top of the part that pouches forwards, and is then lengthened by a series of quite short, careful snips with the scissors downwards, taking care not to interfere with the ureter or the large lateral vessels which flow to the uterus. After the child is delivered it will be seen that the incision has been made with its lower end at the boundary of the outer os uteri and at the beginning of the vagina.

Suturing the incised wound is very simple, as the whole of the operation area is well in view in the Trendelenberg position. The uterine wall is stitched with a continuous catgut thread, and covered with the loose connective tissue of the bladder and with the bladder itself by another continuous thread, and the abdominal wall is then closed completely without drainage."

If infection be suspected, he advises that the cellular tissue

should be drained into the vagina and not through the abdominal wound.

Post-operative complications are, as one would expect, numerous in these extra-peritoneal cases. Jeannin[65] states they occur in 30 per cent. of cases, sepsis being the cause in 25 per cent. The remaining 5 per cent. of morbidity being due to lacerations, fistulæ, hæmaturia, etc. The mortality is from 3 to 5 per cent. In 65 extra-peritoneal operations there were 2 deaths; in 77 trans-peritoneal there were 3 deaths; deaths were mainly due to peritonitis in spite of the fact that the general peritoneal cavity is presumed to be shut off from the operation area.

One or other of these varieties of extra-peritoneal Cæsarean section is considered by their advocates to be indicated in doubtfully septic cases, especially where the conjugata vera is less than $2\frac{3}{4}$ inches (6·9 cm.), where the case is advanced in labour, the membranes ruptured, the uterus retracted and Bandl's ring present, with a marked expansion of the lower uterine segment. Such probably septic cases are clearly unsuitable for classical Cæsarean section, and most British obstetricians would in such cases do craniotomy or Cæsarean hysterectomy. Hastings Tweedy[5] considers that the possibility of sepsis should not prevent these operations, but in order to lessen the exposure of cellular tissues has proposed a slight modification in technique.

Sellheim,[66] believing that all the above cervical Cæsarean sections are dangerous in infected cases, has more recently advocated the formation of a utero-abdominal fistula in cases of undoubted infection. He does this by opening the abdomen by a longitudinal incision in the linea alba, stitching the parietal peritoneum to the skin, and he also stitches the parietal peritoneum to the uterine peritoneum which is incised longitudinally, and stripped off the line of the intended uterine incision. The bladder is then turned down and the child extracted through a longitudinal uterine incision. The edges of the uterine wound are then stitched to the edges of the abdominal wound, leaving the utero-abdominal fistula open. The fistula, as a rule, rapidly closes or can be made to close by a plastic operation. Veit[67] adopts the technique of the operation so far as shutting off the peritoneal cavity but does not consider the formation of the fistula essential. He either unites the detached peritoneum of the lower segment to the parietal peritoneum by clamps, or stitches the parietal peritoneum on to the uterus temporarily.

It is possible that such an operation may help to save lives in septic cases, and in a recent case of my own (1045) I have no doubt that a utero-abdominal fistula, which accidentally formed, was an important factor in saving the patient's life, primary union of the uterine wound having failed to occur.

Whether extra-peritoneal Cæsarean section will ever take the place of classical Cæsarean section in non-infected cases or whether Sellheim's utero-abdominal fistula operation will be substituted for Cæsarean hysterectomy in infected cases time will show.

As regards infected cases, however, the opinion is steadily gaining ground on the continent that extra- or trans-peritoneal Cæsarean section is a dangerous proceeding. It is obvious that it must be so and the caution of the British obstetrician in refusing to adopt the present indications for the operation and its technique as at present performed is abundantly justified. The disadvantages in infected cases are numerous:—

1. The uterus with its large placental site and decidual surface and its incised wall is retained as a channel for infection;

2. The peritoneum is bruised, and when stripped off from its subserous attachments loses to a very large extent its blood supply, and becomes less resistant to septic processes.

3. The under-surface of the peritoneum thus partially deprived of its blood supply, is during the operation constantly in contact with any septic germs present in utero and this probably explains the fact that many of these cases die of peritonitis;

4. A very large cellular area of connective tissue is exposed to infection;

5. The bladder if detached may become displaced, and if cellulitis occur is apt to be secondarily inflamed and to become adherent in an unsatisfactory position.

Meanwhile it seems clear from the mother's point of view, that in infected cases with a C.V. of under 2½ inches (5 cm.) hysterectomy should be performed, and that if the C.V. be over that size the operation chosen should be either hysterectomy or craniotomy according to other circumstances in the case.

Seven cases of extra-peritoneal Cæsarean section are given in the tables, 2 performed by Russell (Cases 1222, 1240), one by Savage (969). 1 by Sinclair(1041), and 3 by Hastings Tweedy (1129, 1150, (1168). Six of the mothers recovered. One had a troublesome vesico-abdominal fistula and another a temporary cystitis. Six of the children survived. Three of the cases were "suspect cases."

SUMMARY OF CONCLUSIONS.

As a concise *summary*, therefore, in cases of *contracted pelvis* the following would be the usual line of treatment in the United Kingdom:—

1. *If the patient be seen early enough during pregnancy.*

Induction of premature labour at or after the 35th week if the child be living and the head be found to be presenting and not to

be relatively too large. If the pelvis be too small for induction at the 35th week, or if the head be not presenting and external cephalic version prove unsuccessful, await full term with the patient's consent and perform a conservative Cæsarean section.

2. *If the patient be only seen at full term or in labour.*

(*a*) *Where no attempts have been made to deliver.* Conservative Cæsarean section if the child be alive, with the possible alternative of pubiotomy or symphysiotomy if the head were impacted and apparently only a little more room were needed. At present this alternative course is adopted by very few owing to the large post-operative morbidity.

(*b*) *Where attempts have been made to deliver or where the membranes are ruptured, frequent examinations have been made, and infection is presumed to be present.* Here the favourite treatment in the hands of experts would be Cæsarean hysterectomy, if the conjugata vera is under 2½ inches (6·2 cm.) and the child alive, in preference to any variety of extra-peritoneal Cæsarean section. If the conjugata vera is over 2½ inches (6·2 cm.), the choice would be between Cæsarean hysterectomy and craniotomy. Most obstetricians would prefer craniotomy in "suspect cases" of apparently mild infection, and some variety of hysterectomy if virulent infection were thought to be present. The ultimate decision would sometimes have to be left to the parents who may prefer the extra risk of Cæsarean hysterectomy in the immediate hope of having a living child. In general practice or in the hands of all but gynæcological experts craniotomy would be the definite choice.

Pubiotomy or symphysiotomy, even by the subcutaneous methods, are considered by most operators to be unsuitable in general practice and in cases supposed to be septic, and the same opinion is largely held as regards all varieties of extra-peritoneal Cæsarean section, even as regards Sellheim's utero-abdominal fistula operation, in all of which the uterus is retained as a channel for a general infection, in addition to the tissues opened up by the operations.

A 2.

Indications for Cæsarean Section in cases of Fibroids complicating Pregnancy and Labour.

It is recognized that the large majority of patients whose pregnancies are complicated by fibro-myomata go to full term and are delivered spontaneously without serious difficulty. Even if the fibroid be primarily pelvic, it is almost always drawn up out of the pelvis before or during labour, and if only partially occupying the pelvis, Cullingworth[69] has shewn that it undergoes softening and flattening, "*assouplissement*" as Depaul has called it, and thus gives rise to no real difficulty. Every such patient seen during pregnancy

should, therefore, be encouraged to go to full term, unless pressure symptoms become severe and intractable or unless evidences of degeneration of the fibroid are present. In such cases induction of abortion is now entirely discountenanced, and if an abdominal operation is required, myomectomy should in suitable cases be adopted instead of hysterectomy, so as to give the patient a good chance of going to full term. Labour appears to be induced in 40 per cent. of cases after myomectomy for embedded fibroids, but in only 6 per cent. where the fibroid is pedunculated.

When fibroids are found actually obstructing labour, owing to the fibroid being cervical, or intra-ligamentous, or adherent to the floor of the pelvis or definitely impacted, Cæsarean section will be required, followed by myomectomy if this is practicable, or some variety of hysterectomy. As these proceedings are usually easy of performance at full term, they should be done at once to save a second operation if the operator's skill be adequate, the patients's condition satisfactory and the environment suitable.*

Myomectomy was first performed during pregnancy in the United Kingdom by Knowsley Thornton[70] of London, in 1879, and Campbell, of Belfast (Case 148), appears to have been the first to successfully perform a myomectomy after Cæsarean section at full term in 1899. Herman performed a successful Cæsarean section with oöphorectomy in 1892 (Case 53).

M. Handfield-Jones in 1885 was the first British obstetrician to perform supra-vaginal hysterectomy with extra-peritoneal treatment of the stump for an obstructing fibroid, whilst Gow in 1896 (Case 120) was the first to treat the uterine stump by the intra-peritoneal method. In 1895 (Case 86a) Sir William Smyly[72] performed a successful vagino-abdominal panhysterectomy following Cæsarean section for a full term pregnancy complicated by fibroids in one horn of a double term. Herbert Spencer,[73] in 1905 (Case 500), was the first to perform an abdominal panhysterectomy for an obstructing fibroid. In the last three of these cases the mothers recovered.

* *Panhysterectomy* v. *Sub-total hysterectomy.* Herbert Spencer,[92] who is the chief exponent of panhysterectomy in England, whether the patient be pregnant or not, believes that the complete removal of the uterus is safer, because by it "drainage can be better secured, and concealed hæmorrhage, pelvic exudations and subsequent infection or cancer of the cervix do not occur." He refers to 24 published cases of cancer having occurred in the cervix after sub-total hysterectomy.

Those who disagree with Spencer point to the longer duration of the operation in panhysterectomy and the somewhat greater loss of blood, the interference with the integrity of the pelvic floor, and the shortening of the vagina which may cause dyspareunia. They require further evidence to show that carcinoma of the retained cervix is liable to occur, and they point to the loss of the internal secretion of the glandular cervix if it be removed. Conservative surgery seems to require the retention of the cervix unless it can be shown that its removal adds to the security of the patient. Statistics are not conclusive either way. (See Tables I. and V.)

TABLE I.

Showing Cases of Fibro-myomata complicating Pregnancy and Labour treated by Cæsarean Section and Hysterectomy.

Treatment	Number of Cases	Deaths.			
		Mother	Per-centage	Chil-dren	Per-centage
Cæsarean Section - - -	20	6	30·0	4	20·0
Cæsarean Section + oöphorectomy	3	2	66·6	2	66·6
Cæsarean Section + myomectomy -	5	0	0	0	0·0
C.S. followed by supra-vaginal hysterectomy with extra-peritoneal treatment of stump -	7	1	14·3	1	14·3
C.S. followed by supra-vaginal hysterectomy with intra-peritoneal treatment of stump -	26	4	15·4	4	15·4
C.S. followed by panhysterectomy	13	1	7·7	5	37·7
Total - - - -	74	12	16·5	14	18·9

A 3.

Cæsarean Section in cases of Cancer of Genital Passages.

A. *Patients seen early in pregnancy with operable cancer of the cervix* should be treated by panhysterectomy by the abdominal (Wertheim) operation, or by the vaginal route (Duhrssen) as appears advisable, the uterus being emptied first, after cervical incisions if need be in the latter case.

B. *Patients seen early in pregnancy with inoperable cancer of the cervix* or vagina may be allowed to go to nearly full term and then be delivered by Cæsarean section or Cæsarean hysterectomy (see D).

C. *Patients seen at or near full term with operable cancer of the cervix* should be treated by abdominal Cæsarean section followed by panhysterectomy. Panhysterectomy following Cæsarean section can be done in such cases, as Munro Kerr says, by four methods:—

1. Abdominal panhysterectomy by Wertheim's method, using especially his vaginal clamps, to prevent peritoneal infection. One such case by Micholitsch lived over 5 years without recurrence.

2. *Zweifel's method.* Removal of body of uterus by the abdo-

minal route by supra-vaginal amputation, and removal of the cervix by the vagina. (See Munro Kerr's case 396.)

3. *Olshausen's method.* Removal of the whole organ by the vagina after tying off the ovarian and uterine vessels and other connections by the abdomen (Munro Kerr, Case 469).

4. *Vaginal Cæsarean section followed by vaginal hysterectomy* is advocated by Dührssen, Bumm, and Orthmann, and the latter has collected 29 cases with 5 deaths (17 per cent.). This is not an operation at all favoured in the United Kingdom.

Herbert Spencer,[75] who is strongly against vaginal Cæsarean section, advised in 1904 that in *early cases of squamous epithelioma* where the cervix is well dilated and labour advanced, instead of doing either vaginal or abdominal Cæsarean section, the child should be delivered by the natural passages and the uterus removed immediately by the vagina by means of the galvano-cautery.

He described three such cases where he had removed the *cervix* during the puerperium by the high vaginal amputation with the galvano-cautery leaving the body of the uterus intact. The patients remained free from recurrence 11, 8½ and 8 years after operation, and these cases together with one case by Dmitri de Ott, another by Olshausen and a third by Micholitsch, six cases in all, constitute all the cases of cancer complicating pregnancy which have lived for over 5 years from the date of operation without recurrence.

All these cases, except Micholitsch's which was a Wertheim, were delivered by the vagina and operated upon *during the puerperium* (one as long as 5 months after delivery).

It is difficult to explain these excellent results by a method which is now considered to be more or less obsolete, for Spencer and most other operators would now in such cases prefer abdominal Cæsarean section followed by the extended Wertheim abdominal hysterectomy, except where labour is far advanced.

D. *Patients seen at or near full term with inoperable cancer of the cervix* may be delivered by Cæsarean section by the classical method, taking particular pains to apply accurately the superficial peritoneal suture to cover in completely the uterine wound and the suture knots. This, however, leaves the uterus, and especially the placental site, liable to be infected by the septic cervix, so that many prefer to follow the Cæsarean section by sub-total hysterectomy. If so, one of two methods must be employed:—

1. *Abdominal supra-vaginal hysterectomy with extra-peritoneal treatment of the stump.* This has been advocated by Spencer but may be dangerous owing to the possible traction on the friable carcinomatous tissues of the supra-vaginal cervix. If in order to avoid such traction amputation of the uterus is performed high up, the danger of infection is still present.

2. *Abdominal supra-vaginal hysterectomy with intra-peritoneal treatment of the stump.* This is advised by Munro Kerr.

In the cases collected by me there have been 33 cases of cancer of the cervix treated by Cæsarean section. Thirteen of these were operable and were further treated by panhysterectomy, mostly by Wertheim's method with three maternal deaths, nine children being saved. One case (Munro Kerr, 396) was by a vagino-abdominal operation (see also Case 469). In addition to these, Gemmell successfully performed vaginal Cæsarean section and vaginal hysterectomy in another case. Of the remaining 20 inoperable cases 12 were treated by simple Cæsarean section with 4 deaths, 10 children surviving; 3 by supra-vaginal hysterectomy with extra-peritoneal treatment of the stump, all the mothers and children surviving; 5 by supra-vaginal hysterectomy with intra-peritoneal treatment of the stump, 4 of the mothers and 4 of the children surviving.

The high mortality of the "inoperable" cases of cancer treated by Cæsarean section only is partly explained by the fact that several were moribund or so weak that the further ordeal of supra-vaginal hysterectomy was thought unjustifiable.

TABLE II.

Cases of Cancer of the Cervix treated by Cæsarean Section and Hysterectomy.

	Cases	Maternal Deaths		Fœtal Deaths	
		Number	Percentage	Number	Percentage
Cæsarean Section only* - -	12	4	33·3	2	16·6
Cæsarean Section and supra-vaginal hysterectomy with extra-peritoneal treatment of the stump -	3	0	0·0	0	0·0
Cæsarean Section and supra-vaginal hysterectomy with intra-peritoneal treatment of the stump -	5	1	20·0	1	20·0
Cæsarean Section and abdominal panhysterectomy - - -	12	3	25·0	3	25·0
Cæsarean Section and vaginal panhysterectomy - - -	1	0	0·0	0	0·0
Total - - - -	33	8	24·2	6	18·1

* These 4 deaths occurred out of 5 cases (2, 24, 188, 221, 256) thus operated upon before 1902. The 7 cases operated upon since that date recovered from the operation.

A 4.

Cæsarean Section for Ovarian Tumour.

Ovarian tumours are said to complicate pregnancy with a frequency of 1 in 1,500 (Munro Kerr[77]) or 1 in 891 (Fehling).

McKerron[78] collected 862 cases and the nature of the tumours were—dermoid cysts 23 per cent., other cysts 68 per cent., malignant tumours 5 per cent., fibromata 2 per cent. He states that torsion occurs in 12 per cent. during pregnancy, and 20 per cent. during the puerperium, as compared with 8 per cent. in cases uncomplicated by pregnancy. He finds that rupture of an ovarian cyst during labour occurs in 13 per cent.

These statistics show the frequency and risks of the complication.

The question which in this paper one has to consider is whether there is a place for Cæsarean section in such cases.

1. *Ovarian tumours discovered during pregnancy.*

These should be removed to prevent the risks of pressure upon the pregnant uterus and of torsion of the pedicle and possible rupture of the cyst. Small pelvic tumours can be easily and safely removed by the vagina. In five cases of vaginal ovariotomy which I have performed during early pregnancy only one ended in abortion. Abdominal tumours, or tumours only partially pelvic should be removed by the abdomen. The mortality of abdominal ovariotomy during pregnancy is about 3·3 per cent. (McKerron), and the same author states that labour is induced by the operation in 16 per cent. in the first half and 34 per cent. in the later months of pregnancy.

2. *Ovarian tumours discovered shortly before or during labour.*

(*a*) If the tumour be abdominal and not so large as to interfere with respiration, it may be left till after labour and removed during the puerperium, or even later if the patient can be kept under observation in case torsion should occur. If, however, removal of such a cyst be required during labour, delivery should be left to nature or may be facilitated by forceps by an assistant if the parts are sufficiently dilated, whilst the patient is still under anæsthesia.

(*b*) *If the patient be in labour and the tumour be in the pelvis.*

Delivery by forceps, version or craniotomy past an obstructing body is very dangerous to the mother, as Braxton Hicks long since proved.

Attempts may be made to displace the pelvic tumour upwards per vaginam or rectum under deep anæsthesia in the Sims', genu-pectoral or Trendelenburg position. If this fail, the cyst should be removed either by the vaginal or abdominal route. In some cases where vaginal ovariotomy for a small cyst is being attempted labour might come on so rapidly that the pedicle could not be secured after the cyst contents (simple or dermoid) had been expelled.

In such a case a stout silk ligature should be tied to the cyst and the vaginal wound temporarily closed. After labour is over the vaginal wound should be re-opened, the cyst drawn down out of the pouch of Douglas, its pedicle secured and replaced and the vaginal wall firmly sutured. Most obstetricians, however, would prefer to remove the cyst by the abdomen, as Sir John Williams and Spencer[79] have done, allowing labour to proceed as stated above (2 *a*). Haultain, on the other hand, prefers to deliver the child by Cæsarean section before removing the cyst, but cases where a pelvic ovarian tumour, even when adherent, cannot be drawn up out of the pelvis if the uterus be turned out of the abdomen, must be relatively very rare.

As a matter of routine, therefore, there is only a place for Cæsarean section under the following exceptional circumstances:—

(*a*) Where the tumour though pelvic is solid and cannot therefore be dealt with by vaginal incision, and is also too large or fixed to be pushed out of the pelvis, and where during the subsequent cœliotomy, the pelvic tumour cannot be lifted out of the pelvis, even if the pregnant uterus be turned out of the abdomen.

(*b*) Where cœliotomy has been performed to remove an adherent pelvic or broad ligament cyst and it is found impracticable to separate the adhesions or enucleate the cyst without first reducing the size of the uterus by Cæsarean section.

(*c*) Where after ovariotomy during labour the patient is found to be also suffering from some serious constitutional disease or pelvic abnormality which renders delivery *per vias naturales* undesirable.

(*d*) Where owing to unusual rigidity or undilatability of the soft parts, as might for instance occur in an elderly primigravida, it is thought wise not to let the abdominal wound run the risk of injury by the prolonged strain of a tedious labour, and where instrumental labour is considered to be impracticable or undesirable.

Such conditions as these are rare, but the 28 cases,* 26 of which were pelvic, recorded in the table of cases, show they are met with. Twenty-six of these cases recovered from the operation, the two deaths being one where the pelvis was blocked by a malignant ovarian tumour, and the other by a solid tumour, both being dealt with by supra-vaginal hysterectomy with intra-peritoneal treatment of the stump(Cases 771 and 934). Eleven of the 26 pelvic tumours were dermoids, 2 were malignant, 3 solid, and there was also a parovarian cyst.

* Barber (538), Boxall (114), Braithwaite (125, 144), Croft (1204), Favell (203, 819), Ferguson (1020), Haultain (290, 1207), Jardine (626), Kerr (771), Lewers (888), Lyle (1120), Martin (934), Pearson (1146), Purslow (563), Scharlieb (482), Sinclair (163, 215, 529), Spencer (381), (thought to be a uterine tumour), Stevens (1006, 1116), Swayne (348), Targett (1017), Wallace (628).

A 5.

Cæsarean Section for other Pelvic Tumours.

Such tumours are mostly fixed and malignant growths of rectum or bladder or urethra, or enchondromata, osteomata and osteo-sarcomata growing mainly from the pelvic joints, and if in any sense obstructive can only be dealt with by Cæsarean section and by the appropriate treatment for the growth itself.

Munro Kerr[80] and Blacker[81] allude to cases of *vesical calculus* in the practice of Smellie, Hugenberger and others.

In the cases here collected there are 8* cases of cancer of the rectum with 3 deaths (Cases 141, 599, 711), and there were also 3 enchondromata, 5 osteo-sarcomata, 6 obstructing exostoses,, and 1 subperitoneal growths, 15 cases in all,† with 3 deaths (Cases 35, 68, 724) (see Table VI. at end).

Eden (851) and Gow (842) describe two cases of undefined cancer in the pelvis requiring C.S.

There are also five cases of obstruction due to the retroflexion or enlargement of a *second horn of a bicornute uterus* (Cameron (250), Clifford (634), Favell (949), Lyle (412), Playfair (644), the last patient dying of septicæmia.

Blacker has a remarkable case of *calcified hydatid cyst* obstructing labour (116).

A 6

Cæsarean Section for cervical and vaginal stenosis.

Excluding cases due to carcinoma of the cervix already discussed these stenoses are mainly cicatricial, the result of injuries received during a previous confinement. One among the cases collected followed the amputation of a cancerous cervix two years previously (Spencer, 98) and one was for a very small vagina in a nullipara aged 44 (Grimsdale, 927).

In the cases collected by me there are 8 cases‡ of cervical and vaginal stenosis without any mortality. Of these five had Cæsarean section alone performed, and three sub-total hysterectomy, one (Spencer) with extra-peritoneal, and two (Herman and Routh) with intra-peritoneal treatment of the stump.

* Barber (747), Duncan (119), Ferguson (599), Griffith (141), Grimsdale (134), Johnston (711), Robinson (328), Williamson (881).

† *Enchondromata*: Briggs (720), Collins (373), Stookes (1127).
Osteo-Sarcomata: Champneys (137), Herman (35), Lyle (746), Maclean (724), Spencer (68).
Exostoses: Barber (431), Dakin (278), Donald (154), Fitzgerald (593), Herman (310), Rayner (1019).
Subperitoneal Tumours: Champneys (225).

‡ Blacker (1108), Favell (553), Gow (812), Grimsdale (927), Herman (244), Hewetson (1087), Routh (748), Spencer (98).

A 7.

Miscellaneous Group.

Amongst this group there are 7 cases (see Table VI at end of paper) of *previous ventrifixation* causing dystocia occurring in the practice of Cameron (971, 1137), Jardine (950), Munro Kerr (1217), Lyle (1253), Spencer (323) and Targett (691). Spencer's case was due to a previous myomectomy with extra-peritoneal treatment of the stump of the fibroid. One of these died (1253). Neither Lyle, Spencer nor Targett sterilized their patients.

Tonic contraction of the uterus required Cæsarean section in 8 cases, with 4 maternal and 7 fœtal deaths, Collins (1042), Edge (1101), Fothergill (906 and 945), Gow (857), John Phillips (211 and 227). All the children died. Rupture of the uterus appeared imminent in most of the cases and in some the pelvis was also contracted. In Phillips' two cases the presenting shoulder was so impacted in the pelvis that the children could not be delivered after Cæsarean section till they had been eviscerated. Both mothers recovered. Tenison Collins performed C.S. to save the child on a woman with a prominent sacrum and an impacted mento-posterior presentation (Case 548).

Champneys (Case 468) also had to perform Cæsarean section in a remarkable case of *Hour-glass contraction of the uterus* in the first stage of labour. No other abnormality of mother or child was present. Forceps had previously failed to deliver.

There are also 4 cases of *missed labour* or *prolonged gestation.* In Buist's case (1000) gestation was supposed to be 11 months advanced, the child was anencephalic and weighed 10 lbs. Version had been attempted. The woman recovered. In Mrs. Scharlieb's case (94) the os uteri was occluded, and the uterus gangrenous, making panhysterectomy the only chance. Cameron's case (250) was supposed to be 12 months pregnant, and at the operation the macerated fœtus was found in the right half of a uterus duplex.

Horne of Dublin (704) had a case of convulsions due to spinal meningitis, but he was unable to save either mother or child.

B. CÆSAREAN SECTION FOR UTERINE HÆMORRHAGE.

1. *Concealed Accidental Hæmorrhage.*

Every one has met with cases of this dangerous complication of labour where an inert uterus is distended with blood before the child is born, and where when the child is delivered and the uterus emptied a further post partum hæmorrhage occurs and the patient dies.

When the uterus is tense and tender and cannot be made to contract, and the concealed hœmorrhage is increasing, and the patient is becoming more collapsed and bloodless, it is justifiable to

perform Cæsarean section in the interests of the mother, even though it is almost certain the child is dead. In such a case hysterectomy should be performed at once as inertia uteri is present. Abdominal supra-vaginal amputation of the uterus with intra-peritoneal treatment of the stump is probably here the best form of hysterectomy, though extra-peritoneal treatment of the stump would be the quicker if urgency were extreme.

Vaginal Cæsarean section followed by vaginal hysterectomy is not approved of, for although the child being dead can be removed easily through the first cervical incisions after perforating the head, and the full-term emptied uterus can be easily removed at full term in a multipara, the actual operation takes a longer time and requires more skill and special instruments than by the abdominal route. Hæmorrhage, too, from the emptied uterus, pending its removal, is so much more under control by the abdominal route by clamping the ovarian and uterine vessels, that the latter route is preferable. The opportunity too is simultaneously afforded during the latter operation of filling the abdomen by hot saline to reduce the existing collapse.

In the collected cases, abdominal Cæsarean section for this condition has been done 4 times (Bagot 29, Briggs 80, Savage 1230, Targett 455). The two cases which died were moribund at the time of operation, but those operated on by Bagot in 1891, and Targett in 1904, were in better condition and survived. In three cases Cæsarean section was followed by supra-vaginal hysterectomy, two with external, one with intra-peritoneal treatment of the stump. The 4th was too ill to do more than Cæsarean section.

B 2.

Cæsarean Section in Placenta Prævia.

Abdominal Cæsarean Section for this condition as first advocated by Lawson Tait in 1890 stands on an entirely different footing to that treatment for concealed accidental hæmorrhage: and very few, if any, operators advocate it, except for special and rare complications.

Vaginal Cæsarean Section in cases of placenta prævia, is almost universally condemned, yet Savage, of Birmingham, has performed it in four cases, and Edge of Wolverhampton in 2 cases, all successfully. The best European results are those of Bumm who had 1 death in 15 cases. Vaginal incision sufficient to allow the insertion of two fingers to enable podalic version to be performed is advised by some. The risk of further laceration during subsequent delivery is obvious even if the incision be sutured.

At a discussion upon a paper on the subject, read before the Royal Society of Medicine by Dr. Jellett,[82] of Dublin, the President, Dr. Macnaughton-Jones, Drs. Champneys, Spencer, Purslow, Grif-

fith, Gow and myself agreed with the opinion of the author of the paper, that as a routine treatment of placenta prævia there was no place for Cæsarean section.

Dr. Jellett showed that in the Rotunda Hospital and in America, in expert hands, the mortality of placenta prævia was only 3 to 3·5 per cent., and in the Clinics of Pinard, Kronig and Dmitri de Ott the mortality was as low as 2·18, 2·1 and 2·5 respectively. The opinion held by the author and most of the speakers was that the only condition for which abdominal Cæsarean section was indicated was where, especially in cases of central placenta prævia, the cervix was so rigid and undilatable that the treatment by bi-polar version, as first suggested by Braxton Hicks, was impossible. The author of the paper showed that this rigidity was rare and certainly did not occur in more than 5 per cent. of all cases of placenta prævia.

It was, however, pointed out that in cases of placenta prævia centralis, hæmorrhage usually took place early, before fœtal viability and that if the child survived after Cæsarean section it was usually puny and undeveloped. Any operation therefore in such an early case, to save the child at an increased risk to the mother is unjustifiable.

Statistics of abdominal Cæsarean section in placenta prævia were given by the President and the author of the paper. In America there had been 43 such operations for placenta prævia with a mortality of 7 mothers or 16·3 per cent.; Kronig and Sellheim had no mortality in 26 cases, and all the children survived.

In the cases here collected abdominal Cæsarean section was performed seven times in cases of placenta prævia, Gow (1228), Griffith (480), Munro Kerr (1100), Rayner (1156), Nigel Stark (1259), Walls (127), and Williamson (849). Walls performed Cæsarean section to save the child as the patient was dying. The other 6 mothers and 3 of the children survived.

The conclusion seems to be that in cases where there is a rigid undilatable cervix, where free hæmorrhage occurs on any manipulation pointing to placenta prævia centralis, where the mother is not collapsed and the child alive and nearly at full term, it may be right to attempt to save both mother and child by abdominal Cæsarean section, but that there is no place for Cæsarean section in the treatment of placenta prævia in other than these very exceptional cases.

C. CÆSAREAN SECTION FOR CONSTITUTIONAL CRISES.

1. *Cæsarean Section in Eclampsia Gravidarum.*

Van der Akker in 1875 was the first to perform successfully abdominal Cæsarean section for eclampsia. Since then the operation has often been performed. In 1897 Kettlitz collected 28 cases with 14 deaths. In 1899 Hillman[83] collected 40 cases with 21 deaths, and Streickeisen,[84] in 1903, added 26 cases with 8 deaths.

In the list of cases collected for the purposes of this paper, there have been 10 cases with 6 deaths. Olshausen reports three Cæsarean sections in 250 cases of eclampsia with 1 death. Thus in 105 cases treated by abdominal Cæsarean section, the deaths were 50, a mortality of 47·6 per cent.

At a discussion on the subject at the Royal Society of Medicine in May 1910, the author of the paper, Dr. F. J. McCann[86] expressed the opinion that there is a distinct place for abdominal Cæsarean section when the fits are severe and rapidly recurring, the patient not in labour and the cervix undilatable; or when the mother is moribund and the fœtus living; or where delivery *per vias naturales* is for some reason impracticable.

If the theory be correct that eclampsia is an auto-toxæmia due directly or indirectly to altered metabolism in the fœtus or placenta, it is only reasonable to assume that emptying the uterus will prevent further toxines entering the woman's circulation. All clinical experience tends in the same direction, and as Dr. McCann postulated in his paper it is probable "that the termination of pregnancy exerts a more powerful and constant influence on the course of the disease than any method of treatment yet employed." In 1902 Herman[87] collected 2,142 cases of puerperal eclampsia, amongst which fits ceased after delivery in 905 and continued in 816. Dührssen and Zweifel state that improvement is greater after artificial than after spontaneous delivery. This latter view is stoutly combated by Herman and to some extent by Spencer.

If it be true that spontaneous or artificial delivery is beneficial to the patient, and if in a given case it is desired to empty the uterus with a rigid undilatable cervix, it is probable that the most rapid and least injurious and disturbing method—at all events in a hospital—would be by abdominal Cæsarean section.

Vaginal Cæsarean section for eclampsia was discountenanced by most speakers, but I have ascertained that it would be considered as a possible alternative to other methods of rapid vaginal delivery (*e.g.*, Bossi's dilator) by the following:—

Barbour, *Blair Bell*, *Bonney*, *Ferguson*, Gibson, Griffith, Halliday Croom, Hellier, Holland, *Kerr*, *Lea*, Lockyer, McCann, Malins, Phillips, Playfair, Rayner, Savage, Darwall Smith, Walls and Wilson. Those whose names are in italics, and probably some of the others also, would only perform vaginal Cæsarean section before the 7th month of gestation.

I can only find 15 cases of vaginal Cæsarean section performed by British operators for eclampsia, with a maternal mortality of 7, 4 children being saved. These operations were performed by Halliday Croom, Edge, Haig Ferguson, Gibson, Griffith, Grimsdale, Munro Kerr, Savage and Walls (see p. 45).

Speaking generally, therefore, the view held appears to be that Dührssen and Bumm's advice to empty the uterus by abdominal or

vaginal Cæsarean section "after the first fit" is not justified and should not be adopted, for 75 per cent. recover without such operations. If, however, the patient is steadily getting worse and the cervix is undilatable, abdominal Cæsarean section is a justifiable method of endeavouring to save the patient's life.

A case of Sir William Smyly's (1254) is recorded in the collected cases bearing out this view. The patient had her first fit on May 15. The fits rapidly recurred, but under morphia, free purgation, and a milk diet, they ceased for a few days, though her general condition was bad. Convulsions recurred on May 21, and as a last chance Sir W. Smyly performed abdominal Cæsarean section, the patient being then semi-conscious, and the fits at once ceased, the woman recovering. The child was born alive but had convulsions till it died 60 hours after birth.

C 2.

Miscellaneous Group of Constitutional conditions (Table VI).

Cæsarean section was required in the collected cases for such conditions as Advanced Heart Disease (Grimsdale, 523), Maniacal Chorea (Blair Bell, 589), General Anasarca involving especially the genital outlet (Lyle, 1201), Myasthenia gravis (Gemmell, 454).

VAGINAL CÆSAREAN SECTION.

This operation was first described by Dürhssen[89] in 1895 and has been since then perfected by him and is now advocated also by Bumm, Veit, Kronig, Olshausen and others. The operation is of course contra-indicated for cases of marked pelvic contraction where abdominal Cæsarean section is more or less absolutely indicated, and is practically only useful when delivery is impossible at the time required owing to obstruction from the mother's soft parts. It is now extensively practised abroad but is not viewed with favour by the majority of British operators, except in the first three or four months of pregnancy, when in a few rare cases of rigid cervix a moderate anterior-cervical incision may be needed to empty the uterus in cases of missed or incomplete abortion.

Such incisions ought not to be included under the term "Vaginal Cæsarean Section" which is loosely applied by some to incisions through the cervix in all cases where the woman is pregnant. "Abdominal Cæsarean Section" is not so called unless the child is viable, for in the earlier months the uterus would be removed entire without previous incision. There ought to be some period of pregnancy after which the name "Vaginal Cæsarean Section" would be solely applied, some name like "Vaginal hysterotomy" being reserved for the first two or three months.

In the United Kingdom cervical incisions have sometimes been made in cases of carcinoma of the cervix to enable the uterus to be emptied, as a preliminary to vaginal hysterectomy in operable cases at all periods of gestation, but vaginal Cæsarean section between the 13th and 28th week of gestation has been mainly performed

where rapid delivery is considered to be required in grave crises, such as in cases of eclampsia gravidarum where delivery *per vias naturales* is impossible owing to rigidity or disease preventing dilatation of the cervix. Very few operators consider vaginal Cæsarean section justifiable under any circumstances at full term or even after fœtal viability.

The classical abdominal Cæsarean section is in such cases preferred because the actual operation takes less time,* and is less difficult at or near full term; because it avoids the point of obstruction, the rigid or malignant cervix, and cuts through healthy tissue only, leaving an ideal surgical wound, which is less likely to become infected than in the vaginal operation; and because the post-operative morbidity is far less than after vaginal Cæsarean section.

Vaginal Cæsarean section is condemned more or less strongly by Russell Andrews, Stanmore Bishop, Blacker, Champneys, Donald, Eden, Fothergill, Giles, Herman, Munro Kerr (after 6th month), Lewers, Mansell Moullin, Purefoy, Routh, Mrs. Scharlieb, Spencer, Tate, Taylor. Many others, though not entirely against the operation, do not recommend its adoption.

A. Amongst those who have performed vaginal Cæsarean section (omitting cervical incisions for emptying the uterus in the early months) may be named:—

Statistics of the above cases of vaginal Cæsarean section.

Indications.	No. of Cases	Maternal Deaths
For Eclampsia: Croom (4), Edge, Ferguson (2), Gibson (2), Griffith, Grimsdale, Kerr (2), Savage (2), Walls (several)	15 +	7
For Concealed Accidental Hæmorrhage: McCann, Briggs, Edge (3), Gibson, Phillips (Sheffield)	7	3
For Placenta Prævia: Edge (2), Savage (4)	6	0
For Hyperemesis Gravidarum: Ferguson (2)	2	1
For Stenosis of Cervix: Briggs, Brewis, Ferguson	3	0
For Carcinoma of Cervix: Gemmell, Savage, Wilson (2)	4	0
For Heart Disease: McCann, Ferguson (2), Johnstone	4	1
For Advanced Sepsis and Sloughing of Bladder: Hastings Tweedy (2)	2	2
	43	14

* By painting the abdomen with a 2 per cent. solution of iodine in rectified spirit widely round the site of the intended incision, the delay in preparing the patient is greatly obviated (H. F. Waterhouse, *B.M.J.*, 1910, Vol. ii, p. 61).

The following are operators who consider that vaginal Cæsarean section may be occasionally employed for special indications, or generally where rapid delivery is required with an undilated cervix in preference to forcible dilatation by Bossi's dilator. *The large majority of these, however, prefer to do abdominal Cæsarean section at or near full term.*

General indication as above. Blair Bell, Brewis, Briggs, Griffith, Hewetson, Jardine, Handfield-Jones, Kynoch, Lackie, Savage, Stabb, Swayne, Williamson.

In Eclampsia. Barbour, Bonney, Brewis, Croom, Edge, Gibson, Grimsdale, Hellier, Hewetson, Holland, Lea, Lockyer, Malins, McCann, Munro Kerr, Phillips (London), Playfair, Rayner, Savage, Darwall Smith, Walls, Wilson.

Accidental Hæmorrhage. Barbour, Edge, Gibson, Hewetson, McCann, Phillips (Sheffield), Rayner.

Placenta Prævia. Edge, Hewetson, Lea, Russell, Savage, Wilson.

Vomiting of Pregnancy. Kynoch, Savage.

Carcinoma of Cervix. Gemmell, Malins.

Heart Disease. Brewis, Ferguson, Hewetson, Johnstone, Kynoch, McCann.

Stenosis or extreme rigidity of Cervix. Brewis, Briggs, FitzGibbon, Kynoch, Lackie, Savage, Stabb.

Some infected cases. Hastings Tweedy, Haultain.

STATISTICS.

(*See Table III.*)

The cases collected (1282) represent the complete consecutive list of all cases of Cæsarean section operated upon for all sorts of indications in Great Britain and Ireland by obstetricians and gynæcologists living on June 1, 1910.

Of the 1282 Cæsarean section operations performed up to June 30, 1910, 1254 have been operated upon for all conditions since 1890 with a mortality of 145 or 11·6%.

During the last uncompleted 5 years (Jan. 1, 1906—June 30, 1910) 711 cases of Cæsarean section have been here performed with 58 deaths, or 8·1%, and this may roughly be considered to be the present death rate of Cæsarean section for *all indications* in the United Kingdom. The death rate for cases of contracted pelvis during last 5 years will be seen to be 6·1%, and Table IV. shows that the death rate of "favourable" cases of Cæsarean section (469 in all), is only 2·9%.

TABLE III.

Table showing Percentages of Mortality before 1891 and during periods of five years from 1891-1910 for Cæsarean Section performed for all indications.

Indications	Before 1891			Jan. 1, 1891, to Dec. 31, 1895			Jan. 1, 1896, to Dec. 31, 1900			Jan. 1, 1901, to Dec. 31, 1905			Jan. 1, 1906, to June 30, 1910			Total			Total	
	Cases	Maternal Deaths	%	Cases	Maternal Deaths	%	Cases	Maternal Deaths	%	Cases	Maternal Deaths	%	Cases	Maternal Deaths	%	Cases	Maternal Deaths	%	Fœtal Deaths (Stillbirths) Nos.	%
Pelvic Contraction	26	8	30·7	62	14	22·5	65	7	10·7	303	37	12·2	602	37	6·1	1058	103	9·7	51	4·8
Obstructing Fibromyomata	...	...	...	8	3	37·5	11	3	27·2	23	5	21·7	32	3	9·3	74	14	18·9	16	21·6
Cancer of Cervix	2	2	100·0	4	1	25·0	2	0	0·0	13	4	30·7	12	1	8·3	33	8	24·2	5	15·1
Ovarian Tumour	...	...	...	...	...	...	4	0	0·0	9	0	0·0	15	2	13·3	28	2	7·1	1	3·5
Stenosis of Cervix	...	...	...	1	0	0·0	...	...	...	2	0	0·0	5	0	0·0	8	0	0·0	0	0·0
Accidental Hæmorrhage	...	...	...	2	1	50·0	...	...	...	1	0	0·0	1	1	100·0	4	2	50·0	3	75·0
Placenta Prævia	...	...	...	...	...	...	1	1	100·0	1	0	0·0	5	0	0·0	7	1	14·3	4	57·1
Eclampsia	...	...	...	1	1	100·0	2	2	100·0	2	1	50·0	5	2	40·0	10	6	60·0	4	40·0
Miscellaneous	...	...	...	5	3	60·0	6	1	16·6	15	3	20·0	34	12	35·3	60	19	31·6	18	30·0
Total	28	10	35·7	83	23	27·7	91	14	15·3	369	50	13·5	711	58	8·1	1282	155	12 0	102	8·0

See also Table VI for Cæsarean Section for Miscellaneous Indications.

Cæsarean section for Contracted Pelvis. (Tables III, IV.)

Details of 1058 cases of contraction of the bony pelvis are given in the Tables. These include, 4 cases of osteomalachia (Cases 21, 604, 742, 751) and 8 cases of achondroplasia (Cases 79, 128, 356, 535, 592, 651, 1007, 1270).

Before 1891 obstetricians who are now living only performed Cæsarean section for pelvic contraction 26 times with a mortality of 8=30·7%.

Between 1891 and 1900 (ten years) the operation was performed 127 times with 21 deaths, a mortality of 16·5%.

Between 1901 and 1910 Cæsarean section has been done 905 times for this condition with 74 deaths or 8·1%.

During the last uncompleted 5 years, 1906—1910, Cæsarean section has been performed for contracted pelvis 602 times with 37 deaths=6·1%, and this may be taken as the present mortality for Cæsarean section and its modification in Great Britain in cases of contracted pelvis. In favourable cases (see Table IV) the mortality was 2·9 %.

Of the 1058 cases of contracted pelvis in the Tables sufficient details are given in 699 cases to draw up the following table:—

TABLE IV.

Table showing the mortality of Cæsarean operations for contracted Pelvis where details are given, as to possible Infectivity (1891 to 1910).

Condition.	Cases		Maternal Deaths		Percentage	
A. "Not in labour" * - - -	245	469	9	14	3·6	2·9
B. In labour, membrane unruptured - - - -	224		5		2·2	
C. In labour, membrane ruptured	166	230†	18	40	10·8	17·3
D. Frequent examinations, or attempts at delivery - -	64		22		34·3	

* "Membranes intact," or "onset of labour," or "in labour but in hospital some days."

† In the combined groups C and D, out of the 230 cases of possible infectivity, 216 were treated by Cæsarean section alone, with 40 deaths, a mortality of 18·5 per cent. In group D, 58 cases were treated by Cæsarean section alone, with 22 deaths, a mortality of 37·9 per cent. The remaining 14 cases in groups C and D combined had supra-vaginal hysterectomy also performed with intra-peritoneal treatment of the stump, and all the women and 11 of the children survived (Cases 336, 358, 370, 400, 404, 405, 432, 494, 568, 713, 736, 751, 843, 1255). See remarks on infected cases, p. 21, and note to Table V.

It will be seen that the mortality of Cæsarean section for 469 cases of contracted pelvis in favourable cases, *i.e.*, when the patient was "Not in Labour" or "where labour had just commenced" was only 14, a death rate of 2·9 per cent.

TABLE V.

Table to show Maternal and Fœtal Mortality in both Favourable and Unfavourable Cases of Contracted Pelvis under various methods of operating by Living Obstetricians and Gynæcologists (1867 to 1910).

Technique	Cases	Maternal Deaths	Per-centage
Cæsarean Section alone - - - -	969	92	9·4
Cæsarean Section followed by supra-vaginal hysterectomy; stump with extra-peritoneal treatment - - - -	28	4	14·2
Cæsarean Section followed by supra-vaginal hysterectomy; dropping stump into abdomen without covering it with peritoneum - - - - -	1	1	100·0
Cæsarean Section followed by supra-vaginal hysterectomy; stump with intra-peritoneal treatment - - - -	53	7	13·2
Cæsarean Section followed by panhysterectomy (abdominal - - - -	1	0	0·0
Extra-peritoneal Cæsarean Section - -	6	0	0
Total - - - - - -	1058	103	9·7 %

Note.—Most of the supra-vaginal hysterectomies with extra-peritoneal treatment of the stump were done (see pp. 16 and 17) before 1898. Most of the supra-vaginal hysterectomies with intra-peritoneal treatment of the stump were done after 1898, and therefore under better circumstances as regards asepsis than previous to that date. The former were, however, done as alternatives to Cæsarean section as a matter of general routine as being then safer, but many of them were septic at the time of operation; the latter were done by some as a matter of routine but by others when the women were thought to be probably infected. It is curious that in 39 cases treated as a matter of routine by supra-vaginal hysterectomy with intra-peritoneal treatment of the stump there were 7 deaths,

whereas those where infectivity was probable (see note to Table IV) had no mortality. It must be remembered that nearly every case upon which Porro's operation was performed for contracted pelvis before 1898 was more or less infected as the result of previous attempts at delivery, and yet, as Table V. shows, the results were very little worse than after the modern intra-peritoneal sub-total hysterectomy taking all the cases together. Whether panhysterectomy which would remove the cervix also would be better than either of the above supra-vaginal hysterectomies has yet to be decided. (See Remarks on Septic Cases, p. 21 and footnote to Table IV., p. 48.)

TABLE VI.

Table to show Maternal and Fœtal Mortality of Cæsarean Section performed for Miscellaneous Indications (1867—1910).

Indications	Cases	Maternal Deaths	Fœtal Deaths
Ventrification of uterus	7	1	1
Tonic Contraction of Uterus (threatened rupture, &c.)	8	4	7
Hour-glass Contraction	1	1	1
Cancer of Rectum	8	3	1
Cancer in Pelvis	2	1	0
Enchondromata, Sarcomata, Osteomata, &c.	15	3	3
Hydatids	1	0	0
Prolonged Gestation or missed Labour	4	1	4
Bicornute Uterus	5	1	1
Relatively large head	3	0	0
Chorea	1	1	1
Heart Disease	1	1	0
Spinal Meningitis (Convulsions)	1	1	1
Anasarca	1	0	1
Myasthenia gravis	1	0	0
Intestinal Disease	1	1	1
Total	60	19	22

APPENDIX.

The 1282 cases of Cæsarean section collected in the Tables *for all indications* are distributed as follows:—

	Cases	Deaths	Percentage Mortality
England - -	841	87	10·3
Wales - -	13	3	23·0
Scotland - -	375	58	15·4
Ireland - -	53	7	13·2
	1282	155	12·0

Amongst the towns where the largest number of cases have been performed the following may be mentioned:—

	Cases	Deaths.	Percent. Mortality.
ENGLAND.			
London	383	36	9·4
Manchester	155	23	14·7
Liverpool	96	11	11·4
Sheffield	92	6	6·5
Leeds	38	3	7·9
Birmingham	34	4	11·7
Wolverhampton	15	1	6·6
Newcastle	15	4	26·6
Bristol	13	0	0·0
WALES.			
Cardiff	13	3	23·0
SCOTLAND.			
Glasgow	304	46	15·1
Edinburgh	59	9	15·2
Dundee	9	2	22·2
Aberdeen	3	1	33·3
IRELAND.			
Dublin	40	5	12·5
Belfast	9	2	22·2
Cork	4	0	0·0

APPENDIX A.

Amongst the operators in the various towns the following have done the largest number of cases. (The cases and deaths are given in brackets.) It is evident that those obstetricians whose operations were mainly performed previous to 1900 will necessarily have had a high death rate.

London.

R. Andrews (23—2), C. Berkeley (12—1), Blacker (9—0), Bonney (4—0), Champneys (20—5), Dakin (11—1), Duncan (10—2), Eden (17—0), Fairbairn (8—0), Giles (3—0), Godson (3—1), Gow (53—3), Griffith (22—2), Herman* (11—3), Lewers† (28—3), Lockyer (3—0), McCann (3—1), Phillips 6—0), Playfair (3—1), Routh (10—1), Mrs. Scharlieb (8—1), B. Smith (8—2), Spencer (22—1), Stabb (15—1), Stevens (5—0), Targett (24—0), Tate (5—1), Williamson (13—0).

Manchester.

Bishop (5—0), Clifford (9—0), Donald (24—3), Fothergill (9—2), Lea (24—3), Lloyd Roberts (15—4), Sinclair‡ (40—8), Walls (30—3).

Liverpool.

Bell (3—1), Briggs (24—2), Gemmell (16—3), Grimsdale (8—2), Stookes (9—1), Wallace (33—1), Willett (3—1).

Sheffield.

Barber (46—2), Favell (29—2), Martin (13—2), Phillips (5—0).

Leeds.

Croft (12—2), Hellier (24—1).

Birmingham.

Malins (6—0), Purslow (10—0), Savage (8—2), Wilson (8—2).

Wolverhampton.

Edge (15—1).

Newcastle.

Lyle (15—4).

Bristol.

Newnham (5—0), Rayner (5—0), Swayne (3—0).

Cardiff.

Collins (7—2), Maclean (6—1).

* Dr. Herman probably had a few others about 1880, but the details cannot be found.

† Dr. Lewers has not included in his list a few cases before 1901 owing to his having no accurate record of them.

‡ Some of Sir W. Sinclair's records at St. Mary's Hospital, Manchester, for 1905-6 cannot be found.

Glasgow.

Cameron (71—11), Jardine (113—22), Kerr (85—10), Russell (29—0).

Edinburgh.

Barbour (6—0), Brewis (6—0), Croom (12—4), Ferguson (5—1), Haultain (23—2), Lackie (5—0).

Dundee.

Buist (4—1), Kynoch (5—1).

Dublin.

Gibson (4—0), Horne (5—2), Purefoy (3—1), Smyly (7—1), Tweedy (16—1).

Belfast.

Johnstone (7—2).

Cork.

Pearson (4—0).

Among the various operators who have sent in cases it may be interesting to notice the runs of consecutive cases (10 and over) without mortality. Andrews (10, 10), Barber (39), Berkeley (10), Briggs (20), Cameron (12, 18), Donald (13), Eden (17), Favell (16), Gow (42), Griffith (10), Hellier (23), Jardine (12, 13, 18), Kerr (10, 16, 11), Lea (15), Purslow (10), Russell (29), Sinclair (17), Spencer (20), Targett (24), Wallace (24), Walls (22), Williamson (13).

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Cases of Abdominal Cæsarean Section

By Obstetric Physicians and Surgeons in Great Britain and Ireland, who were living on June 1st, 1910.

BY

AMAND ROUTH, M.D.

JANUARY, 1911.

Cases of Abdominal Cæsarean Section

BY OBSTETRIC PHYSICIANS AND SURGEONS IN GREAT BRITAIN AND IRELAND, WHO WERE LIVING ON JUNE 1ST, 1910.

CASES EXTEND FROM 1867 TO JUNE 30, 1910.

The 1282 cases here collected have been sent to me by the operators individually and with one or two exceptions comprise all the Cæsarean sections performed by them. In all the lists sent in the cases are consecutive.

Some of the cases dating back 30 or 40 years ago have been difficult to obtain, but fortunately they were then so rare and hazardous that they were almost always reported in the Medical Press, and the details are therefore available for the present series.

The cases of Cæsarean section and its modifications here collected have been performed by obstetricians and gynæcologists, or by surgeons on the staff of a maternity or gynæcological hospital. Unfortunately some obstetricians who have retired from practice, such as Sir John Williams, Drs. Gervis and Galabin, have not been able to collect all their cases, which are therefore not included in the present series.

It is a distressing circumstance that so many cases are excluded owing to the more or less recent deaths of such distinguished obstetricians as the late Drs. Cullingworth, Horrocks and Rivers Pollock of London, Taylor of Birmingham, Walter of Manchester, Edgar of Glasgow and others. Dr. Targett has sent me a list of 15 cases performed at Guy's Hospital by the late Dr. Horrocks with one death, and Dr. Hedley has sent me details of 5 cases by the late Dr. Cullingworth at St. Thomas' Hospital, but these are manifestly incomplete lists, and are excluded as not having been guaranteed by the operator.

I have excluded cases both of hysterotomy and hysterectomy performed in the early months of pregnancy before fœtal viability, as not being in my opinion true Cæsarean section, and also cases of Ruptured uterus.

AMAND ROUTH, M.D., F.R.C.P.

LONDON.

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CASES OF ABDOMINAL

BY OBSTETRIC PHYSICIANS AND SURGEONS

WHO WERE LIVING

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1867					
1	June 3	D. Lloyd Roberts, Manchester.	21	0	Contracted Pelvis (Robert), Interspin. 8¼″, Intercrist. 8″, C.V. 4″ (10 cm.), Transv. 2⅜″-3¼″ (6·9-8·1 cm.), Interischial 1¼″ (3·2 cm.).	Unfavourable. In labour 48 hours. Tonic contraction of Uterus.
	1872					
2	April	D. Lloyd Roberts, Manchester.	33	—	Cancer of Cervix uteri.	Very unfavourable.
	1881					
3	Feb. 21	Sir A. R. Simpson, Edinburgh.	24	5	Rachitic flat pelvis, C.V. 5·7 cm.	Favourable.
	1882					
4	Nov. 27	Clement Godson, London.	24	0	Contracted pelvis, Interspin. 5¾″, Intercrist, 6¼″, Ext. Conj. 4″, C.V. 1½″ (3·8 cm.).	Favourable. Not in labour, 12 days before full term.
	1883					
5	Jan. 8	Heywood Smith, London.	20	0	Rachitic flat pelvis.	Unfavourable. In labour 48 hours. Head already perforated.
	1884					
6	Feb. 14	G. E. Herman, London.	29	0	Rachitic pelvis, C.V. 1½″ (3·8 cm.).	Unfavourable. In labour 48 hours, membranes ruptured, albuminuria.
7	May 28	Stanmore Bishop, Manchester.	28	5	Flat pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour 1 hour, membranes ruptured, full term.
	1885					
8	June 8	Clement Godson, London.	28	0	Rachitic pelvis, C.V. 2¼″ (5·6 cm.).	Unfavourable. In labour 49 hours, Peritonitis present.
	1888					
9	March 21	Sir F. H. Champneys London.	21	1	Generally contracted flat pelvis, C.V. 1¾″ (4·4 cm.).	Good. In labour 3½ hours, 3 times examined.
10	April 10	Murdoch Cameron Glasgow.	27	0	Contracted pelvis, C.V. 1½″ (3·8 cm.).	Favourable. In labour full term.
11	April 16	F. W. N. Haultain Edinburgh.	23	0	Rachitic flat pelvis, C.V. 1½″ (3·8 cm.). Dwarf.	14 hours in labour.

* "*Result*" *as regards* "*Mother*."—Recovered (R), or died (D) during the puerperium.

"*Result*" *as regards* "*Child*."—"A" means "Alive at Birth." In those cases where there is information as to the child's subsequent death or survival beyond the puerperium it is so stated in the "Remarks."

"*Condition at Time of Operation*."—"Favourable" usually indicates that patient was in good general health, not exhausted, that frequent examination had not been made, nor previous attempts at delivery.

ÆSAREAN SECTION*

GREAT BRITAIN AND IRELAND,

JUNE 1ST, 1910.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	D	A	——	Trans. Obst. Soc., Lond., Vol. ix, 1867, p. 250.
C.S. Not sterilized.	D	A	——	——
C.S. ollowed by supra-vaginal hys-erectomy, tying the stump in (divisions and dropping it into odomen.	D	A	Died in 4 days of Peritonitis.	Brit. Med. Journ., June 11, 1881.
C.S. nd supra-vaginal hysterectomy ith extra-peritoneal treatment ' stump, Kœberle's serrenœud, isterian precautions.	R	A	Pelvis deformed from accident in childhood.	Brit. Med. Journ., Jan. 26, 1884.
C.S. nd supra-vaginal hysterectomy ith extra-peritoneal treatment ' stump.	D	D	Mother died 4th day, Vagina sloughing.	Brit. Med. Journ., Jan. 26, 1884; Trans. Obst. Soc. Lond., 1883, Vol. xxv, p. 2.
C.S. nd supra-vaginal hysterectomy, xtra-peritoneal stump, Law-on Tait's clamp, Lister's car-olic spray.	D	A	Died in 9 days with acute nephritis, pulmonary œdema, Pelvic peritonitis.	Med. Times, 1888, Vol. ii, p. 216; Central fur Gyn., 1885, No. 19.
C.S. nd supra-vaginal hysterectomy, xtra-peritoneal stump.	R	A	1st and 2nd craniotomy, 3rd labour induced 7th month (still-born), 4th ditto and craniotomy, 5 Spontaneous labour 6th month.	Lancet, 1894, Vol. 2, p. 1421.
C.S. nd supra-vaginal hysterectomy, xtra-peritoneal stump, Kœ-erle's serrenœud.	D	D	Mother died in 66 hours, Fœtus macerated.	Brit. Med. Journ., Oct. 10, 1895.
C.S. ot sterilised, silver wire used.	R	A	1st child craniotomy.	Trans. Obstet. Soc., Lond., Vol. xxxi, 1889, p. 136.
C.S.	R	A	——	Brit. Med. Journ., vol. i., p. 180, 1889.
C.S. ad supra-vaginal hysterectomy, xtra-peritoneal stump.	R	A	Done in a two-roomed cottage in country at 2 a.m.	——

Operative technique.—The term "Porro" has been avoided, for in England that term indicates "extra-peritoneal treatment of stump," whilst on the Continent of Europe (*vide* "Porro Memoir" of 1891) all varieties of hysterectomy after Cæsarean Section included under the name of "Porro Cæsarean Section."

"Intra-peritoneal stump" indicates that the stump is left in the peritoneal cavity, and unless otherwise stated is covered by peritoneum, so that it might also be called "retro-" or "sub-peritoneal."

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1888					
12	Nov. 1.	W. Duncan, London.	30	0	Rachitic dwarf. Intercrist. 7½″, Interspin. 9½″.	Not in labour.
	1889					
13	May 8	Murdoch Cameron Glasgow.	18	0	Rachitic dwarf 4 ft. high, C.V. 1″ (2·6 cm.).	In labour 6 hours.
14	Oct. 8	Murdoch Cameron Glasgow.	23	0	Dwarf 4 ft. high, C.V. 2″ (5·2 cm.).	In labour 48 hours.
	1890					
15	Feb. 1	W. L. Reid, Glasgow.	23	0	Rachitic pelvis, C.V. 1¾″ (4·4 cm.).	Unfavourable. Prostitute and heavy drinker. In labour 12 hours. Membranes intact.
16	Ap. 30	Sir Halliday Croom, Edinburgh.	25	0	Contracted pelvis, C.V. 1½″ (3·8 cm.).	Good. Onset of labour.
17	May 1	W. L. Reid, Glasgow.	23	0	Rachitic pelvis, Conj. obliq. 2½″ (5·6 cm), C.V. 1¾″ (4·4 cm.).	Favourable. Labour begun in Hospital.
18	May 11	Sir F. H. Champneys London.	25	0	Generally contracted flat pelvis, C.V. 2″ (5 cm.).	Very unfavourable. Commencing acute pneumonia.
19	July 17	W. Duncan, London.	31	7	Contracted pelvis, C. Diag. 3½″ (8·7 cm.).	——
20	Aug. 21	D. Lloyd Roberts, Manchester.	30	3	Obliquely contracted pelvis, C.V. 2½″ (6·2 cm.).	——
21	Aug. 29	Sir W. J. Sinclair, Manchester.	38	8	Mollities ossium, C.V. about 6 cm. Pelvis "crumpled up."	Well nourished. Rather stout, very "Rheumatic."
22	Sept. 11.	Murdoch Cameron Glasgow.	24	0	Contracted pelvis, C.V. 2″ (5 cm.).	In labour 15 hours.
23	Oct. 28	Murdoch Cameron Glasgow.	19	0	Rachitic dwarf 4 ft. high, C.V. 1¾″ (4·4 cm.).	In labour 14 hours.
24	Nov. 15	D. Lloyd Roberts, Manchester.	39	13	Cancer of cervix uteri. Advanced.	Unfavourable. Severe hæmorrhages. Chronic Bronchitis.
25	Nov. 27	Sir W. J. Sinclair, Manchester.	23	0	Extremely deformed dwarf. Irregularly contracted pelvis. Rudimentary legs.	Poorly nourished. Albuminuria. In labour 9 hours.
26	Dec. 10	Murdoch Cameron Glasgow.	28	0	Contracted pelvis, C.V. 1¾″ (4·4 cm.).	In labour 22 hours.

Operative Technique	Result		Remarks	Reference if Case already published
	Mother	Child		
C.S. ad supra-vaginal hysterectomy, xtra-peritoneal stump.	R	A	——	Lancet, 1889, Vol. i, p. 16.
C.S. Sterilized.	R	A	——	Brit. Med. Journ., March 15, 1890.
C.S. Sterilized.	R	A	——	Brit. Med. Journ., March 7, 1891.
C.S. Sterilized.	D	A	Died 6th day. Pulmonary congestion.	——
C.S. ad supra-vaginal hysterectomy, xtra-peritoneal stump.	R	A	——	Croom's "Clinical Papers," June 1901
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	D	D	Patient died 5 hours after delivery. P.M. proved acute pneumonia. Child's head fixed in pelvis. Died before head could be extracted. Operator regrets not having done craniotomy.	——
C.S. id supra-vaginal hysterectomy, xtra-peritoneal stump.	D	A	Died from general Peritonitis. 1, 2 Craniotomy. 3, 4 induced abortion. 5, 6, 7 induced labour. All dead.	Middlesex Hosp. Reports.
C.S. ad supra-vaginal hysterectomy, xtra-peritoneal stump.	R	A	Right half of pelvis undeveloped owing to leg being amputated 11 years previously for ununited fracture.	——
C.S. ad supra-vaginal hysterectomy, xtra-peritoneal stump.	R	A	First 5 labours normal. 6th and 7th Forceps. 8th version. (Child dead.)	Lancet, Jan. 19, 1901.
C.S. Sterilized.	R	A	Silver wires used for deep sutures, catgut for superficial.	Brit. Med. Journ., March 7, 1891.
C.S. Sterilized.	R	D	——	Brit. Med. Journ., March 7, 1891.
C.S.	D	A	——	——
C.S. d supra-vaginal hysterectomy, xtra-peritoneal stump.	R	A	C.V. 3″ (7·5 cm. Interspin. 7½″. Intercristal. 9″.	Lancet, Jan. 19, 1901.
C.S. Sterilized.	R	A	——	Brit. Med. Journ., March 7, 1891.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1890					
27	Dec. 13	Murdoch Cameron Glasgow.	24	0	Contracted pelvis, C. V. 1¾″ (4·4 cm.).	In labour 12 hours.
28	Dec. 16	Murdoch Cameron Glasgow.	24	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour 7 hours.
	1891					
29	Jan. 1	N. Sidney Bagot, Dublin (now Colorado, U.S.A.).	—	—	Accidental hæmorrhage.	Unfavourable. P. 148. Free and concealed hæmorrhage.
30	Jan. 3	Murdoch Cameron Glasgow.	28	3	Contracted pelvis, C.V. 2″ (5 cm.).	Unfavourable. In labour 8th month after a fall.
31	Feb 15	F. W. N. Haultain Edinburgh.	25	0	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
32	Feb. 16	Murdoch Cameron Glasgow.	28	0	Contracted pelvis, C.V. 2″ (5 cm.).	In labour 9 hours.
33	Feb. 17	Clement Godson, London.	41	0	Rachitic flat pelvis, C.V. 2″ (5 cm.).	Favourable. In labour 22 hours.
34	Feb. 20	N. T. Brewis, Edinburgh.	24	1	Generally contracted pelvis.	Before labour.
35	March 2	G. E. Herman, London.	37	—	Osteo-sarcoma of pelvic bones.	Unfavourable. Emaciation. In labour 18 hours. Vulva œdematous.
36	March 12	Murdoch Cameron Glasgow.	26	0	Contracted pelvis, C.V. 2⅜″ (5·9 cm.).	Œdema of legs. Nephritis. Bronchitis.
37	Ap. 10	Murdoch Cameron Glasgow.	30	1	Contracted pelvis, C.V. 1¾″ (4·4 cm.).	Favourable.
38	June 4	H. Briggs, Liverpool.	30	1	Rachitic pelvis.	Fair.
39	June 14	A. D. Leith Napier, London. (now Adelaide, Australia).	—	1	Flat pelvis, C.V. 2⅝″ (6·5 cm.).	Favourable. Full term. Not in labour.
40	June 14	Sir W. Smyly, Dublin.	—	1	Contracted pelvis.	In labour. Membranes intact.
41	Sept. 20	Murdoch Cameron Glasgow.	25	0	Contracted pelvis, C.V. 1¾″ (4·4 cm.).	——
42	Sept. 30	Murdoch Cameron Glasgow.	31	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
43	Nov. 1	Sir W. Smyly, Dublin.	26	—	Contracted pelvis, C.V. 7 cm. Trans. 11 cm.	48 hours in labour. Membranes ruptured. Forceps previously used.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	——	Brit. Med. Journ., March 7, 1891.
C.S. Sterilized.	R	A	Craniotomy 1 and 2. C.S. by request.	Brit. Med. Journ., March 7, 1891.
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	D	Done at patient's house.	Rotunda Hosp. Reports, Trans. Roy. Acad. Med., Ireland, Vol. xi, 1893.
C.S. Sterilized.	D	A A	Embryotomy 1, 2, 3. C.S. by request. Mother lived 42 hours.	Brit. Med. Journ., March 7, 1891.
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	——	——
C.S. Sterilized.	R	A	——	Brit. Med. Journ., March 7, 1891.
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	——	Brit. Med. Journ., Oct. 10, 1891.
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	——	Edin. Obst. Trans., Vol. xvi, p. 133.
C.S.	D	D	No peritonitis at P.M.	Lancet, Vol. i, 1891, p. 986.
C.S. Sterilized.	D	D	——	——
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	1. Craniotomy.	Med. Press and Circular, 1891.
C.S. Sterilized.	R	A	1. Embryotomy.	Trans. Obst. Soc., Lond., 1892, Vol. xxxiv, p. 105.
C.S. Not sterilized.	R	A	1. Craniotomy.	Trans. Roy. Acad. Med., Ireland, Vol. xi, 1893.
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Child died 8th day (diarrhœa).	——
C.S. Not sterilized.	R	A	Same patient as Oct. 28, 1894 (Smyly). Child's scalp sloughed at forceps wound, and maternal wound suppurated lower end.	Trans. Roy. Acad. Med., Ireland, Vol. xi, 1893.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1891					
44	Nov. 9	Murdoch Cameron Glasgow.	19	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	——
45	Dec. 3	Sir W. Smyly, Dublin.	25	0	Contracted pelvis, C.V. 7 cm. Transv. 10·5 cm.	——
	1892					
46	Feb. 26	Sir W. J. Sinclair Manchester.	28	1	Generally contracted flat pelvis, C.V. 3¼″ (8·1 cm.).	Good. In labour. Membranes ruptured.
47	March 12	W. Duncan, London.	33	3	Contracted pelvis, C. Diag. 3″ (7·5 cm.).	——
48	March 15	Murdoch Cameron Glasgow.	24	0	Contracted pelvis, C. Diag. 2¾″ (6·9 cm.).	Favourable.
49	March 27	Murdoch Cameron Glasgow.	29	0	Contracted pelvis, C. Diag. 2¾″ (6·9 cm.).	Favourable.
50	April 2	Sir W. J. Sinclair, Manchester.	35	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour. Membranes ruptured.
51	April 4	Murdoch Cameron Glasgow.	33	2	Contracted pelvis, C. Diag. 2¾″ (6·9 cm.).	——
52	April 20	Murdoch Cameron Glasgow.	23	2	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	——
53	May 4	G. E. Herman. London.	35	0	Obstructing fibroid.	Favourable.
54	May 11	Murdoch Cameron Glasgow.	27	0	Contracted pelvis, C. Diag. 2¼″ (5·6 cm.).	——
55	May 14	Herbert Spencer, London.	28	0	Fibro myoma of lower segment of uterus and cervix.	Favourable. In labour 12 hours. Membranes ruptured 10 hours. No previous attempts at delivery.
56	May 17	Murdoch Cameron, Glasgow.	22	1	Contracted pelvis, C. Diag. 2¾″ (6·9 cm.).	Favourable.
57	May 18	Murdoch Cameron, Glasgow.	26	2	Contracted pelvis, C. Diag. 2¾″ (6·9 cm.).	——
58	May 24	N. T. Brewis, Edinburgh.	24	1	Generally contracted pelvis, C.V. 6·2 cm.	Favourable. Before labour.
59	June 10	F. W. N. Haultain, Edinburgh.	21	0	Contracted pelvis.	Full term.
60	June 17	R. Favell, Sheffield.	42	?	Contracted pelvis, C. Diag. 3¼″ (8·1 cm.).	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	Compression ring round uterine incision first used.	——
C.S. Not sterilized.	R	D	——	Trans. Roy. Acad. Med., Ireland, Vol. xi, 1893.
C.S. Not sterilized. Keith's drainage tube.	R	A	1. Craniotomy.	Lancet, Jan. 19, 1901, Vol. i, p. 159.
C.S. Sterilized.	D	A	1, 2, 3 Craniotomy. Abdominal wound burst 3rd day.	Middlesex Hosp. Reports.
C.S. Compression ring first used round uterine incision.	R	A	——	——
C.S. Compression ring used and in all subsequent cases of operator.	R	A	——	——
C.S. and supra-vaginal hysterectomy, Intra-peritoneal stump.	R	A	1. Craniotomy.	Lancet, 1901, Vol. i, p. 159.
C.S. Sterilized.	D	A	Died of septicæmia. Previous labour craniotomy.	——
C.S. Sterilized.	R	A	1, Craniotomy. 2, unknown.	——
C.S. Double oophorectomy.	R	D	——	Lancet, Vol. ii, 1893, p. 1508.
C.S. Sterilized.	R	A	——	——
C.S. followed by abdominal panhysterectomy.	R	A	Operation 299 days after last menstruation. Uterus weighed 6 lbs.	Trans. Obst. Soc., Lond., Vol. xxxviii, p. 390.
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Same patient as Oct. 24, 1894. (Cameron).	——
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	R	A	1. Basilysis.	Edin. Obst. Trans., Vol. xvi, p. 13.
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	R	A	——	Edin. Obst. Trans., Vol. xvii, p. 277
C.S. Not sterilized.	R	A	Myomata present.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1892					
61	Oct. 8	Murdoch Cameron, Glasgow.	37	1	Contracted pelvis.	Unfavourable. Examinations before admission.
62	Nov. 3	W. S. A. Griffith, London.	26	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. In labour. No previous attempts at delivery.
	1893					
63	Jan. 27	Edmund Holland, London.	37	0	Obstructing fibroids (multiple).	Favourable. 8½ months gestation.
64	Feb. 8	G. E. Herman, London.	24	0	Rachitic flat pelvis, C.V. 1¾″ (4·4 cm.).	In labour 2½ hours.
65	March 2	G. E. Herman, London.	36	1	Fibro-myoma uteri growing from posterior wall, filling pelvis and causing retroflexion uterus.	In labour. Membranes ruptured 9 hours. Exhausted. T. 140°F.
66	March 11	Skene Keith, London.	32	1	Contracted pelvis, C.V. 1½″.	Not in labour. 37th week.
67	April 5	Murdoch Cameron, Glasgow.	27	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	——
68	April 16	Herbert Spencer, London.	21	0	Sacral Enchondroma, C.V. 1¾″.	Unfavourable. In labour 16 hours. Albuminuria. Examined by midwife.
69	May 10	F. Edge, Wolverhampton.	33	2	Contracted pelvis.	Favourable.
70	June 10	Murdoch Cameron, Glasgow.	30	2	Contracted pelvis, C.V. 2½″.	——
71	June 12	Murdoch Cameron, Glasgow.	19	2	Contracted pelvis, C. Diag. 2¾″	——
72	July 1	Murdoch Cameron, Glasgow.	19	0	Contracted pelvis, C.V. 1½″.	——
73	July 3	G. E. Herman, London.	37	0	Rachitic flat pelvis, C.V. 1¼″.	Unfavourable. Child dead. In labour 12 hours in a dirty house. Version performed before admission, and foot brought down.
74	July 7	G. E. Herman, London.	24	1	Rachitic flat pelvis, C.V. 2½″.	Favourable. Labour induced in Hospital 12 hours previous to C.S.
75	July 12	G. E. Herman, London.	32	1	Fibroids causing obstruction and retention of urine.	Unfavourable. No sleep for 4 days. Severe pain.
76	July 29	Murdoch Cameron, Glasgow.	26	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	D	A	1st premature. 7th month.	——
C.S. Sterilized.	R	A	——	Brit. Med. Journ. 1893, Vol. i, p. 636
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	——	Brit. Med. Journ., March 18, 1893.
C.S. Sterilized.	R	A	——	Lancet, 1893, Vol. ii, p. 1509.
C.S. and supra-vaginal hysterectomy, extra-peritoneal stump.	D	D	Mother died in 4 hours. Child decomposing. Anterior uterine wall very thin.	New York Journ. of Gyn. and Obst., 1893, Vol. iii, p. 484.
C.S. Not sterilized.	R	A	1. Forceps. Skull fractured. Lived 5 weeks.	Brit. Med. Journ., 1893, Vol. ii, p. 8
C.S. Sterilized.	D	A	1. Craniotomy. 2. Abortion.	——
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	D	A	Died 9th day. Chronic interstitial nephritis, pyelitis and dilated ureters.	Trans. Obst. Soc., Lond., Vol. xxxviii, p. 403.
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	——	——
C.S. Sterilized.	D	A	Died 7th day.	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	D	D	Patient died 3rd day. Septicæmia.	Lancet, 1893, Vol. ii, p. 1565.
C.S. Sterilized.	R	A	1. Craniotomy after induction of labour.	Lancet, 1893, Vol. ii, p. 1509.
C.S. Double oophorectomy.	D	D	Patient died 3rd day. No peritonitis.	Lancet, 1893, Vol. ii, p. 1565.
C.S. Sterilized.	R	A	1. Craniotomy.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1893					
77	Aug. 2	Herbert Spencer, London.	20	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour. Membranes intact.
78	Aug. 10	A. Donald, Manchester.	—	—	Cancer of cervix uteri (inoperable).	Unfavourable. 8½ months pregnant. Much exhaustion.
79	Oct. 6	G. E. Herman, London.	24	0	Achondroplasia, C.V. ¾″ (2cm.)	Labour induced in Hospital 12 hours before operation.
80	Oct. 28	H. Briggs, Liverpool.	40	0	Accidental Hæmorrhage, Fœtus inaccessible per vaginam owing to pelvic fibroids.	Unfavourable. Great exhaustion. 8½ months pregnant.
81	Nov. 18	Murdoch Cameron, Glasgow.	22	0	Contracted pelvis, C.V. 1¾″ (4·4 cm.). Dwarf 3ft. 10½in.	——
82	Dec. 10	D. Lloyd Roberts, Manchester.	37	7	Cancer of cervix uteri.	——
	1894					
83	Jan. 26	G. E. Herman, London.	33	1	Obstructing cervical fibromyoma.	In labour 24 hours. Examined before admission.
84	Feb. 6	F. W. N. Haultain, Edinburgh.	27	0	Flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. Before labour.
85	Feb. 25	A. Donald, Manchester.	29	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Unfavourable Urine half albumen.
86	April 21	H. Briggs, Liverpool.	29	0	Rachitic pelvis, C.V. 2″ (5cm.)	Favourable. In labour.
86A	May 2	Sir William Smyly, Dublin.	?	?	Fibro-myoma. Uteri filling pelvis.	Full term. Not in labour.
87	May 18	Murdoch Cameron, Glasgow.	24	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
88	May 20	G. E. Herman, London.	29	?	Cancer of cervix (inoperable).	——
89	May 20	Herbert Spencer, London.	27	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. Not in labour.
90	June 1	W. K. Walls, Manchester.	—	—	Eclampsia.	Moribund, but child alive.
91	July 23	F. W. N. Haultain, Edinburgh.	29	3	Generally contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. Before labour.
92	July 28	Herbert Spencer, London.	21	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. Not in labour.
93	Aug. 12.	A. J. Wallace, Liverpool.	33	9	Advanced cancer of cervix.	Favourable. Not in labour. Full term.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as July 28, 1894, and April 3, 1900 (Spencer).	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump. Drainage tube.	D	A	——	Lancet, 1893, Vol. ii, p. 1510.
C.S. Sterilized.	R	D	Child decomposing.	Lancet, 1893, Vol. ii, p. 1565.
C.S. Not sterilized.	D	D	Too ill for hysterectomy. Bilateral pyelo-nephritis. Died 3rd day.	——
C.S. Sterilized.	D	A	——	——
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	R	A	——	——
C.S. Sterilized and ovaries removed.	D	A	Died 2nd day of peritonitis.	Lancet, 1894, Vol. ii, p. 77.
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	D	A	Died 7th day.	——
C.S. Sterilized.	R	D	——	——
C.S. followed by abdominal supra-vaginal hysterectomy. Cervix then removed per vaginam with second horn of the double uterus.	R	A	After cervix was removed per vaginam mass felt outside clump, and on its removal was found to be small second half of a uterus duplex.	Brit. Med. Journ., 1895, Vol. i., p. 71.
C.S. Sterilized.	R	A	1. Craniotomy.	——
C.S.	R	A	——	Lancet, 1894, Vol. ii, p. 78.
C.S. Not sterilized.	R	A	1, 2. Craniotomy. Same patient as Aug. 17, 1899 (Spencer).	——
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	D	A	——	St. Mary's Hospital (Manchester) Reports.
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	R	A	1, 2, 3. Stillborn.	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Aug. 2, 1893 (Spencer), and April 3, 1900 (Spencer).	Journ. of Obst. and Gyn. Brit. Empire, 1902, Vol. i, p. 138.
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	R	A	——	Liverpool Med. Chir. Journ., Oct. 1902; Practitioner, March 1907.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1894					
94	Sept. 28	Mrs. Scharlieb, London.	29	1	Missed labour, Occlusion of os uteri.	Unfavourable. Pyrexia. Abdominal œdema. Not in labour.
95	Oct. 24	Murdoch Cameron, Glasgow.	28	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Unfavourable. Tubercular.
96	Oct. 28	Sir W. Smyly, Dublin.	28	4	Contracted pelvis, C.V. 7 cm.). Transv. 11 cm.).	Some hours in labour.
97	Nov. 19	Murdoch Cameron, Glasgow.	29	2	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
	1895					
98	March 6	Herbert Spencer, London.	33	5	Cervico-vaginal stenosis after amputation of cancerous cervix (Ap. 8, 1893).	Favourable. Not in labour.
99	March 22	Murdoch Cameron, Glasgow.	29	3	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
100	May 5	Murdoch Cameron, Glasgow.	26	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	——
101	June 24	Murdoch Cameron, Glasgow.	26	1	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	——
102	June 25	Mrs. Scharlieb, London.	23	1	Generally contracted rachitic flat pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. Full term. Not in labour.
103	July 11	Murdoch Cameron, Glasgow.	22	1	Contracted pelvis, C.V. 2″ (5 cm.).	——
104	July 15	Mrs. Scharlieb, London.	20	0	Generally contracted flat pelvis C.V. 2″ (5 cm.).	Favourable. Full term. Not in labour.
105	Aug. 3	F. Edge, Wolverhampton.	24	1	Contracted pelvis.	Favourable.
106	Aug. 22	W. J. Gow, London.	26	0	Rachitic pelvis, C.D. 2″ (5cm.)	Unfavourable. In labour 15 hours. Breech. Leg prolapsed. Tonic contraction of uterus.
107	Sept. 13	Murdoch Cameron, Glasgow.	27	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
108	Oct. 14	G. Elder, Nottingham.	35	0	Obstructing fibro-myoma of uterus.	Favourable.
109	Oct. 16	Murdoch Cameron, Glasgow.	29	3	Contracted pelvis, Conj. Diag. 2¾″ (5·9 cm.).	——

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. and abdominal panhysterectomy.	D	D	Uterus gangrenous. All uterine vessels thromboscd, so no ligatures needed. Mother died in 28 days. Child had died 3 weeks previously.	——
C.S. = Sterilized.	D	D	**2nd C.S.** Same patient as case May 18, 1892 (Cameron).	——
C.S. = Not sterilized.	D	A	**2nd C.S.** Same as patient Nov. 1, 1891 (Smyly). Adhesions. Bowel injured.	Trans. Roy. Acad. Med., Ireland, Vol. xvi, 1898.
C.S. Sterilized.	R	A	1. Forceps. Premature. 2. Induction. Both dead.	——
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	Patient well 11 years after high operation.	Trans. Obst. Soc., Lond., Vol. xxxviii, p. 413.
C.S. Sterilized.	R	A	1, 2. Craniotomy. 3. Induction.	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	D	A	1. Craniotomy.	——
C.S. Sterilized.	R	A	1. Craniotomy after induction at 30th week. Both alive 1910.	Brit. Med. Journ., 1901, Vol. ii, p. 951.
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Child died of syphilis when 6 weeks old. Mother well 1910.	Brit. Med. Journ., 1901, Vol. ii, p. 951.
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	Child died of enteritis 7th day.	Harveian Lectures, March, 1907.
C.S. Sterilized.	R	A	1. Craniotomy.	——
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	——	Brit. Med. Journ., Nov. 30, 1895.
C.S. Sterilized.	D	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1895					
110	Dec. 14	F. Edge, Wolverhampton.	40	0	Fibro-myomata of uterus.	Favourable.
111	Dec. 28	W. S. A. Griffith, London.	30	2	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
	1896					
112	Jan. 10	Murdoch Cameron, Glasgow.	—	0	Contracted pelvis, C.V. 2″ (5 cm.).	Favourable. 36 hours in labour. Membranes ruptured. No previous attempts to deliver.
113	Feb 20	W. S. A. Griffith, London.	37	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. In labour 8 hours. Membranes ruptured. No pre attempt to deliver.
114	March 23	R. Boxall, London.	29	0	Dermoid cyst of ovary obstructing delivery.	Somewhat exhausted. P. 110. In labour 44 hours. Attempt made to elevate tumour under anæsthesia.
115	April 10	Sir W. J. Sinclair, Manchester.	25	0	Pelvic contraction. Curvature of spine. Left hip ankylosed. C.V. 2″ (5 cm.). Interspin. 9″, Intercrist. 9½″.	Unfavourable. Poor health.
116	April 17	G. F. Blacker, London.	31	0	Hydatid cyst (calcified) in pelvis. Thought to be fibroid.	Favourable. Before labour.
117	July 4	J. Mansell Moullin, London.	22	0	Pelvic contraction. Spinal disease.	Favourable.
118	Sept. 16	Murdoch Cameron, Glasgow.	27	0	Contracted pelvis, Conj. Diag. 2¾″ (6·9 cm.).	Unfavourable. Forceps already used.
119	Nov. 10	W. Duncan, London.	26	—	Cancer of Rectum.	——
120	Dec. 8	W. J. Gow, London.	37	0	Obstructing fibro-myoma of uterus.	Not in labour.
	1897					
121	Jan. 1	J. Mansell Moullin, London.	25	0	Contracted pelvis. Large child. Forceps failed.	Favourable, though genitals much swollen.
122	Jan. 24	F. W. N. Haultain, Edinburgh.	24	2	Contracted pelvis (Naegele). C.V. 3″ (7·5 cm.).	In labour 1½ hours.
123	Feb. 21	Murdoch Cameron, Glasgow.	21	0	Contracted pelvis, Conj. Diag. 3-3½″ (7·5 to 8·5 cm.).	Unfavourable. In labour 48 hours.
124	March 26	W. W. H. Tate, London.	38	—	Obstructing fibro-myoma of uterus.	In labour 13½ hours. Membranes ruptured. Os well dilated
125	May 19	J. Braithwaite, Leeds.	26	1	Ovarian tumour blocking pelvis.	Favourable. Onset of labour. Full term.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	——	——
C.S. Sterilized.	R	A	1. Forceps. Full term. Living. 2. Craniotomy. Full term.	——
C.S. Sterilized.	R	D	——	——
C.S. Sterilized.	R	A	Small fundal pedunculated fibroid. Myomectomy also.	——
C.S. and ovariotomy.	R	A	——	Middlesex Hosp. Reports; Trans. Obst. Soc., Vol. xxxvi, 1896, p. 222.
C.S. Not sterilized. Keith's drainage tube.	R	A	C.S. subsequently Aug. 22, 1901, June 23, 1903, and Aug. 1, 1907 (Sinclair).	Lancet, Jan. 19, 1901; Journ. of Obst. and Gyn. Brit. Empire, Vol. v, 1904, p. 13, and Vol. xii, 1907, p. 335.
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	Tumour not removed, but discharged through abdominal wound in a few days.	Journ. Obst. and Gyn. Brit. Emp. 1908, Vol. ii, p. 336.
C.S. Not sterilized.	R	D	Next pregnancy labour induced. Oophorectomy to sterilize 1897.	W. Lond. Med. Journ., Vol. i, No. 4, Oct. 1896.
C.S. Sterilized.	D	A	——	——
C.S.	R	A	——	Lancet, 1898, Vol. i, p. 405.
C.S. and supra-vaginal hysterectomy. Intra-peritoneal stump.	R	A	——	Trans. Obst. Soc., Lond., 1897, Vol. xxxix, p. 7; Harv. Lectures, March, 1907.
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	D	Vesico-vaginal fistula repaired successfully subsequently.	——
C.S. Not sterilized.	R	A	1, 2, Stillborn.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	Died 6th day with peritonitis.	——
C.S. Not sterilized.	R	A	——	Lancet, 1898, Vol. ii, p. 1763.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1897					
126	May 31	Sir F. H. Champneys, London.	32	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour. Membranes intact. No previous attempt to deliver.
127	June 8	W. K. Walls, Manchester.	24	4	Placenta prævia.	Moribund from hæmorrhage.
128	June 21	W. S. A. Griffith, London.	27	0	Achondroplasia. Dwarf. C.V. 3″ (7·5 cm.).	Favourable, but forceps tried after induction of labour.
129	July 22	A. Donald, Manchester.	22	0	Contracted pelvis, C.V. 1⅞″ (4·7 cm.).	——
130	Aug. 19	R. Jardine, Glasgow.	22	0	Rachitic flat pelvis, C.V. 2¾″ (6·9 cm.).	In labour 41 hours. Membranes ruptured.
131	Nov. 27	S. Savage, Birmingham.	23	0	Rachitic pelvis. Dwarf.	Favourable. Full term.
132	Dec. 9	Murdoch Cameron, Glasgow.	34	0	Contracted pelvis, C.V. 2″ (5 cm.).	In labour 2 hours.
133	Dec. 17	F. Edge, Wolverhampton.	38	2	Contracted pelvis.	Favourable.
	1898					
134	Jan. 6	T. B. Grimsdale, Manchester.	29	3	Cancer of rectum, reaching forwards to within 2·25 inches from symphysis pubis.	General emaciation. P. 120.
135	Jan. 11	R. Jardine, Glasgow.	20	0	Rachitic flat pelvis, C.V. 1½″ (3·8 cm.).	In labour.
136	Jan. 17	R. Jardine, Glasgow.	22	1	Rachitic flat pelvis, C.V. 1⅝″ (4·1 cm.).	In labour. Gonorrhœal vaginitis. Purulent discharge.
137	Jan. 18	Sir F. H. Champneys, London.	30	2	Sarcoma of pelvis, Available Space 4″ × 3″ (10 × 7·5 cm.).	Favourable. In labour. Membranes intact
138	March 13	R. Jardine, Glasgow.	24	3	Rachitic flat pelvis, C.V. 2½″ (6·2 cm.).	In labour.
139	April 6	Sir F. H. Champneys, London.	25	4	Rachitic flat pelvis, C.V. 3½″ (9·3 cm.).	Favourable. In labour. Membranes ruptured.
140	April 18	F. Edge, Wolverhampton.	30	0	Obstructing fibro-myoma of uterus.	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	—	—
C.S.	D	D	Practically a P.M. C.S. Done on couch in Hospital receiving room.	—
C.S. Sterilized.	R	A	—	Queen Charlotte's Hosp. Reports.
C.S. and panhysterectomy.	R	A	—	—
C.S. Sterilized.	R	A	—	Trans. Edin. Obst. Soc., Vol. xxiii, Brit. Med. Journ., 1898, Vol. i, p. 1331.
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	R	A	—	Lancet, Feb. 5, 1898.
C.S. Sterilized.	R	A	—	Glasgow Hospital Reports, 1901.
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	R	A	—	—
C.S.	R	A	Mother died 6 months later from cancer of liver and exhaustion.	North of Eng. Obst. and Gyn. Trans., 1898; Brit. Med. Journ., 1898, Vol. i, p. 648.
C.S. Sterilized.	R	A	Silk stitches came out a year later.	Trans. Edin. Obst. Soc., Vol. xxiii, Brit. Med. Journ., 1898, Vol. i, p. 1331.
C.S. Sterilized.	D	A	Septic peritonitis.	Trans. Edin. Obst. Soc., Vol. xxiii, Brit. Med. Journ., 1898, Vol. i, p. 1331.
C.S. Sterilized.	R	A	Sarcoma growing from left side of bony pelvis. Superior maxilla removed 2 years before for sarcoma.	—
C.S. Sterilized.	D	A	Complete suppression of urine. Abdominal and uterine wound healed. No sepsis. 1, 2, 3, Craniotomies.	Trans. Edin. Obst. Soc., Vol. xxxiii, Brit. Med. Journ., 1898, Vol. i, p. 1331.
C.S. Sterilized.	R	A	1. Forceps. Still born. 2. Forceps. Died 8th day. 3, 4, Craniotomy.	—
C.S. and supra-vaginal hysterectomy, Extra-peritoneal stump.	R	A	—	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1898					
141	May 21	W. S. A. Griffith, London.	37	1	Cancer of rectum; almost occluding pelvic cavity.	Favourable. In labour. C.S. to save child.
142	June 6	Murdoch Cameron, Glasgow.	27	2	Contracted pelvis, C.V. 2½″ (6·2 cm.).	In labour 2 hours.
143	July 30	R. Jardine, Glasgow.	28	0	Contracted pelvis, C.V. 1½″ (3·8 cm.).	Not in labour. Child dead.
144	Sept. 6	J. Braithwaite, Leeds.	?	?	Ovarian cyst blocking pelvis.	Favourable.
145	Dec. 3	F. W. Kidd, Dublin.	32	0	Obstructing fibro-myoma of cervix.	Favourable. Not in labour.
146	Dec. 28	W. J. Gow, London.	24	1	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	Favourable 1st stage of labour.
147	Dec. 30	R. Jardine, Glasgow.	36	Multi-para	Contracted pelvis.	In labour.
	1899					
148	Jan. 3	J. Campbell, Belfast.	35	0	Obstructing fibro-myoma of uterus.	Favourable. Not in labour.
149	Jan. 4	Murdoch Cameron, Glasgow.	28	1	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	In labour 3 hours.
150	Feb. 20	W. S. A. Griffith, London.	31	0	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Good general condition. 20 hours in labour, but no attempt to deliver.
151	March 6	E. Malins, Birmingham.	22	2	Generally contracted pelvis. C.V. 2″ (5 cm.).	Favourable. Near full term. Time elected. Not in labour.
152	April 11	R. Jardine, Glasgow.	43	8	Obstructing fibro-myoma of uterus.	Exhausted by ante-partum hæmorrhage. In labour. Prolapse of cord.
153	April 13	Murdoch Cameron, Glasgow.	34	4	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour 6 hours.
154	May 11	A. Donald, Manchester.	25	4	Tumour of pelvic bones.	——
155	June 30	Mrs. Scharlieb, London.	29	2	Generally contracted pelvis, C.V. 3½″ (8·1 cm.).	Favourable. Not in labour. Full term.
156	Aug. 17	H. Spencer, London.	32	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. Not in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	D	A	1. Forceps. Full term. Child lived. Mother died in 9 days.	——
Sterilized. C.S.	R	A	——	Glasgow Hosp. Reports, 1901.
Sterilized. C.S.	R	A	——	Trans. Edin. Obst. Soc., Vol. xxii.
Sterilized. Removed small ovarian cyst.	R	A	Child died in 24 hours.	Lancet, 1898, Vol. ii, p. 1763.
C.S. Not sterilized.	R	A	Child lived 3 days. On Sept 2, 1900, patient was safely delivered by forceps of child (8½ lbs.) after being in labour 73 hours.	Trans. Roy. Acad. Med., Ireland, Vol. xvii, 1899, p. 441, and Vol. xix, 1901, p. 158; Brit. Med. Journ., 1899, Vol. ii, p. 148.
C.S. Not sterilized.	R	A	Same patient as Dec. 6, 1899 (Gow). 1. Craniotomy (1897). Child 7lbs. 12oz.	Harv. Lectures, March, 1907.
C.S.	R	A	——	——
C.S. Myomectomy. Not sterilized.	R	A	Fibroid growing from anterior part of supra-vaginal cervix. 2 children subsequently.	——
C.S. Sterilized.	R	A	——	Glasgow Hosp. Reports, 1901.
C.S. Sterilized.	R	A	Sterilized by ligature of tubes. Patient became pregnant again.	Queen Charlotte's Hosp. Reports.
C.S. Not sterilized.	R	A	——	——
C.S.	D	D	Mother died in 40 hours of shock.	Trans. Glasgow Obst. Soc., Vol. ii, 1899.
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	R	A	——	Glasgow Hosp. Reports, 1901.
C.S.	R	A	——	——
C.S. Not sterilized.	R	A	1. Craniotomy. 2. Induction 34th week, died during delivery of head.	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as May 20, 1894 (Spencer).	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1899					
157	Aug. 31	W. J. Gow, London.	29	0	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	Favourable. First stage of labour.
158	Oct. 12	Murdoch Cameron, Glasgow.	32	4	Contracted pelvis, C.V. 2″ (5 cm.).	In labour 3 hours.
159	Oct. 16	E. Malins, Birmingham.	34	4	Flat pelvis.	Favourable. Full term. Not in labour.
160	Oct. 22	Sir Halliday Croom, Edinburgh.	20	0	Eclampsia. Rigid undilatable cervix. Pelvis somewhat contracted.	Unfavourable. Convulsions every five minutes. Comatose. T. 101°F.
161	Nov. 15	A. Donald, Manchester.	—	—	Contracted pelvis.	——
162	Dec. 6	W. J. Gow, London.	25	2	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	Not in labour.
163	Dec. 31	Sir W. J. Sinclair, Manchester.	30	1	Solid ovarian tumour in front of fœtal head.	Favourable.
	1900					
164	Jan. 1	Sir Halliday Croom, Edinburgh.	46	0	Eclampsia. Cervix undilatable.	Comatose 10 hours. 12 hours in labour.
165	Jan. 7	F. Edge, Wolverhampton.	27	1	Contracted pelvis.	Favourable.
166	Jan. 12	W. S. A. Griffith, London.	30	1	Flat pelvis.	In labour 52 hours. Membranes ruptured twelve hours. Manual dilatation tried.
167	Jan. 14	F. W. Kidd, Dublin.	40	0	Obstructing fibro-myoma of uterus.	Unfavourable. Full term. In labour 48 hours. Frequent examinations.
168	Jan. 15	W. S. A. Griffith, London.	24	5	Flat pelvis, C.V. 3″ (7·5 cm.).	Good. Membranes ruptured 60 hours. No attempts at delivery Transverse presentation.
169	Feb. 2	F. W. N. Haultain, Edinburgh.	29	3	Flat pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
170	Feb. 16	W. J. Gow, London.	26	1	Contracted pelvis, C.D. 3⅛″ (7·8 cm.).	Not in labour.
171	March 1	W. K. Walls, Manchester.	27	0	Contracted pelvis.	——

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as March 9, 1902 (Blacker).	Harveian Lectures, March, 1907.
C.S. Sterilized.	R	A	——	Glasgow Hosp. Reports, 1901.
C.S. Not sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy. Extra-peritoneal stump.	D	D	Patient died in 6 hours, after a severe fit.	Trans. Edin. Obst. Soc., Vol. 30, p. 194.
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Dec. 28, 1898 (Gow). Child 5lbs. 8ozs., died in 21 hours. 1. Craniotomy.	Harveian Lectures, 1907.
C.S. and ovariotomy. Not sterilized. Keith's drainage tube.	R	A	Examination 1900 showed uterus adherent as after ventrifixation.	Lancet, Jan. 19, 1901.
C.S. Not sterilized.	D	A	Cessation of fits after operation. Previously every half hour, coma between. Died from pneumonia 7 days after operation.	Trans. Edin. Obst. Soc., Vol. 30, p. 194.
C.S. and supra-vaginal hysterectomy. Intra-peritoneal stump.	R	A	——	——
C.S.	R	A	——	Queen Charlotte's Hosp. Reports.
C.S. and panhysterectomy.	R	D	Sent from Co. Kildare to Coombe Hospital in labour. Child dead. No movements felt for 3 days.	Trans. Roy. Acad. Med., Ireland, Vol. xviii, 1900, p. 301.
C.S. Sterilized.	R	A	Induction of labour 3 times. All children dead.	Queen Charlotte's Hosp. Reports.
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Craniotomy. Child 5lbs. 8ozs.	Harveian Lectures, 1907.
C.S. Not sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1900					
172	March 10	W. J. Gow, London.	21	0	Contracted pelvis, C.D. 3⅝″ (9·3 cm.).	1st stage of labour. Membranes ruptured.
173	March 23	F. Edge, Wolverhampton.	35	2	Contracted pelvis.	Pulmonary tuberculosis.
174	March 27	Amand Routh, London.	30	0	Fibromyoma uteri at level of os internum.	Favourable. In labour, induced by bougie.
175	April 3	Herbert Spencer, London.	27	2	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. Not in labour.
176	May 1	D. Lloyd Roberts, Manchester.	34	0	Obstructing fibro-myoma uteri blocking pelvis.	Unfavourable. In labour 2 days. Previous examinations.
177	May 3	N. T. Brewis, Edinburgh.	31	4	Generally contracted pelvis, C.V. 6·5 cm.	Favourable. Full term. Not in labour.
178	May 8	E. Malins, Birmingham.	27	2	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Near full term. Not in labour.
179	May 10	R. Jardine, Glasgow.	28	1	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Unfavourable. In labour 12 hours. Frequent examinations before admission.
180	May 11	W. J. Gow, London.	24	0	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	In labour 27 hours. Cord prolapsed. Breech presentation.
181	May 20	J. B. Hellier, Leeds.	33	5	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. Labour just beginning.
182	May 29	G. E. Herman, London.	28	1	Rachitic flat pelvis, C.V. 2½″ (6·2 cm.).	Not in labour. Some accidental hæmorrhage
183	June 3	John Phillips, London.	24	0	Rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Not in labour. Full term.
184	June 5	Stanmore Bishop, Manchester.	30	3	Flat pelvis	Favourable. In labour. Membranes intact.
185	June 5	Sir W. J. Sinclair, Manchester.	27	1	Contracted pelvis.	Favourable. Onset of labour. Membranes intact.
186	June 16	Sir W. J. Sinclair, Manchester.	31	2	Contracted pelvis.	Favourable. 1st stage labour. Not previously examined.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Child 7lbs. 1oz. Head failed to engage.	Harveian Lectures, March, 1907.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	D	A	Pneumonia supervened.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Placenta anterior. Mother and child well 1908.	Trans. Obst. Soc., Lond., 1900, Vol. xlii, p. 244.
C.S. Under local anæsthesia. Not sterilized.	R	A	**3rd C.S.** 1° August 2, 1893 (Spencer). 2° July 28, 1894 (Spencer). Both these children subsequently died.	Journ. of Obst. and Gyn. Brit. Empire, Vol. i, p. 138.
C.S. Not sterilized.	R	A	Tumour too adherent for removal. Offensive lochia. Suppuration of wound. Prolonged convalescence.	Lancet, 1900, Vol. ii, p. 1016.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1, Forceps. 7th month. Stillborn. 2, Basilysis. Full term. 3, 4, Abortions.	Edin. Obst. Trans., Vol. xxv, p. 186.
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized. Small parovarian cyst removed.	D	A	Died of sepsis.	——
C.S. Not sterilized.	R	A	Child premature, 3lbs. 14ozs., lived 9 days.	Harveian Lectures, March, 1907.
C.S. Sterilized.	D	A	Died 7th day of broncho-pneumonia. Suppuration of uterine wound.	Lancet, 1904, Vol. i, 76.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1. Cephatotripsy. Placenta anterior. Child 7lbs. 2ozs.	Lancet, 1901, Vol. i, p. 1604.
C.S. Not sterilized.	R	A	Pregnant again June 1910.	——
C.S. Uterus attached to abdominal wall.	R	A	1. Craniotomy. 2. Induced at 36th week. 3. Induced at 32nd week—all died.	——
C.S. Not sterilized.	R	A	1. Forceps. Stillborn. November 1900. Uterus found firmly "ventrifixed."	Lancet, Jan. 19, 1901.
C.S. Not sterilized.	R	A	1, 2, Craniotomy on living children. November 1900. Uterus high up—adherent to parietes.	Lancet, Jan. 19, 1901.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1900					
187	June 27	W. J. Gow, London.	33	1	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	Favourable. Not in labour.
188	June 30	E. Malins, Birmingham.	42	5	Cancer of cervix, advanced.	Near full term.
189	July 5	T. W. Eden. London.	25	0	Pelvic contraction from active hip joint disease.	Weak from prolonged suppuration. Several sinuses.
190	July 15	R. D. Purefoy, Dublin.	26	0	Contracted pelvis, C.V. 7·25cm.	Favourable.
191	July 26	E. O. Croft, Leeds.	20	2	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	Onset of labour. Full term.
192	Aug. 16	Sir W. J. Sinclair, Manchester.	23	2	Rachitic pelvis. Dwarf.	Favourable. Onset of labour in hospital. Membranes intact.
193	Aug. 20	Nigel Stark, Glasgow.	23	0	Rachitic pelvis.	Exhausted. Frequent attempts with forceps.
194	Aug. 31	Malcolm Black, Glasgow.	22	2	Contracted pelvis, C.Diag. 3½″ (8·7 cm.).	Favourable. Onset of labour in hospital.
195	Oct. 6	Sir W. J. Sinclair, Manchester.	26	5	Pelvic contraction. Bad obstetric history.	Favourable. Not in labour.
196	Oct. 10	A. W. W. Lea, Manchester.	27	0	Rachitic pelvis.	In labour 12 hours.
197	Oct. 14	J. E. Gemmell, Liverpool.	42	5	Cancer of cervix uteri.	Favourable. In labour. Cord prolapsed through cervix.
198	Nov. 19	W. J. Gow, London.	26	0	Contracted pelvis, C.D. 3″ (7·5 cm.).	In labour 24 hours.
199	Nov. 21	J. B. Hellier, Leeds.	24	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. Admitted in labour.
200	Dec. 1	W. Duncan, London.	30	6	Generally contracted pelvis, C.V. 2½″ (6·2 cm.), Interspin. 8¾″, Intercrist. 9¼″.	——
201	Dec. 5	G. E. Herman, London.	31	5	Intra-ligamentous fibroid obstructing pelvis.	Not in labour, but much pain for a month. Supposed 8th month.
202	Dec. 15	R. D. Purefoy, Dublin.	36	1	Fibro-myoma of uterus obstructing labour.	Very unfavourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as Nov. 25, 1903 (Gow). Child 6lbs. 1oz. 1. Craniotomy.	Harveian Lectures, March, 1907.
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Convalescence febrile but not prolonged.	——
C.S. Not sterilized.	R	A	Same patient as 7.8.05 (Fitz-Gibbon).	Rotunda Hospital Reports.
C.S. Not sterilized.	R	A	Bronchitis during puerperium. Both well 4 months later.	Brit. Med. Journ., 1900, Vol. ii, p. 1377.
C.S. Eventration before incision. Not sterilized.	R	A	1. Prolonged forceps, child only living 24 hours. 2. Craniotomy on living child. Patient Rigor 8th day. Recovered well.	Lancet, Jan. 19, 1901.
C.S. Sterilized.	D	A	——	——
C.S. Sterilized.	R	A	1. Abortion 2½ months. 2. Craniotomy.	——
C.S. Not sterilized.	R	A	1, 2, 3, 4, 5, (twins), all craniotomy with living children (6 in all). November, 1900, Examination, uterus as after ventrifixation.	Lancet, Jan. 19, 1901.
C.S. Not sterilized.	R	A	——	——
C.S. and panhysterectomy (abdominal).	R	D	——	Journ. of Obst. and Gyn. Brit. Empire, Vol. i, 1902, p. 152.
C.S. Not sterilized.	R	A	Same patient as Jan. 1 1904 (Gow). Child 6lbs. 9ozs.	Harveian Lectures, March, 1907.
C.S. Sterilized.	R	A	All previous children died.	Brit. Med. Journ., 1901, Vol. i, p. 17; Lancet, 1904, Vol. i, p. 76.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1, 2, 3, Abortion. 4, 5, 6, Craniotomy.	Trans. Obst. Soc., Lond., 1901, Vol. xliii, p. 9.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Exploratory laparotomy for diagnosis, Sept. 14, 1900. Necrotic change in fibroid at C.S. operation. Pelvic abscess during convalescence. Child died in 5 hours.	Lancet, 1901, Vol. i, p. 1605.
C.S.	D	A	Died 10th day—sepsis.	Rotunda Hospital Reports.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1901					
203	Jan. 1	R. Favell, Sheffield.	27	0	Ovarian dermoid filling pelvis.	Favourable.
204	Jan. 26	E. Malins, Birmingham.	33	3	Generally contracted flat pelvis.	Favourable. Near full term. Not in labour.
205	Feb. 13	A. Donald, Manchester.	24	1	Fibro-myoma of uterus.	——
206	Feb. 13	R. Jardine, Glasgow.	37	0	Contracted pelvis, C.V. 2″ (5 cm.).	Prolonged labour.
207	Feb. 16	Comyns Berkeley, London.	29	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Forceps tried in hospital.
208	Feb. 19	R. Jardine, Glasgow.	27	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted before labour.
209	Feb. 20	W. S. A. Griffith, London.	24	0	Flat pelvis, C.V. 3″ (7·5 cm.).	Labour had just begun.
210	Feb. 27	Sir W. J. Sinclair, Manchester.	35	6	Contracted pelvis. Bad obstetric history.	Favourable. In labour while in hospital. Admitted too late for induction
211	March 4	John Phillips, London.	37	15	Tonic uterine contraction. Shoulder presenting. Inability to dilate cervix by any method.	Temperature 100°F. Pulse In labour 72 hours.
212	March 10	A. Donald, Manchester.	28	5	Contracted pelvis.	Unfavourable. Previous attempts at delivery with forceps.
213	March 11	G. F. Blacker, London.	33	1	Flat pelvis.	Favourable. Not in labour.
214	March 15	J. M. Munro Kerr. Glasgow.	33	2	Generally contracted rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour. Membranes ruptured.
215	April 1	Sir W. J. Sinclair, Manchester.	31	4	Ovarian tumour obstructing pelvis.	Unfavourable. Health good, but exhausted by previous efforts to deliver by forceps. In labour 14 hours.
216	April 5	A. J. Wallace, Liverpool.	39	0	Fibro-myoma (intra-ligamentous) obstructing inlet of pelvis.	Favourable. In early labour.
217	April 6	A. J. Wallace, Liverpool.	27	0	Generally contracted pelvis, C.V. 2¼″ (5·6 cm.).	Unfavourable. Syphilis. In labour 3 days.
218	April 19	J. M. Munro Kerr. Glasgow.	23	0	Generally contracted rachitic flat pelvis, C.V. 2¾″ (6·9 cm.).	In labour. Membranes intact.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. and ovariotomy. Not sterilized.	R	A	Had second child 1903.	Brit. Med. Journ., 1901, Vol. i. p. 894.
C.S. Not sterilized.	R	A	Same patient as Jan. 26, 1908 (Malins).	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Sterilized.	D	D	During the operation a piece of plaster fell from the roof, and some of it fell into the abdomen.	——
C.S. Sterilized.	R	A	——	City of London Lying-in-Hospital Reports.
C.S. Sterilized.	R	A	1, Craniotomy. 2, 3, Induction.	——
C.S. Sterilized.	R	A	Single woman. Child lived 14 days, died of meningitis.	Queen Charlotte's Hosp. Reports.
C.S. Not sterilized.	R	A	1, 2, 3, 4, Craniotomy. 5, 6, Induction at 8 months. Living.	——
C.S. could not extract impacted child all after evisceration of thorax. Sterilized.	R	D	1, Natural. Child lived. 2, 3, 4, 5, 6, Stillborn—macerated. Next six induced about 8th month—only one survived.	——
C.S. Not sterilized.	R	A	Child born alive, died shortly afterwards.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1, Craniotomy.	——
C.S. Sterilized.	R	A	Child 7lbs. Placenta posterior wall. 1, 2, Craniotomy.	Brit. Med. Journ., 1901, Vol. i. p. 949; Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. and ovariotomy.	R	A	Fœtal skull injured.	——
C.S.	R	A	Abdominal hysterectomy a year later.	Practitioner, March, 1907; Liverpool Med. Chir., 1902.
C.S. Not sterilized.	R	A	Same patient as April 16, 1902 (Wallace), and April 15, 1905 (Wallace).	Trans. of Obst. and Gyn. Brit. Empire, 1902, Vol. ii, p. 555.
C.S. Sterilized.	R	D	Child 7½lbs. Was alive 2 hours before operation.	Brit. Med. Journ., 1901, Vol. i. p. 949; Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1901					
219	April 22	Sir W. J. Sinclair, Manchester.	31	—	Obliquely contracted pelvis.	Favourable.
220	April 25	J. M. Munro Kerr. Glasgow.	25	1	Generally contracted rachitic flat pelvis, C.V. 2¼″ (5·6 cm.).	In labour. Membranes ruptured, but some days in hospital before operation.
221	April 27	T. B. Grimsdale, Liverpool.	37	Multi-para.	Cancer of cervix, very advanced.	Unfavourable. In labour 36 hours. Membranes ruptured.
222	May 8	R. Jardine, Glasgow.	31	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour.
223	May 11	Sir W. J. Sinclair, Manchester.	39	0	Contracted pelvis owing to infantile paralysis. Not in labour.	Unfavourable. Chronic bronchitis and asthma. Alcoholic heart.
224	May 15	R. Jardine, Glasgow.	?	3	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Not in labour.
225	May 19	Sir F. H. Champneys, London.	33	1	Subperitoneal pelvic tumour.	Favourable. Not in labour.
226	May 20	R. Jardine, Glasgow.	23	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour 24 hours. Membranes ruptured.
227	June 1	John Phillips, London.	27	0	Shoulder impacted. Tonic contraction of uterus. Extraction *per vaginam* impossible owing to constriction and undilatability of cervix.	Temp. 98·4°F, Pulse 110. In labour 21 hours.
228	June 23	R. Jardine, Glasgow.	21	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	In labour.
229	June 28	R. Jardine, Glasgow.	29	2	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Unfavourable. In labour, and membranes ruptured long time. Retraction ring very distinct.
230	July 1	Sir Halliday Croom, Edinburgh.	37	0	Fibro-myoma of uterus blocking pelvis.	1st stage of labour. 7 months pregnant. Patient exhausted.
231	July 11	C. E. Purslow, Birmingham.	23	0	Rachitic pelvis. Dwarf, C.V. 2½″ (6·2 cm.).	Full term. Not in labour.
232	July 21	R. Jardine, Glasgow.	30	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	——
233	July 21	A. J. Horne, Dublin.	23	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour 10 hours. Membranes ruptured.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Child 6½lbs. 1, Craniotomy.	Brit. Med. Journ., 1901, Vol. i, p. 949; Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S.	D	D	Mother died in 3 days. Exhaustion. Perforation of bowel.	——
C.S. Sterilized.	R	A	——	——
C.S. Spinal anæsthesia by cocaine.	R	A	——	Journ. of Obst. and Gyn. Brit. Empire, 1902, Vol. ii, p. 221.
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Tumour attached to pelvic wall—not removed. Nature? Patient in good health afterwards. Patient's child living.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	D	Evisceration of child's abdomen required before delivery owing to impaction.	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	D	A	1, 2, Craniotomy.	——
C.S. and supra-vaginal hysterectomy extra-peritoneal stump.	R	A	Child lived 14 days.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	Commun. to Birmingham and Midland Branch of Brit. Med. Assoc., November 1906.
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	Brit. Med. Journ., 1902, Vol. i, p. 244; Journ. of Obst. and Gyn. Brit. Empire, 1902, Vol. i, p. 204.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1901					
234	July 22	E. O. Croft, Leeds.	21	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Admitted long in labour. Repeated previous examinations.
235	Aug. 3	A. Donald, Manchester.	34	3	Contracted pelvis.	——
236	Aug. 5	Sir W. J. Sinclair, Manchester.	31	0	Contracted pelvis.	In labour. Cord prolapsed.
237	Aug. 9	P. E. Barber, Sheffield.	33	5	Generally contracted flat pelvis, Con. Diag. 3⅛″ (7·8 cm.).	——
238	Aug. 9	A. W. W. Lea, Manchester.	28	2	Flat pelvis.	In labour 12 hours. Previous attempts to deliver by forceps.
239	Aug. 11	J. M. Munro Kerr, Glasgow.	32	3	Generally contracted rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
240	Aug. 16	A. Donald, Manchester.	?	?	Contracted pelvis.	Unfavourable. Heart disease. Attempts at delivery by forceps before admission
241	Aug. 22	Sir W. J. Sinclair, Manchester.	28	1	Contracted pelvis. Curvature of spine. Ankylosis left hip. Interspin. 9″, Intercrist. 9½″, C.V. 2″ (5 cm.).	——
242	Sept. 6	J. B. Hellier, Leeds.	25	0	Rachitic flat pelvis, C.V. 2¾″ (6·9 cm.).	In labour. Cord prolapsed.
243	Sept. 25	R. C. Buist, Dundee.	26	0	Rachitic flat pelvis, C.Diag. 2½″ (6·2 cm.). Dwarf 4ft.	Unfavourable. Midwife's case. In labour 18 hours. Membranes ruptured 16 hours.
244	Sept. 25	G. E. Herman, London.	28	1	Cervical and vaginal cicatricial stenosis following previous instrumental delivery. Vesico-vaginal fistula.	General condition good.
245	Sept. 27	J. M. Munro Kerr, Glasgow.	25	0	Generally contracted rachitic flat pelvis.	In labour. Membranes intact.
246	Sept. 28	A. Donald, Manchester.	34	6	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	——
247	Sept. 30	J. M. Munro Kerr, Glasgow.	—	1	Generally contracted rachitic pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour. In hospital some days.
248	Oct. 17	Murdoch Cameron, Glasgow.	33	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
249	Oct. 17	R. Favell, Sheffield.	23	0	Funnel-shaped pelvis.	In labour 24 hours. Forceps had failed.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	D	A	No doubt already infected. Wound suppurated. Peritonitis.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Midwife ruptured membranes and sent for doctor, who sent patient at once to hospital.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	Died of general peritonitis, 5th day.	——
C.S. Sterilized.	R	A	Child 5½lbs.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	D	A	Mother died in 10 hours of heart failure. Baby died in 3 weeks of congenital suphilis.	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as April 10, 1896, June 23, 1903, and Aug. 1, 1907 (all Sinclair).	Lancet, Jan. 19, 1901; Journ. of Obst. and Gyn. Brit. Empire, 1904, Vol. v, p. 13, and 1907, Vol. xii, p. 335.
C.S. Sterilized.	R	D	Child died by compression of cord.	Lancet, 1904, Vol. i, p. 76; Brit. Med. Journ., 1901, Vol. ii, p. 1340.
C.S. Not sterilized.	D	A	Died 4th day. Peritonitis.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Sterilized.	R	A	Child 5½lbs. Placenta anterior wall.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	R	A	3 Craniotomies. Symphysiotomy (1895).	——
C.S. Not sterilized.	R	A	Child 9lbs. Same patient as May 1, 1903 (Munro Kerr).	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1901					
250	Oct. 22	Murdoch Cameron, Glasgow.	24	1	Uterus duplex. Prolonged gestation of 12 months. No communication between gravid right half and vagina.	Not in labour. Amenorrhœa 12 months. Milk in breasts.
251	Oct. 22	W. H. C. Newnham Clifton, Bristol.	38	0	Fibro-myoma of uterus blocking pelvis completely.	Very good.
252	Oct. 25	T. Wilson, Birmingham.	42	2	Fibro-myoma of uterus filling pelvic cavity growing from posterior lip of cervix.	P. 130. Vagina and cervix sloughing. Liq. amnii long escaped.
253	Oct. 27	J. M. Munro Kerr, Glasgow.	23	0	Generally contracted rachitic pelvis, C.V. 2¾″ (6·9 cm.).	In labour when admitted.
254	Oct. 29	W. J. Gow, London.	21	1	Contracted pelvis, C.D. 3¾″ (9·3 cm.).	Favourable. First stage of labour. Membranes ruptured.
255	Oct. 29	J. M. Munro Kerr, Glasgow.	—	2	Rachitic flat pelvis, C.V. 3″.	In labour, but patient in hospital 12 hours previously.
256	Oct. 30	Sir F. H. Champneys, London.	36	5	Cancer of cervix.	Very unfavourable. In [illegible]. Membranes intact. 8½ mo[illegible]
257	Nov. 16	R. Jardine, Glasgow.	29	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour.
258	Nov. 26	R. Jardine, Glasgow.	24	2	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Not in labour.
259	Dec. 4	H. Briggs, Liverpool.	42	0	Kyphotic pelvis. Narrow outlet with trans. diam. 1⅞″ (4·7 cm.).	Delicate woman. Not in labour.
260	Dec. 11	Sir W. J. Sinclair, Manchester.	21	0	Contracted pelvis.	Albuminuria as in pre-eclamptic condition. Chronic bronchitis.
261	Dec. 21	R. Jardine, Glasgow.	29	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour.
	1902					
262	Jan. 4	T. W. Eden, London.	23	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour 8 hours. Membranes intact.
263	Jan. 7	T. G. Stevens, London.	38	0	Large cervical fibro-myoma filling pelvis.	Favourable. Not in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Uterine wound stitched to abdominal wound and uterus drained through abdominal incision for 3 days.	R	D	1. Abortion 5 months (1899). Mass expelled April and labour pains July 1901. Two living children since.	Journ. of Obst. and Gyn. Brit. Empire, 1902, Vol. i, p. 67.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	D	Enormous tumour.	——
C.S. and abdominal panhysterectomy and enucleation of fibroid embedded in pelvic connective tissue.	D	D	Mother died 6th day of septic peritonitis. Child emaciated. Dead some days.	——
C.S. Fritsch's fundal incision. Sterilized.	R	A	——	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323; ourn. of Obst. and Gyn. Brit. Empire, 1902, Vol. ii, p. 22.
C.S. Not sterilized.	R	A	Same patient as Jan. 1, 1904 (Gow). Child 6lbs. 12oz. 1. Craniotomy.	Harveian Lectures, 1907.
C.S. Fritsch's fundal incision. Placenta encountered. Not sterilized.	R	A	Placenta anterior wall. 1, 2, Craniotomy.	Trns. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323; Journ. of Obst. and Gyn., Brit. Empire, 1902, Vol. ii, p. 22.
C.S. Not sterilized.	D	A	Inoperable cancer. Secondary growth in liver.	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	Died suddenly in 2½ hours—shock. P.M. no hæmorrhage in abdomen. All organs pale and small. Dating probably from spinal caries in 3rd year.	——
C.S. Not sterilized.	R	A	Died of renal disease and hæmoptysis in 3 months.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Convalescence febrile but not prolonged.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Married 7 years. Her first pregnancy.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1902					
264	Jan. 11	Murdoch Cameron, Glasgow.	28	—	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	In labour. Membranes ruptured. Cord prolapsed.
265	Jan. 16	J. M. Munro Kerr, Glasgow.	25	0	Generally contracted rachitic flat pelvis, C.V. 2″ (5 cm.).	In labour but in hospital for day before.
266	Jan. 17	D. Lloyd Roberts, Manchester.	?	?	Contracted pelvis.	——
267	Jan. 25	A. Donald, Manchester.	35	—	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable.
268	Jan. 27	Murdoch Cameron, Glasgow.	19	—	Contracted pelvis, C.V. 1¼″ (3·2 cm.).	——
269	Jan. 30	Amand Routh, London.	34	0	Fibro-myoma of uterus. Adherent to pelvic floor.	Favourable, 38 weeks pregnant. Not in labour.
270	Feb. 5	W. S. A. Griffith, London.	37	1	Kyphotic pelvis. Trans. diam. at outlet, 2″ (5 cm.).	Onset of labour.
271	Feb. 18	W. H. C. Newnham Clifton, Bristol.	43	0	Contracted pelvis.	Unfavourable.
272	Feb. 22	R. Jardine, Glasgow.	28	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
273	Feb. 27	H. Briggs, Liverpool.	22	1	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour. Membranes intact.
274	March 1	Sir A. R. Simpson, Edinburgh.	26	2	Contracted pelvis in a rachitic dwarf, 4ft. 4in, seen too late for induction of labour.	Unfavourable. Epileptic fits during each pregnancy. Urine normal.
275	March 9	G. F. Blacker, London.	33	1	Contracted pelvis, C.D. 3⅜″ (9 cm.).	Favourable. Not in labour.
276	March 11	A. W. W. Lea, Manchester.	24	1	Rachitic pelvis, C.V. 2¾″ (6·9 cm.).	In labour 12 hours. Membranes ruptured.
277	March 14	A. W. Russell, Glasgow.	24	2	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. Labour begun. In hospital 6 weeks beforehand.
278	March 27	W. R. Dakin, London.	32	4	Exostosis of sacrum.	Favourable.
279	April 16	Sir W. J. Sinclair, Manchester.	30	13	Contracted pelvis. Bad obstetric history.	Chronic alcoholism. Very fat.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	——	——
C.S. Fritsch's fundal incision. Not sterilized.	R	A	Placenta encountered. Same patient as November 3, 1903 (Munro Kerr).	Journ. of Obst. and Gyn. Brit. Empire, 1902, Vol. ii, p. 22.
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Monstrosity.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Mother and child well 1908.	Trans. Obst. Soc., Lond., 1902, Vol. xliv, p. 41; Journ. of Obst. and Gyn. Brit. Empire, 1902, Vol. ii, p. 359.
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Craniotomy. Same patient as December 17, 1907 (Briggs), and December 4, 1909 (Briggs).	Med. Press and Circular, 1891.
C.S.	D	A	1. Craniotomy. 2. Premature labour. Spontaneous (6th mon.). This child only lived 2 days. Mother died 4th day of septic infection.	Brit. Med. Journ., 1908, Vol. i, p. 67.
C.S. Sterilized. Uterus incised to right of first incision.	R	A	**2nd C.S.** First by Dr. Gow, Aug. 31, 1899. The first child died in 8th week. Silk sutures plainly visible in scar.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Child 8½lbs. Placenta anterior.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1, 2, 3, 4, all premature between 6th and 7th months.	——
C.S. Not sterilized.	R	A	Most labours craniotomy.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1902					
280	April 16	A. J. Wallace, Liverpool.	28	1	Generally contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. Onset of labour.
281	April 17	A. E. Giles, London.	31	0	Fibro-myoma uteri adherent in hollow of sacrum.	Unfavourable. In labour 10 hours. Version already tried. Cord and one foot at vulva.
282	April 28	H. Briggs, Liverpool.	26	0	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour 48 hours. Liq. amnii drained away.
283	May 2	J. M. Munro Kerr, Glasgow.	—	3	Rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Admitted in labour.
284	May 3	R. Jardine, Glasgow.	29	Multi-para	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.
285	May 7	R. Jardine, Glasgow.	22	0	Contracted pelvis, C.V. 3″ (7·5 cm.). Eclampsia.	Unfavourable. Comatose from eclampsia.
286	May 8	Murdoch Cameron, Glasgow.	36	?	Contracted pelvis, C.V. 1½″ (3·8 cm.).	——
287	May 8	W. J. Gow, London.	39	2	Contracted pelvis, C.D. 2¾″ (6·9 cm.).	1st stage of labour.
288	May 10	W. J. Gow, London.	39	2	Contracted pelvis, C.D. 3″ (7·5 cm.).	Not in labour.
289	May 15	J. M. Munro Kerr, Glasgow.	27	2	Generally contracted rachitic flat pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour. Cord prolapsed. Membranes long ruptured.
290	May 16	F. W. L. Haultain, Edinburgh.	22	0	Dermoid ovarian cyst in pelvis.	In labour 5 hours.
291	June 4	F. Edge, Wolverhampton.	23	0	Fibro-myoma uteri obstructing pelvis.	Favourable.
292	June 10	A. H. N. Lewers, London.	42	0	Fibro-myoma uteri, in right broad ligament.	Favourable. Not in labour.
293	June 17	J. M. Munro Kerr, Glasgow.	?	0	Generally contracted rachitic flat pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In hospital 3 weeks before operation.
294	June 17	J. M. Munro Kerr, Glasgow.	36	4	Cancer of cervix uteri.	Not in labour.
295	July 4	A. F. Stabb, London.	30	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour. Membranes intact.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as April 6, 1901, and April 15, 1905 (Wallace).	Journ. of Obst. and Gyn. Brit. Empire, 1902, Vol. ii, p. 555; Practitioner, March 1907.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	D	—	—
C.S. Sterilized.	R	A	—	—
C.S. Fritsch's fundal incision. Placenta not encountered. Not sterilized.	R	A	Child 8lbs. 1, Premature—died 2, 3, Craniotomy.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Sterilized.	R	A	—	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	D	A	Died of pneumonia. Abdominal and uterine wounds healed.	"Clinical Obstetrics," 1910, p. 412.
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	1, 2, Craniotomy. Child 5lbs. 7oz.	Harveian Lectures, March 1907.
C.S. Not sterilized.	R	A	1, 2, Abortion induced 4th month. Child 6lbs. 14oz.	Harveian Lectures, March 1907.
C.S. Fritsch's fundal incision. Placenta encountered. Not sterilized.	D	A	1. Craniotomy. 2. Craniotomy after induction of labour. Mother died of sepsis 6th day.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. and ovariotomy. Not sterilized.	R	A	Has had 3 children since.	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	—	—
C.S. Sterilized.	R	A	Placenta anterior, severe pressure symptoms at 4th month.	Lancet, 1903, Vol. i, p. 157.
C.S. Not sterilized.	D	A	Placenta anterior wall. Died from internal hæmorrhage from slipped ligatures.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Mother died 9 months later.	Brit. Med. Journ., 1904, Vol. ii, p 1312; Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	R	A	1. Craniotomy.	Queen Charlotte's Hosp. Reports.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1902					
296	July 15	A. F. Stabb, London.	31	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour. Membranes ruptured 3 hours.
297	July 19	Mrs. Stanley Boyd, London.	43	0	Fibro-myoma uteri, pedunculated, growing from posterior wall, prolapsed and adherent in Douglas' pouch.	Favourable.
298	July 22	H. Briggs, Liverpool.	28	4	Rachitic pelvis, C.V. 3½″ (8·7 cm.).	In labour 2 days. Membranes ruptured.
299	July 25	J. W. Martin, Sheffield.	31	4	Flat pelvis, C.V. 2½″ (6·2 cm.).	In labour 4 hours. Membranes intact.
300	Aug. 4	T. B. Grimsdale, Liverpool.	29	3	Contracted pelvis.	Favourable.
301	Aug. 26	A. J. Wallace, Liverpool.	28	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour.
302	Aug. 27	J. B. Hellier, Leeds.	33	0	Rachitic dwarf 3ft. 1in. high, C.V. 2″ (5 cm.).	Favourable. Admitted in labour.
303	Aug. 30	Murdoch Cameron, Glasgow.	25	?	Contracted pelvis, C.V. 2½″ (6·2 cm.).	
304	Aug. 30	A. F. Stabb, London.	30	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour. Membranes intact.
305	Sept. 25	W. H. C. Newnham Clifton, Bristol.	27	0	Contracted pelvis.	Unfavourable.
306	Sept. 25	W. W. H. Tate, London.	26	4	Contracted pelvis.	In labour 12 hours. Membranes ruptured.
307	Oct. 3	T. Wilson, Birmingham.	28	0	Oblique pelvis. Left hip-joint ankylosed, thigh at right angles, C.V. 2½″ (6·2 cm.). Left side of pelvis undeveloped. Outlet 2″ x 2½″ (5 x 6·2 cm.).	Unfavourable. Frequent examinations.
308	Oct. 11	H. Briggs, Liverpool.	35	0	Rachitic pelvis, C.V. 2¼″ (5·6 cm.).	In labour 24 hours. Membranes ruptured.
309	Oct. 13	W. W. H. Tate, London.	30	0	Flat pelvis, C.V. 2½″ (6·2 cm.).	In labour 8 hours. Membranes ruptured.
310	Oct. 15	G. E. Herman, London.	26	0	Sacral outgrowth ? sarcoma ? exostosis.	Bougie passed 24 hours before. Membranes ruptured. No pains.
311	Oct. 16	R. Jardine, Glasgow.	21	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Admitted in labour.
312	Oct. 18	R. Jardine, Glasgow.	27	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour 11 hours. Cord prolapsed.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	——	Queen Charlotte's Hosp. Reports.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	D	A	Died in 2 days with enormous abdominal distension. Child 9lbs.	Journ. of Obst. and Gyn. Brit. Empire, 1904, Vol. v, p. 315.
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Child 7½lbs. 1, 2, Craniotomy. 3, Abortion. 4, Induction 32nd week and craniotomy.	Journ. of Obst. and Gyn. Brit. Empire, 1902, Vol. ii, p. 467.
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1, Cephalotripsy.	Journ. of Obst. and Gyn. Brit. Empire, 1902, Vol. ii, p. 555; Practitioner, March 1907.
C.S. Sterilized.	R	A	——	Brit. Med. Journ., 1903, Vol. i, p. 16.
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1, Craniotomy	Queen Charlotte's Hosp. Reports.
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	1, 2, 3, Full term with much difficulty—all dead. 4, Induction. 30 weeks, lived 6 weeks.	——
C.S. Not sterilized.	D	A A	Children 8½ and 7lbs. Mother died 24th day. Suppurative peritonitis.	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Got up 19th day and developed œdema left leg. Convalescence delayed.	——
C.S.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1902					
313	Oct. 20	Sir F. H. Champneys, London.	24	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour. Membranes ruptured.
314	Oct. 20	R. Jardine, Glasgow.	26	4	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Prolonged labour. Retraction ring present.
315	Nov. 2	A. J. Wallace, Liverpool.	25	1	Rachitic flat pelvis, C.V. 2⅝″ (6·5 cm.).	Unfavourable. Membranes ruptured.
316	Nov. 8	A. H. N. Lewers, London.	35	0	Fibro-myoma uteri (subperitoneal) growing from supravaginal cervix.	Favourable. Not in labour.
317	Nov. 10	Amand Routh, London.	35	7	Cancer of cervix uteri, and vagina. Advanced.	Favourable. 38 weeks pregnant. Not in labour.
318	Dec. 6	W. S. A. Griffith, London.	44	6	Flat pelvis, C.V. 3½″ (8·7cm.).	Favourable. Onset of labour.
319	Dec. 19	W. S. A. Griffith, London.	30	1	Fibro-myoma uteri obstructing labour.	Very unfavourable. 103° F. on admission. Not in labour. 8½ months pregnant.
320	Dec. 27	J. M. Munro Kerr, Glasgow.	—	0	Rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Onset of labour with pr[illegible] uterine inertia.
	1903					
321	Jan. 1	R. D. Purefoy, Dublin.	24	0	Flat pelvis.	Unfavourable.
322	Jan. 1	J. B. Hellier, Leeds.	28	0	Rachitic flat pelvis, C.V. 1½″ (3·8 cm.).	Admitted in labour. Cord prolapsed.
323	Jan. 13	Herbert Spencer, London.	30	0	Ventrifixation, resulting from myomectomy, pedicle being treated as extra-peritoneal stump	Favourable. Not in labour.
324	Jan. 24	T. Wilson, Birmingham.	30	2	Rachitic flat pelvis, C.V. 2·8″ (7 cm.).	Favourable. Not in labour, six days before full term.
325	Feb. 1	H. Briggs, Liverpool.	39	1	Fibro-myoma uteri in right broad ligament obstructing labour.	Favourable. In labour 6 hrs. Membranes intact.
326	Feb. 7	W. J. Gow, London.	30	1	Contracted pelvis, C.D. 3½″ (8·7 cm.). Breech presenting.	1st stage of labour.
327	Feb. 13	J. H. Targett, London.	42	3	Generally contracted rachitic pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. Full term. In labour. Membranes ruptured.
328	Feb. 17	Drummond Robinson, London.	—	Multipara	Cancer of rectum. Connective tissue everywhere involved.	Very unfavourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as November 10, 1909 (Fairbairn).	——
C.S. Sterilized.	D	A	Sepsis. Profuse diarrhœa.	——
C.S. Not sterilized.	R	A	Same patient as March 4, 1905 (Wallace).	Practitioner, March 1907.
C.S.	R	A	Patient married 10 years before pregnancy. Sterilization attempted.	Lancet, 1903, Vol. i, p. 157.
C.S. Not sterilized.	R	A	Patient lived 3 months after operation.	Lancet, 1904, Vol. ii, p. 1613.
C.S. Not sterilized.	R	A	Child only survived 14 hours.	Queen Charlotte's Hosp. Reports.
C.S. nd supra-vaginal hysterectomy, ntra-peritoneal stump.	D	A	1, Forceps. Full time. Living child. Mother died of pneumonia. Verified P.M. Fibroids inflamed.	——
C.S. ra-vaginal hysterectomy, itoneal stump.	R	A	——	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. ot sterilized.	R	A	——	Rotunda Hospital Reports.
C.S. Sterilized.	R	D	Ascitic fluid in abdomen.	Lancet, 1904, Vol. i, p. 76; Brit. Med. Journ., 1903, Vol. i, p. 607.
C.S. Not sterilized.	R	A	Child died in a few hours from hæmorrhage from loose ligature on funis.	——
C.S. Sterilized.	R	A	1, 2, Stillborn. Child 7lbs. 2oz. Some inertia uteri after operation.	——
C.S. Not sterilized.	R	A	Vaginal enucleation of fibroid June 6, 1903.	——
C.S. Not sterilized.	R	A	Child 6lbs. 7oz.	Harveian Lectures, March 1907.
C.S. Sterilized.	R	A	1, 2, Craniotomy. 3, Premature —breech—died. Patient had goitre.	——
C.S.	R	A	Nearly died during operation. Left hospital much improved constitutionally.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1903					
329	Feb. 28	A. Donald, Manchester.	30	2	Contracted (oblique) pelvis.	——
330	March 2	Sir W. J. Sinclair, Manchester.	30	Multi-para	Contracted pelvis. Bad obstetric history.	Favourable.
331	March 6	J. H. Targett, London.	22	4	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour 5 hrs. Membranes intact.
332	March 12	A. H. N. Lewers, London.	25	2	Generally contracted pelvis, C.D. 4″, Interspin. 9″, Intercris. 10″.	Favourable. Not in labour.
333	March 17	F. W. L. Haultain, Edinburgh.	28	2	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
334	March 17	J. M. Munro Kerr, Glasgow.	—	0	Generally contracted rachitic pelvis, C.V. 2¾″ (6·9 cm.).	Onset of labour. In hospital several days.
335	March 20	Herbert Spencer, London.	34	11	Cancer of cervix. Very advanced.	Unfavourable. 8th month. In labour.
336	March 20	J. M. Munro Kerr, Glasgow.	33	4	Generally contracted rachitic pelvis, C.V. 2¾″ (6·9 cm.).	Far advanced in labour. Membranes ruptured. ? infect[illegible]
337	April 1	A. Donald, Manchester.	38	10	Cancer of cervix uteri. Advanced.	——
338	April 16	E. J. Maclean, Cardiff.	17	0	Contracted pelvis, C.V. 2″ (5 cm.).	Favourable. Not [illegible] labour. Full term.
339	April 21	J. M. Munro Kerr, Glasgow.	19	0	Generally contracted flat pelvis	In labour.
340	April 21	E. J. Maclean, Cardiff.	35	3	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. Not in labour. Full term.
341	April 29	P. E. Barber, Sheffield.	27	3	Contracted pelvis.	Unfavourable. Membranes ruptured 48 hours. Stinking vaginal discharge. P. 160.
342	May 1	J. M. Munro Kerr, Glasgow.	28	2	Generally contracted rachitic pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour. Some days in hospital. Much abdominal pain during pregnancy.
343	May 10	R. Jardine, Glasgow.	35	5	Cancer of cervix. Advanced.	Very weak from severe hæmorrhage. Child dead.
344	May 17	Murdoch Cameron, Glasgow.	—	—	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Unfavourable. Heart disease
345	June 1	R. Jardine, Glasgow.	28	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Admitted in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as January 7, 1905 (Donald).	——
C.S. Not sterilized.	R	A	Several craniotomies and fatal forceps deliveries	——
C.S. Sterilized.	R	A	Two craniotomies.	——
C.S. Sterilized.	R	A	1, Stillborn. 2, Cephalotripsy.	Lancet, 1903, Vol. ii, p. 1089.
C.S. Not sterilized.	R	A	1, 2, Stillborn.	——
C.S. Not sterilized.	R	A	Placenta posterior.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. nd supra-vaginal hysterectomy, ttra-peritoneal stump.	R	A	Patient died in 7 months of the cancer.	Trans. Obst. Soc., Lond., Vol. xlvi, p. 374.
C.S. supra-vaginal hysterectomy, ritoneal stump.	R	A	Previous children stillborn. Operation done in country.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S.	R	A	Baby died 5th week.	——
C.S. Sterilized.	R	A	——	Brit. Med. Journ., 1903, Vol. ii, p. 812.
C.S. Not sterilized.	R	A	Child 9½lbs.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Sterilized.	R	A	1, 2, 3, Craniotomies.	Brit. Med. Journ., 1903, Vol. ii, p. 812.
C.S. Not sterilized.	D	A	Mother died 4th day. Child died in 16 hours.	——
C.S. d supra-vaginal hysterectomy, tra-peritoneal stump.	R	D	**2nd C.S.** Same patient as September 30, 1901 (Munro Kerr). Extensive adhesions round uterine scar.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Supra-vaginal hysterectomy, tra-peritoneal stump.	R	D	Patient lived several months.	"Clinical Obstetrics," 1910, p. 615.
C.S. Sterilized.	D	A	Heart failure.	"Clinical Obstetrics," p. 617.
C.S. Sterilized.	R	A A	Children only lived 10 days. 1, Craniotomy.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1903					
346	June 9	R. Jardine, Glasgow.	27	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Admitted in labour. Membranes ruptured 12 hours.
347	June 11	D. Lloyd Roberts, Manchester.	30	6	Generally contracted flat pelvis.	——
348	June 12	W. C. Swayne, Bristol.	22	0	Ovarian dermoid cyst, completely blocking pelvis.	Favourable. In labour 6 hrs. Membranes ruptured, but no attempts to deliver.
349	June 16	Herbert Spencer, London.	36	3	Contracted pelvis, C.V. 3½″ (8·7 cm.). Head would not pass brim.	Unfavourable. In labour. Severe toxæmia. Vomiting.
350	June 21	J. B. Hellier, Leeds.	27	0	Rachitic pelvis, C.V. 2″ (5cm).	Favourable. Admitted in labour.
351	June 23	Sir W. J. Sinclair, Manchester.	30	2	Extreme pelvic contraction. See details April 10, 1896.	Favourable.
352	June 24	T. B. Grimsdale, Liverpool.	41	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable.
353	July 13	W. J. Gow, London.	30	0	Fibro-myoma uteri blocking pelvis.	1st stage of labour.
354	July 16	J. M. Munro Kerr, Glasgow.	31	3	Generally contracted rachitic pelvis.	Admitted in lab[illegible] Membranes ruptured. [illegible]our.
355	July 19	A. H. N. Lewers, London.	?	1	Generally contracted pelvis.	Unfavourable. In labour 2[illegible] hours. Membranes ruptured [illegible] hours. Two attempts at forceps delivery.
356	July 23	D. Lloyd Roberts, Manchester.	25	0	Achondroplasia, C.V. 1½″ (3·8 cm).	——
357	July 30	C. Lockyer, London.	38	6	Cancer of cervix (advanced).	Unfavourable. In labour 1[illegible] hours. Very exhausted. P. 140
358	Aug. 21	C. E. Purslow, Birmingham.	32	2	Contracted pelvis.	In labour 12 hours. Membranes ruptured 7 hours. Attempts at forceps delivery.
359	Sept. 3	Sir W. J. Sinclair, Manchester.	25	0	Contracted pelvis.	——
360	Sept. 5	J. B. Hellier, Leeds.	28	3	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. Not in labour.
361	Sept. 7	E. Stanmore Bishop. Manchester.	36	2	Rachitic pelvis.	Favourable. Gestation 36 wk[illegible]

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Same patient as July 29, 1907 (Lloyd Roberts). 1, 2, 3, 5, 6, Craniotomy. 4, Induction 8th month and forceps. Stillborn.	Trans. N. of Eng. Obst. and Gyn. Soc., 1907-8, p. 126.
C.S. and ovariotomy. Not sterilized.	R	A	Child alive a year later. Full term delivery October 1, 1906. Vesical calculus, 1907.	Bristol Med. Chir. Journ., 1904, Vol. xxii, p. 120.
C.S. Not sterilized.	R	A	Child died in 7 hours with cerebral hæmorrhage. 1, Cephalotripsy. 2, 3, Induction. Died.	——
C.S. Sterilized.	R	A	——	Lancet, 1904, Vol. i, p. 76.
C.S. Not sterilized.	R	A	**3rd C.S.** Same patient as April 10, 1896 and August 22, 1901, and August 1, 1907 (Sinclair).	Journ. of Obst. and Gyn. Brit. Empire, 1904, Vol. v, p. 17, and 1907, Vol. xii, p. 335.
C.S. Not sterilized.	R	A	——	——
C.S. sterilized.	R	A	Child 7lbs.	Harveian Lectures, March 1907.
C.S. Fritsch. fundal incision. Not sterilized.	R	A	1, 3, Stillborn. 2, Induction. Lived a few months.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	R	D	Fœtal heart heard before operation, but could not be revived.	Lancet, 1903, Vol. ii, p. 1089.
C.S. Not sterilized.	R	A	Child lived 2 months.	Journ. of Obst. and Gyn. Brit. Empire, 1908, Vol. xiii, p. 305.
C.S. Not sterilized.	R	A	After getting up, got weaker and died 4 weeks later.	Brit. Med. Journ., 1909, Vol. ii, p. 1044.
C.S. and supra-vaginal hysterectomy, extra-peritoneal stump.	R	D	1, 2, Craniotomy.	Birmingham and Midland Branch of Brit. Med. Assoc., Nov., 1906.
C.S. Not sterilized.	D	?	——	——
C.S. Not sterilized.	R	A	——	Lancet, 1904, Vol. i, p. 76.
C.S. Sterilized by request by removing ovaries and tubes.	R	A	Child died in 2 months. 1, Embryotomy. 2, Abortion induced.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1903					
362	Sept. 10	H. Playfair, London.	30	4	Rachitic flat pelvis, C.V. 3¼″ (7·5 cm.).	Favourable. Not in labour.
363	Sept. 22	P. E. Barber, Sheffield.	24	4	Contracted pelvis.	——
364	Oct. 2	Mrs. Scharlieb, London.	31	1	Extreme kyphosis, Interischial 2¼″ (5·6″).	Favourable. Full term. Not in labour.
365	Oct. 8	R. Favell, Sheffield.	37	2	Flat pelvis.	——
366	Oct. 14	A. W. Russell, Glasgow.	22	1	Contracted pelvis, C.V. 2⅞″ (5·9 cm.).	Favourable. In labour.
367	Oct. 24	J. M. Munro Kerr, Glasgow.	?	3	Rachitic flat pelvis, C.V. 3″ (7·5 cm).	In labour. Membranes intact.
368	Oct. 27	R. Jardine, Glasgow.	25	1	Contracted pelvis, C.V. 2½″ (6·2 cm).	Admitted in labour.
369	Nov. 3	J. M. Munro Kerr, Glasgow.	26	1	Generally contracted rachitic flat pelvis, C.V. 2″ 5 cm.).	Admitted in labour.
370	Nov. 7	R. Jardine, Glasgow.	23	0	Contracted pelvis, C.V. 1¾″ (4·4 cm.).	Admitted in labour. [illegible] lapsed and pulseless. [illegible]lent exhausted and dirty.
371	Nov. 7	R. Jardine, Glasgow.	25	2	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Not in labour.
372	Nov. 7	R. Jardine, Glasgow.	22	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.
373	Nov. 14	E. Tenison Collins, Cardiff.	29	3	Enchondroma of left sacro-iliac joint.	Exhausted. In labour 24 hours.
374	Nov. 16	R. Jardine, Glasgow.	35	4	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Not in labour.
375	Nov. 18	J. W. Martin, Sheffield.	23	0	Spondylolisthetic pelvis.	Favourable.
376	Nov. 18	Sir W. J. Sinclair, Manchester.	30	0	Contracted pelvis.	Favourable. In Hospital some days. Not in labour.
377	Nov. 19	R. Jardine, Glasgow.	23	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.
378	Nov. 24	W. J. Gow, London.	24	0	Contracted pelvis, C.D. 3″ (7·5 cm).	1st stage of labour.
379	Nov. 25	W. J. Gow, London.	36	2	Contracted pelvis, C.D. 3½″ (8·1 cm.).	1st stage of labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1-4 craniotomy or forceps. All stillborn. This child 7½lbs.	——
C.S.	R	D	——	——
C.S. Sterilized.	R	A	Child 7lbs.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Same patient as July 8, 1906 (Russell). Child 7½lbs.	——
C.S. Not sterilized.	R	A	Developed double parotitis.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	R	A	——	——
C.S. = …d supra-vaginal hysterectomy, …ra-peritoneal stump.	R	A	**2nd C.S.** Same patient as Jan. 16, 1902 (Kerr). No pain during pregnancy. Adhesions front of uterus, not over fundal incision.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. …vaginal hysterectomy, int…neal stump.	R	D	These 3 patients operated upon in one day, within 14 hours. 1, Craniotomy	"Clinical Obstetrics," 1910, p. 616.
C.S. Sterilized.	R	A		"Clinical Obstetrics," 1910, p. 619.
C.S. Not sterilized.	R	A		"Clinical Obstetrics."
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Same patient as May 17, 1909 (Jardine). 1, 2, 4, Craniotomy.	"Clinical Obstetrics," 1910, p. 619.
C.S. Not sterilized.	R	A	Same patient as May 22, 1908 (M. H. Phillips).	——
C.S. Not sterilized.	R	A	Same patient as May 31, 1910 (Sinclair).	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Child 6lbs. 15ozs.	Harveian Lectures, March 1907.
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as June 27, 1906 (Gow).	Harveian Lectures, March 1907.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1903					
380	Nov. 26	A. Donald, Manchester.	36	3	Contracted flat pelvis.	——
381	Nov. 28	Herbert Spencer, London.	38	0	Ovarian fibroma (incarcerated).	Favourable. Not in labour.
382	Dec. 4	R. Jardine, Glasgow.	26	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.
383	Dec. 5	Russell Andrews, London.	29	2	Generally contracted flat pelvis, C.D. 3½″ (8·7 cm.).	In labour 10 hours. Axis-traction forceps had been applied.
384	Dec. 5	A. H. N. Lewers, London.	23	0	Generally contracted pelvis.	Unfavourable. In labour 36 hours. Membranes ruptured 12 hours.
385	Dec. 31	A. J. Wallace, Liverpool.	23	0	Generally contracted pelvis.	Prolonged labour. Several attempts made to deliver before admission.
	1904					
386	Jan. 1	Sir Halliday Croom, Edinburgh.	28	0	Fibro-myoma uteri obstructing labour.	Advanced labour. Membranes ruptured. Transverse position. Arm presenting. Previous attempts at delivery exhausted.
387	Jan. 1	W. J. Gow, London.	23	1	Contracted pelvis, C.D. 3¾″ (9·3 cm.).	1st stage of labour.
388	Jan 2	J. A. C. Kynoch, Dundee.	21	1	Generally contracted rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour.
389	Jan. 10	F. Edge, Wolverhampton.	29	1	Contracted pelvis.	Favourable.
390	Jan. 10	Sir W. J. Sinclair, Manchester.	34	0	Contracted pelvis.	Favourable, but membranes ruptured 5 days.
391	Jan. 11	E. J. Maclean, Cardiff.	20	1	Contracted pelvis, C.V. 3½″ (8·7 cm.).	Favourable. Not in labour. Full term.
392	Jan. 14	J. B. Hellier, Leeds.	25	0	Generally contracted rachitic flat pelvis, C.V. 2¾″ (6·9 cm.).	In labour. Liq. amnii drained away. Many examinations made ? infected.
393	Jan. 27	A. H. N. Lewers, London.	26	?	Contracted pelvis.	Very unfavourable. In labour 4 days. Tonic contraction of uterus.

Operative Technique	Result		Remarks	References If Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Diagnosed as uterine fibroid. Patient again pregnant and aborted 1904.	Proc. Roy. Soc. Med., 1909, Vol. ii, p. 232.
C.S. Sterilized.	R	A	Baby died of jaundice on 3rd day.	"Clinical Obstetrics," 1910, p. 621.
C.S. Not sterilized.	R	A	Same patient as May 24, 1909 (Andrews). This child deep depression fœtal head (sacral pressure). Child died pertussis at 18 months. 1, 2, Cephalotripsy.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	Died of sepsis. At P.M. uterine wound gaping and purulent peritonitis.	Practitioner, March 1907.
C.S. Not sterilized.	D	D	Child alive at beginning of operation.	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Nov. 19, 1900 (Gow).	Harveian Lectures, March 1907.
C.S. Sterilized.	R	A	——	Trans. Edin. Obst. Soc., Vol. xxxii, p. 222.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	1. Craniotomy. Child died in 24 hours from hæmorrhage due to slipping of ligature on umbilical cord.	——
C.S. Not sterilized.	R	A	Septic puerperium. T. 104°F. Uterus irrigated with iodine solution during puerperium.	Lancet, 1904, Vol. ii, p. 952.
C.S. Not sterilized. Incision at retraction ring to extract child's head.	D	A	Incision of retraction ring caused severe hæmorrhage. Died in 6 hours.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1904					
394	Jan. 30	J. M. Munro Kerr, Glasgow.	32	8	Generally contracted flat pelvis.	Admitted in labour. Membranes ruptured.
395	Feb. 2	W. J. Gow, London.	23	0	Contracted pelvis, C.D. 3″ (7·5 cm).	1st stage of labour.
396	Feb. 2	J. M. Munro Kerr, Glasgow.	30	3	Cancer of cervix uteri.	In labour. 38th week of gestation.
397	Feb. 3	J. M. Munro Kerr, Glasgow.	?	2	Generally contracted rachitic flat pelvis, C.V. 3″ (7·5 cm.).	In labour some hours when admitted. Patient very delicate.
398	Feb. 5	H. Playfair, London.	31	1	Generally contracted rachitic flat pelvis. Induction refused.	——
399	Feb. 12	W. J. Gow, London.	39	1	Contracted pelvis, C.D. 4″ (10 cm).	2nd stage of labour.
400	Feb. 13	J. M. Munro Kerr, Glasgow.	24	0	Generally contracted rachitic flat pelvis.	In advanced labour when admitted. Cord prolapsed.
401	Feb. 19	J. M. Munro Kerr, Glasgow.	37	6	Rachitic flat pelvis, C.V. 3″ (7·5 cm.). Head overlapped brim.	In hospital some days before operation.
402	Feb. 25	J. M. Munro Kerr, Glasgow.	?	2	Generally contracted rachitic flat pelvis.	Not in labour.
403	Feb. 25	R. P. R. Lyle, Newcastle-on-Tyne.	37	0	Generally contracted rachitic flat pelvis, C.V. 2¾″ (6·9 cm.). Transv. 3¼″ (8·1 cm.)	Extremely emaciated, and exhausted from want of sleep. Dwarf.
404	March 5	R. Jardine, Glasgow.	27	2	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Admitted after 36 hours in labour. Frequent examinations.
405	March 6	J. M. Munro Kerr, Glasgow.	23	0	Generally contracted rachitic flat pelvis, C.V. 2¾″ (6·9 cm.).	Advanced in labour, and previous examinations made.
406	March 7	R. Jardine, Glasgow.	27	1	Contracted pelvis, C.¼″ (5·6	Admitted in labour with severe accidental hæmorrhage. Patient feeble and starved.
407	March 8	R. Jardine, Glasgow.	28	1	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Admitted in labour.
408	March 9	W. S. A. Griffith, London.	29	2	Flat pelvis, C.V. 3⅛″ (7·8 cm.).	Favourable. Onset of labour.
409	March 15	W. S. A. Griffith, London.	21	0	Flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. Onset of labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	All eight children stillborn.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	R	A	Child 6lbs. 6ozs.	Harveian Lectures, March 1907.
C.S. and panhysterectomy. First removed cervix per vaginam, tying off uterine arteries. Then abdominal C.S. and abdominal hysterectomy, closing vaginal vault from the abdomen.	D	A	Patient died 5th day of septic peritonitis.	Brit. Med. Journ., 1904, Vol. ii, p. 1312.
C.S. Sterilized.	R	A	1, Stillborn. 2, Craniotomy.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	R	A	1, Version and craniotomy. Child 8lbs.	——
C.S. Not sterilized.	R	A	Child 7lbs. 15ozs.	Harveian Lectures, March 1907.
C.S. [illegible] supra-vaginal hysterectomy, [illegible] peritoneal stump.	R	A	Pelvic cellulitis during puerperium. Recovered well.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Sterilized.	R	A	4 stillborn and 2 living children.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Sterilized.	R	A	1, Craniotomy. 2, Induction. Stillborn.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	D	A	Patient died in 8 hours from exhaustion and P.P.H.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Puerperium normal.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Sterilized.	R	A	——	"Clinical Obstetrics," 1910, p. 621.
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	Queen Charlotte's Hosp. Reports.
C.S. Not sterilized.	R	A	Single woman.	Queen Charlotte's Hosp. Reports.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1904					
410	March 25	R. Favell, Sheffield.	28	1	Kyphotic pelvis.	Favourable.
411	March 28	W. J. Gow, London.	21	0	Contracted pelvis, C.D. 3¾″ (9·3 cm.). Forceps failed.	2nd stage of labour.
412	March 29	R. P. R. Lyle, Newcastle-on-Tyne.	31	3	Uterus and vagina duplex. Myomatous second uterus blocking pelvis.	Favourable. In labour 12 hrs. No previous attempts at delivery.
413	March 30	R. Jardine, Glasgow.	25	1	Contracted pelvis, C.V. 3″ (7·5 cm).	Admitted in labour.
414	March 31	A. H. N. Lewers, London.	34	?	Contracted pelvis.	Favourable. Not in labour.
415	April 12	A. W. W. Lea, Manchester.	33	8	Rachitic pelvis, C.V. 2·75″ (6·9 cm.).	In labour. Membranes ruptured.
416	April 15	R. P. R. Lyle, Newcastle-on-Tyne.	27	0	Rachitic flat pelvis, scoliosis, C.V. 2½″ (6·5 cm.).	Favourable. Onset of labour.
417	April 20	R. Jardine, Glasgow.	23	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Admitted in labour.
418	April 21	J. H. Targett, London.	41	5	Rachitic pelvis. Reniform brim. C.V. 3¼″ (8·1 cm.).	Favourable. In labour hrs. Membranes intact.
419	April 25	D. Lloyd Roberts, Manchester.	32	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	——
420	May 4	W. J. Gow, London.	24	0	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	1st stage of labour.
421	May 6	D. Lloyd Roberts, Manchester.	21	0	Contracted pelvis.	——
422	May 10	R. Jardine, Glasgow.	27	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
423	May 10	J. M. Munro Kerr, Glasgow.	21	3	Generally contracted rachitic flat pelvis, C.V. 3″ (7·5 cm.).	In labour, but in hospital 24 hours beforehand.
424	May 12	A. H. N. Lewers, London.	28	1	Contracted pelvis.	Favourable. Not in labour.
425	May 16	J. M. Munro Kerr, Glasgow.	24	2	Rachitic flat pelvis, C.V. 3″ (7·5 cm.).	In labour when admitted.
426	May 18	W. J. Gow, London.	43	0	Eclampsia and contracted pelvis, C.V. 3¾″ (9·3 cm.).	In labour 78 hours. Much albumen in urine.
427	May 30	J. M. Munro Kerr, Glasgow.	21	0	Generally contracted rachitic flat pelvis, C.V. 2½″ (6·2 cm.).	Not in labor, and in hospital 4 weeks beforehand.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as August 7, 1906 (J. W. Martin).	——
C.S. Not sterilized.	R	A	——	Harveian Lectures, March 1907.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump of 2nd uterus.	R	A	2nd uterus weighed 15oz., impacted in pelvis. 3 abortions previously at 3 months.	Journ. of Obst. and Gyn. Brit. Empire, 1904, Vol. vi, p. 438.
C.S. Sterilized.	D	A	Bowels paralysed after operation. At P.M. no evidence of sepsis.	"Clinical Obstetrics," 1910, p. 622.
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Craniotomy 7 times.	——
C.S. Sterilized.	R	A	Sterilized at urgent request of parents.	——
C.S. Sterilized.	R	A	Serious collapse 2nd day. Venous saline infusion.	"Clinical Obstetrics," 1910, p. 623.
C.S. Not sterilized.	R	D	Child hydrocephalus, and large spina bifida, presenting by breech.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Child 7lbs. 2oz. Same as patient July 20, 1906 (Targett).	Harveian Lectures, March, 1907.
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	D	A	Paralysis of bowel after operation. No signs of peritonitis.	——
C.S. Not sterilized.	R	A	All children previously stillborn.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	R	A	Same case as July 26, 1906 (Lewers). 1. cephalotripsy.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Not sterilized.	R	A	Child 8lbs. 11oz.	Harveian Lectures, March, 1907.
C.S. Not sterilized.	R	A	Disturbed puerperium. Retention of clots, and later pleuro-pneumonia.	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1904					
428	June 6	J. B. Hellier, Leeds.	28	0	Rachitic pelvis, C.V. 1⅜″ (3·5 cm.) . Spinal curvature.	In labour 16 hours. Membranes ruptured.
429	June 7	T. Wilson, Birmingham.	26	0	Kypho-scoliotic pelvis. Tubercular caries of spine in dorsal region, C.V. (outlet) 2″ (5 cm.).	Favourable. 39th week of gestation.
430	June 10	J. M. Munro Kerr, Glasgow.	23	0	Rachitic flat pelvis, C.V. 2¾″ (6·9 cm.).	In labour, but in hospital month beforehand.
431	June 22	P. E. Barber, Sheffield.	27	0	Exostosis on right pelvic wall.	——
432	July 4	Comyns Berkeley, London.	23	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. In labour. Membranes ruptured.
433	July 4	E. Hastings Tweedy, Dublin.	28	0	Contracted pelvis, C.V. (8 cm.). Transv. 13 cm.).	In labour 12 hours. Membranes intact.
434	July 5	J. Phillips, London.	35	4	Cancer of cervix uteri. Advanced.	Favourable. 36th week.
435	July 13	A. W. Russell, Glasgow.	25	1	Scolio-rachitic pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour.
436	July 22	Amand Routh, London.	26	0	Flat pelvis, C.V. 2¾″ (6·9 cm.).	Unfavourable. In labour 24 hours. Many attempts at delivery by version, forceps and cephalotripsy. Extreme exhaustion. Vagina, cervix and bladder torn.
437	July 27	J. W. Martin, Sheffield.	25	?	Contracted pelvis.	——
438	July 28	H. Russell Andrews, London.	31	3	Generally contracted flat pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. Not in labour.
439	July 30	A. W. Russell, Glasgow.	35	4	Contracted pelvis Marked overlapping of head.	Favourable. In labour.
440	Aug. 4	P. E. Barber, Sheffield.	24	1	Rachitic flat pelvis, C.D. 3⅛″ (7·8 cm.), C.V. 2½″ (6·2 cm.).	——
441	Aug. 5	R. Jardine, Glasgow.	22	1	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Admitted in labour. Gonorrhœa. Abscess of Bartholomew's glands.
442	Aug. 10	P. E. Barber, Sheffield.	39	6	Generally contracted flat pelvis, C.D. 3½″ (8·7 cm.).	——
443	Aug. 14	A. F. Stabb, London.	32	0	Rachitic flat pelvis.	Favourable. In labour 24 hours. Membranes ruptured. Eighth month.
444	Aug. 26	P. E. Barber, Sheffield.	32	0	Obliquely contracted pelvis. Old hip disease. Excision of hip at 12 years of age. Ankylosis. Lumbar lordosis.	——

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Broncho-pneumonia during puerperium.	Lancet, 1904, Vol. ii, p. 952.
C.S. Sterilized.	R	A	Child 6½lbs.	——
C.S. Not sterilized.	R	A	——	Trans. Obst. Soc., Lond., 1904, Vol. xlvi, p. 323.
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	Same patient as Nov. 30, 1905 (Tweedy).	Journ. of Obst. and Gyn. Brit. Empire, 1905, Vol. vii, p. 200.
C.S. after Pacquelin's cautery to growth. Not sterilized	R	A	Patient died of cancer 8 mons. later.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	D	D	Patient died suddenly third day after rallying well. Too exhausted for hysterectomy.	——
C.S. Sterilized.	D	A	Died of intestinal obstruction 4th day.	——
C.S. Not sterilized.	R	A	Previous children stillborn.	——
C.S. Not sterilized.	R	A	1, 2, 3, 4. Craniotomy. Phlegmasia dolens during puerperium.	——
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	D	A	"The infection spread up through the stump."	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1904					
445	Aug. 26	Sir W. J. Sinclair, Manchester.	23	0	Contracted pelvis.	——
446	Aug. 28	W. J. Gow, London.	31	4	Contracted pelvis, C.V. 3½″ (8·7 cm.).	In labour 29 hours.
447	Aug. 29	Murdoch Cameron, Glasgow.	25	?	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	——
448	Sept. 1	A. F. Stabb, London.	39	3	Rachitic pelvis.	Favourable.
449	Sept. 22	Sir W. J. Sinclair, Manchester.	28	?	Contracted pelvis.	——
450	Sept. 26	D. Lloyd Roberts, Manchester.	34	3	Fibro-myoma cervicis uteri.	——
451	Oct. 1	E. O. Croft, Leeds.	39	8	Rachitic pelvis.	Onset of labour.
452	Oct. 1	E. O. Croft, Leeds.	24	3	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	Onset of labour. Pyosalpinx present.
453	Oct. 4	W. S. A. Griffith, London.	37	1	Fibro-myoma uteri, impacted in pouch of Douglas.	Unfavourable. P. 126. In labour 25 hours. Membranes ruptured. No attempts at delivery.
454	Oct. 10	J. E. Gemmell, Liverpool.	25	3	Myasthenia gravis. Respiratory spasm.	Unfavourable. At term.
454	Oct. 12	Sir W. J. Sinclair, Manchester.	30	0	Contracted pelvis.	Very unfavourable. Acute yellow atrophy of liver.
455	Oct. 19	J. H. Targett, London.	34	7	Concealed accidental hæmorrhage. Uterus greatly distended	Very anæmic and collapsed. P. 144. 7th month.
456	Oct. 24	R. Favell, Sheffield.	28	0	Rachitic flat pelvis, C.V. 2⅝″ (6·5 cm.).	Not in labour
457	Nov. 1	J. M. Munro Kerr, Glasgow.	?	?	Carcinoma of cervix. Advanced.	——
458	Nov. 7	F. W. N. Haultain, Edinburgh.	35	0	Fibro-myoma of cervix uteri.	In labour 12 hours.
459	Nov. 7	E. Hastings Tweedy, Dublin.	29	0	Contracted pelvis, C.V. 5·5 cm. Transv. 11 cm.).	One hour in 1st stage. Membranes intact.
460	Nov. 11	E. Hastings Tweedy, Dublin.	26	0	Contracted pelvis, C.V. 6 cm.	18 hours in 1st stage.
461	Nov. 24	W. J. Gow, London.	27	3	Contracted pelvis, C.D. 3½″ (8·7 cm.).	In labour 30 hours.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Child 7lbs. 5oz.	Harveian Lectures, March 1907.
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1, 2, 3. Stillborn.	——
C.S. Not sterilized.	D	?	"Died from shock."	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Several inductions.	——
C.S. Salpingectomy.	D	A	Acute gonorrhœa about date of conception. Pelvic peritonitis. Probably tube still infective.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1. Craniotomy.	——
C.S.	R	A	——	Journ. of Obst. and Gyn. Brit. Empire, 1905, Vol. vii, p. 260.
C.S. Not sterilized.	D	A	Died within the week.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	D	Tedious convalescence. Severe thrombosis in both legs.	——
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. and panhysterectomy.	D	A	Died within 12 hrs. ? hæmorrhage.	Edin. Obst. Trans., Vol. xxxiii.
C.S. Not sterilized.	R	A	Placenta anterior.	Journ. of Obst. and Gyn. Brit. Empire, 1905, Vol. vii, p. 200.
C.S. Not sterilized.	R	D	——	Journ. of Obst. and Gyn. Brit. Empire, 1905, Vol. vii, p. 200.
C.S. Not sterilized.	R	A	Child 8lbs. 9oz. Mother pelvic abscess and phlebitis during puerperium.	Harveian Lectures, March, 1907.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1904					
462	Nov. 25	A. Donald, Manchester.	21	0	Contracted pelvis. Both hips dislocated.	——
463	Dec. 1	J. M. Munro Kerr, Glasgow.	23	1	Rachitic pelvis, C.V. 2¾″ (7·2 cm.).	In labour.
464	Dec. 1	A. H. N. Lewers, London.	30	2	Contracted pelvis.	Not in labour.
465	Dec. 1	R. P. R. Lyle, Newcastle-on-Tyne.	40	0 4	Rachitic pelvis, C.V. 5 cm. Dwarf 4ft. 1in.	Onset of labour
466	Dec. 4	E. Hastings Tweedy, Dublin.	34	3	Contracted pelvis, C.V. 6·3 cm. Transv. 10·3 cm.	15 hours in 1st stage. Membranes ruptured. Cord prolapsed.
467	Dec. 6	W. R. Dakin, London.	30	2	Contracted pelvis.	Favourable.
468	Dec. 11	Sir F. H. Champneys, London.	25	0	Hour-glass contraction of uterus in 1st stage. No impaction of presenting part. No other apparent cause for delay.	Unfavourable. Membranes ruptured. Forceps tried by doctor outside.
469	Dec. 20	J. M. Munro Kerr, Glasgow.	7	8	Carcinoma of cervix.	In labour 2 days. Membranes intact.
470	Dec. 20	D. Lloyd Roberts, Manchester.	36	6	Contracted pelvis.	——
471	Dec. 21	J. M. Munro Kerr, Glasgow.	25	2	Rachitic pelvis, C.V. 2¾″ (6·9 cm.).	——
472	Dec. 27	A. H. N. Lewers, London.	31	8	Contracted pelvis. Bad obstetric history.	Admitted in labour. Forceps failed to deliver in Hospital.
473	Dec. 27	J. H. Targett, London.	28	3	Simple flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour, membranes intact. Full term.
474	Dec. 31	W. J. Gow, London.	28	2	Contracted pelvis, C.D. 3″ (7·5 cm.).	Not in labour.
475	**1905** Jan. 1	W. K. Walls, Manchester.	30	1	Contracted pelvis.	——
476	Jan. 7	A. Donald, Manchester.	32	3	Obliquely contracted pelvis.	——

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	1. Craniotomy.	—
C.S. Not sterilized.	R	A	1, 2. Cephalotripsy.	—
C.S. Not sterilized.	D	A	Patient syphilitic. Uterus myomatous. Died from intestinal obstruction.	—
C.S. Not sterilized.	R	A	1, 2, 3. Craniotomy.	Journ. of Obst. and Gyn. Brit. Empire, 1905, Vol. vii, p. 200.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	2 stillborn children.	—
C.S. Not sterilized.	D	D	Patient died of peritonitis, probably infected before admission. Child 8½lbs. Dead before extraction.	—
C.S. (Ovarian and uterine vessels ligatured by abdomen, and vaginal panhysterectomy performed.	R	A	Phlegmasia left leg during puerperium.	Trans. Obst. Soc. Lond., 1905, Vol. xlvii, p. 195.
C.S. Not sterilized.	D	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Sterilized.	R	A	1. Natural. Died 4 months old. 2. Symphysiotomy. Child now alive. 3. Induction 8th month. Alive. 4. Premature. Forceps. Living. 5. Ditto. Stillborn. 6. Induction. Alive. 7. Premature. Forceps. Dead. 8. Induction. Stillborn.	Lancet, 1908, Vol. ii, p. 1211.
C.S. Sterilized.	R	A	Had 2 inductions previously. Result?	—
C.S. Not sterilized.	R	A	Same patient as December 19, 1907 (Gow). Child 5lbs. 10ozs.	—
C.S. Not sterilized.	R	A	1. Craniotomy.	—
C.S. Sterilized.	R	A A	**2nd C.S.** Same patient as February 28, 1903 (Donald).	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1905					
477	Jan. 8	Comyns Berkeley, London.	40	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Unfavourable. In labour 3 days. Forceps delivery previously attempted.
478	Jan. 12	P. E. Barber, Sheffield.	29	2	Generally contracted flat pelvis, C.V. 2¾″ (6·9 cm.).	——
479	Jan. 12	J. H. Targett, London.	27	3	Generally contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. In labour 22 hrs, but membranes intact.
480	Jan. 15	W. S. A. Griffith, London.	38	0	Placenta prævia (centralis). Severe hæmorrhage 3 times. High rigid cervix. Narrow vagina.	Favourable but anæmic.
481	Jan. 19	R. Jardine, Glasgow.	27	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.
482	Jan. 19	Mrs. Scharlieb, London.	30	0	Adeno-carcinoma of right ovary filling pelvic cavity.	Unfavourable. Not in labour. Eighth month.
483	Jan. 28	R. Jardine, Glasgow.	25	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour
484	Jan. 29	R. Jardine, Glasgow.	21	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.
485	Jan. 31	R. Jardine, Glasgow.	29	4	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour and cord prolapsed, but admitted before onset of labour.
486	Feb. 1	T. B. Grimsdale, Liverpool.	25	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable.
487	Feb. 1	J. M. Munro Kerr, Glasgow.	?	0	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	——
488	Feb. 2	Bellingham Smith, London.	30	1	Flat pelvis, C.V. 2½″ (6·2 cm.).	Unfavourable. In labour 24 hours, membranes ruptured.
489	Feb. 3	W. J. Gow, London.	26	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
490	Feb. 4	W. R. Dakin, London.	?	?	Contracted pelvis.	Favourable.
491	Feb. 8	F. J. McCann, London.	27	0	Contracted pelvis.	Unfavourable. In labour 48 hours. Membranes ruptured. Forceps delivery attempted.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	D	A	Death from exhaustion—fatty heart.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1, 2. Stillborn. Full term. 3. Induction. Stillborn.	——
C.S. Not sterilized.	R	A	——	Journ. of Obst. and Gyn. Brit. 1909, Vol. xvi, p. 359.
C.S. Sterilized.	R	A	——	——
C.S. and ovariotomy.	R	A	Child died in 4 days, weighed 5½lbs. Patient had recurrence and another laparotomy in 12 months, and finally died of the disease.	Proc. Roy. Soc. Med.
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	Same patient as Aug. 24, 1908 (Blair Bell), and Jan. 2, 1910 (Grimsdale).	——
C.S. Fundal incision. Not sterilized.	R	A	Placenta encountered.	——
C.S. Not sterilized.	D	A	Patient died 3rd day of general peritonitis. Child died in a few hours.	——
C.S. Not sterilized.	R	A	Child 5lbs. 10ozs.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1905					
492	Feb. 11	J. M. Munro Kerr, Glasgow.	32	6	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable.
493	Feb. 20	J. E. Gemmell, Liverpool.	25	2	Flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. 7 days before full term. Not in labour.
494	Feb. 21	R. Jardine, Glasgow.	22	0	Contracted pelvis, C.V. 2¾″ (6·9 cm..	Admitted in labour. Membranes ruptured. Frequent examinations made before admission.
495	Feb. 23	R. Jardine, Glasgow.	25	1	Generally contracted flat pelvis, C.V. 3″ (7·5 cm.).	Very weak and ill from gastric ulcer.
496	Feb. 24	R. Jardine, Glasgow.	32	0	Pseudomalacosteon pelvis, C.V. 1″ (2·6 cm.).	Very weak. Vaginal discharge.
497	Feb. 26	Sir F. H. Champneys, London.	23	1	Contracted pelvis, C.V. 2″ (5 cm.).	Favourable. In labour. Membranes intact
498	Feb. 27	R. Favell, Sheffield.	26	1	Generally contracted flat pelvis.	Favourable.
499	March 4	A. J. Wallace, Liverpool.	28	2	Rachitic flat pelvis, C.V. 2⅝″ (6·5 cm.).	Favourable. Not in labour.
500	March 19	Herbert Spencer, London.	28	0	Fibro-myomata; Foot presenting; Ascites; Albuminuria.	Unfavourable. Emergency operation in middle of night. In labour, membranes ruptured.
501	March 25	J. B. Hellier, Leeds.	24	3	Flat pelvis.	Not in labour.
502	March 29	J. M. Munro Kerr, Glasgow.	34	1	Rachitic pelvis, C.V. 2¼″ (5·6 cm.).	Admitted in labour.
503	April 7	R. Jardine, Glasgow.	24	2	Contracted pelvis, C.V. 2¾″ (6,9 cm.).	Not in labour.
504	April 15	A. J. Wallace, Liverpool.	31	2	Generally contracted pelvis, C.V. 2¼″ (5·6 cm.).	Not in labour.
505	April 17	P. E. Barber, Sheffield.	22	1	Generally contracted pelvis.	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1, 2. Craniotomy. Same patient as July 22, 1908 (Gemmell).	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Sterilized.	D	A	Hæmatemesis from the gastric ulcer began after operation and continued till death.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	D	A	Deformity began at 13, from late rickets. One side of pelvis buckled in—inlet nearly closed. "Died of sepsis spreading from vagina."	"Clinical Obstetrics."
C.S. Not sterilized.	R	A	1. Craniotomy. Same patient as July 10, 1909 (Champneys).	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Nov. 2, 1902 (Wallace).	Practitioner, March, 1907.
C.S. and abdominal panhysterectomy	R	A	Patient had recovered from ruptured tubal pregnancy without operation 13 months before.	Trans. Obst. Soc., Lond., Vol. xlviii, p. 240.
C.S. Not sterilized.	R	A	Same patient as May 6, 1906 (Hellier). 1, 2, 3, Stillborn, two at term. Child only lived 4 days.	Lancet, 1908, Vol. i, p. 1618.
C.S. Not sterilized.	D	A	Died of sepsis on 8th day.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	D	A	**2nd C.S.** Died of shock. At P.M. no evidence of sepsis or hæmorrhage.	——
C.S. Not sterilized.	R	A	**3rd C.S.** Same patient as April 6, 1901 (Wallace), and April 16, 1902 (Wallace).	——
C.S. Sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1905					
506	April 20	A. H. N. Lewers, London.	28	1	Contracted pelvis.	Not in labour.
507	April 25	J. S. Fairbairn, London.	29	4	Contracted pelvis. Bad obstetric history.	Onset of labour. Membranes intact.
508	May 2	J. W. Martin, Sheffield.	22	1	Generally contracted pelvis.	Favourable.
509	May 3	J. E. Gemmell, Liverpool.	29	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour. Three days before full term.
510	May 4	A. J. Wallace, Liverpool.	32	1	Generally contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
511	May 8	Mrs. Stanley Boyd, London.	37	7	Carcinoma of cervix.	Favourable. Several hæmorrhages during the pregnancy.
512	May 8	R. Jardine, Glasgow.	24	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Admitted in labour, duration 24 hours.
513	May 11	P. E. Barber, Sheffield.	29	3	Rachitic flat pelvis, C.D. 3½″ (8·7 cm.).	——
514	May 11	W. H. C. Newnham Clifton, Bristol.	28	0	Contracted pelvis.	Favourable. In labour. Membranes ruptured.
515	May 14	J. H. Targett, London.	23	0	Generally contracted flat pelvis, 2¾″ (6·9 cm.).	In labour some hours. Membranes ruptured. Meconium escaping.
516	May 19	P. E. Barber, Sheffield.	41	1	Kyphotic pelvis. Fibromyomata.	——
517	May 23	W. J. Gow, London.	23	0	Contracted pelvis, C.V. 3½″ (8.7 cm.).	Not in labour.
518	June 1	W. S. A. Griffith, London.	33	0	Flat pelvis, 2¾″ (6·9 cm.). Cord prolapsed.	In labour. Membranes ruptured.
519	June 2	J. H. Targett, London.	29	0	Generally contracted pelvis. Knees and hips ankylosed. Mitral disease. C.V. 3½″ (8·7 cm.).	In labour (35th week) 24 hours. Membranes ruptured.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	1. Premature—lived 7 months. 2. Full term, died in 2 years. 3. Head injured at birth. Epileptic. Imbecile. 4. Craniotomy.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Child 5lbs. 14oz. 1. Craniotomy. Same patient as Nov. 29, 1909 (Gemmell).	——
C.S. Not sterilized.	R	A	Child died in a few hours. Same patient as July 1, 1906 (Wallace), and March 20, 1910 (Wallace).	——
C.S. and abdominal panhysterectomy.	D	A	Mother died in 5 hours. Severe hæmorrhage during operation. Child (7 months) lived 2 hours.	——
C.S. Not sterilized.	R	A	Same patient as April 16, 1907 (Russell).	——
C.S. Sterilized.	R	A	Marked rachitic limbs.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	D	Some patient as July 30, 1906 (Targett). Cord pulseless. Child could not be revived.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Placenta anterior.	——
C.S. Not sterilized.	R	A	Child 7lbs. 6oz.	Harveian Lectures, March, 1907.
C.S. Not sterilized.	R	A	Child died 3rd day.	Queen Charlotte's Hos. Reports.
C.S. Not sterilized.	R	A	Child 4½lbs.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1905					
520	June 8	W. J. Gow, London.	28	1	Contracted pelvis, C.V. 3½″ (8·7 cm.).	——
521	June 9	R. Jardine, Glasgow.	20	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Not in labour.
522	June 10	A. F. Stabb, London.	34	0	Contracted pelvis.	In labour. Membranes ruptured.
523	June 25	T. B. Grimsdale, Liverpool.	20	0	Advanced mitral stenosis.	Unfavourable. Great œdema of vulva and legs. Orthopnœa.
524	July 2	H. Briggs, Liverpool.	29	4	Rachitic pelvis, C.V. 3½″ (8·7 cm.). Breech presenting.	In labour 7 hours. Membranes intact.
525	July 4	W. R. Dakin, London.	28	0	Contracted pelvis.	Favourable.
526	July 6	A. F. Stabb, London.	19	0	Flat pelvis, C.V. 3⅛″ (7·8 cm.).	In labour. Membranes ruptured 8 hours.
527	July 9	R. Jardine, Glasgow.	23	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Admitted in labour. Membranes ruptured.
528	July 14	J. M. Munro Kerr, Glasgow.	?	0	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	Admitted in labour.
529	July 15	Sir W. J. Sinclair, Manchester.	29	0	Solid ovarian tumour obstructing labour.	Favourable.
530	July 27	W. J. Gow, London.	33	1	Fibro-myoma uteri, blocking pelvis. Breech presentation.	Not in labour.
531	July 28	J. M. Munro Kerr, Glasgow.	26	0	Rachitic pelvis, C.V. 3¼″ (8·1 cm.).	In labour, but some days in Hospital.
532	July 31	A. H. F. Barbour, Edinburgh.	33	5	Contracted pelvis, C.D. 4¼″ (10·6 cm.). Trans. (outlet) 2¾″ (6·9 cm.). Marked inward projection of ischial spines.	Favourable. Not in labour.
533	Aug. 3	W. J. Gow, London.	25	4	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	Not in labour.
534	Aug. 7	Gibbon Fitzgibbon Dublin.	23	1	Contracted pelvis, C.V. 7·25cm.	Not in labour. Full term.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as Dec. 31, 1906 (Gow). 1. Craniotomy. Child 6lbs. 14oz. Mother phlebitis left leg.	Harveian Lectures, March 1907.
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	?	2nd operation for intestinal obstruction 17 days later. Intestines adherent to scar and portion semi-gangrenous. Abscess to left of uterus drained. Eventual recovery.	——
C.S. Not sterilized.	D	A	Mother died 12th day from heart failure.	——
C.S. Not sterilized.	R	A	1. Forceps. 2. Craniotomy. 3, 4. Inductions. All dead.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	D	——	——
C.S. Not sterilized.	R	A	Same patient as Nov. 20, 1906 (Stabb).	Queen Charlotte's Hos. Reports.
C.S. Not sterilized.	D	A	No P.M. Sepsis probable.	——
C.S. Not sterilized.	R	A	——	——
C.S. and ovariotomy.	R	A	——	——
C.S. Not sterilized.	R	A	Some pyrexia, with tenderness over fibroid during puerperium.	Harveian Lectures, March 1907.
C.S. Not sterilized.	R	A	Child 9lbs.	——
C.S. Not sterilized.	R	A	1, 2, 3, 4. Forceps. All dead. 5. Craniotomy.	——
C.S. Not sterilized.	R	A	Same patient as June 25, 1906 (Gow). Child 5lbs. 5oz.	Harveian Lectures, March 1907.
C.S. Sterilized.	R	A	**2nd C.S.** Same patient as July 15, 1900 (Purefoy). 1st child living.	Med. Press and Circular, 1905, p. 375 (October).

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1905					
535	Aug. 9	D. C. Rayner, Bristol.	35	0	Achondroplasia. Contracted pelvis, C.V. 2½″ (6·2 cm.). All diameters contracted.	Not in labour.
536	Aug. 10	W. R. Dakin, London.	31	8	Contracted pelvis.	Favourable.
537	Aug. 14	A. W. Russell, Glasgow.	18	0	Contracted pelvis, C.V. 2⅜″ (6 cm.).	In labour.
538	Aug. 16	P. E. Barber, Sheffield.	29	4	Ovarian cyst obstructing labour.	In labour two days.
539	Aug. 20	W. J. Gow, London.	37	1	Fibro-myomata uteri (pelvic).	Not in labour.
540	Aug. 28	J. S. Fairbairn, London.	30	3	Contracted pelvis.	In labour. Membranes ruptured 2½ hours.
541	Aug. 29	P. E. Barber, Sheffield.	33	0	Rachitic flat pelvis, C.D. 3¼″ (8·1 cm.). Transv. presentation.	In labour.
542	Sept. 12	H. Briggs, Liverpool.	41	8	Contracted pelvis, C.V. 3½″ (8·7 cm.).	In labour. Membranes ruptured. Cord prolapsed.
543	Sept. 15	J. M. Munro Kerr, Glasgow.	36	2	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
544	Sept. 23	A. J. Wallace, Liverpool.	26	2	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	In labour. Membranes intact.
545	Sept. 26	P. E. Barber, Sheffield.	21	0	Generally contracted flat pelvis, C.D. 3½″ (8·7 cm.).	——
546	Sept. 28	J. M. Munro Kerr, Glasgow.	26	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour when admitted.
547	Sept. 30	D. C. Rayner, Bristol.	39	2	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour two hours. Membranes ruptured. No previous attempts to deliver.
548	Oct. 2	E. T. Collins, Cardiff.	25	3	Impacted mento-posterior presentation, with prominent sacral promontory.	Very collapsed on admission.
549	Oct. 11	R. Jardine, Glasgow.	23	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Not in labour.
550	Oct. 15	Sir W. J. Sinclair, Manchester.	25	0	Contracted pelvis.	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	Child 7lbs.	——
C.S. and ovariotomy.	R	A	Cyst could not be reached till uterus was emptied.	——
C.S. Not sterilized.	R	A	1. Abortion.	Harveian Lectures, March 1907.
C.S. Sterilized.	R	A	1, 2, 3. Craniotomy.	——
C.S. Sterilized.	R	A	——	——
C.S Not sterilized.	R	A	All previous labours premature or difficult—all stillborn.	——
C.S. Sterilized.	R	A	1, 2. Craniotomy.	——
C.S. Not sterilized.	R	A	1, 2. Forceps. Stillbirths. Same case as Sept. 26, 1906 (Wallace), and Oct. 31, 1908 (Wallace).	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	Died of sepsis. 1. Symphysiotomy.	——
C.S. Sterilized.	R	A	1. Aborted 10th week. 2. Craniotomy.	——
C.S. Sterilized.	D	A	Died of collapse in 2 hours.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1905					
551	Oct. 17	Herbert Spencer, London.	37	2	Contracted pelvis, C.V. 2¾″ (6.9 cm.).	Not in labour.
552	Oct. 23	R. Favell, Sheffield.	23	1	Generally contracted rachitic flat pelvis, C.D. 3½″ (8·7 cm.).	Favourable.
553	Oct. 24	R. Favell, Sheffield.	25	4	Acquired vaginal atresia.	——
554	Nov. 3	W. J. Gow, London.	36	3	Contracted pelvis, C.D. 3½″ (8·7 cm.).	Not in labour.
555	Nov. 3	Herbert Spencer, London.	37	0	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour 8¾ hrs. Membranes ruptured.
556	Nov. 9	W. Duncan, London.	28	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	——
557	Nov. 11	A. E. Giles, London.	38	5	Flat pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
558	Nov. 11	R. Jardine, Glasgow.	33	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Admitted in labour, in very dirty condition.
559	Nov. 11	W. C. Swayne, Bristol.	30	0	Contracted pelvis, C.V. 2·4″ (6 cm.).	In labour 3 hours. Membranes intact. No previous attempts to deliver.
560	Nov. 19	R. Jardine, Glasgow.	26	0	Contracted pelvis, C.V. 2¾″ (6.9 cm.).	Not in labour.
561	Nov. 23	J. W. Martin, Sheffield.	26	2	Flat pelvis, C.D. 2¾″ (7·2 cm).	Favourable.
562	Nov. 24	H. Russell Andrews, London.	22	0	Generally contracted pelvis.	Favourable. Towards end of 1st stage.
563	Nov. 30	C. E. Purslow, Birmingham.	23	0	Ovarian dermoid impacted in pelvis during labour.	In labour. Membranes intact.
564	Nov. 30	E. Hastings Tweedy, Dublin.	29	1	Contracted pelvis, C.V. 8 cm. Transv. 13 cm	Early in 1st stage.
565	Dec. 3	D. C. Rayner, Bristol.	43	9	Fibro-myoma uteri obstructing delivery.	In labour 1 hour. Membranes intact.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1, 2. Craniotomy. Child delivered in 70 seconds. Same case as May 22, 1909 (Spencer).	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	1. Craniotomy. 2, 3. Abortion. Child 6lbs. 1oz.	Harveian Lectures, March 1907.
C.S. Not sterilized.	R	A	—	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Sterilized.	D	A	Sepsis from date of operation. Dense fog. Solutions constantly changed, as smuts kept falling into them.	—
C.S. Sterilized.	R	A	—	—
C.S. Sterilized.	R	A	—	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. and ovariotomy. Not sterilized.	R	A	Child died before patient left hospital. Patient has had living child since.	Birmingham and Midland Branch of Brit. Med. Assoc., Nov. 1896.
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as July 4, 1904 (Tweedy).	Rotunda Hosp. Reports, 1905-6
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Fibroid growing from supra-vaginal cervix, filling pelvis.	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1905					
566	Dec. 4	Sir F. H. Champneys, London.	28	2	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. In labour. Membranes intact
567	Dec. 10	R. Jardine, Glasgow.	29	1	Contracted pelvis, C.V. 2⅜″ (5·9 cm.).	Admitted in labour.
568	Dec. 15	R. Jardine, Glasgow.	27	1	Contracted pelvis, C.V. 2¾″ (6,9 cm.).	Admitted in labour. Membranes ruptured.
569	Dec. 26	Sir Halliday Croom, Edinburgh.	28	0	Pseudo-malacosteon pelvis. Available C.V. 3½″ (8·7 cm.).	Onset of labour. Albuminuria. Bloodstained vomit.
570	Dec. 26	J. Haig Ferguson, Edinburgh.	28	3	Rachitic flat pelvis.	1st stage of labour. Membranes intact.
571	Dec. 30	W. S. A. Griffith, London.	37	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
	1906					
572	Jan. 2	A. W. Russell, Glasgow.	24	0	Contracted pelvis, C.V. 2″ (5 cm.).	Favourable. In labour.
573	Jan. 8	T. Wilson, Birmingham.	37	6	Cancer of cervix. Inoperable.	P. 120. Strong labour pains at term.
574	Feb. 5	J. M. Munro Kerr, Glasgow.	32	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
575	Feb. 9	W. R Dakin, London.	33	10	Contracted pelvis.	Favourable. In labour 24 hours.
576	Feb. 14	C. E. Purslow, Birmingham.	33	6	Contracted pelvis, C.V. 3½″ (8·7 cm.).	Not in labour. Full term.
577	Feb. 16	R. Favell, Sheffield.	32	2	Flat pelvis, C.D. 3½″ (8·7 cm.).	Favourable.
578	Feb. 16	J. A. C. Kynoch, Dundee.	21	0	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour 24 hours.
579	Feb. 17	M. J. Gibson, Dublin.	28	8	Rachitic flat pelvis, C.V. 7 cm.	In labour 2 hours. Membranes ruptured. No previous attempt to deliver.
580	Feb. 17	A. Stookes, Liverpool.	25	0	Rachitic pelvis. Dwarf, 4 ft.	Chronic bronchitis. Fœtid ear discharge.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1. Stillborn. 2. Induction 272 days. Forceps. Stillborn.	——
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	D	Same patient as Sept. 30, 1908 (Griffith). Child 4½lb., deeply jaundiced. 1. Podalic version. Dead.	——
C.S. Not sterilized.	R	A	Child 6½lbs.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Child only lived 8 hours. Five full term. 1. Abortion.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1. Craniotomy.	——
C.S.	R	A	——	——
C.S. Sterilized.	R	A	1, 2, Craniotomy. 3, 4, 5, 6, Induction, two children lived.	Birmingham and Midland Branch of Brit. Med. Assoc., Nov. 1896.
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Child died when 2 months old.	Trans. Edinb. Obst. Soc., Vol. xxxii, p. 222.
C.S. Uterus eventrated before incision.	R	A	Craniotomy once. Induction in five. Forceps once. One premature child alone survived.	——
C.S. Not sterilized.	R	A	P. rose from 80 to 160 and T. to 103°F. soon after operation.	Journ. of Obst. and Gyn. Brit. Empire, 1906, Vol. x, p. 82.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1906					
581	Feb. 20	H. Russell Andrews, London.	29	2	Generally contracted pelvis.	Favourable. In labour 6 hours.
582	Feb. 20	J. H. Targett, London.	36	9	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	36th week. In labour 22 hours. Membranes intact.
583	Feb. 21	J. A. C. Kynoch, Dundee.	26	1	Rachitic pelvis, C.V. 2¾″ (8·1 cm.). Cervix stenosed.	Not in labour.
584	Feb. 22	T. W. Eden, London.	39	6	Contracted pelvis, C.V. 3½″ (8·7 cm.).	In labour 24 hours. Forceps failed.
585	Feb. 25	W. J. Gow, London.	26	0	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	1st stage of labour.
586	Feb. 28	J. M. Munro Kerr, Glasgow.	34	6	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour.
587	March 11	W. J. Gow, London.	19	0	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	1st stage of labour.
588	March 13	F. J. McCann, London.	30	0	Fibro-myoma uteri. Larger than the pregnant uterus.	Unfavourable. Hyperemesis for some months. Emaciation extreme.
589	March 17	W. Blair Bell, Liverpool.	22	1	Maniacal chorea.	Very bad. Under anæsthesia several hours to control violence.
590	March 18	J. W. Martin, Sheffield.	37	1	Flat pelvis, C.D. 3¾″ (9·3 cm.).	Favourable.
591	March 18	J. W. Martin, Sheffield.	19	1	Generally contracted flat pelvis, C.D. 3″ (7·5 cm.).	Tonic uterine contraction.
592	March 20	T. W. Eden, London.	25	0	Achondroplasia. Contracted pelvis, C.V. 2½″ (6·2 cm.).	Not in labour.
593	March 22	G. W. Fitzgerald, Manchester.	36	3	Exostosis from 2nd sacral vertebra. Available C.V. 2″ (5 cm.).	Favourable. In labour 2 hours. Membranes intact.
594	March 22	R. Jardine, Glasgow.	31	0	Contracted pelvis. Interischial (outlet) 2″ (5 cm.).	Not in labour.
595	March 22	R. Jardine, Glasgow.	23	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
596	March 27	R. Jardine, Glasgow.	27	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	D	Child dead 3 hours before delivery (3lbs. 3oz.). 1. Stillborn. 2. Premature. Forceps. Lived 7 days.	——
C.S. Sterilized.	R	A	Six previous inductions. Result?	——
C.S. Sterilized.	D	A	Death probably due to stenosed cervix preventing drainage.	Trans. Edinb. Obst. Soc., Vol. xxxii, p. 222.
C.S. Sterilized.	R	A	1, 2, 3, 4, 5, Born alive. 6. Craniotomy.	Queen Charlotte's Hospital Reports.
C.S. Not sterilized.	R	A	Child 6lbs. 10oz.	Harveian Lectures, March, 1907.
C.S. Not sterilized.	R	A	5 Stillborn. 1 Living. Same patient as June 16, 1908 (Kerr).	——
C.S. Not sterilized.	R	A	Child 7lbs. 14oz.	Harveian Lectures, March, 1907.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	D	A	Patient died 6th day from the vomiting which persisted. Child kept in incubator, now in good health.	——
C.S. Uterus brought outside before incision.	D	D	Chorea persisted after C.S. Chorea slight in first pregnancy.	——
C.S. Sterilized.	R	D	Macerated.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Normal labour. 2. Forceps. 3. Craniotomy.	——
C.S. Sterilized.	R	A	——	"Clinical Obstetrics."
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	2nd C.S. 1st C.S., Dec., 1904.	"Clinical Obstetrics," 1910, p. 624.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1906					
597	March 30	W. W. H. Tate, London.	36	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
598	March 31	J. L. Lackie, Edinburgh.	29	2	Contracted pelvis. C.V. 2½″ (6·2 cm.).	Onset of labour. Membranes intact.
599	April 8	J. Haig Ferguson, Edinburgh.	38	2	Cancer of rectum blocking pelvic outlet.	Unfavourable. Complete intestinal obstruction.
600	April 10	J. B. Hellier, Leeds.	40	0	Rachitic pelvis, C.V. 1¾″ (4·4 cm.). Dwarf.	In labour. Membranes ruptured.
601	April 14	A. H. N. Lewers, London.	35	2	Contracted pelvis.	Favourable. In labour 8 hours.
602	April 18	J. B. Hellier, Leeds.	27	4	Rachitic pelvis, C.V. 3¼″ (8·1 cm.).	Not in labour.
603	April 19	A. H. N. Lewers, London.	26	1	Contracted pelvis.	Not in labour.
604	April 21	P. E. Barber, Sheffield.	36	6	Malacosteon pelvis. Interspin. 18 cm., Intercrist. 25 cm., Interischial 6 cm. Beaked symphysis. Sacrum doubled up vertically.	——
605	April 23	F. W. N. Haultain, Edinburgh.	30	2	Flat pelvis, C.V. 2¾″ (6·9 cm.).	In labour 4 hours.
606	April 23	W. Duncan, London.	37	6	Contracted pelvis.	——
607	April 28	W. S. A. Griffith, London.	25	0	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour. Membranes ruptured 8 hours.
608	May 4	W. R. Dakin, London.	26	5	Contracted pelvis.	Unfavourable. T. 103° from unknown cause.
609	May 6	J. B. Hellier, Leeds.	25	4	Flat pelvis.	In labour.
610	May 11	H. Spencer, London.	33	0	Generally and obliquely contracted pelvis, old hip disease, narrow outlet. Head above brim.	Favourable. 8½ months. In labour. Membranes ruptured.
611	May 12	C. Y. Pearson, Cork.	38	0	Fibro-myoma uteri in supravaginal cervix (anterior).	Weak. Not in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	1, 2, Forceps. Stillborn.	——
C.S. = Sterilized.	R	A	**2nd C.S.** First Xmas, 1904. 1. Embryotomy. 2. C.S.	——
C.S. and colotomy at same time.	D	A	Mother died of exhaustion in 2 days.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Cephalotripsy. 2. Symphysiotomy.	——
C.S. Not sterilized.	R	A	Same patient as Nov. 8, 1907 (Hellier). Previous children stillborn. This child survived, weight 4½lbs.	Lancet, 1908, Vol. i, p. 1618.
C.S. Sterilized.	R	A	1. Cephalotripsy.	——
C.S. Salpingo-oophorectomy.	R	A	Disease began with severe pain 1898 when pregnant with 5th child. 1—4, normal or forceps. 5. Version after forceps. 6. Premature 7th month.	N. of Eng. Obst. and Gyn. Soc.
C.S. = Not sterilized.	R	A	**2nd C.S.**	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1, 4, 5, Premature. 2, 3, Craniotomy.	——
C.S. Not sterilized.	R	A	——	——
C.S.	R	A	Previous children all stillborn.	——
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as March 25, 1905 (Hellier). Scar adherent to omentum. Placenta anterior.	——
C.S. Not sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Os uteri out of reach per vaginam and fibroid fixed.	Med. Press and Circular, June 12, 1907.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
612	1906 May 13	H. Russell Andrews, London.	23	2	Generally contracted pelvis, C.D. 4¼″ (10·6 cm.).	In labour. Membranes ruptured 18 hours.
613	May 17	P. E. Barber, Sheffield.	32	0	Flat pelvis.	——
614	May 23	J. M. Munro Kerr, Glasgow.	?	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
615	May 27	A. J. Wallace, Liverpool.	38	1	Generally and obliquely contracted pelvis. Lordosis. Ankylosis of left hip joint.	Favourable. Not in labour.
616	May 30	Mrs. Scharlieb, London.	25	1	Generally and obliquely contracted pelvis, CV. 3¾″ (9·3 cm.).	Favourable. Induction just before term and forceps tried.
617	June 4	A. W. Russell, Glasgow.	25	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour.
618	June 8	J. M. Munro Kerr, Glasgow.	23	1	Rachitic pelvis, C.V. 3¼″ (8·1 cm.).	Admitted in labour.
619	June 15	S. Savage, Birmingham.	32	3	Generally contracted flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. 1st stage of labour.
620	June 18	J. M. Munro Kerr, Glasgow.	28	0	Fibro-myoma uteri.	Not in labour.
621	June 25	W. J. Gow, London.	27	5	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	Not in labour.
622	July 1	A. J. Wallace, Liverpool.	33	2	Generally contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. Not in labour.
623	July 5	H. Russell Andrews, London.	25	1	Generally contracted pelvis.	Favourable.
624	July 5	E. Stanmore Bishop, Manchester.	28	1	Contracted pelvis (reniform), C.V. 3¾″ (9·3 cm.).	Favourable. In labour, but membranes intact. Full term.
625	July 8	A. W. Russell, Glasgow.	25	2	Contracted pelvis, C.V. 2⅜″ (5·9 cm.).	In labour, but five days in Hospital.
626	July 12	R. Jardine, Glasgow.	?	Multi-para.	Dermoid cyst of ovary obstructing labour.	In labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as June 18, 1908 (R. Andrews). Previous children stillborn.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Embryotomy.	"Practitioner," March, 1907.
C.S. Not sterilized.	R	A	1. Craniotomy after forceps. Child 7½lbs. Child would not have survived a forceps delivery.	——
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1. Craniotomy.	——
C.S. Not sterilized.	R	A	1. Forceps. Living. 2. Craniotomy. 3. Induction, version, stillborn.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	D	A	Mother died 12th day from embolism and cardiac failure.	——
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as Aug. 3, 1905 (Gow). Child 5lbs. 9oz.	Harveian Lectures, March 1907.
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as May 4, 1905 (Wallace), and March 20, 1910 (Wallace).	"Practitioner," March, 1907.
C.S. Not sterilized.	R	A	Same patient as June 21, 1908 (Andrews). 1. Embryotomy.	——
C.S. Not sterilized.	R	A	1. Induction at 8th month. Forceps. Stillborn.	——
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as Oct. 14, 1903 (Russell). Child 7½lbs.	——
C.S. and ovariotomy. Sterilized.	R	A	Intended to remove cyst and deliver child through vagina, but cyst was too adherent to be removed till uterus emptied.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1906					
627	July 17	A. F. Stabb, London.	30	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Onset of labour.
628	July 19	A. J. Wallace, Liverpool.	38	0	Dermoid ovarian cyst.	In labour. Membranes intact.
629	July 20	J. H. Targett, London.	26	1	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour. Full term.
630	July 26	A. H. N. Lewers, London.	30	1	Contracted pelvis.	Favourable. Not in labour.
631	July 27	J. H. Targett, London.	29	1	Rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour. Full term.
632	July 30	A. W. Russell, Glasgow.	33	1	Contracted pelvis.	Favourable. In labour.
633	July 30	J. H. Targett, London.	24	1	Generally contracted flat pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. Not in labour. Full term.
634	Aug. 5	H. Clifford, Manchester.	33	3	Bicornuate uterus.	Favourable.
635	Aug. 6	R. C. Buist, Dundee.	32	0	Extremely contracted pelvis.	Favourable. In Hospital 17 days.
636	Aug. 7	J. E. Gemmell, Liverpool.	29	4	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Full term.
637	Aug. 7	J. W. Martin, Sheffield.	30	2	Kyphotic pelvis.	Favourable.
638	Aug. 8	P. E. Barber, Sheffield.	23	2	Kyphotic pelvis.	——
639	Aug. 10	J. W. Martin, Sheffield.	29	2	Generally contracted pelvis, C.D. 3½″ (8·7 cm.).	Favourable.
640	Aug. 13	Sir W. J. Sinclair, Manchester.	27	0	Rachitic pelvis. Dwarf.	In labour. Membranes ruptured long time.
641	Aug. 13	H. Williamson, London.	20	0	Flat pelvis, C.V. 3¼″ (8·1 cm.).	In 2nd stage two hours. Head above brim. Profuse purulent vaginal discharge.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Child died 10th day of congenital splenic anæmia.	—
C.S. and ovariotomy. Not sterilized.	R	A	—	"Practitioner," March, 1907.
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as May 4, 1904 (Gow). Uterus firmly adherent. Sutures of uterus still present.	—
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as May 12, 1904 (Lewers). 1. Cephalotripsy.	—
C.S. Not sterilized.	R	A	1. Craniotomy.	—
C.S. Sterilized.	R	A	1. Symphysiotomy. Child stillborn.	—
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as May 14, 1905 (Targett). Not sterilized as 1st child stillborn.	—
C.S. Not sterilized.	R	A	All children previously stillborn, during version for transverse lie.	—
C.S. Sterilized.	R	A	Congenital imbecile and insanity of pregnancy. Still in asylum.	—
C.S. Not sterilized.	R	A	Child 7 lbs. Induction 4 times. Only one child survived.	—
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as March 25, 1904 (Favell).	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	Child died same day.	—
C.S. Not sterilized.	R	A	—	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1906					
642	Aug. 20	W. J. Gow, London.	31	1	Contracted pelvis, C.D. 3½″ (8·7 cm.).	Not in labour.
643	Aug. 22	J. W. Martin, Sheffield.	28	3	Contracted pelvis.	Favourable.
644	Aug. 22	H. Playfair, London.	23	0	Bicornuate uterus. Retroflexed enlarged second horn.	Favourable, but delicate. In labour. Membranes ruptured.
645	Aug. 23	H. Williamson, London.	31	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour. Membranes ruptured
646	Sept. 2	A. J. Wallace, Liverpool.	24	1	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour. Membranes intact.
647	Sept. 3	H. Russell Andrews, London.	39	1	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	In labour 13 hours. Membranes ruptured.
648	Sept. 7	H. Russell Andrews, London.	33	7	Cancer of cervix. Early.	Not in labour.
649	Sept. 10	G. F. Blacker, London.	?	4	Oblique pelvis.	Favourable, but in labour, and membranes ruptured 3 days.
650	Sept. 16	F. Edge, Wolverhampton.	35	2	Contracted pelvis.	Favourable.
651	Sept. 16	A. J. Wallace, Liverpool.	26	0	Achondroplasic dwarf, 3ft. 6in. high. C.V. 1¾″ (4·4 cm.).	Favourable. Not in labour.
652	Sept. 20	Bellingham Smith, London.	32	2	Generally contracted pelvis, C.V. 3½″ (8·7 cm.).	Not in labour.
653	Sept. 24	H. Russell Andrews, London.	23	0	Rostrate pelvis. Available C.V. 1½″ (3·8 cm.).	In labour. Prolapsed cord. Child dead.
654	Sept. 25	T. W. Eden, London.	30	2	Contracted pelvis, C.V. 3½″ (8·7 cm.).	Favourable. Not in labour.
655	Sept. 26	P. E. Barber, Sheffield.	31	7	Generally contracted pelvis.	——
656	Sept. 26	A. J. Wallace, Liverpool.	27	2	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1. Craniotomy.	Harveian Lectures, March, 1907.
C.S. Not sterilized.	R	A	——	——
C.S.	D	A	Died of Sepsis on 3rd day. Could not elevate 2nd horn till after C.S.	——
C.S. Not sterilized.	R	A	Small multiple fibroids. One enucleated.	——
C.S. Not sterilized.	R	A	Same patient as Nov. 3, 1908 (Wallace). 1. Craniotomy.	Practitioner, March, 1907.
C.S. Not sterilized.	R	A	1. Cephalotripsy. Acute dilatation of stomach after C.S.	——
C.S. and abdominal panhysterectomy.	R	D	Child premature, 28th week. Operation entirely in interest of mother.	——
C.S. Not sterilized.	R	A	Same patient as March 10, 1909 (Blacker). 1. Transverse lie. Decapitation. 2, 3, 4, Induction. All stillborn.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	Same patient as March 8, 1909 (Wallace).	Practitioner, March, 1907
C.S. Not sterilized.	R	A	1, 2, Craniotomy. Vesico-vaginal fistula, and stenosis vaginæ followed last craniotomy. Same patient as Sept. 8, 1908 (B. Smith.).	——
C.S. Not sterilized.	R	D	Absolute indication.	——
C.S. Not sterilized.	R	A	1, 2, Craniotomy.	——
C.S. Sterilized	R	A	——	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Sept. 23 1905 (Wallace), and October 31 1908 (Wallace). 1, 2, Forceps. Stillborn.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1906					
657	Oct. 9	R. Favell, Sheffield.	?	0	Generally contracted pelvis. Double congenital dislocation of hip.	Favourable.
658	Oct. 11	H. Russell Andrews, London.	33	0	Fibro-myoma uteri growing from posterior supra-vaginal cervix. Size of cocoanut.	Favourable. Not in labour.
659	Oct. 11	G. F. Blacker, London.	40	0	Rachitic flat pelvis, C.V. $2^4/_8$" (7 cm.).	Onset of labour. Membranes intact.
660	Oct. 19	Amand Routh, London.	28	1	Generally contracted pelvis, C.V. 3" (7·5 cm.).	Favourable. In labour. Membranes intact.
661	Oct. 27	R. Favell, Sheffield.	42	1	Generally contracted flat pelvis, C.D. $3\frac{1}{2}$" (8·7 cm.).	Favourable.
662	Oct. 29	R. Favell, Sheffield.	32	0	Generally contracted flat pelvis, C.D. $3\frac{3}{4}$" (9·3 cm.).	Favourable.
663	Nov. 2	N. T. Brewis, Edinburgh.	37	0	Fibro-myoma uteri in lower uterine segment.	In labour. Membranes ruptured some hours. Full term.
664	Nov. 3	N. T. Brewis, Edinburgh.	33	0	Cervical fibroid.	Severe pressure symptoms.
665	Nov. 17	R. Favell, Sheffield.	42	?	Fibro-myoma uteri—sub-peritoneal—obstructing labour.	——
666	Nov. 20	A. F. Stabb, London.	20	1	Contracted pelvis, C.V. 3" (7·5 cm.).	Favourable. Onset of labour.
667	Nov. 25	Bellingham Smith, London.	32	7	Flat pelvis, C.V. $3\frac{1}{2}$" (8·7 cm.).	Unfavourable. In labour. Pyelitis.
668	Dec. 1	P. E. Barber, Sheffield.	32	3	Fibro-myoma uteri obstructing labour.	——
669	Dec. 10	J. M. Munro Kerr, Glasgow.	33	5	Rachitic pelvis, C.V. 3" (7·5 cm.).	In labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	—	—
C.S. and myomectomy. Not sterilized.	R	A	—	Trans. Obst., Soc. Lond., Vol. xlviii, p. 313.
C.S. Not sterilized.	R	A	—	—
C.S. Sterilized.	R	A	1. Craniotomy. Severe "after pains."	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	Same patient as Feb. 8, 1908 (Favell).	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	—	Edin. Obst. Trans., Vol. xxxiii, p. 50. Journ. of Obst. and Gyn. Brit. Empire, Vol. xi, p. 199.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	D	—	
C.S. and panhysterectomy.	R	A	—	—
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as July 6, 1905 (Stabb).	—
C.S. = Not sterilized.	D	A	**2nd C.S.** 1st C.S. by late Dr. Horrocks (Nov. 23, 1904). Twins born alive but died soon after. Previous children all craniotomy. Patient died 12th day from pyelo-nephritis and suppression of urine. Wound healthy.	—
C.S. and panhysterectomy.	R	A	—	—
C.S. = Sterilized.	R	A	**2nd C.S.** 1. Twins, premature. Dead. 2. Forceps, term. Dead. 3. Spontaneous labour. Dead. 4. Forceps. Dead. 5. C.S.	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
670	1906 Dec. 17	J. M. Munro Kerr, Glasgow.	29	4	Rachitic pelvis, C.V. 3⅛″ (7·8 cm.).	Not in labour. In Hospital 4 days.
671	Dec. 27	J. A. C. Kynoch, Dundee.	31	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour.
672	Dec. 29	Miss Frances Ivens, Liverpool.	37	5	Flat pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. Not in labour.
673	Dec. 29	J. M. Munro Kerr, Glasgow.	25	0	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	In labour.
674	Dec. 29	C. Y. Pearson, Cork.	33	3	Contracted pelvis and spondylolisthesis.	Favourable. Not in labour.
675	Dec. 29	A. W. Russell, Glasgow.	25	0	Contracted pelvis, C.V. 2⅜″ (5·9 cm.).	Favourable. In labour. Cord prolapsed.
676	Dec. 30	J. S. Fairbairn, London.	27	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Onset of labour. Membranes intact.
677	Dec. 31	W. J. Gow, London.	30	2	Contracted pelvis, C.D. 3½″ (8·7 cm.).	Not in labour.
678	1907 Jan. 3	H. Briggs, Liverpool.	39	0	Contracted pelvis, C.V. 3½″ (8·7 cm.).	Favourable. In labour. Membranes ruptured.
679	Jan. 4	H. Russell Andrews, London.	25	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour 48 hours.
680	Jan. 5	R. Jardine, Glasgow.	32	7	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
681	Jan. 8	W. Duncan, London.	36	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	——
682	Jan. 9	J. B. Hellier, Leeds.	34	2	Flat pelvis, C.V. 3½″ (8·7 cm.).	Onset of labour.
683	Jan. 11	Sir Halliday Croom, Edinburgh.	28	2	Contracted pelvis, C.V. 3¼″ (8·1 cm.). "Too small for induction."	Onset of labour. Full term.
684	Jan. 12	R. Jardine, Glasgow.	19	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1. Forceps. Dead. 2, 3, Craniotomy. 4. Induction. Died 3rd week.	——
C.S. Sterilized.	R	A	——	Trans. Edin. Obst. Soc., Vol. xxxii, p. 222. Lancet, 1907, i, 163.
C.S. Sterilized.	D	A	1. Forceps. Alive. 2. Breech. Dead 3, 4, 5, Forceps. Dead. "C.S. chosen in order to sterilize." Mother died 6th day of paralytic ileus. No sepsis.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Craniotomy. 2. Embryotomy. 3. 6½ months. Dead.	Med. Press and Circular, June 12, 1907.
C.S. Sterilized.	R	A	Child 6lbs. Difficult to resuscitate.	——
C.S. Not sterilized.	R	A	1. Craniotomy.	——
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as June 8, 1905 (Gow). 1. Craniotomy.	Harveian Lectures, March, 1907.
C.S. Not sterilized.	R	A	Breech presentation.	
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	1, 2, Stillborn. Child died in 3½ hours. Atelectasis pulmonum.	Lancet, 1908, Vol. i, p. 1518.
C.S. Not sterilized.	R	A	1, 2, Craniotomy. Same patient as July 9, 1908 (Barbour).	——
C.S. Not sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1907					
685	**Jan. 15**	Murdoch Cameron, Glasgow.	29	?	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
686	**Jan. 29**	H. Briggs, Liverpool.	33	3	Rachitic pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. Not in labour.
687	**Jan. 29**	R. Jardine, Glasgow.	26	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
688	**Jan. 31**	R. Jardine, Glasgow.	27	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour. Membranes ruptured.
689	**Feb. 1**	W. K. Walls, Manchester.	30	1	Contracted pelvis.	——
690	**Feb. 3**	J. B. Hellier, Leeds.	32	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour. Ante-partum hæmorrhage.
691	**Feb. 4**	J. H. Targett, London.	34	1	Ventri-fixation. Extreme distortion of uterus.	Favourable. Not in labour. Had gone 14 days over full term.
692	**Feb. 5**	E. Hastings Tweedy, Dublin.	27	3	Contracted pelvis, C.V. 6 cm. Transv. 9 cm.	In labour 8 hours. Membranes ruptured.
693	**Feb. 8**	R. Jardine, Glasgow.	22	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
694	**Feb. 9**	F. W. N. Haultain, Edinburgh.	31	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
695	**Feb. 10**	P. E. Barber, Sheffield.	24	0	Generally contracted pelvis.	——
696	**Feb. 11**	P. E. Barber, Sheffield.	28	0	Generally contracted flat pelvis.	In labour. Membranes ruptured 2 hours.
697	**Feb. 13**	F. W. N. Haultain, Edinburgh.	37	1	Multiple fibro-myomata uteri. prolonged gestation 12 months. False labour 3 months previously.	——
698	**Feb. 13**	R. Jardine, Glasgow.	32	6	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	Child, 8lbs.	——
C.S. Not sterilized.	R	A	1, 2, Craniotomies. 3 Inductions. Stillborn. Same patient as March 22, 1909 (Briggs).	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	1. Craniotomy.	——
C.S. Not sterilized.	R	A	Same patient as May 3, 1908 (Hellier).	——
C.S. Not sterilized.	R	A	Fundus firmly adherent to abdominal scar. Child lying in sac formed by enormous distension of posterior wall of uterus. 1. Induction 32nd week for severe colpocele. Ventrifixation 1902 for retroversion and prolapsus uteri.	——
C.S. Not sterilized.	R	A	Same patient as June 3, 1910 (Tweedy).	Rotunda Hosp. Reports, 1906-7.
C.S. Not sterilized.	R	A	——	——
C.S. ≡	R	A	**3rd C.S.** Previous children did not survive.	——
C.S. Not sterilized.	R	A	Child died 9th day. Same patient as May 10, 1908 (Barber).	——
C.S. Not sterilized.	R	A	——	——
C.S. and panhysterectomy.	R	D	——	Edin. Obstet Journ., Vol 33.
C.S. Sterilized.	D	A	Peritoneal adhesions over uterus ¼" thick. Uterine wall very friable. Evidences of acute sepsis within a few hours; and died next day. P.M.: Interior of uterus showed acute sepsis. "Uterus must have contained organisms prior to operation as no vaginal examination had been made and inside of uterus was not touched at operation."	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1907					
699	Feb. 17	H. Briggs, Liverpool.	27	3	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. In labour 2 days. Membranes ruptured.
700	Feb. 17	J. W. Martin, Sheffield.	37	8	Generally contracted flat pelvis.	Favourable.
701	Feb. 19	R. Jardine, Glasgow.	27	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
702	Feb. 20	J. Haig Ferguson, Edinburgh.	36	1	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Onset of labour. Membranes intact.
703	Feb. 21	Sir W. J. Sinclair, Manchester.	?	?	Contracted pelvis.	Injuries to soft parts from attempted forceps delivery before admission.
704	Feb. 22	A. J. Horne, Dublin.	18	1	Convulsions. Temp. 106°F. Cerebro-spinal meningitis.	Unfavourable.
705	Feb. 23	J. A. C. Kynoch, Dundee.	22	0	Contracted pelvis, C.V. 2¾″ (6.9 cm.).	Favourable. In labour.
706	March 1	Herbert Spencer, London.	33	0	Generally contracted pelvis. Old tuberculosis of sacro-iliac joint. Fibroid left lower segment.	In labour. Membranes ruptured. Emergency operation at 3 a.m.
707	March 3	J. M. Munro Kerr, Glasgow.	29	5	Rachitic pelvis.	Not in labour. Four days in Hospital.
708	March 4	A. F. Stabb, London.	42	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour. Membranes ruptured.
709	March 13	A. F. Stabb, London.	24	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Membranes intact.
710	March 14	A. H. N. Lewers, London.	35	2	Contracted pelvis.	Favourable.
711	March 16	R. J. Johnstone, Belfast.	37	3	Cancer of rectum, involving and blocking vagina.	Unfavourable. In labour 3 hours.
712	March 18	P. E. Barber, Sheffield.	33	0	Fibro-myoma uteri obstructing labour.	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1, 2, 3, Stillborn.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	——	——
C.S. Not sterilized.	D	D	Admitted unconscious. Autopsy proved eclampsia due to cerebro-spinal meningitis.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Small fibroid anterior wall removed. Larger fibroid lower segment not removed.	——
C.S. Sterilized.	R	A	**2nd C.S.** Some adhesions to scar, but peritoneal cavity not shut off.	——
C.S. Sterilized.	R	A	1. Craniotomy.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	"Uterus did not contract well. Operator was away directly after the operation for some days. His representative re-opened the abdomen, and punctured the gut in 5 places two days after the C.S."	——
C.S. Not sterilized.	D	D	Colotomy for inoperable rectal cancer 10 months previously. Mother died from septic peritonitis. "Invasion from vagina upwards (P.M.)." Child weighed 3¼lbs.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1907					
713	March 19	N. T. Brewis, Edinburgh.	27	1	Contracted pelvis. Lordosis.	Favourable. In labour and membranes ruptured some hours.
714	March 22	A. H. N. Lewers, London.	39	4	Contracted pelvis.	Favourable. Not in labour.
715	March 25	F. W. N. Haultain, Edinburgh.	34	1	Cervical fibro-myoma uteri.	In labour 5½ hours. 7½ months gestation.
716	April 4	J. M. Munro Kerr, Glasgow.	32	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour, but in Hospital 3 days before operation.
717	April 5	T. W. Eden, London.	24	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour.
718	April 7	W. K. Walls, Manchester.	20	1	Contracted pelvis, C.V. 3½″ (8·7 cm.).	——
719	April 9	A. Donald, Manchester.	30	4	Contracted oblique pelvis, C.V. 3¼″ (8·1 cm.).	——
720	April 11	H. Briggs, Liverpool.	28	4	Enchondroma from right sacro-iliac joint.	Favourable. Not in labour.
721	April 12	E. J. Maclean, Cardiff.	34	1	Rachitic pelvis, $2^{4}/_{5}$″ (7 cm.).	Favourable. Not in labour. Estimated full term.
722	April 16	A. W. Russell, Glasgow.	27	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Onset of labour, but in Hospital 4 days.
723	April 23	J. L. Lackie, Edinburgh.	23	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	In labour 3 hours. Membranes intact.
724	April 23	E. J. Maclean, Cardiff.	22	?	Chondro-sarcoma of left side of pelvis. Operation done as child thought to be possibly alive.	Very unfavourable. In labour 4 days. Exhausted. Repeated attempts at delivery before admission.
725	April 30	R. Favell, Sheffield.	28	0	Generally contracted rachitic flat pelvis, C.D. 3″ (7·5 cm.).	Favourable. In labour 24 hours.
726	April 30	R. Jardine, Glasgow.	32	3	Generally contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
727	May 1	R. Jardine, Glasgow.	19	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	Admitted in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1. Craniotomy.	—
C.S. Not sterilized.	R	A	—	—
C.S. and panhysterectomy.	R	A	Child died in 1 hour.	—
C.S. Not sterilized.	R	A	1. Craniotomy.	—
C.S. Not sterilized.	R	D	1. Induction 7th month. Still-born.	—
C.S. Not sterilized.	R	A	1. Embryotomy.	—
C.S. Not sterilized.	R	A	Child died in 3 weeks.	—
C.S. Not sterilized.	R	A	1, 2, 3, Stillbirths. 4. Induction alive 1903. Operator's only case which developed a ventral hernia radically cured in 1909. X-rays failed to show growth.	—
C.S. Sterilized.	R	A	1. Embryotomy.	—
C.S. Sterilized.	R	A	**2nd C.S.** Same patient as May 8, 1905 (Jardine).	—
C.S. Not sterilized.	R	A	Same patient as Feb. 22, 1910 (Lackie). 1. Craniotomy. Acute pneumonia during puerperium.	—
C.S. Not sterilized.	D	D	Mother died 6 hours after operation. Child evidently dead some days.	—
C.S. Not sterilized.	R	A	Child died in a few days. Same patient as July 9, 1908 (Favell).	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1907					
728	May 3	P. E. Barber, Sheffield.	33	5	Generally contracted flat pelvis, and fibro-myoma.	——
729	May 12	J. H. Targett, London.	28	0	Generally contracted flat pelvis, C.V. 3″ (7·5 cm.). Irregular brim from old hip disease. Right hip ankylosed.	Favourable. Old phthisis. In labour six hours. Membranes intact.
730	May 14	A. Donald, Manchester.	?	1	Cervical fibro-myoma uteri.	——
731	May 21	R. Jardine, Sheffield.	37	4	Contracted pelvis, C.V. 3″ (7·5 cm.).	Admitted in labour.
732	May 26	P. E. Barber, Glasgow.	32	4	Flat pelvis.	In labour 2 days. Membranes ruptured.
733	May 29	H. Russell Andrews, London.	44	2	Flat pelvis, C.V. 3½″ (8·7 cm.). Great skeletal deformity.	In labour. Membranes ruptured 24 hours.
734	May 30	J. H. Targett, London.	29	2	Contracted pelvis, C.V. 3¾″ (9·1 cm.).	Favourable. Not in labour. Full term.
735	June 3	J. E. Gemmell, Liverpool.	31	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Unfavourable. In labour 15 hours. Previous attempts to deliver by forceps and cranioclast.
736	June 9	R. Jardine, Glasgow.	31	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	Admitted in labour. Membranes ruptured.
737	June 10	H. Russell Andrews, London.	23	?	Generally contracted pelvis, C.D. 3¾″ (9·3 cm.).	In labour. Membranes ruptured 24 hours.
738	June 10	J. H. Targett, London.	37	0	Generally contracted pelvis, C.V. 3¼″ (8·1 cm.). Congenital dislocation right hip.	Favourable. In labour 8 hours. Membranes ruptured.
739	June 12	W. Duncan, London.	29	4	Contracted pelvis. Serious antepartum hæmorrhage.	——
740	June 12	Sir W. J. Sinclair, Manchester.	34	2	Contracted pelvis.	——
741	June 17	E. Hastings Tweedy, Dublin.	32	0	Contracted pelvis, C.V. 5·4 cm. Transv. 9·8 cm.	In labour. Membranes ruptured 2 hours.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. and myomectomy. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. and myomectomy. Not sterilized.	R	A	—	—
C.S. Sterilized.	D	A	Stitch abscess in abdominal wound. Saphenous vein thrombosed and suppurated. These were freely opened and drained but patient died in 3 weeks from exhaustion.	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	D	A	Sudden pain, cyanosis and twitching on 4th day, and death in 5 minutes. P.M. No cause of death found.	—
C.S. Not sterilized.	R	A	1, 2, Craniotomy.	—
C.S. Not sterilized.	D	D	Death from pulmonary thrombosis 40 hours after admission.	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	—	—
C.S. = Not sterilized.	R	A	**2nd C.S.** Child died in a few hours.	—
C.S. Not sterilized.	R	A	—	Rotunda Hosp. Reports, 1906.7.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1907					
742	June 22	J. B. Hellier, Leeds.	33	8	Osteomalachia.	Not in labour.
743	June 22	R. P. R. Lyle, Newcastle-on-Tyne.	28	6	Simple flat pelvis, C.V. 7·5 cm.	Unfavourable. In labour 7 days. Membranes ruptured. No attempts at delivery.
744	June 25	R. Jardine, Glasgow.	21	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Admitted in labour.
745	June 26	R. Jardine, Glasgow.	36	4	Contracted pelvis, C.V. 2½ (6·2 cm.).	Admitted in advanced labour.
746	June 26	R. P. R. Lyle, Newcastle-on-Tyne.	29	2	Fibro-sarcoma, size and shape of goose's egg, growing from posterior surface of right pubic ramus.	Favourable. In labour 6 hours. Membranes intact.
747	June 27	P. E. Barber, Sheffield.	32	3	Carcinoma of recto-vaginal septum. Advanced.	——
748	July 7	Amand Routh, London.	30	6	Stenosis (cicatricial) of cervix and vagina.	In labour 12 hours. Membranes ruptured three hours. Previous examinations made.
749	July 9	W. S. A. Griffith, London.	32	1	Rachitic flat pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. Membranes ruptured. No previous attempt to deliver.
750	July 12	R. Favell, Sheffield.	24	3	Funnel-shaped pelvis.	In labour. Membranes ruptured 12 hours.
751	July 13	R. Jardine, Glasgow.	31	4	Osteo-malachia. Beaked pelvis and contracted outlet. Available C.V. 1″ (2·6 cm.).	Critical condition. P. 130. In labour. Membranes ruptured. Attempts made to deliver before admission.
752	July 16	R. Favell, Sheffield.	27	4	Flat pelvis, C.D. 3½″ (8·7 cm.).	Favourable.
753	July 25	E. T. Collins, Cardiff.	39	Multi-para.	Contracted pelvis.	Favourable.
754	July 25	R. Favell, Sheffield.	33	0	Generally contracted pelvis.	In poor health.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Salpingo-oophorectomy.	R	A	Child lived 11 weeks. Osteomalachia improved after operation.	Lancet, 1908, Vol. i, p. 1618.
C.S. Not sterilized.	R	A	1. Premature. Born alive. 2. Difficult. Alive. 3, 4, 5, 6, Craniotomy. Same patient as April 25, 1910 (Lyle).	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Alive. 2. Stillborn. Tumour removed per vaginam 4 weeks later.	——
C.S.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Floor of bladder, 4 square inches of vaginal wall; and 2 inches of anterior lip of uterus torn away by midwife who thought swollen anterior lip was placenta. Large vesico-vaginal fistula subsequently cured; but much cicatricial stenosis resulted.	Trans. Roy. Soc. Med., Lond., 1907, Vol. i, p. 1.
C.S. Not sterilized.	R	A	1. Induction.	——
C.S. Not sterilized.	R	A	Same patient as May 10, 1910 (Barber).	——
C.S. and supra-vaginal hysterectomy intra-peritoneal stump.	R	A	1, 2, 3, Normal. 4. Forceps. "Rheumatism" 12 months. Brought 16 miles in ambulance.	Journ. of Obst. and Gyn., 1908, Vol. xiii, p. 31.
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	D	All previous children stillborn.	——
C.S. Not sterilized.	D	A	Mother died 11th day of pneumonia.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1907					
755	July 27	R. P. R. Lyle, Newcastle-on-Tyne.	36	5	Cancer of cervix.	Favourable. In labour and membranes ruptured 48 hours. No attempts at delivery.
756	July 29	D. Lloyd Roberts, Manchester.	34	8	Flat pelvis, C.V. 3″ (7·5 cm.). Bad obstetric history.	Onset of labour whilst in Hospital. Membranes intact.
757	Aug. 1	Sir W. J. Sinclair, Manchester.	34	3	Pelvis contracted. (See Case April 10, 1896.)	In labour. Membranes intact. No examination previously made.
758	Aug. 13	A. W. Russell, Glasgow.	34	1	Contracted pelvis. Large mass of varicose veins in roof of vagina.	In labour. Retraction ring well marked. Much overlapping of head.
759	Aug. 16	J. E. Gemmell, Liverpool.	29	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour. Four days before full term.
760	Aug. 19	Mrs. Stanley Boyd, London.	33	1	Obstruction for relatively large head.	In labour 30 hours. Membranes ruptured. Previous attempts at forceps delivery.
761	Aug. 20	Sir W. J. Sinclair, Manchester.	?	0	Contracted pelvis.	——
762	Aug. 20	J. Nigel Stark, Glasgow.	36	10	Cancer of cervix. Advanced.	Very feeble.
763	Aug. 21	A. W. Russell, Glasgow.	24	0	Contracted pelvis. Marked overlapping of head.	Favourable. In labour.
764	Aug. 25	H. Russell Andrews, London.	25	0	Generally contracted pelvis, C.D. 3¾″ (9·3 cm.).	In labour 22 hours. Membranes ruptured.
765	Aug. 25	C. E. Purslow, Birmingham.	25	2	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Not in labour. Full term.
766	Aug. 28	P. E. Barber, Sheffield.	?	0	Rachitic flat pelvis.	——
767	Aug. 28	A. W. Russell, Glasgow.	24	2	Contracted pelvis.	Favourable. In labour.
768	Sept. 1	H. Russell Andrews, London.	31	1	Rachitic flat pelvis, C.D. 3¾″ (9·3 cm.).	Unfavourable. In labour 4 days. Membranes ruptured 3 days. Forceps applied before admission. P. 120. T. 99·5°F.

Operative Technique	Result		Remarks	References If Case already published
	Mother	Child		
C.S. and abdominal panhysterectomy.	R	A	Patient died 2 years later from recurrence. Growth was a squamous-celled epithelioma.	——
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as June 11, 1903 (L. Roberts).	Trans. N. of E. Obst. and Gyn. Soc., 1907-8, p. 126.
C.S. ≡ Not sterilized.	R	A	**4th C.S.** Same patient as April 10, 1896, Aug. 22, 1901, and June 23, 1903 (Sinclair). Uterus and abdomen firmly adherent.	Journ. of Obst. and Gyn. Brit. Empire, 1907, Vol. xii, p. 335.
C.S. Sterilized.	R	A	Placenta posterior.	——
C.S. Not sterilized.	R	A	1, Craniotomy. Same patient as March 1, 1910 (Gemmell).	——
C.S. Not sterilized.	R	A	Child died in 11 days. Mother had paralysis of right external popliteal nerve 9 days after operation, and lame since.	——
C.S. Partial ventri-fixation to obtain adhesions. Not sterilized.	R	A	——	——
C.S. and abdominal panhysterectomy.	D	A	Patient died suddenly 10th day from pulmonary embolism. Very well till then.	——
C.S. Not sterilized.	R	A	Same patient as Nov. 12, 1908 (Jardine). Seriously ill during puerperium. Fœtid lochia. Bed-sore. Eventual good recovery.	See "Obstetric Clinics" (Jardine), 1910, p. 624.
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	1, 2, Craniotomy.	——
C.S. Sterilized.	R	A	——	——
C.S. = Sterilized.	R	A	**2nd C.S.** Stitch abscess and probably cellulitis during puerperium.	——
C.S. Not sterilized.	R	A	1. Cephalotripsy.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1907					
769	Sept. 4	D. Lloyd Roberts, **Manchester.**	27	1	Generally contracted flat pelvis, C.V. 3″ (7·5 cm.). Interspin. 8″, Intercrist. 9¾″, Interischial 1½″ (3·8 cm.).	Not in labour.
770	Sept. 4	W. K. Walls, **Manchester.**	30	3	Contracted pelvis.	——
771	Sept. 8	J. M. Munro Kerr, Glasgow.	35	5	Solid ovarian tumour. Very adherent.	In labour 16 hours. Forceps previously applied.
772	Sept. 10	J. S. Fairbairn, London.	42	4	Flat pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
773	Sept. 14	R. Jardine, Glasgow.	25	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour.
774	Sept. 15	R. C. Buist, **Dundee.**	22	0	Rachitic flat pelvis, 2½″ (6·3 cm.).	Favourable. Membranes ruptured 12 hours.
775	Oct. 1	A. J. Horne, **Dublin.**	25	1	Contracted pelvis.	Favourable.
776	Oct. 1	J. M. Munro Kerr, Glasgow.	?	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
777	Oct. 8	W. J. Gow, London.	35	0	Fibro-myoma uteri.	Not in labour.
778	Oct. 12	E. O. Croft, **Leeds.**	25	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
779	Oct. 15	R. Jardine, Glasgow.	28	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
780	Oct. 16	J. M. Munro Kerr, Glasgow.	?	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour some hours when admitted.
781	Oct. 20	P. E. Barber, Sheffield.	29	3	Contracted pelvis, Interspin. 23 cm., Intercrist. 27 cm., C.V. 3¾″ (9·3 cm.). Bad obstetric history.	In labour. Membranes ruptured 3 hours.
782	Oct. 20	J. M. Munro Kerr, Glasgow.	26	1	Rachitic pelvis, C.V. 2⅞″ (7·2 cm.).	In labour.
783	Oct. 21	J. M. Munro Kerr, Glasgow.	33	1	Rachitic pelvis, C.V. 2⅞″ (7·2 cm.).	In labour, but in Hospital some days.
784	Oct. 21	A. W. Russell, Glasgow.	23	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour. Cord prolapsed

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1. Craniotomy.	Trans. N. of E. Obst. and Gyn. Soc., 1907-8, p. 128.
C.S. Not sterilized.	R	A	——	——
C.S. and supravaginal hysterectomy, intraperitoneal stump and ovariotomy.	D	A	Died in 24 hours.	Journ. of Obst. and Gyn. Brit. Empire. Vol. xiii, 1908, p. 69.
C.S. Not sterilized.	R	A	1, 2, Embryotomy. 3, 4, Induction, one survived, delicate.	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	Mother died of broncho-pneumonia on 5th day.	——
C.S. and supravaginal hysterectomy, intraperitoneal stump.	D	A	1. Craniotomy. Mother died of sepsis.. After hæmatoma of pelvis.	——
C.S. and supravaginal hysterectomy, intraperitoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	Same case as Jan. 5, 1910 (Croft).	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	D	1. Craniotomy. This child was alive shortly before operation.	——
C.S.	R	A	1, 2, Abortions. 3, Craniotomy.	——
C.S. Not sterilized.	R	A	1. Craniotomy.	——
C.S. Not sterilized.	R	A	1. Craniotomy.	——
C.S. Not sterilized.	R	D	Child 6lbs. Same patient as March 23, 1909 (Russell).	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1907					
785	Oct. 22	J. M. Munro Kerr, Glasgow.	42	1	Rachitic pelvis, C.V. 2¾″ (6·9 cm.).	In labour, but in Hospital some days.
786	Oct. 22	R. G. McKerron, Aberdeen.	29	1	Generally contracted pelvis, C.V. 3¾″ (6·9 cm.).	Onset of labour. Membranes intact. No previous examination.
787	Oct. 25	E. Hastings Tweedy, Dublin.	32	0	Contracted pelvis, C.V. 6·25 cm.	In labour 18 hours.
788	Oct. 29	W. H. C. Newnham, Clifton, Bristol.	34	0	Contracted pelvis.	Unfavourable. In labour many hours.
789	Oct. 30	R. Jardine, Glasgow.	32	4	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
790	Nov. 8	J. B. Hellier, Leeds.	28	5	Rachitic pelvis, C.V. 3¼″ (8·1 cm.).	Onset of labour.
791	Nov. 12	Sir Halliday Croom, Edinburgh.	37	2	Contracted pelvis, C.D. 4″ (10 cm.). Obstetric history.	Anxious to get living child even at increased maternal risk.
792	Nov. 12	R. Jardine, Glasgow.	23	1	Generally contracted flat pelvis.	Admitted in labour. Membranes ruptured.
793	Nov. 12	Amand Routh, London.	24	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. Not in labour. 39th week.
794	Nov. 12	A. F. Stabb, London.	29	1	Contracted pelvis.	Unfavourable. In labour 23 hours.
795	Nov. 13	A. Donald, Manchester.	23	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable.
796	Nov. 13	W. Duncan, London.	39	4	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	——
797	Nov. 18	W. J. Gow, London.	32	3	Contracted pelvis.	Favourable.
798	Nov. 23	R. P. R. Lyle, Newcastle-on-Tyne.	18	0	Rachitic flat pelvis, C.V. 7·5 cm.	Favourable, but in labour two days and two previous attempts at forceps delivery.
799	Dec. 1	P. E. Barber, Sheffield.	34	4	Generally contracted pelvis.	——

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1. Craniotomy.	——
C.S. Not sterilized.	R	A	1. Induction at 34th week. Living. Since then became so stout that C.S. selected instead of induction. This child died of broncho-pneumonia in 6 months.	——
C.S. Not sterilized.	R	A	——	Rotunda Hospital, 1906-7.
C.S. Sterilized.	R	D	——	——
C.S. Sterilized.	R	A	Removed also right hydrosalpinx.	——
C.S. = Sterilized by request.	R	A	**2nd C.S.** Same patient as April 18, 1906 (Hellier). Adhesion uterus and abdomen. Placenta anterior over uterine incision.	Lancet, 1908, Vol. i, p. 1618.
C.S. Not sterilized.	R	A	1. Craniotomy. 2. Induction. Stillborn.	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Slight albuminuria.	——
C.S. Not sterilized.	D	A	Died 12th day. P.M. refused. Pyrexia. Offensive lochia. Probably sepsis.	Queen Charlotte's Hospital Reports.
C.S. Not sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	Child premature. Hare lip and cleft palate. Died in 3 hours.	Queen Charlotte's Hospital Reports, 1907.
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1907					
800	Dec. 2	P. E. Barber, Sheffield.	31	2	Generally contracted pelvis.	——
801	Dec. 3	R. Jardine, Glasgow.	30	5	Contracted pelvis, C.V. 3⅛″ (7·8 cm.).	Not in labour.
802	Dec. 17	H. Briggs, Liverpool.	28	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. Not in labour.
803	Dec. 17	Murdoch Cameron, Glasgow.	26	?	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
804	Dec. 19	W. J. Gow, London.	27	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable.
805	Dec. 20	Victor Bonney, London.	28	1	Generally contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. Not in labour.
806	Dec. 20	D. Lloyd Roberts, Manchester.	25	0	Scoliotic pelvis, C.V. 2¾″ (6·9 cm.). Intercrist. and interspin. 9½″. Dwarf. External conjugate 5½.	Favourable.
807	Dec. 21	J. H. Targett, London.	23	0	Contracted pelvis.	Favourable. In labour.
808	Dec. 23	E. Hastings Tweedy, Dublin.	36	4	Contracted pelvis, C.V. 6·25 cm.	Early in 1st stage.
809	Dec. 23	A. Dempsey, Belfast.	27	2	Generally contracted pelvis.	Favourable.
810	Dec. 24	P. E. Barber, Sheffield.	?	3	Generally contracted pelvis.	——
811	Dec. 28	R. P. R. Lyle, Newcastle-on-Tyne.	25	0	Rachitic flat pelvis, C.V. 8 cm.	Very unfavourable. Several attempts at forceps delivery during two previous days.
812	Dec. 29	W. J. Gow, London.	40	1	Cicatricial stenosis of cervix and vagina.	Favourable.
813	Dec. 30	Bellingham Smith, London.	39	2	Generally contracted pelvis, C.V. 3¼″ (8·7 cm.).	In labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. 〓 Not sterilized.	R	A	**2nd C.S.** Same patient as Feb. 27, 1902 (Briggs), and Dec. 4, 1909 (Briggs).	——
C.S. Sterilized.	R	A	——	——
C.S. 〓 Not sterilized.	R	A	**2nd C.S.** Same patient as Dec. 31, 1904 (Gow).	Queen Charlotte's Hospital Reports.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	1. Cephalotripsy.	——
C.S. Not sterilized.	R	A	——	N. of E. Obst. and Gyn. Soc., 1908, p. 28.
C.S. Not sterilized.	R	A	Both in good health, 1910.	——
C.S. Not sterilized.	D	A	Previous children stillborn (forceps and premature). Patient died of shock 3 hours after operation. Collapsed during separation of densely adherent placenta.	Rotunda Hosp. Reports, 1907-8.
C.S. Not sterilized.	R	A	1, 2, Craniotomy. Same case as April 22, 1909 (Johnstone).	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	Child's head badly damaged with forceps and only lived 2 days. Uterus when opened at operation contained air which was very fœtid.	——
C.S. Not sterilized.	R	A	——	Queen Charlotte's Hospital Reports.
C.S. Not sterilized.	R	A	1. Child 8lbs. Dead. 2. Child 12lbs. Cephalotripsy.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1908					
814	Jan. 2	R. Favell, Sheffield.	34	0	Generally contracted flat pelvis.	Favourable.
815	Jan. 3	H. Clifford, Manchester.	30	1	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable.
816	Jan. 3	W. Stephenson, Aberdeen.	?	0	Generally contracted flat pelvis, C.V. 2″ (5 cm.). Absolute indication.	Very unfavourable. Anæmia. Nephritis. Saline transfusion before operation. In labour 30 hours.
817	Jan. 7	H. Russell Andrews, London.	27	1	Contracted pelvis, C.D. 3½″ (8·7 cm.).	Favourable.
818	Jan. 7	Bellingham Smith, London.	32	1	Generally contracted pelvis.	In labour.
819	Jan. 9	R. Favell, Sheffield.	39	6	Parovarian cyst obstructing labour.	In labour. Forceps tried before admission.
820	Jan. 9	A. W. W. Lea, Manchester.	27	3	Funnel-shaped pelvis, transverse at outlet = 2½″ (6·2 cm.).	Not in labour.
821	Jan. 10	J. M. Munro Kerr, Glasgow.	34	0	Rachitic pelvis, C.V. 2⅞ (7·2 cm.).	In labour, but in Hospital some days before operation.
822	Jan. 18	A. Donald, Manchester.	30	1	Contracted pelvis.	——
823	Jan. 25	J. M. Munro Kerr, Glasgow.	39	4	Rachitic pelvis, C.V. 3⅛″ (7·8 cm.).	——
824	Jan. 26	E. Malins, Birmingham.	40	4	Generally contracted pelvis, C.V. 2¾″ (6·9 cm.).	Near full term.
825	Jan. 26	A. W. Russell, Glasgow.	39	4	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour.
826	Jan. 29	H. Briggs, Liverpool.	31	2	Generally contracted rachitic pelvis, C.V. 3½ (8·7 cm.).	Favourable. In labour.
827	Jan. 31	J. E. Gemmell, Liverpool.	37	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Unfavourable. Marked cyanosis. P. 120, Resp. 36. In labour two hours. Membranes intact.
828	Jan. 31	Amand Routh, London.	31	0	Contracted pelvis in rachitic dwarf, C.V. 1½″ (3·8 cm.).	Favourable. In labour 4 hours. Membranes intact.
829	Feb. 1	H. Briggs, Liverpool.	32	4	Generally contracted rachitic pelvis, C.V. 3½″ (8·7 cm.).	Favourable. In labour 13 hours.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as Oct. 1909 (Favell).	—
C.S. Not sterilized.	R	A	—	—
C.S.	D	A	Patient died in 3 days. Exhaustion and (?) sepsis.	—
C.S. Not sterilized.	R	A	1. Cephalotripsy.	—
C.S. Not sterilized.	R	A	1. Premature 8th month. Stillborn.	—
C.S. and excision of cyst. Not sterilized.	R	A	—	Journ. of Obst. and Gyn. Brit. Empire, Vol. xiv, p. 150.
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	1, 2, 3, 4. Induction. All stillborn.	—
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Jan. 26, 1901 (Malins).	—
C.S. Not sterilized.	R	A	1, 2, 3, 4. Induction. All stillborn.	—
C.S. Not sterilized.	R	A	1, 2. Forceps. Children died when a few months old.	—
C.S. Not sterilized.	R	A	1. Craniotomy.	—
C.S. Sterilized.	R	A	Graves's disease.	—
C.S. Not sterilized.	R	A	1—4. Forceps.	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1908					
830	Feb. 2	A. W. W. Lea, Manchester.	21	1	Kyphotic pelvis, transverse at outlet = 2″ (5 cm.).	Not in labour.
831	Feb. 2	E. O. Croft, Leeds.	29	3	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
832	Feb. 3	J. H. Targett, London.	39	0	Fibro-myoma uteri blocking pelvis, growing from supra-vaginal cervix.	Favourable. Not in labour. Full term.
833	Feb. 6	C. E. Purslow, Birmingham.	29	2	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Not in labour. Full term.
834	Feb. 7	E. J. Maclean, Cardiff.	37	0	Cervical Fibro-myoma blocking pelvis.	Not favourable. In labour 30 hours.
835	Feb. 8	R. Favell, Sheffield.	33	1	Generally contracted flat pelvis, C.D. 3¾″ (9·3 cm.).	Favourable.
836	Feb. 9	J. M. Munro Kerr, Glasgow.	23	2	Rachitic pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour. In Hospital some days.
837	Feb. 12	H. Briggs, Liverpool.	31	0	Scoliosis. Generally contracted pelvis. Large child, C.V. 2¼″ (8·1 cm.).	Favourable. Not in labour.
838	Feb. 18	R. J. Johnstone, Belfast.	27	1	Generally contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. In labour 12 hours.
839	Feb. 19	A. W. W. Lea, Manchester.	22	1	Kypho-scoliotic pelvis.	Not in labour.
840	Feb. 20	Comyns Berkeley, London.	31	2	Distorted pelvis. Old hip disease. Acetabulum projecting into pelvic cavity.	Favourable.
841	Feb. 20	J. M. Munro Kerr, Glasgow.	21	0	Rachitic pelvis, C.V. 2¼″ (5·6 cm.).	In labour two days before admission.
842	Feb. 23	W. J. Gow, London.	38	5	Cancer in pelvis.	Emaciated.
843	Feb. 24	Comyns Berkeley, London.	28	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. In labour. Membranes ruptured 12 hours.
844	Feb. 25	W. K. Walls, Manchester.	27	2	Contracted pelvis.	Favourable.
845	Feb. 25	W. K. Walls, Manchester.	21	1	Contracted pelvis.	Favourable.
846	Feb. 25	W. K. Walls, Manchester.	25	2	Contracted pelvis	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Had suffered from caries of lumbar vertebræ.	—
C.S. Not sterilized.	R	A	1, 2, 3, Craniotomy.	—
C.S. Sterilized.	R	A	—	—
C.S. Sterilized.	R	A	1, 2, Craniotomy.	—
C.S. Not sterilized.	R	D	Child had been dead over a week.	—
C.S. Sterilized.	R	A	**2nd C.S.** Same patient as Oct. 29, 1906 (Favell).	—
C.S. Not sterilized.	R	A	1, 2, Craniotomy. Same patient as April 1, 1910 (Kerr).	—
C.S. Not sterilized.	R	A	—	—
C.S. Sterilized by supra-vaginal hysterectomy, extra-peritoneal stump.	R	A	1. Embryotomy.	—
C.S. Not sterilized	R	A	Had suffered from sacro-iliac disease.	—
C.S. Sterilized.	R	A	1, 2, Stillborn.	—
C.S. Not sterilized.	D	A	When uterus opened at operation, very fœtid smell, though child alive. Died sepsis 3rd day.	—
C.S. Not sterilized.	D	A	Died 15th day. Cancer of sigmoid flexure, perforation of bowel, and abscess communicating with it.	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	—	—
C.S. Not sterilized.	R	A	Same patient as April 14, 1910 (Walls).	—
C.S. Not sterilized.	R	A	—	—
C.S. Sterilized.	R	A	**3rd C.S.** 1st C.S. May 6, 1904 (late Dr. Walter). 2nd C.S. July 13, 1905 (late Dr. Walter).	—

These 3 operations done on same day.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1908					
847	Feb. 28	R. Jardine, Glasgow.	28	0	Generally contracted flat pelvis, C.V. 2¼″ (5·6 cm.).	In labour. Membranes ruptured. Cord prolapsed.
848	Feb. 29	R. Jardine, Glasgow.	34	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
849	March 2	H. Williamson, London.	42	0	Central placenta prævia. Fibro-myoma in lower uterine segment. Transverse presentation.	Anæmic from ante-partum hæmorrhage. 8th month.
850	March 8	P. E. Barber, Sheffield.	39	?	Generally contracted flat pelvis.	——
851	March 9	T. W. Eden, London.	42	0	Solid malignant pelvic tumour, obstructing pelvis.	Not in labour. Much ascites.
852	March 9	W. K. Walls, Manchester.	31	3	Contracted pelvis.	Attempts at forceps delivery before admission.
853	March 10	W. K. Walls, Manchester.	24	2	Contracted pelvis.	Favourable.
854	March 10	A. H. N. Lewers, London.	27	4	Contracted pelvis.	Favourable. Not in labour.
855	March 14	Sir F. H. Champneys, London.	36	1	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. In labour. Membranes ruptured.
856	March 15	P. E. Barber, Sheffield.	23	0	Contracted pelvis.	——
857	March 15	W. J. Gow, London.	31	0	Tonic contraction of uterus.	Collapsed by many attempts at forceps delivery, and ineffectual craniotomy before admission.
858	March 16	F. W. N. Haultain, Edinburgh.	30	3	Naegele's pelvis.	Not in labour.
859	March 20	R. Jardine, Glasgow.	21	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Not in labour.
860	March 20	R. Jardine, Glasgow.	29	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.
861	March 21	T. Wilson, Birmingham.	23	1	Kyphotic pelvis, C.V. 6 cm. Dwarf.	Admitted 2nd stage of labour. 8th month.
862	March 26	R. Favell, Sheffield.	39	?	Fibro-myoma uteri obstructing delivery.	Favourable. In labour.

Operative Technique	Result		Remarks	References If Case already published
	Mother	Child		
C.S. Not sterilized.	D	A	Bowels became paralysed.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Child died of convulsions 4 hours after birth.	——
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Mother died in 9 months. P.M. Primary cancer of liver.	——
C.S. Not sterilized.	D	A	Mother died of heart failure on 2nd day.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Same patient as March 29, 1910 (Lewers).	——
C.S. Not sterilized.	R	A	1. Craniotomy. Same patient as March 23, 1910 (Champneys).	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	D	D	Patient died in 23 hours of shock.	——
C.S. Not sterilized.	R	A	1, 2, 3, Stillborn.	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Tuberculous caries of spine and joint. Child weighed 1320 gms. Kept alive for 52 days.	——
C.S. Myomectomy and supra-vaginal hysterectomy, extra-peritoneal stump.	R	A	Hysterectomy after myomectomy owing to severe hæmorrhage.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
863	1908 March 29	Herbert Spencer, London.	38	0	Fibro-myoma adherent in Douglas's pouch, causing retro-flexio uteri.	Emergency operation. In labour three days. Membranes ruptured 32 hours. Dirty brown discharge. Child dead.
864	April 2	H. Briggs, Liverpool.	30	0	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	In labour 56 hours. Membranes ruptured. Cord prolapsed. Tonic contraction of uterus
865	April 6	Sir F. H. Champneys, London.	26	0	Kyphosis. Between tubra ischii, 2¼″ (6·9 cm.).	Favourable. Not in labour.
866	April 8	W. K. Walls, Manchester.	20	1	Contracted pelvis.	Favourable.
867	April 10	R. Jardine, Glasgow.	26	4	Generally contracted flat pelvis, C.V. 3¾ (9·3 cm.).	Not in labour.
868	April 13	A. W. W. Lea, Manchester.	31	0	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour.
869	April 15	H. Clifford, Manchester.	30	0	Fibro-myoma of lower segment of uterus.	Favourable. In labour.
870	April 20	F. J. McCann, London.	26	1	Eclampsia. Extreme rigidity and elongation of cervix—could not be dilated.	Unfavourable. Recurring seven fits. 7½ months.
871	April 26	R. Favell, Sheffield.	37	9	Contracted pelvis.	Favourable.
872	April 26	W. K. Walls, Manchester.	20	0	Contracted pelvis.	Favourable.
873	April 27	S. Savage, Birmingham.	43	9	Flat pelvis, C.V. 3″ (7·5 cm.).	Favourable, 39th week.
874	May 3	J. B. Hellier, Leeds.	33	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour.
875	May 4	A. H. F. Barbour, Edinburgh.	30	3	Generally contracted flat pelvis, C.D., 3⅜″ (8·4 cm.).	In labour 2 hours. Membranes ruptured.
876	May 4	T. W. Eden, London.	39	8	Pelvic contraction, C.V. 3″ (7·5 cm.).	Not in labour.
877	May 4	A. Stookes, Liverpool.	23	0	Rachitic pelvis. Dwarf.	Favourable.
878	May 7	A. Stookes, Liverpool.	26	0	Rachitic pelvis. Dwarf.	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. and abdominal panhysterectomy.	R	D	Extreme distension and thinning of anterior uterine wall.	Proc. Roy. Soc. Med. (Obst. Sect.), Vol. ii, p. 79.
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	High kyphosis.	—
C.S. Not sterilized.	R	A	—	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	D	Mother not again pregnant.	Proc. Roy. Soc. Med. (Obstet. Sect.), 1910, p. 193.
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S.	R	A	Locomotor ataxy since 13 years old. 1—6, Normal. 7, Forceps. 8, 9, Craniotomy.	—
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as Feb. 3, 1907 (Hellier).	—
C.S. Not sterilized.	R	A	1, Craniotomy. 2, 3, Induction. Stillborn.	—
C.S. Sterilized.	R	A	—	Queen Charlotte's Hospital Reports.
C.S. Not sterilized.	R	A	Child 6lbs. 10oz. Same patient as Sept. 11, 1909 (Stookes).	—
C.S. Not sterilized.	R	A	Same patient as June 2, 1910 (Stookes).	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1908					
879	May 10	P. E. Barber, Sheffield.	32	1	Generally contracted round pelvis.	Favourable.
880	May 10	S. Savage, Birmingham.	32	5	Generally contracted flat pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. 1st stage of labour. Forceps failed in Hospital.
881	May 11	H. Williamson, London.	39	4	Cancer of rectum, size of fist, fixed to sacrum.	Favourable. Not in labour.
882	May 14	W. K. Walls, Manchester.	32	0	Contracted pelvis. Ankylosis of hips.	Favourable.
883	May 20	J. S. Fairbairn, London.	27	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour. Repeated attempts at forceps delivery before admission.
884	May 20	W. E. Fothergill, Manchester.	25	3	Contracted pelvis.	Favourable.
885	May 22	M. H. Phillips, Sheffield.	28	1	Spondylolisthetic pelvis.	Favourable. 1st stage.
886	May 26	R. Jardine, Glasgow.	27	4	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Admitted in labour.
887	May 31	A. W. W. Lea, Manchester.	36	2	Rachitic pelvis, C.V. 2″ (5 cm.).	In labour.
888	June 4	A. H. N. Lewers, London.	23	1	Ovarian tumour adherent in pelvis.	Unfavourable. Ill in bed for some time with pain and pyrexia. 7½ months.
889	June 5	A. H. N. Lewers, London.	28	1	Contracted pelvis.	Favourable. Not in labour.
890	June 8	Murdoch Cameron, Glasgow.	24	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	——
891	June 8	W. J. Gow, London.	24	0	Contracted pelvis.	Favourable.
892	June 11	Amand Routh, London.	38	1	Generally contracted flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour 10 hours. Membranes ruptured. No attempts to deliver.
893	June 12	H. Spencer, London.	34	1	Contracted pelvis, C.V. 3″ (7·5 cm.). Persistent transverse presentation.	Favourable. Not in labour. Near full term.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Feb. 10, 1907.	—
C.S. Not sterilized.	R	A	1, 2, 3, Forceps. 4, 5, Craniotomy.	—
C.S.	R	A	Previous labour normal.	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Nov. 18, 1903 (J. W. Martin).	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	Same patient as June 2, 1910 (Lea).	—
C.S. and ovariotomy. Not sterilized.	R	A	Tumour universally adherent. Appendix also removed. Child died in a few minutes.	—
C.S. Not sterilized.	R	A	Same patient as May 27, 1910 (Lewers). 1. Cephalotripsy. Acute pneumonia during puerperium. Good recovery.	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Sterilized.	R	A	1. Craniotomy. Mother and child well, 1910.	—
C.S. Not sterilized.	R	A	1. Decapitation, transverse. This child delivered in 82 seconds.	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
894	**1908** June 13	W. K. Walls, Manchester.	26	0	Contracted pelvis.	Favourable.
895	June 15	A. H. F. Barbour, Edinburgh.	26	6	Generally contracted pelvis, C.D. 3½″ (8·7 cm.).	In labour and membranes ruptured. Cord prolapsed.
896	June 16	R. Jardine, Glasgow.	26	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
897	June 16	J. M. Munro Kerr, Glasgow.	36	7	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Not in labour. In Hospital some days.
898	June 16	A. H. N. Lewers, London.	19	0	Contracted pelvis.	Favourable. Not in labour.
899	June 18	H. Russell Andrews, London.	26	3	Generally contracted pelvis.	Favourable. Onset of labour.
900	June 19	W. K. Walls, Manchester.	23	1	Contracted pelvis.	Favourable.
901	June 20	A. W. W. Lea, Manchester.	21	0	Generally contracted pelvis.	In labour. Forceps previously applied above the brim.
902	June 21	H. Russell Andrews, London.	27	2	Generally contracted pelvis.	Favourable. Onset of labour.
903	June 24	E. T. Collins, Cardiff.	?	?	Contracted pelvis.	Favourable.
904	June 25	A. W. W. Lea, Manchester.	33	4	Flat pelvis.	In labour 15 hours.
905	June 29	R. Jardine, Glasgow.	25	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
906	July 1	W. E. Fothergill, Manchester.	41	0	Tonic contraction of uterus. Impacted face. Threatened rupture. Cervix already torn and lower segment very thin.	Unfavourable. Forceps previously attempted.
907	July 2	G. W. Fitzgerald, Manchester.	24	1	Generally contracted pelvis, C.V. 2¼″ (5·6 cm.).	Favourable. Not in labour. Full term.
908	July 4	R. G. McKerron, Aberdeen.	25	1	Generally contracted flat pelvis, C.V. 2¼″ (5·6 cm.).	Not in labour. Albuminuria.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Same patient as April 27, 1910 (Fothergill).	——
C.S. Not sterilized.	R	A	Same patient as April 21, 1910 (Haultain).	——
C.S. Sterilized	R	A	——	——
C.S. ═ and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	**2nd C.S.** Same patient as Feb. 28, 1906 (Kerr).	——
C.S. Not sterilized.	R	A	——	——
C.S. ═ Sterilized by request.	R	A	**2nd C.S.** Same patient as May 13, 1906 (Andrews). Omental adhesions to front of uterus, but its scar not seen.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized by request.	R	A	**2nd C.S.** Same patient as July 5, 1906 (Andrews).	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	D	D	——	——
C.S. Not sterilized.	R	A	1. Craniotomy.	——
C.S. Not sterilized.	R	A	Admitted to hospital 3 weeks before operation with marked albuminuria and œdema. Improved under treatment.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
909	1908 July 7	R. Jardine, Glasgow.	29	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Admitted in labour.
910	July 9	A. H. F. Barbour, Edinburgh	29	3	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Not in labour.
911	July 9	R. Favell, Sheffield.	29	2	Generally contracted rachitic flat pelvis, C.D. 3″ (7·5 cm.).	Favourable.
912	July 9	R. Jardine, Glasgow.	23	4	Generally contracted flat pelvis, C.V. 3¼″ (8·1 cm.).	Not in labour.
913	July 13	H. Williamson, London.	39	11	Generally contracted rachitic pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. Onset of labour.
914	July 15	Sir F. H. Champneys, London.	32	8	Contracted pelvis.	In labour. Membranes ruptured. Forceps failed.
915	July 15	J. S. Fairbairn London.	32	2	Contracted pelvis.	In labour.
916	July 19	T. W. Eden, London.	26	2	Contracted pelvis.	Not in labour.
917	July 21	A. F. Stabb, London.	37	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour. Membranes intact.
918	July 22	G. E. Gemmell, Liverpool.	27	3	Contracted flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. 233rd day of gestation.
919	July 24	W. R. Dakin, London.	30	1	Contracted pelvis.	——
920	July 27	Stanley Dodd, London.	27	2	Rachitic flat pelvis, C.V. 9 cm.	Favourable. Not in labour.
921	July 31	A. W. Russell, Glasgow.	32	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour.
922	Aug. 5	J. M. Munro Kerr, London.	27	2	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Not in labour, and in Hospital some days.
923	Aug. 6	Mrs. Scharlieb, London.	35	0	Generally contracted flat pelvis. C.V. 2½″ (6·2 cm.).	Very unfavourable. Long in labour. Membranes ruptured 14 hours. Tonic contraction of uterus P. 108. Constant vomiting. Meconium passing.
924	Aug. 7	R. Jardine, Glasgow.	26	3	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	In labour.

Operative Technique	Result		Remarks	References If Case already published
	Mother	Child		
C.S. Sterilized.	R	A	—	—
C.S. Sterilized.	R	A	**2nd C.S.** Same patient as Jan. 11, 1907 (Croom). 1, 2, Craniotomy.	—
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as April 30, 1907 (Favell).	—
C.S. Sterilized.	R	A	—	—
C.S. Sterilized.	R	A	4—11. Inductions. All died.	—
C.S. Not sterilized.	R	A	Previous labour normal.	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	2. Induction. Child died.	Queen Charlotte's Hospital Reports.
C.S. Not sterilized.	R	A	—	Queen Charlotte's Hospital Reports.
C.S Not sterilized.	R	A	**2nd C.S.** Same patient as Feb. 20, 1905 (Gemmell).	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	—	—
C.S. Not sterilized.	R	A	Same patient as Sept. 18, 1909 (Dodd). 1, 2, Skull fractured. Both died.	—
C.S. Not sterilized.	R	A	In Hospital 7 weeks, being treated for syphilis.	—
C.S. Not sterilized.	R	A	**2nd C.S.** Uterus adherent to abdominal parietes. 1, 2, Craniotomy.	—
C.S. Not sterilized.	R	A	Lower segment of uterus as thin as membrane. Child 5½lbs.	—
C.S. Sterilized.	R	A	—	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1908					
925	**Aug. 9**	R. Jardine, Glasgow.	34	4	**Contracted pelvis, C.V. 2¾″ (6·9 cm.).**	**In labour. Cord prolapsed.**
926	**Aug. 12**	A. W. W. Lea, Manchester.	24	1	**Flat pelvis, C.V. 3¼″ (8·1 cm.).**	Not in labour.
927	**Aug. 14**	T. B. Grimsdale, Liverpool.	44	0	Narrow rigid vagina in elderly nullipara.	Favourable.
928	**Aug. 18**	J. M. Munro Kerr, Glasgow.	40	10	Cancer of cervix.	In labour.
929	**Aug. 20**	M. H. Phillips, Sheffield.	34	4	**Flat pelvis, C.D. 4″ (10 cm.). Large child.**	In labour. Os fully dilated. Forceps failed before admission.
930	**Aug. 21**	J. E. Gemmell, Liverpool.	21	1	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour 18 hours 2nd stage 3 hours. No attempt at delivery.
931	**Aug. 21**	R. J. Johnstone, Belfast.	38	10	Cancer of cervix.	Favourable. Onset of labour.
932	**Aug. 22**	R. Jardine, Glasgow.	24	3	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Not in labour.
933	Aug. 23	H. Russell Andrews, London.	36	0	Generally contracted pelvis, C.D. 3¾″ (9·3 cm). Fibro-myoma of fundus uteri.	Favourable. Early in labour. Membranes intact.
934	Aug. 23	J. W. Martin, Sheffield.	43	5	Malignant ovarian tumour.	Very unfavourable
935	Aug. 24	W. Blair Bell, Liverpool.	29	2	Contracted pelvis, C.D. 3¼″ (8·1 cm.).	Favourable
936	Aug. 25	J. E. Gemmell, Liverpool.	24	1	Flat pelvis, C.V. 2⅞ (7·2 cm.).	Favourable In labour 8 hours. Membranes intact.
937	Aug. 25	W. K. Walls, Manchester.	21	0	Contracted pelvis.	——
938	Aug. 28	J. M. Munro Kerr, Glasgow.	35	0	Rachitic pelvis, C.V. 2¾″ (6·9 cm.).	In labour.
939	Aug. 29	J. M. Munro Kerr, Glasgow.	22	2	Rachitic pelvis, C.V. 2¾″ (6·9 cm.).	In labour.
940	Sept. 8	Bellingham Smith, London.	34	3	Flat pelvis, C.V. 3½″ (8·7 cm.).	Not in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	Journ. of Obst. and Gyn. Brit. Empire, Vol. xv, 1909, p. 323.
C.S. and abdominal panhysterectomy.	R	D	Carcinoma far advanced.	——
C.S. Not sterilized.	R	A	1, 2, 3, 4, Forceps successfully by same doctor who failed this time.	——
C.S. Not sterilized.	R	A	1. Forceps. Child injured and death in 3 days. This child lived, and weighed 7lbs. 14oz.	——
C.S. and abdominal panhysterectomy (Wertheim).	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. and myomectomy. Not sterilized.	R	A	Myomectomy of semi-cystic fibroid from fundus uteri.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	D	D	Mother died in a few hours.	——
C.S. = Not sterilized. Uterus brought outside before incision.	R	A	**2nd C.S.** Same patient as Feb. 1, 1905 (Grimsdale), and Jan. 2, 1910 (Grimsdale). 1. Craniotomy.	——
C.S. Not sterilized.	R	A	1. Forceps. Stillborn.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as Sept. 20, 1906 (B. Smith).	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1908					
941	Sept. 9	M. H. Phillips, Sheffield.	32	2	Generally contracted flat pelvis, C.D. $3\frac{7}{8}$″ (9·6 cm.).	In 2nd stage 3 hours. No previous attempts to deliver.
942	Sept. 14	Comyns Berkeley, London.	29	1	Contracted pelvis, C.V. $3\frac{1}{2}$″ (8·7 cm.).	Favourable.
943	Sept. 14	H. Williamson, London.	29	1	Contracted pelvis, C.V. $3\frac{1}{2}$″ (8·7 cm.). Head would not engage.	Favourable. In labour. Membranes intact.
944	Sept. 16	T. W. Eden, London.	25	0	Contracted pelvis, C.V. $3\frac{1}{2}$″ (8·7 cm.).	In labour 48 hours. Membranes intact. No attempts to deliver.
945	Sept. 19	W. E. Fothergill, Manchester.	40	3	Tonic contraction of uterus. Threatened rupture. Transverse presentation in small pelvis. Arm prolapsed. Bandl's ring well defined. Dare not turn.	Unfavourable.
946	Sept. 19	H. Williamson, London.	30	0	Small funnel-shaped pelvis, C.V. 3″ (7·5 cm.).	Very unfavourable. In labour. Forceps tried frequently and perforation. Vagina and bladder torn. Patient apparently dying. P. 130.
947	Sept. 28	P. E. Barber, Sheffield.	29	4	Generally contracted flat pelvis, C.V. $3\frac{1}{8}$″ (7·8 cm.).	——
948	Sept. 30	W. S. A. Griffith, London.	40	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour. Membranes intact.
949	Oct. 4	R. Favell, Sheffield.	23	0	Bicornuate uterus, with one horn impacted in pelvis.	Favourable.
950	Oct. 6	R. Jardine, Glasgow.	35	5	Ventrifixation of uterus.	Admitted in labour. Uterus threatening to rupture.
951	Oct. 13	W. J. Gow, London.	30	3	Contracted pelvis.	Favourable.
952	Oct. 13	A. J. Wallace, Liverpool.	31	1	Pelvic deformity.	Favourable. Onset of labour.
953	Oct. 17	W. R. Dakin, London.	27	?	Contracted pelvis.	Favourable.
954	Oct. 17	R. Favell, Sheffield.	23	0	Generally contracted flat pelvis.	Favourable.
955	Oct. 20	A. J. Wallace, Liverpool.	24	0	Extreme pelvic contraction. Absolute indication. Child dead.	In labour 24 hours. Brow presentation.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1. Stillborn. 2. Forceps. Died soon after birth.	——
C.S. Not sterilized.	R	A	1. Craniotomy.	——
C.S. Not sterilized.	R	D	1. Craniotomy. This child macerated.	——
C.S. Not sterilized.	R	A	——	Queen Charlotte's Hospital Reports.
C.S. = Not sterilized.	R	A	**2nd C.S.** 1st C.S. by Sinclair.	——
C.S. Not sterilized.	R	D	Operation performed as affording a slight chance. Prolonged convalescence from suppuration. An abdomino-vesical fistula temporarily supervened.	——
C.S.	R	A	——	——
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as Dec. 30, 1905 (Griffith).	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Fundus found fixed by strong adhesions just above symphysis pubis.	Brit. Med. Journ., 1909, Vol. ii, p. 1037.
C.S. Sterilized.	R	A	Child died of visceral syphilis 14th day.	Queen Charlotte's Hospital Reports.
C.S. = Not sterilized.	R	A	**2nd C.S.**	——
C.S.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	D	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1908					
956	Oct. 24	R. J. Johnstone, Belfast.	23	0	Generally contracted pelvis.	Unfavourable. In labour 38 hours.
957	Oct. 27	J. M. Munro Kerr, Glasgow.	31	3	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour.
958	Oct. 30	J. B. Hellier, Leeds.	23	0	Rachitic flat pelvis. Dwarf.	In labour.
959	Oct. 31	A. J. Wallace, Liverpool.	31	4	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable.
960	Nov. 2	S. Savage, Birmingham.	23	0	Generally contracted pelvis, C.V. 2¾″ (6·9 cm.).	Unfavourable. Membranes ruptured 48 hours. Offensive liquor amnii.
961	Nov. 3	A. J. Wallace, Liverpool.	27	2	Generally contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour 18 hours.
962	Nov. 6	H. Russell Andrews, London.	23	0	Generally contracted pelvis.	Favourable. Shortly after onset of labour.
963	Nov. 12	R. Jardine, Glasgow.	25	2	Contracted pelvis, C.V. 2¾″.	Admitted in labour. Membranes ruptured 2 hours. Marginal placenta prævia.
964	Nov. 12	Sir W. J. Sinclair, Manchester.	33	0	Contracted pelvis.	Unfavourable. Prolonged attempts at forceps delivery before admission.
965	Nov. 13	R. P. R. Lyle, Newcastle-on-Tyne.	25	1	Rachitic flat pelvis, C.V. 7·5 cm.	Favourable. Not in labour.
966	Nov. 15	A. J. Wallace, Liverpool.	32	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour 14 hours. Membranes ruptured and cord prolapsed whilst patient being carried into theatre.
967	Nov. 17	Murdoch Cameron, Glasgow.	30	1	Contracted pelvis, C.V. 2⅞″ (7·2 cm.).	——
968	Nov. 17	C. Lockyer, London.	32	5	Cancer of cervix uteri.	Favourable. Premature.
969	Nov. 18	Sir J. Halliday Croom, Edinburgh,	32	3	Rachitic flat pelvis, C.V. 3¼″ (8·1 cm.).	Onset of labour. Full term.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	D	D	Patient never rallied, died 4th day.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	**3rd C.S.** Same patient as Sept. 23, 1905 (Wallace), and Sept. 26, 1906 (Wallace).	——
C.S. Extra-peritoneal. Transverse supra-pubic incision.	R	A	Vesical fistula with suppuration of wound for weeks. Ultimate recovery. Child died 18 hours after birth.	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Sept. 2, 1906 (Wallace).	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A A	**2nd C.S.** (Twins.) Same patient as Aug. 21, 1907 (Russell). Adhesions over uterine scar.	Journ. of Obst. and Gyn. Brit. Empire, 1908, Vol. xiv, p. 399. "Clinical Obstetrics," 1910, p. 625.
C.S. Not sterilized.	D	D	——	——
C.S. Not sterilized.	R	A	1. Craniotomy. This child imbecile.	——
C.S. Not sterilized.	R	A	Suppurating appendix removed on 3rd day.	——
C.S. Sterilized.	R	A	——	——
C.S. followed by abdominal panhysterectomy (Wertheim).	R	A	Child died in 24 hours. Mother no recurrence in 1909.	Brit. Med. Journ., 1909, Vol. ii, p. 1044.
C.S. Not sterilized.	R	A	1. Craniotomy. 2. Induction. Child lived 4 hours. 3. Induction. Stillborn.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
970	1908 Nov. 23	J. B. Hellier, Leeds.	35	2	Flat pelvis.	Onset of labour.
971	Dec. 7	Murdoch Cameron, Glasgow.	35	5	Ventrifixation of uterus after 4th confinement.	In labour. Membranes ruptured. Tonic contraction.
972	Dec. 7	Sir J. Halliday Croom, Edinburgh.	45	0	Contracted pelvis. Stenosis of cervix and vagina. Eclampsia.	Albuminuria. Fits for 12 hours at intervals of 30 minutes. Comatose.
973	Dec. 8	A. J. Wallace, Liverpool.	34	0	Generally contracted pelvis, C.V. 3½″ (8·1 cm.).	Favourable. Not in labour.
974	Dec. 17	P. E. Barber, Sheffield.	24	0	Generally contracted pelvis.	——
975	Dec. 22	Sir W. J. Sinclair, Manchester.	21	0	Contracted pelvis.	——
976	Dec. 24	A. J. Wallace, Liverpool.	38	0	Contracted pelvis.	In labour 13 hours.
977	Dec. 27	H. Clifford, Manchester.	33	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable.
978	Dec. 29	A. J. Wallace, Liverpool.	25	0	Kyphotic pelvis.	Favourable. In labour 12 hours.
979	Dec. 30	D. Lloyd Roberts, Manchester.	32	4	Simple flat pelvis, C.V. 3″ (7·5 cm.). Dwarf. No evidence of rickets.	——
980	1909 Jan. 1	H. Williamson, London.	27	0	Generally contracted pelvis, C.V. 2¾″ (6·9 cm.). Head would not engage.	Favourable. In labour. Membranes intact.
981	Jan. 2	H. Clifford, Manchester.	28	1	Contracted pelvis.	Favourable.
982	Jan. 5	R. Jardine, Glasgow.	25	1	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	Admitted in labour. Patient very feeble.
983	Jan. 7	J. B. Hellier, Leeds.	31	0	Multiple fibro-myomata uteri obstructing delivery.	In labour. Membranes intact.
984	Jan. 7	W. K. Walls, Manchester.	37	0	Contracted pelvis.	——
985	Jan. 10	W. K. Walls, Manchester.	23	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	——

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1, 2, Stillborn.	——
C.S. Sterilized.	R	A	Cervix very high up. Transverse presentation.	Brit Med. Journ., 1909, Vol. ii, p. 1036 (Case 1).
C.S. Not sterilized.	D	A	Mother never recovered consciousness, and died during a fit 8 hours after the operation.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	D	Same patient as Dec. 23, 1909 (Wallace).	——
C.S. Not sterilized.	R	A	Same patient as Jan. 15, 1910 (Lea).	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1, 2, 3, Craniotomy. 4, Induction. Lived 6 months.	N. of E. Obst. and Gyn. Soc., Feb., 1909.
C.S. Not sterilized.	R	A	Child depressed parietal bone.	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	D	A	Died of exhaustion. Coffee-ground vomiting throughout. Previously gastric ulcer.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump. One ovary left.	R	A	——	Brit. Med. Journ., 1909, Vol. i, pp. 1237, 1478.
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
986	Jan. 13	T. G. Stevens, London.	34	3	Contracted flat pelvis, C.V. 3″ 7·5 cm.).	Favourable. Not in labour.
987	Jan. 14	W. K. Walls, Manchester.	23	0	Contracted pelvis.	——
988	Jan. 18	R. J. Johnstone, Belfast.	30	3	Generally contracted pelvis.	Favourable.
989	Jan. 21	W. K. Walls, Manchester.	29	1	Contracted pelvis.	——
990	Jan. 22	J. B. Hellier, Leeds.	35	0	Multiple fibro-myomata uteri obstructing labour.	In labour. Membranes ruptured.
991	Jan. 23	A. W. W. Lea, Manchester.	36	0	Flat pelvis, C.D. 3¼″ (9·3 cm.).	In labour 18 hours. Previous attempts at forceps delivery.
992	Jan. 24	T. Wilson, Birmingham.	33	2	Generally contracted flat pelvis, C.V. 6·8 cm. Fibroid at fundus.	Favourable.
993	Jan. 25	H. Russell Andrews, London.	38	0	Rachitic flat pelvis.	Favourable. Not in labour.
994	Jan. 26	Sir J. Halliday Croom, Edinburgh,	27	0	Contracted pelvis, Interspin. 8″, Intercrist, 8¾″, transv. outlet 3″. Stenosis of cervix.	In labour 4 hours.
995	Feb. 6	J. Phillips, London.	24	2	Rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour.
996	Feb. 11	P. E. Barber, Sheffield.	?	0	Contracted pelvis, C.D. 3¾″ (9·3 cm.). Head relatively too large.	——
997	Feb. 12	W. J. Gow, London.	29	3	Contracted pelvis.	Favourable.
998	Feb. 13	T. W. Eden, London.	31	0	Cancer of vagina. Both broad ligaments infiltrated. Cervix healthy.	Favourable. Not in labour.
999	Feb. 16	P. E. Barber, Sheffield.	?	1	Contracted pelvis.	In labour.
1000	Feb. 19	R. C. Buist, Dundee.	46	4	Prolonged gestation (11 month). Slight pelvic contraction.	Favourable. In labour 18 hours.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1, 2, Craniotomy. 3, Stillborn.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	D	——	——
C.S. Sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump. One ovary left.	R	A	——	Brit. Med. Journ., 1909, Vol. i, pp. 1237 and 1478.
C.S. Not sterilized.	R	A	——	——
C.S. and myomectomy. Not sterilized.	R	A	Small fibroid at fundus removed, adherent to omentum.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized (by desire. Roman Catholic).	R	A	Acute exacerbation of chronic bronchitis during puerperium.	——
C.S.	R	A	——	——
C.S. Not sterilized.	R	A	**2nd C.S.** Previous children stillborn.	Queen Charlotte's Hospital Reports, 1909.
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Mother lived several months. Hysterectomy performed for fear of infection from septic vagina.	Queen Charlotte's Hospital Reports, 1909, p. 25.
C.S.	D	A	1. Craniotomy. Operation in country cottage. Mother had suppuration of wound and died in a few days.	——
C.S. Not sterilized.	R	D	C.S. after podalic version had failed to deliver as affording less maternal risk than embryotomy. 1, 2, 3, 4, Forceps. Fœtus 10lbs. Anencephalus.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1001	Feb. 22	C. E. Purslow, Birmingham.	39	0	Fibro-myoma uteri obstructing delivery. Growing from posterior wall of lower segment.	In labour 24 hours. Membranes ruptured 10 hours. Os uteri could not be reached.
1002	Feb. 27	M. J. Gibson, Dublin.	19	1	Generally contracted flat pelvis, C.V. 7 cm.	In labour 48 hours. Membranes ruptured.
1003	Feb. 28	C. Y. Pearson, Cork.	28	0	Ovarian cyst impacted in pelvis.	Favourable. In labour. Membranes ruptured.
1004	March 3	J. H. Willett, Liverpool.	34	5	Cancer of cervix (squamous-celled).	Favourable. 7½ months pregnant.
1005	March 4	P. E. Barber, Sheffield.	19	2	Generally contracted flat pelvis, C.D. 3¼″ (8·1 cm.). Interspin. 8·4″, Intercrist. 10″. Brim felt all round.	1st stage of labour.
1006	March 7	T. G. Stevens, London.	26	0	Ovarian cysts obstructing delivery.	Favourable. In labour 12 hours. Membranes intact. No attempts at delivery.
1007	March 8	A. J. Wallace, Liverpool.	28	1	Achondroplasic dwarf, 3ft. 6in., C.V. 1¾″ (4·4 cm.).	Favourable.
1008	March 10	F. W. N. Haultain, Edinburgh.	31	4	Naegele's pelvis.	Not in labour.
1009	March 10	G. F. Blacker, London.	?	5	Oblique pelvis.	Favourable. Onset of labour.
1010	March 15	P. E. Barber, Sheffield.	32	0	Generally contracted flat pelvis, C.D. 3¼″ (8·1 cm.). Intercrist. 9·6″, Interspin. 8·8″.	1st stage of labour.
1011	March 15	W. K. Walls, Manchester.	35	2	Contracted pelvis.	——
1012	March 19	Sir F. H. Champneys, London.	30	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour.
1013	March 19	A. W. W. Lea, Manchester.	29	2	Generally contracted pelvis.	In labour 36 hours. Two attempts at forceps delivery.
1014	March 19	A. H. N. Lewers, London.	39	3	Contracted pelvis.	Favourable. Not in labour.
1015	March 21	A. W. Russell, Glasgow.	40	7	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	Lancet, June 5, 1909.
C.S. Uterus brought outside before incision. Not sterilized.	R	A	C.S. chosen as fœtal heart slow and irregular.	——
C.S. followed by ovariotomy. Not sterilized.	R	A	Patient travelled 60 miles in labour to Hospital. Cyst removed without tapping. Great difficulty in lifting cyst out of pelvis.	——
C.S. and abdominal panhysterectomy (Wertheim).	R	A	Mother in good health, 1910. No recurrence. Child died 4 weeks after leaving hospital.	Trans. N. of Eng. Obst. and Gyn. Soc., April, 1909. Journ. of Obst. and Gyn. Brit. Empire, 1909, Vol. xvi, p. 68.
C.S. Not sterilized.	R	A	——	Jessop Hospital Reports, 1909, p. 9.
C.S. and double ovariotomy.	R	A	Tumour wedged between fœtal head and sacral promontory. Both ovaries adeno-cystomata.	Queen Charlotte's Hospital Reports, 1909, p. 25.
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as Sept. 16, 1906 (Wallace).	——
C.S. Sterilized.	R	A	——	——
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as Sept. 10, 1906 (Blacker).	——
C.S. and myomectomy. Not sterilized.	R	A	Small fibroid at fundus.	Jessop Hospital Report, 1909, p. 9.
C.S. Not sterilized.	R	D	——	——
C.S. Sterilized.	R	A	1. Embryotomy.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	Chest symptoms very soon, and died of pyæmia 9th day. Infection due (?) to excessive crowding of theatre by students.	——
C.S. Not sterilized.	R	A	Child 8½lbs.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1016	March 22	H. Briggs, Liverpool.	34	1	Scolio-rachitic pelvis, C.V. 3″ (7·5 cm.). Breech presentation.	Unfavourable. In labour 2 days. Liquor amnii drained away.
1017	March 22	J. H. Targett, London.	43	1	Large dermoid ovarian cyst, impacted in pelvis.	Favourable. In labour 5 hours. Ventral hernia from previous C.S.
1018	March 23	A. W. Russell, Glasgow.	25	4	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour.
1019	March 24	D. C. Rayner, Bristol.	36	0	Flat pelvis and exostosis opposite left sacro-iliac synchondrosis, C.V. 3″ (7·5 cm.).	Favourable. In labour some hours. Membranes ruptured. No attempts at delivery.
1020	March 26	J. Haig Ferguson, Edinburgh.	42	1	Torsion of uterus and small ovarian cyst	1st stage of labour. Much exhausted. Before full term.
1021	March 26	F. W. N. Haultain, Edinburgh.	29	2	Flat pelvis, C.V.″ (7·5 cm.).	In labour 4 hours.
1022	March 26	R. P. R. Lyle, Newcastle-on-Tyne.	27	1	Simple flat pelvis, C.V. 7 cm.	Favourable. In labour 12 hours. Face presentation. No previous attempts to deliver.
1023	April 5	J. M. Munro Kerr, Glasgow.	21	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour but in Hospital for some days previously.
1024	April 7	A. W. Russell, Glasgow.	24	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour.
1025	April 8	E. Hastings Tweedy, Dublin.	25	4	Contracted pelvis, C.V. 8 cm. Transv. 11 cm.	Not in labour.
1026	April 13	W. J. Gow, London.	35	3	Contracted pelvis.	Favourable.
1027	April 13	F. W. Haultain, Edinburgh.	28	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
1028	April 13	J. L. Lackie, Edinburgh.	34	1	Obliquely contracted pelvis. Tubercular hip disease.	Favourable. In labour 6 hours. Membranes ruptured.
1029	April 13	A. W. W. Lea, Manchester.	42	2	Flat pelvis, C.D. 3½″ (8·7 cm.).	Not in labour.
1030	April 15	E. Holland, London.	26	1	Rachitic flat pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. In labour 12 hours. Membranes intact.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Jan. 29, 1907 (Briggs). No peritoneal adhesion between uterus and abdominal scar.	——
C.S. and ovariotomy.	R	A	**2nd C.S.** 1st C.S. January, 1898.	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Oct. 21, 1907 (Russell). Last child died.	——
C.S. Sterilized.	R	A	Left oblique diameter of cavity much reduced by growth.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump, and ovariotomy.	R	D	——	——
C.S. Not sterilized.	D	A	Acute pneumonia beginning at time of operation. T. 101°F. Cough. Died 2 days later.	——
C.S. Not sterilized.	R	D	——	——
C.S. Sterilized.	R	A	**2nd C.S.** 1st C.S. May, 1908	——
C.S. Not sterilized.	R	A	Child 8½lbs.	——
C.S. Not sterilized.	R	A	1. Prolapsed cord. 2, 3, 4, Forceps. All children stillborn and all fractured skulls.	Rotunda Hosp. Reports, 1908-9.
C.S. Not sterilized.	R	A	——	Queen Charlotte's Hospital Reports.
C.S. Not sterilized.	R	A	1, 2, 3, Stillborn.	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1, 2, Craniotomy.	——
C.S. Not sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1031	April 16	J. L. Lackie, Edinburgh.	27	4	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour.
1032	April 17	J. H. Targett, London.	37	10	Contracted pelvis, C.V. 4″ (10 cm.). Mitral disease. Large child.	Unfavourable. In labour several days and heart failing.
1033	April 21	Comyns Berkeley, London.	25	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable.
1034	April 22	R. J. Johnstone, Belfast.	29	3	Generally contracted pelvis.	Favourable. In labour 4½ hours.
1035	April 24	A. J. Horne, Dublin.	24	1	Contracted pelvis.	Favourable.
1036	April 26	R. Favell, Sheffield.	23	0	Eclampsia. Œdema vulvæ, size of cocoanut.	Advanced phthisis. Had had 3 fits. Urine solid on boiling. 8½ months.
1037	April 27	J. E. Gemmell, Liverpool.	30	4	Flat pelvis, C.V. 2½″ (6·2 cm.).	Favourable. Onset of labour. Membranes intact.
1038	April 30	M. J. Gibson, Dublin.	24	3	Generally contracted pelvis, C.V. 7 cm.	Favourable. Not in labour.
1039	April 30	A. W. Russell, Glasgow.	28	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour.
1040	May 7	J. W Martin, Sheffield.	28	0	Generally contracted flat pelvis, C.D. 4″ (10 cm.).	Favourable. 1st stage of labour.
1041	May 7	Sir W. J. Sinclair, Manchester.	32	1	Contracted pelvis. "Suspect."	Injured by prolonged efforts at forceps delivery before admission.
1042	May 11	E. T. Collins, Cardiff.	27	2	In labour 3 days. Impacted arm and funis presentation. Both gangrenous.	Almost moribund on admission.
1043	May 14	R. J. Johnstone, Belfast.	34	8	Generally contracted pelvis.	Unfavourable. In labour 14 hours. Exhausted by previous attempts at forceps delivery. P. 130.
1044	May 15	F. Edge, Wolverhampton.	29	0	Deformed pelvis.	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	1, 2, Full term. Stillborn. 3, 4, Inductions.	——
C.S. Sterilized.	R	A	4, 5, 6, 7, 8, Inductions at 8th month and forceps. All lived. 9th cephalotripsy.	——
C.S. Not sterilized.	R	A	1, 2, Stillborn.	——
C.S. Sterilized.	R	A	**2nd C.S.** Same patient as Dec. 23, 1907 (Dempsey).	——
C.S. Not sterilized.	R	A	1. Craniotomy.	——
C.S. Not sterilized.	D	A	Improved at first but died on 5th day from the phthisis.	Jessop Hospital Reports, 1909, p. 19.
C.S. Not sterilized.	R	A	1. Premature stillborn. 2, 3, 4, Induction. Forceps. Stillborn. This child 6lbs.	——
C.S. Uterus brought outside before incision. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Child 6½lbs	——
C.S. Sterilized.	R	A	——	Jessop Hospital Reports, 1909, p. 9.
C.S. Modified extra-peritoneal.	D	A	Parietal and uterine peritoneum stitched together during the C.S.	St. Mary's Hosp. Report, 1909, p. 8 (Case 6).
C.S. Not sterilized.	D	D	Mother died in 10 hours.	——
C.S. Not sterilized.	R	A	C.S. was done because a colleague who was present had delivered by embryotomy before and owing to great contraction had been unable to complete delivery under 2 hours.	——
C.S. Not sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1045	May 15	Amand Routh, London.	25	0	Generally contracted flat pelvis.	Unfavourable. In labour 48 hours. Many attempts at forceps delivery by experienced obstetricians previous to admission.
1046	May 17	R. Jardine, Glasgow.	41	6	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Not in labour.
1047	May 17	R. Jardine, Glasgow.	31	4	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Not in labour.
1048	May 20	E. O. Croft, Leeds.	30	?	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	Not in labour.
1049	May 20	R. Jardine, Glasgow.	28	6	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour.
1050	May 22	H. Spencer, London.	41	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. Not in labour.
1051	May 24	H. Russell Andrews, London.	35	3	Generally contracted flat pelvis, C.D. 3½″ (8·7 cm.).	Favourable. Not in labour.
1052	May 27	A. H. F. Barbour, Edinburgh.	21	0	Contracted pelvis. Kyphosis in lumbar region. Rachitic limbs, C.D. 4¾″ (11·7 cm.). Outlet small in all diameters.	In labour. Membranes ruptured.
1053	May 29	H. Clifford, Manchester.	35	3	Contracted pelvis.	Favourable.
1054	May 29	J. S. Fairbairn, London.	39	5	Contracted pelvis, C.V. 3$^{1}/_{5}$″ (8 cm.).	In labour. Membranes intact. Full term.
1055	June 1	J. H. Willett, Liverpool.	33	5	Sloughing cervical fibro-myoma of uterus obstructing labour.	Unfavourable. In labour 48 hours. Membranes ruptured 18 hours. Liquor amnii offensive. Exhausted.
1056	June 2	Comyns Berkeley, London.	31	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable.
1057	June 2	J. E. Gemmell, Liverpool.	23	0	Generally contracted pelvis, C.V. 3½″ (8·7 cm.).	Unfavourable. In labour 15 hours. Membranes ruptured 3 hours. Forceps twice attempted. Exhausted.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Septic sloughs appeared over abrasions on child's head, and over abdominal wound, and utero-abdominal fistula developed. Fistula cured during operation for appendicitis in Feb., 1910. *	Journ. of Obst. and Gyn. Brit. Empire, Vol. xvii, p. 455.
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Nov. 16, 1903 (Jardine). Uterus so adherent that peritoneal cavity not opened.	"Clinical Obstetrics," 1910, p. 620.
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Oct. 17, 1905 (Spencer). Child delivered in 60 seconds.	—
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Dec. 5, 1903 (Andrews).	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S.	D	D	Too exhausted for hysterectomy. Died from sapræmia. In last labour, 2 years previously, child (stillborn) delivered by forceps past obstructing fibroid.	—
C.S.	R	A	1, 2, Axis traction forceps. One lived.	—
C.S. Not sterilized.	D	A	Child 9lbs. Mother developed ether pneumonia in 6 hours and died 8 days later.	—

* 1045. This patient emigrated to a remote farm in Canada, and writes (September, 1910) that she is again pregnant.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1058	June 2	Sir W. J. Sinclair, Manchester.	39	1	Contracted pelvis.	Favourable.
1059	June 7	J. B. Hellier, Leeds.	42	?	Contracted pelvis.	Onset of labour.
1060	June 11	Comyns Berkeley, London.	25	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. Forceps previously tried.
1061	June 15	W. J. Gow, London.	32	?	Fibro-myoma uteri obstructing pelvis.	Not in labour.
1062	June 16	S. Savage, Birmingham.	25	1	Irregularly contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. 1st stage of labour.
1063	June 17	W. Blair Bell, Liverpool.	32	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour some hours. Bag of membranes at vaginal orifice.
1064	June 24	Murdoch Cameron, Glasgow.	26	2	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
1065	June 24	W. K. Walls, Manchester.	23	1	Contracted pelvis.	——
1066	June 25	V. Bonney, London.	40	10	Generally contracted flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. 1st stage of labour.
1067	June 26	E. O. Croft, Leeds.	?	3	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	Not in labour.
1068	June 28	H. Jellett, Dublin.	37	0	Fibro-myomata uteri growing from lower segment of uterus obstructing labour.	Favourable, but alcoholic history. Not in labour. Full term.
1069	July 4	Bellingham Smith, London.	25	0	Kyphotic pelvis.	Not in labour.
1070	July 5	A. H. N. Lewers, London.	33	5	Contracted pelvis.	Rather unfavourable. In labour 20 hours. Attempted forceps delivery before admission.
1071	July 6	T. Wilson, Birmingham.	38	Multi-para.	Cancer of cervix. Advanced.	Onset of labour. Exhausted.
1072	July 10	Sir F. H. Champneys, London.	27	2	Contracted pelvis, C.V. 2″ (5 cm.).	Favourable. In labour. Membranes ruptured.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S.	R	A	**2nd C.S.**	—
C.S. Sterilized.	R	A	—	—
C.S. Sterilized.	R	A	—	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	—	—
C.S. Not sterilized.	R	A	Six years before had had pelvis fractured by cart-wheel running over her. 1. Craniotomy of after-coming head.	—
C.S. Incision after uterus brought outside.	R	D	Head of child impacted in pelvis. Died during extraction. Weighed 3½lbs. 1, 2, Craniotomy. Uterus bi-cornuate. Pregnancy left horn.	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Sterilized.	R	A	3 Children born alive, the other 7 craniotomy.	—
C.S. Not sterilized.	R	A	1, 2, 3, Craniotomy.	—
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. and abdominal panhysterectomy (Wertheim).	R	A	Child much asphyxiated when born. Recovered.	—
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Feb. 26, 1905 (Champneys).	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1073	July 10	H. Spencer, London.	37	4	Fibro-myoma uteri. Persistent pain. Obstetric history bad.	Favourable. Not in labour. 38½ weeks.
1074	July 16	W. K. Walls, Manchester.	24	1	Contracted pelvis.	Favourable.
1075	July 17	H. Clifford, Manchester.	21	1	Contracted pelvis.	Favourable.
1076	July 17	A. H. N. Lewers, London.	26	2	Contracted pelvis.	In labour 3 hours.
1077	July 21	Mrs. Willey, London.	35	7	Contracted pelvis. Large abnormally ossified child's head.	In 2nd stage 3 hours. Head would not engage. Sagittal suture close to pubic bone.
1078	July 22	A. W. W. Lea, Manchester.	33	1	Generally contracted pelvis.	In labour 24 hours. Forceps previously applied.
1079	July 26	W. C. Swayne, Bristol,	24	0	Obliquely contracted pelvis. Old hip disease.	Favourable. In labour. Membranes intact. Full term.
1080	July 27	P. E. Barber, Sheffield.	23	3	Generally contracted flat pelvis, C.V. 3¾″ (9·3 cm.).	1st stage of labour.
1081	July 27	J. H. Targett, London.	38	3	Naegele's pelvis. Left ala of sacrum very defective. Between tuber ischii 3″ (7·5 cm.).	Favourable. In labour some hours. Membranes unruptured.
1082	July 28	W. E. Fothergill, Manchester.	22	0	Contracted pelvis.	——
1083	July 30	Murdoch Cameron, Glasgow.	23	3	Contracted pelvis, C.V. under 3″ (7·5 cm.).	Favourable.
1084	July 30	Murdoch Cameron, Glasgow.	26	2	Contracted pelvis, C.V. under 2½″ 6·2 cm.).	——
1885	July 30	R. Jardine, Glasgow.	22	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour.
1086	Aug. 2	J. M. Munro Kerr, Glasgow.	27	1	Rachitic pelvis, C.V. 2¾″ (6·9 cm.).	In labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. (posterior low incision) and pan hysterectomy.	R	A	1. Forceps to after coming head. Born alive but mother nearly died. 2. Forceps. Head injured. Child delicate. 3. Head injured. Both arms broken. Child imbecile. 4. Induced 6½ months as severe hæmorrhages.	Proc. Roy. Soc. Med. (Obst Section), 1910, Vol. iii, p. 82.
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Infusion of saline given as hæmorrhage severe. Child weighed 11½lbs.	——
C.S. Not sterilized.	R	A	Child's head hard and unmouldable. Anterior fontanelle very small.	——
C.S. Not sterilized	R	A	Vagina thoroughly washed out with antiseptic solution.	——
C.S. Sterilized.	R	A	Child alive 8 months later.	——
C.S.	R	A	1, 2, Craniotomy. 3. Small child born alive.	Jessop Hospital Reports, 1909, p. 9.
C.S. Not sterilized.	R	A	1. Axis traction forceps. Lived 3 months. 2, 3, Induction, 36th week, died owing to the difficulty of birth.	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Pubiotomy.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1087	Aug. 3	J. T. Hewetson, Birmingham.	28	3	Cicatricial stenosis of cervix and vagina following vesico-vaginal fistula from 1st labour.	Favourable. In labour 7 hours. Membranes intact.
1088	Aug. 5	M. H. Phillips, Sheffield.	29	5	Flat pelvis, C.V. 3¼″ (8·1 cm.).	1st stage labour. Membranes ruptured.
1089	Aug. 8	M. H. Phillips, Sheffield.	29	1	Generally contracted pelvis.	In 2nd stage two hours. No previous attempts to deliver.
1090	Aug. 9	J. T. Hewetson, Birmingham.	31	0	Generally contracted rachitic pelvis, C.V. 2¾″ (6·9 cm.). Child alive.	Unfavourable. In labour 48 hours. Membranes ruptured 36 hours. Repeated attempts at forceps delivery. Liquor amnii foul.
1091	Aug. 10	J. M. Munro Kerr, Glasgow.	24	3	Rachitic pelvis, C.V. 2¾″ (6·9 cm.).	In labour.
1092	Aug. 15	H. Clifford, Manchester.	28	3	Contracted pelvis.	Favourable.
1093	Aug. 15	A. Stookes, Liverpool.	31	2	Contracted pelvis.	Favourable.
1094	Aug. 22	C. E. Purslow, Birmingham.	29	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour. Membranes intact. Head above brim.
1095	Aug. 22	W. K. Walls, Manchester.	25	3	Contracted pelvis.	——
1096	Aug. 24	A. J. Wallace, Liverpool.	25	0	Pelvis deformity.	Favourable, though in labour 48 hours.
1097	Aug. 25	T. G. Stevens, London.	24	0	Flat pelvis, C.V. 3¼″ (8·1 cm.).	Unfavourable. In labour 20 hours. Membranes ruptured. Face presenting above the brim. Full term.
1098	Aug. 30	J. E. Gemmell, Liverpool.	38	1	Fibro-myoma uteri completely filling pelvis growing from anterior wall.	Favourable. Not in labour. 39½ weeks.
1099	Aug. 30	J. M. Munro Kerr, Glasgow.	35	8	Contracted pelvis, C.V. 3¼″ (8·1 cm.). Large head.	Not in labour. In Hospital before operation.
1100	Sept. 1	J. M. Munro Kerr, Glasgow.	28	0	Placenta prævia centralis. Hæmorrhage. Multiple fibro-myomata.	Not in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	**3rd C.S.** 1. 7 years previously, vagina and bladder being torn with instrument. 2. C.S. 1904 (late Prof. Taylor). 3. C.S. 1906 (late Prof. Taylor).	——
C.S. Sterilized.	R	A	——	Jessop Hospital Reports, 1909, p. 9.
C.S. Not sterilized.	R	A	Wound suppurated. 1. Craniotomy.	Jessop Hospital Reports, 1909, p. 9.
C.S. Not sterilized.	R	A	Stitch abscess, otherwise good recovery.	——
C.S. Not sterilized.	R	A	1. "Instruments." Stillborn. 2. Craniotomy. 3. Breech. Stillborn.	——
C.S. Not sterilized.	R	A A	Male and female.	——
C.S. Not sterilized.	R	A	Child 7lbs. 15oz. 1. Craniotomy. 2. Forceps. Stillborn.	——
C.S. Sterilized.	R	A	Child 8½lbs. 1. Craniotomy.	——
C.S. Not sterilized.	R	A	Child died within a few minutes.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Induction refused. Child 5lbs. 8oz.	Queen Charlotte's Hospital Reports, 1909.
C.S. and abdominal myomectomy. Not sterilized.	R	A	Child 6lbs. 4oz.	——
C.S. Not sterilized.	R	A	1—4. Forceps. Alive. 5, 6. Craniotomy. 7, 8. Abortion. C.S. because child's head overlapped brim. Child 10½lbs.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Child 7½lbs., well and healthy.	Journ. of Obst. and Gyn. Brit. Empire, Vol. xvi, p. 358. Lancet, 1909, Vol. ii, p. 1282.

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1101	Sept. 3	F. Edge, Wolverhampton.	36	3	Tonic contraction of uterus. Transverse presentation. Rupture of uterus suspected.	Exhausted. Delivery attempted by various means for many hours.
1102	Sept. 4	A. W. Russell, Glasgow.	31	2	Contracted pelvis, C.V. 2″ (6·9 cm.).	Favourable. In labour. Membranes ruptured.
1103	Sept. 7	W. J. Gow, London.	33	0	Contracted pelvis.	Favourable.
1104	Sept. 9	H. Russell Andrews, London.	19	1	Generally contracted pelvis, C.D. 4⅛″ (10·3 cm.).	Favourable. Not in labour.
1105	Sept. 11	J. D. Malcolm, London.	40	3	Fibromyoma of lower segment of uterus, blocking pelvis.	Favourable. No pains, but membranes ruptured 24 hours.
1106	Sept. 11	A. Stookes, Liverpool.	27	1	Rachitic pelvis. Dwarf.	Favourable.
1107	Sept. 12	A. W. W. Lea, Manchester.	31	0	Flat pelvis.	In labour 12 hours.
1108	Sept. 16	G. F. Blacker, London.	?	2	Stenosis of vagina, which only admits little finger.	Favourable. Not in labour.
1109	Sept. 18	Stanley Dodd, London.	28	3	Rachitic flat pelvis, C.D. 9 cm.	Favourable. Not in labour.
1110	Sept. 18	A. W. Russell, Glasgow.	33	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour.
1111	Sept. 21	A. W. Russell, Glasgow.	36	7	Contracted pelvis.	In labour.
1112	Sept. 21	J. M. Munro Kerr, Glasgow.	26	1	Rachitic pelvis, C.V. 3″ (7·5 cm.).	In labour. In Hospital some weeks.
1113	Sept. 22	A. Donald, Manchester.	30	1	Contracted pelvis, C.V. 3½″ (8·7 cm.).	——

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	D	Uterus not ruptured as suspected.	——
C.S. Not sterilized.	R	A	Child died of hypertrophic stenosis of pylorus in 8 weeks.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Craniotomy.	——
C.S. and panhysterectomy.	R	A	Both well April, 1910. On April 28, 1909, when 4½ months pregnant, exploratory abdominal incision made, thinking myomectomy possible, but as fibroid was deeply imbedded in lower segment nothing was done. Some phlebitis cruris, Sept. 24, 1909.	——
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as May 4, 1908 (Stookes). Slight ether pneumonia after operation. Child 6lbs. 12oz.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Induction at 7 month. Child alive. 2. Induction. Stillborn.	——
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as July 27, 1908 (Dodd). Some adhesions between uterus and abdominal wall.	——
C.S. Not sterilized.	R	A	Membranes adherent to posterior wall, and showed greenish discolouration. Had to be scraped off with knife. Phlegmasia dolens during puerperium.	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	D	A	On night of operation window blown in by storm. Patient removed along cold corridor. Lobar pneumonia. Death 4th day. No sepsis.	——
C.S. Not sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1114	Sept. 22	A. J. Wallace, Liverpool.	40	5	Transverse contraction and deformity of pelvis due to bilateral hip joint disease.	Favourable. Not in labour.
1115	Sept. 28	A. W. Russell, Glasgow.	23	2	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour.
1116	Sept. 30	T. G. Stevens, London.	31	0	Dermoid cyst of ovary obstructing delivery.	Favourable. In labour 12 hours. Membranes intact.
1117	Oct. 2	A. E. Giles, London.	22	1	Generally contracted pelvis, C.V. 3½″ (8·7 cm.).	Long in labour. Membranes ruptured. Arm presenting.
1118	Oct. 3	E. Stanmore Bishop, Manchester.	40	5	Contracted pelvis.	Favourable. In labour. Membranes intact. Full term.
1119	Oct. 3	E. T. Collins, Cardiff.	41	8	Fibromyomata uteri. One in pelvis obstructing delivery.	Unfavourable
1120	Oct. 3	R. P. R. Lyle, Newcastle-on-Tyne.	19	1	Ovarian dermoid cyst, size of fœtal head impacted in pelvis.	Favourable. Onset of labour.
1121	Oct. 4	V. Bonney, London.	21	0	Generally contracted and funnel-shaped pelvis. Tonic contraction of uterus.	Very unfavourable. Head perforated and most of vault removed. Head jammed in pelvis. Vulva black and excoriated. Bladder full and catheter could not be passed owing to impaction of head.
1122	Oct. 8	R. Favell, Sheffield.	36	1	Generally contracted flat pelvis, C.V. 3⅛″ (7·8 cm.).	Favourable. 1st stage of labour. Full term.
1123	Oct. 9	Herbert Spencer, London.	34	2	Contracted pelvis, C.V. 2½″ to 2¾″ (6·2—6·9 cm.).	Favourable. Not in labour. Membranes intact.
1124	Oct. 9	A. J. Wallace, Liverpool.	41	6	Pelvic deformity.	In labour.
1125	Oct. 13	T. W. Eden, London.	26	0	Contracted rachitic pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour several hours. No attempts at delivery.
1126	Oct. 14	C. O. Croft, Leeds.	?	Multipara.	Cancer of cervix, advanced.	Favourable. Not in labour.
1127	Oct. 15	A. Stookes, Liverpool.	26	3	Enchondroma of sacrum.	Favourable.

Operative Technique	Result		Remarks	References if Cases already published
	Mother	Child		
C.S. Not sterilized.	R	A	1. Induction. 4. Premature labour.	——
C.S. Not sterilized.	R	A	——	——
C.S. and ovariotomy. Not sterilized.	R	A	Tumour wedged between fœtal head and sacral promontory.	Queen Charlotte's Hospital Reports, 1909, p. 26.
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1. Placenta prævia. Forceps. Dead. 2. Craniotomy. 3. Induction 8th month. Still-born. 4. Induction 7th month. Still-born. 5. Abortion (induced) 5th month.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	D	——	——
C.S. and ovariotomy. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	D	Convalescence excellent, although sloughs formed in cervix and vagina owing to injuries before admission.	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Jan. 2, 1908 (Favell).	Jessop Hospital Reports, 1909, p. 9.
C.S. Not sterilized.	R	A	1. Died in utero 39th week. 2. Died in utero 37th week.	——
C.S. Sterilized.	R	A	Sterilised by request. 1, 2, 3, 4, 5, Forceps. 6. Craniotomy.	——
C.S. Not sterilized.	R	A	Mother had advanced rachitic bone disease. Child 7lbs. 1oz.	Queen Charlotte's Hospital Report, 1909.
C.S. Not sterilized.	R	D	——	——
C.S. Sterilized.	R	A	Child 8lbs.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1128	Oct. 16	G. F. Darwall Smith, London.	28	1	Fibro-myoma uteri, growing from posterior wall at level of internal os.	Not in labour. Had had pyelitis gravidarum (staphylococcus pyogenes) for 5 months without much constitutional disturbance.
1129	Oct. 25	E. Hastings Tweedy, Dublin.	35	0	Contracted pelvis, C.V. 6 cm.	In labour 14 hours. Membranes ruptured some hours.
1130	Oct. 28	W. J. Gow, London.	41	6	Contracted pelvis.	Favourable.
1131	Oct. 31	Comyns Berkeley, London.	40	10	Contracted pelvis, C.V. 4″ (10 cm.). Forceps failed.	Favourable. Head would not enter brim.
1132	Oct. 31	A. Lionel H. Smith, London.	35	5	Contracted pelvis. C.D. 3¾″ (9·3 cm).	In labour. Membranes intact. Full term.
1133	Nov. 2	W. R. Dakin, London.	28	3	Contracted pelvis.	Not in labour. Nearly full term.
1134	Nov. 2	J. H. Targett, London.	33	2	Flat pelvis, C.V. 3″ (7·5 cm.). Breech presentation.	Favourable. In labour 6 hours. Membranes intact.
1135	Nov. 4	R. Jardine, Glasgow.	25	0	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Not in labour. Delicate woman.
1136	Nov. 4	Bellingham Smith, London.	32	1	Kyphotic pelvis	Not in labour.
1137	Nov. 5	Murdoch Cameron, Glasgow.	33	4	Ventrifixation of uterus.	Cervix could only be reached by passing whole hand into vagina.
1138	Nov. 6	W. E. Fothergill, Manchester.	25	1	Contracted pelvis.	Favourable.
1139	Nov. 7	T. W. Eden, London.	40	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
1140	Nov. 8	Murdoch Cameron, Glasgow.	20	2	Contracted pelvis, C.V. 2″ (5 cm.).	——
1141	Nov 9	R. Jardine, Glasgow.	23	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Far advanced in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	Pyelitis gradually disappeared. Probably due to compression of right ureter by fibroids.	——
C.S. Extra-peritoneal.	R	A	——	Proc. Roy. Soc. Med. (Obst. Section), 1910, p. 119.
C.S. Not sterilized.	R	A	Child 6lbs. 14oz.	Queen Charlotte's Hospital Report, 1907.
C.S. Sterilized.	R	A	Child 12lbs. 4ozs. 1. Forceps. Alive. 2. Craniotomy. 3, 4, 5, 6, 7, 8, 9, Induction. Dead. 10. Induction. Alive.	——
C.S. Not sterilized.	R	A	——	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Not sterilized.	R	A	1, 2, "Instruments." Both still-born.	——
C.S. Not sterilized.	D	A	Patient vomited altered blood, but there was also sepsis beginning in deep part of abdominal wound. "Seemed to be from the catgut used for peritoneum. Gloves worn."	——
C.S. Not sterilized.	R	A	1. Craniotomy.	——
C.S. Sterilized.	R	A	3. Craniotomy.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1, 2, 3, Stillborn. This child 8lbs. 12oz.	Queen Charlotte's Hospital Report, 1909.
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1142	Nov. 10	J. S. Fairbairn, London.	31	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	In labour 27 hours. Membranes ruptured 14 hours.
1143	Nov. 11	R. J. White, Dublin.	21	0	Generally contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour 36 hours. Membranes intact.
1144	Nov. 12	G. F. Blacker, London.	28	2	Flat pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. Onset of labour.
1145	Nov. 14	H. Williamson, London.	29	0	Generally contracted pelvis. Head would not engage.	Favourable. In labour. Membranes intact.
1146	Nov. 19	C. Y. Pearson, Cork.	28	0	Ovarian cyst impacted in pelvis.	Favourable. In labour. Membranes ruptured.
1147	Nov. 21	R. Jardine, Glasgow.	22	0	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
1148	Nov. 24	R. Jardine, Glasgow.	27	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
1149	Nov. 24	S. Savage, Birmingham.	26	1	Generally contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. 1st stage.
1150	Nov. 24	E. Hastings Tweedy, Dublin.	28	2	Contracted pelvis, C.V. 6·5 cm. Transv. 10 cm.	In labour 24 hours. Membranes intact. At least eight vaginal examinations made by different men before admission.
1151	Nov. 25	T. W. Eden, London.	37	4	Contracted pelvis, C.V. 3½″ (8·7 cm.).	In 2nd stage 4 hours.
1152	Nov. 28	A. J. Wallace, Liverpool.	23	0	Kyphotic pelvis.	Favourable
1153	Nov. 29	J. E. Gemmell, Liverpool.	33	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Full term.
1154	Nov. 29	C. E. Purslow, Birmingham.	28	1	Contracted pelvis.	In labour 4 hours. Membranes intact.
1155	Nov. 30	A. H. N. Lewers, London.	38	1	Contracted pelvis.	Favourable. Not in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S.	R	A	**2nd C.S.** Same patient as Oct. 20, 1902 (Champneys). Silkworm gut suture in scar appeared quite fresh.	—.
Not sterilized. C.S.	R	A	Child 7lbs.	—
C.S. Not sterilized.	R	A	1. Induced 7 months. Lived. 2. Induced. Died.	—
C.S. Not sterilized.	R	A	—	—
C.S. and ovariotomy without previous tapping. Not sterilized.	R	A	Operation immediately after admission after train journey of 60 miles. Cyst almost completely filled pelvic cavity.	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	D	A	Sepsis beginning in deep part of abdominal wound. "Seemed to be from catgut used for peritoneum. Gloves worn."	—
C.S. Not sterilized.	D	A	Tachycardia after operation. Intestinal paresis not relieved by aperients or enemata. No peritonitis found at P.M. Sigmoid flexure found pressed against brim of pelvis. 1. Forceps. Stillbirth.	—
C.S. Extra-peritoneal	R	A	1. Prolapsed cord. Pubiotomy. Version. Child alive. 2. Version. Perforation.	Proc. Roy. Soc. Med. (Obstet. Section), 1909, p. 119.
C.S. Not sterilized.	R	A	2 previous stillborn children. This child 11lbs.	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as May 3, 1905 (Gemmell). Child 7lbs. 11oz.	—
C.S. Not sterilized.	R	A	1. Craniotomy.	—
C.S. Sterilized.	R	A	**2nd C.S.** Portion of uterine tissue resected at incision as it was so thin.	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1909					
1156	Dec. 1	D. C. Rayner, Bristol.	33	3	Flat pelvis, C.V. 3¼″ (8·1 cm.). Placenta prævia.	Unfavourable. In labour 4 hours. Membranes ruptured. No attempt at delivery. Severe A.P. hæmorrhage.
1157	Dec. 1	A. Lionel H. Smith, London.	32	2	Contraction of pelvic outlet.	Not in labour. Nearly at term.
1158	Dec. 3	A. Stookes, Liverpool.	29	4	Contracted pelvis.	Unfavourable. Repeated attempts at forceps delivery.
1159	Dec. 4	H. Briggs, Liverpool.	30	2	Rachitic pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour 12 hours. Membranes ruptured. Meconium in amniotic sac.
1160	Dec. 13	Murdoch Cameron, Glasgow.	23	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
1161	Dec. 16	J. H. Targett, London.	29	0	Obstructed labour from old spinal and hip disease. Very pendulous belly.	Unfavourable. In labour some hours. Membranes ruptured.
1162	Dec. 22	Sir J. Halliday Croom, Edinburgh.	39	4	Generally contracted pelvis.	Onset of labour. Full term.
1163	Dec. 22	R. Jardine, Glasgow.	22	1	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Not in labour.
1164	Dec. 22	Sir W. J. Sinclair, Manchester.	?	?	Contracted pelvis.	——
1165	Dec. 23	A. J. Wallace, Liverpool.	39	1	Contracted pelvis.	Favourable.
1166	Dec. 26	P. E. Barber, Sheffield.	26	1	Generally contracted pelvis.	——
1167	Dec. 31	R. Jardine, Glasgow.	39	9	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour. Membranes ruptured.
	1910					
1168	Jan. 1	E. Hastings Tweedy, Dublin.	31	3	Contracted pelvis, C.V. 8 cm. Transv. 13 cm.	In labour 24 hours. Membranes ruptured 21 hours. Walcher's position 9½ hours, but head remained unfixed.
1169	Jan. 2	T. B. Grimsdale, Liverpool.	30	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S Sterilized.	R	D	Placenta partly overlapped internal os. 1. Twins. Small children. One lived. 2. Full term. Craniotomy. 3. Induction 7½ months. Lived 4 days.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	D	A	Acute septic peritonitis. Child 7lbs. 13oz.	——
C.S. ≡ Sterilized.	R	A	**3rd C.S.** Same patient as Feb. 27, 1902, and Dec. 17, 1907 (Briggs). No peritoneal adhesions. A clean smooth serous surface of the uterus.	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as Dec. 24, 1908 (Wallace).	——
C.S. Sterilized	R	A	1. Craniotomy.	——
C.S. Sterilized.	R	A	——	——
C.S. Extra-peritoneal.	R	A	1. Symphysiotomy. 2, 3. Normal.	Proc. Roy. Soc. Med. (Obstet. Section), 1910, p. 119.
C.S. ≡ Sterilized	R	A	**3rd C.S.** Same patient as Feb. 1, 1905 (Grimsdale), and Aug. 24, 1908 (Blair Bell).	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1910					
1170	Jan. 3	H. Clifford, Manchester.	30	1	Obliquely contracted pelvis due to dislocated hip.	Favourable.
1171	Jan. 5	E. O. Croft, Leeds.	28	2	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
1172	Jan. 7	Murdoch Cameron, Glasgow.	23	3	Contracted pelvis, C.V. 2½″ (6·2 cm.).	——
1173	Jan. 8	W. K. Walls, Manchester.	27	1	Contracted pelvis.	——
1174	Jan. 10	A. F. Stabb, London.	23	1	Contracted pelvis, C.V. 3⅝″ (9·3 cm.) after induction had failed.	Favourable. Membranes intact.
1175	Jan. 11	R. Jardine, Glasgow.	35	1	Generally contracted flat pelvis, C.V. 3″ (7·5 cm.).	Favourable.
1176	Jan. 11	A. H. N. Lewers, London.	31	2	Contracted pelvis.	Favourable. Not in labour.
1177	Jan. 12	Murdoch Cameron, Glasgow.	18	1	Contracted pelvis, C.V. 2″ (5 cm.) and eclampsia.	——
1178	Jan. 13	Sir F. H. Champneys, London.	33	2	Eclampsia. Tonic contraction of uterus. Lower segment would not yield. C.S. to give patient a chance by emptying uterus.	Very unfavourable. Labour induced by Champetier de Ribes' bag. Tonic contraction. Child dead. Full term.
1179	Jan. 13	W. W. H. Tate, London.	27	1	Rachitic pelvis.	Onset of labour.
1180	Jan. 15	E. O. Croft, Leeds.	31	5	Rachitic pelvis, C.V. 3¼″ (8·1 cm.).	Not in labour.
1181	Jan. 15	A. W. W. Lea, Manchester.	34	1	Rachitic pelvis, C.D. 2½″ (6·2 cm.).	Not in labour.
1182	Jan. 20	R. Davies-Colley, London.	25	2	Generally contracted pelvis, C.V. 3¼″ (8·1 cm.).	In labour 12 hours. Membranes ruptured.
1183	Jan. 21	H. Williamson, London.	43	3	Contracted pelvis, C.V 3⅝″ (9·3 cm.). Head would not engage.	Favourable. In labour. Membranes intact.
1184	Jan. 29	A. F. Stabb, London.	23	0	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. In labour. Membranes intact.
1185	Jan. 30	H. Williamson, London.	33	1	Rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Favourable, 1st stage of labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Oct. 12, 1907 (Croft).	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A A	Twins.	—
C.S. Not sterilized.	R	A	Induction 38th week first tried, but head failed to engage.	—
C.S. Sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	—	—
C.S. Sterilized.	R	A	Child died 24 hours after birth from convulsions.	—
C.S. Not sterilized.	D	D	Operation seemed to have no effect either way as regards the eclampsia.	—
C.S. Not sterilized.	R	A	1. Craniotomy.	—
C.S. Right tube excised for salpingitis. Left for sterilization.	R	A	—	—
C.S. Not sterilized.	D	A	**2nd C.S.** Same patient as Dec. 27, 1908 (Clifford). Death from streptococcic peritonitis.	—
C.S. Not sterilized.	R	A	1. Craniotomy. 2. "Instruments" 8th month.	—
C.S. Sterilized.	R	A	1, 2, 3, Inductions. Stillborn.	—
C.S. Not sterilized.	R	A	—	—
C.S. Not sterilized.	R	A	1. Craniotomy in India.	—

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1910					
1186	Jan. 31	Sir F. H. Champneys, London.	23	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour. Membranes ruptured.
1187	Feb. 2	J. M. Munro Kerr, Glasgow.	23	3	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Admitted in labour.
1188	Feb. 2	G. F. Darwall Smith, London.	32	2	Generally contracted flat pelvis, C.V. 2⅜″ (5·9 cm.).	Favourable. In labour 5 hours, very strong pains. Membranes ruptured. No previous attempts to deliver.
1189	Feb. 2	A. F. Stabb, London.	30	1	Contracted pelvis.	Favourable. Membranes intact.
1190	Feb. 5	E. Holland, London.	32	7	Rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. Not in labour. Full term.
1191	Feb. 10	V. Bonney, London.	26	1	Flat pelvis, C.V. 3¼″ (8·1 cm.).	General condition good. Forceps attempted 3 times.
1192	Feb. 13	C. Lockyer, London.	20	0	Contracted pelvis, C.V. 2″ (5 cm.).	Favourable. In labour. Membranes ruptured 4 hours.
1193	Feb. 15	W. J. Gow, London.	26	0	Contracted pelvis.	In labour. Membranes ruptured 48 hours.
1194	Feb. 16	J. Haig Ferguson, Edinburgh.	35	4	Non-rachitic flat pelvis.	Favourable. End of 1st stage. Membranes ruptured.
1195	Feb. 18	A. W. Russell, Glasgow.	28	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour.
1196	Feb. 21	T. H. Targett, London.	27	1	Generally contracted pelvis.	Favourable. Not in labour.
1197	Feb. 22	F. W. N. Haultain, Edinburgh.	30	2	Generally contracted pelvis, C.V. 3¼″ (8·1 cm.).	Not in labour.
1198	Feb. 22	F. W. N. Haultain, Edinburgh.	29	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.
1199	Feb. 22	J. L. Lackie, Edinburgh.	26	3	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. In labour 1 hour. Membranes intact.
1200	Feb. 23	J. M. Munro Kerr, Glasgow.	23	1	Rachitic pelvis, C.V. 2¾″ (6·9 cm.).	Admitted in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	1, 2, 3, Craniotomy.	——
C.S. Sterilized.	R	A	1. Forceps. Alive. 2. Forceps. Dead. 3. Pubiotomy.	——
C.S. Sterilized.	R	A	1, 2, Craniotomy. Sterilization by request.	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized.	R	A	5 children died "during birth." 6. Induction. Died. 7. Induction. Lived.	——
C.S. (through lower segment).	R	A	Incision made through lower segment of uterus but not extra-peritoneal.	——
C.S. Not sterilized.	R	A	Child died in 9 days.	——
C.S. Not sterilized.	D	A	Died on 6th day with intestinal paresis and peritonitis.	Queen Charlotte's Hospital Reports.
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Operation begun by Pfannenstiel's incision with a view to extra-peritoneal C.S., but difficulty arose with peritoneum on bladder.	——
C.S. Not sterilized.	R	A	1. Craniotomy, recto-vaginal fistula resulting.	——
C.S. Not sterilized.	R	A	Child died in 30 minutes.	——
C.S. = Not sterilized.	R	A	**2nd C.S.**	——
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as April 23, 1907 (Lackie).	——
C.S. Not sterilized.	R	A	1. Craniotomy.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1910					
1201	Feb. 27	R. P. R. Lyle, Newcastle-on-Tyne.	48	8	Very obese woman with an extreme degree of anasarca, especially of vulva. Much œdema of vaginal walls.	Unfavourable. Forceps tried several times. Patient seriously ill. P. 145.
1202	March 1	W. E. Fothergill, Manchester.	27	1	Contracted pelvis.	——
1203	March 1	J. E. Gemmell, Liverpool.	32	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Favourable. Full term.
1204	March 2	E. O. Croft, Leeds.	24	1	Post-rectal dermoid cyst in pelvis.	Not in labour.
1205	March 2	A. J. Wallace, Liverpool.	36	2	Generally contracted pelvis, C.V. 2½″ (6·2 cm.).	Favourable. Onset of labour.
1206	March 4	E. Hastings Tweedy, Dublin.	39	8	Fibro-myoma uteri obstructing delivery.	In labour 17 hours. Membranes intact. Several vaginal examinations before admission.
1207	March 5	F. W. N. Haultain, Edinburgh.	28	0	Dermoid ovarian cyst impacted in pelvis.	In labour 12 hours.
1208	March 5	A. W. W. Lea, Manchester.	26	2	Generally contracted pelvis, C.D. 3¼″ (8·1 cm.).	Not in labour.
1209	March 8	F. W. N. Haultain, Edinburgh.	30	2	Flat pelvis, C.V. 3″ (7·5 cm.).	In labour 12 hours.
1210	March 10	G. F. Blacker, London.	31	1	Flat pelvis, C.D. 3¼″ (8·1 cm.).	Favourable. Early in 1st stage.
1211	March 10	A. W. W. Lea, Manchester.	25	2	Flat pelvis, C.D. 4″ (10 cm.).	In labour 16 hours. Repeated attempts at forceps delivery.
1212	March 12	P. E. Barber, Sheffield.	24	1	Generally contracted flat pelvis.	——
1213	March 12	T. W. Eden, London.	33	2	Contracted pelvis, C.V. 3½″.	Not in labour.
1214	March 14	H. Briggs, Liverpool.	32	3	Rachitic pelvis, C.V. 3½″ (8·7 cm.).	Favourable. In labour 12 hours. Membranes ruptured. Meconium in amniotic sac.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	D	Child 10½lbs.	——
C.S. Not sterilized.	R	A	Child only lived one day.	——
C.S. Not sterilized.	D	A	**2nd C.S.** Same patient as Aug. 16, 1907 (Gemmell). Acute intestinal obstruction in 48 hours. Abdomen re-opened and six inches of small bowel found incarcerated between uterus and promontory. Death from shock in 12 hours.	——
C.S. Not sterilized.	R	A	Cyst subsequently treated by free drainage per vaginam going to right of rectum.	Trans. N. of Eng. Obst. and Gyn. Soc., 1910. Brit. Med. Journ., 1910, Vol. I, p. 994.
C.S. Not sterilized.	R	A	1, 2, Cephalotripsy.	——
C.S. followed by panhysterectomy.	R	A	Previous labours normal.	Rotunda Hosp. Report, 1909-10.
C.S. and ovariotomy. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Premature labour had been attempted.	——
C.S. Not sterilized.	R	A	1. Craniotomy	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	1, 2, 3, Forceps. Stillborn. All small children.	

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1910					
1215	March 16	H. Williamson, London.	19	0	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. In labour. Membranes intact.
1216	March 17	T. W. Eden, London.	24	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
1217	March 20	J. M. Munro Kerr, Glasgow.	28	4	Previous ventrifixation.	Admitted in labour.
1218	March 20	F. E. Taylor, London.	34	1	Rachitic flat pelvis, C.V. 3⅛″ (7·8 cm.).	Favourable. In labour 2 hours. Membranes ruptured. No previous attempts to deliver.
1219	March 20	A. J. Wallace, Liverpool.	37	3	Generally contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. Not in labour.
1220	March 21	A. W. W. Lea, Manchester.	26	0	Contracted pelvis, C.V. 3¾″.	In labour. Membranes ruptured. Forceps before admission.
1221	March 23	Sir F. H. Champneys, London.	35	2	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. In labour. Membranes ruptured.
1222	March 24	A. W. Russell, Glasgow.	23	2	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Favourable. In labour.
1223	March 28	M. J. Gibson, Dublin.	40	10	Rachitic flat pelvis.	Favourable. In labour 4 hours.
1224	March 29	W. E. Fothergill, Manchester.	22	0	Impending death from peritonitis of intestinal origin. Child still alive.	Unconscious. Dying.
1225	March 29	A. H. N. Lewers, London.	29	5	Contracted pelvis.	Favourable. Not in labour.
1226	April 1	J. M. Munro Kerr, Glasgow.	25	3	Rachitic pelvis, C.V. 3″ (7·5 cm.).	Admitted in labour.
1227	April 3	J. H. Willett, Liverpool.	29	0	Rachitic flat pelvis, C.V. 3″ (7·5 cm.).	Favourable. In labour 30 hours. Membranes ruptured. No attempt at delivery.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	Labours previous to ventrifixation normal.	——
C.S. Sterilized.	R	A	1. Craniotomy after 3 days in labour.	——
C.S. ≡ Not sterilized.	R	A	**3rd C.S.** Same patient as May 4, 1905 (Wallace), and July 1, 1906 (Wallace). Child only lived a few minutes, probably cardiac malformation. P.M. refused.	——
C.S. Not sterilized.	R	A	Child 8lbs.	——
C.S. = Not sterilized.	R	A	**2nd C.S.** Same patient as March 14, 1908 (Champneys).	——
Extra-peritoneal C.S. after distending bladder with boric acid solution.	R	A	Peritoneum accidentally torn owing to misunderstanding of assistant. Temporary cystitis followed operation.	——
C.S. Sterilized.	R	A	Child died 3 weeks later.	——
C.S. Not sterilized.	D	D	Practically a postmortem C.S. Done solely in attempt to save the child.	——
C.S. = Sterilized.	R	A	**2nd C.S.** Same patient as March 10, 1908 (Lewers).	——
C.S. = Sterilized.	R	A	**2nd C.S.** 1, 2, Craniotomy. 3. C.S. Feb. 9, 1908 (Kerr). Uterus very adherent to abdominal wall.	——
C.S. Not sterilized.	R	A	Discharged 18th day.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1910					
1228	April 5	W. J. Gow, London.	43	7	Central placental prævia. Rigid cervix. Bleeding on smallest manipulation.	In labour. Os size of a shilling. Near full term. Child alive.
1229	April 9	E. T. Collins, Cardiff.	30	0	Contracted pelvis.	Unfavourable. In labour 5 days. Forceps and version attempted.
1230	April 11	S. Savage, Birmingham.	41	8	Concealed accidental hæmorrhage. Very severe.	Unfavourable. Blanched, cold, clammy. P. 150. Uterus globular, tense, tender.
1231	April 12	J. M. Munro Kerr, Glasgow.	31	2	Rachitic pelvis, C.V. 3″ (7·5 cm..).	In Hospital 3 days before operation
1232	April 14	A. Donald, Manchester.	35	0	Contracted pelvis, C.V. 3½″ (8·7 cm.).	Favourable.
1233	April 14	Sir W. J. Sinclair, Manchester.	31	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	Very unfavourable. Malignant endo-carditis. Mitral stenosis. T.101°F.
1234	April 14	W. K. Walls, Manchester.	29	2	Contracted pelvis, C.V. 3″.	Favourable.
1235	April 15	F. Edge, Wolverhampton.	28	1	Contracted pelvis.	Favourable.
1236	April 18	J. B. Hellier, Leeds.	31	1	Contracted pelvis, C.V. 3″ (7·5 cm.).	Onset of labour.
1237	April 21	F. W. N. Haultain, Edinburgh.	28	1	Flat pelvis, C.V. 2¾″ (6·9 cm.).	——
1238	April 21	A. W. Russell, Glasgow.	33	0	Severe eclampsia beginning April 11—at least 10 fits. Failure of palliative treatment.	Far from favourable. Persistent headaches. Serious interference with vision. Full term June 6.
1239	April 23	F. Edge, Wolverhampton.	30	1	Contracted pelvis.	Favourable.
1240	April 24	A. W. Russell, Glasgow.	27	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	In labour 3 days. Membranes ruptured.
1241	April 25	R. P. R. Lyle, Newcastle-on-Tyne.	30	8	Simple flat pelvis, C.V. (7·5	Favourable. Onset of labour.
1242	April 26	J. M. Munro Kerr, Glasgow.	28	0	Rachitic pelvis, C.V. 2⅞″ (7·2 cm.).	In labour and examined before admission.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Sterilized.	R	A	Uterus was very anæmic, and contracted down well as soon as child and placenta were removed.	Proc. Roy. Soc. Med. (Obstet. Section), 1910, Vol. iii, p. 180.
C.S. Sterilized.	R	D	——	——
C.S. and supra-vaginal hysterectomy, extra-peritoneal stump.	D	A	Placenta found detached and loose in uterus, with much blood clot. Spite of intravenous saline infusion died on 8th day.	——
C.S. Not sterilized.	R	A	1. Forceps. Dead. 2. Induction. Alive.	——
C.S. Not sterilized.	R	A	Child 5lbs. 12oz.	——
C.S. Not sterilized.	D	A	Patient died in 3 days of heart failure. Child 5lbs. 8oz. 1, 2, Craniotomy, followed by puerperal fever.	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same as Feb. 25, 1908 (Walls). Child 7lbs. 4oz	——
C.S. Not sterilized.	R	A	——	——
C.S. Sterilized.	R	A	1. Stillborn.	——
C.S. Sterilized.	R	A	**2nd C.S.** Same patient as June 15, 1908 (Barbour).	——
C.S.	R	A	Child 3¼lbs., but has survived.	——
C.S. Not sterilized.	R	A	——	——
C.S. Extra-peritoneal. Pfannenstiel's transverse incision.	R	A	——	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as June 22, 1907 (Lyle).	——
C.S. Not sterilized.	R	A	Slightly febrile puerperium.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1910					
1243	April 27	A. Donald, Manchester.	41	3	Contracted pelvis, C.V. 3″ (7·5 cm.).	——
1244	April 27	W. E. Fothergill, Manchester.	20	1	Contracted pelvis, C.V. 3½″ (8·7 cm.).	In labour 8 hours.
1245	May 1	F. Edge, Wolverhampton.	36	2	Contracted pelvis.	Favourable.
1246	May 6	A. H. N. Lewers, London.	39	4	Contracted pelvis.	Favourable. Not in labour.
1247	May 6	J. Phillips, London.	40	11	Contracted pelvis, C.V. 3¼″ (8·1 cm.).	Favourable. Onset of labour.
1248	May 10	P. E. Barber, Sheffield.	27	3	Generally contracted flat pelvis.	——
1249	May 10	A. W. W. Lea, Manchester.	31	2	Contracted pelvis.	In labour some hours and examined 3 times before admission
1250	May 13	Murdoch Cameron, Glasgow.	35	8	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	——
1251	May 18	Murdoch Cameron, Glasgow.	30	4	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	——
1252	May 20	W. E. Fothergill, Manchester.	36	0	Contracted pelvis, C.V. 3½″ (8·7 cm.).	In labour some hours. Forceps attempted before admission.
1253	May 21	R. P. R. Lyle, Newcastle-on-Tyne.	36	12	Ventri-suspension 11 years previously. Dense adhesions. Uterus anteverted. Whole hand had to be introduced into vagina to reach cervix, which was 4 inches above sacral prominence.	Chronic intestinal obstruction for 12 months. Hydramnios. In labour. Membranes intact.
1254	May 21	Sir W. Smyly, Dublin.	25	0	Eclampsia in 34th week of gestation.	Fits began May 15th, relieved by morphia, with diet, etc., and coma did not supervene. Fits returned on 21st, and patient became partly comatose. C.S. 1½ hours after recurrence of fits, which then ceased at once.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	All previous labours "instrumental."	——
C.S. Not sterilized.	R	D	**2nd C.S.** Same patient as June 13, 1908 (Walls). Child's head severely moulded.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump; and removal of appendages.	R	D	Some pelvic peritonitis and adhesions round appendages, so preferred more radical operation.	——
C.S. Sterilized.	R	A	1, 2, 3, Cephalotripsy. 4. Symphysiotomy.	——
C.S. Sterilized.	R	A A	All previous labours instrumental, with 6 still-births. This time, twins, uniovular, 7½ and 6lbs.	——
C.S. Sterilized.	R	A	**2nd C.S.** Same patient as July 12, 1907 (Favell).	——
C.S. Not sterilized.	R	A	1. Premature. Forceps. Lived. 2. Forceps. Dead. This child 8lbs.	——
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	A	——	——
C.S. Sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Child 6lbs. 12oz.	——
C.S. Not sterilized. Uterus freed and adhesions ligatured off.	D	D	Mother died of intestinal obstruction. Abdomen re-opened 6th day, enterrorrhaphy performed, but died next day. This child hydrocephalus. There were 7 abortions before ventri-fixation. 8, 10, Normal delivery. 9 and 11. Instruments and puerperal fever. 12. Instruments.	——
C.S. Not sterilized.	R	D	Child had convulsions till it died in 60 hours.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1910					
1255	May 24	Murdoch Cameron, Glasgow.	25	3	Contracted pelvis, C.V. 2½″ (6·2 cm.).	Forceps attempted before admission. Fœtal heart sounds weak.
1256	May 24	R. Jardine, Glasgow.	29	1	Contracted pelvis. Outlet especially contracted.	Not in labour.
1257	May 27	A. H. N. Lewers, London.	29	2	Contracted pelvis.	Favourable. Not in labour.
1258	May 31	Sir W. J. Sinclair, Manchester.	37	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	——
1259	May 31	Nigel Stark, Glasgow.	29	3	Placenta prævia. Alarming hæmorrhages occurring frequently. Cervix undilatable. Plugging useless.	Very anæmic and in severe pain. Exhausted. About 28th week of gestation.
1260	June 1	W. E. Fothergill, Manchester.	26	2	Contracted pelvis, C.V. 3½″ (8·7 cm.).	——
1261	June 2	A. W. W. Lea, Manchester.	38	3	Contracted pelvis, C.V. 2″ (5 cm.).	In labour 36 hours.
1262	June 2	A. Stookes, Liverpool.	25	1	Rachitic pelvis. Dwarf.	Favourable.
1263	June 3	T. W. Eden, London.	35	0	Flat pelvis, C.V. 2¾″ (6·9 cm.).	In labour 10 hours. Membranes ruptured.
1264	June 3	E. Hastings Tweedy, Dublin.	28	4	Contracted pelvis, C.V. 6 cm. Transverse 9 cm.	Not in labour.
1265	June 6	R. Jardine, Glasgow.	29	0	Contracted pelvis, C.V. 2¼″ (5·6 cm.).	In labour.
1266	June 7	R. Jardine, Glasgow.	25	2	Contracted pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
1267	June 8	R. Jardine, Glasgow.	28	4	Generally contracted flat pelvis, C.V. 3″ (7·5 cm.).	Not in labour.
1268	June 9	P. E. Barber, Sheffield.	?	9	Generally contracted pelvis. Head relatively too large.	——

Operative Technique	Result		Remarks	References If Case already published
	Mother	Child		
C.S. and supra-vaginal hysterectomy, intra-peritoneal stump.	R	D	Child's head marked with forceps and much bruised.	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as June 5, 1908 (Lewers).	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Nov. 18, 1905 (Sinclair). Extensive adhesions between uterus and abdominal wall.	——
C.S. and supra-vaginal hysterectomy, with intra-peritoneal stump.	R	D	Very severe uncontrollable hæmorrhage on any attempt to dilate cervix. Death seemed likely to occur from this hæmorrhage during operation.	——
C.S. Not sterilized.	R	A	Child 6¼lbs. 1. Craniotomy. 2. Induction 7th month.	——
C.S. Not sterilized.	D	A	**2nd C.S.** Same patient as May 31, 1908 (Lea). Child 8lbs. Peritonitis 4th day. Died 7th day.	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as May 7, 1908 (Stookes).	——
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	**2nd C.S.** Same patient as Feb. 5, 1907 (Tweedy). Five silk knots found in uterine wall.	Rotunda Hosp. Reports, 1909.10.
C.S. Sterilized.	R	A	Child died on 3rd day.	——
C.S. Sterilized.	R	A	**2nd C.S.**	——
C.S. Sterilized.	R	A	——	——
C.S. Sterilized by request.	R	A	Nine craniotomies. This child 10lb. 4oz. Abdominal wound burst during attack of bronchitis in first week, but recovered well.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1910					
1269	June 9	W. K. Walls, Manchester.	23	0	Contracted pelvis, C.V. 3″ (7·5 cm.).	——
1270	June 14	Sir F. H. Champneys, London.	21	0	Achondroplasia. Contracted pelvis, C.V. 1¾″ (4·4 cm.). Interspin. 9″. Intercr. 9½″.	Favourable. No evidence of heart and kidney disease.
1271	June 14	W. K. Walls, Manchester.	30	0	Contracted pelvis, C.V. 3¾″ (9·3 cm.).	In labour. Examined 6 times before admission.
1272	June 15	A. H. F. Barbour, Edinburgh.	21	2	Kyphotic pelvis. Much contraction at outlet.	Favourable. Onset of labour. Full term.
1273	June 18	R. Favell, Sheffield.	28	2	Generally contracted pelvis, C.V. 3½″ (8·7 cm.).	Favourable. In labour 1 hour. Membranes intact.
1274	June 18	A. W. W. Lea, Manchester.	25	1	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Frequently examined before admission.
1275	June 18	R. D. Maxwell, London.	30	0	Contracted pelvis, C.D. 3¼″ (8·1 cm.). Rachitic dwarf.	Unfavourable. In labour 48 hours. Membranes ruptured. Forceps previously applied. P. 110.
1276	June 18	A. Stookes, Liverpool.	34	5	Obliquely contracted pelvis. Anchylosed hip joint.	Favourable.
1277	June 21	P. E. Barber, Sheffield.	30	2	Obliquely contracted pelvis. Ankylosis left hip—almost at right angles with pelvis. Left sacral wing undeveloped. Forceps failed to deliver, C.V. 3½″ (8·1 cm.).	Favourable. In labour.
1278	June 24	R. Jardine, Glasgow.	33	3	Contracted pelvis, C.V. 2¾″ (6·9 cm.).	Not in labour.

Operative Technique	Result		Remarks	References if Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	Patient had old-standing phlebitis.	——
C.S. Not sterilized.	D	A	Patient ceased breathing after uterine incision, but rallied after artificial respiration. Pulse, however, remained very feeble, and she died 1 hour after operation. At P.M. heart, lungs, kidneys, brain, etc., normal, but thyroid gland much enlarged. Uterus well-contracted. No peritonitis. Typical achondroplasic characters.	——
C.S. Not sterilized.	R	A	Child 5lb. 12oz.	——
C.S. (lower segment).	R	A	1, 2, Craniotomy.	——
C.S. Not sterilized.	R	A	1. Forceps. Stillborn. 2. Craniotomy. All children large. This child 8lb. 10oz.	——
C.S. Not sterilized.	R	A	Chid 5lb. 1. Premature 7 months. Died.	——
C.S. Not sterilized. Skin prepared by tincture of iodine one hour and immediately before operation. Amniotic cavity irrigated freely with normal saline solution through soft pewter tube previous to operation. Uterus eventrated before incision.	R	A	Child 7lb. Marked forceps "grip" on head and excessive moulding and "caput." Mild maternal pyrexia for 3 days.	Lancet, 1910, Vol. ii, p. 306.
C.S. Not sterilized.	R	A	Child 6lb. 2 children alive, natural labour. 3 stillborn (forceps, craniotomy, version).	——
C.S. Not sterilized.	R	A	1. Forceps—living. 2. Forceps—version, craniotomy.	——
C.S. Sterilized.	R	A	This child 9½lb. Symphyseotomy 7 years ago.	——

No.	Date	Operator and Locality	Age of Patient	No. of previous Pregnancies	Indications for Operation	Condition of Patient at time of Operation
	1910					
1279	June 25	Comyns Berkeley, London.	34	4	Contracted pelvis, C.V. 3¼″ (8·1 cm.). Head would not enter brim.	In labour. Membranes ruptured. Cord prolapsed.
1280	June 25	H. Briggs, Liverpool.	23	0	Rachitic pelvis, C.V. 2⅞″ (7·2 cm.).	Favourable. In labour 18 hours. Membranes ruptured 4 hours. Cord prolapsed. No attempts to deliver.
1281	June 26	Comyns Berkeley, London.	23	0	Generally contracted pelvis. Head would not enter brim.	Operation 3 days before full term.
1282	June 29	Murdoch Cameron, Glasgow.	32	1	Contracted pelvis, C.V. 2½″. (6·2 cm.)	——

Operative Technique	Result		Remarks	References If Case already published
	Mother	Child		
C.S. Not sterilized.	R	A	——	——
C.S. Not sterilized.	R	A	Child 6lb. 4oz.	——
C.S. Not sterilized.	R	A	Several severe spasmodic attacks during first week after operation.	——
C.S. Sterilized.	R	A	1. Craniotomy.	——

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