Some remarks on the treatment of unavoidable hæmorrhage by extraction of the placenta before the child : with a few observations on Dr. Lee's objections to the practice / by J.Y. Simpson.

SOME REMARKS

ON THE

TREATMENT

OF

UNAVOIDABLE HÆMORRHAGE

BY

EXTRACTION OF THE PLACENTA BEFORE THE CHILD.

WITH

A few Observations on Dr. Lee's Objections to the Practice.

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All the more severe forms of uterine hæmorrhage that are liable to occur in the later periods of pregnancy, and during delivery, are generally allowed, by obstetric pathologists, to depend upon the separation of a greater or less portion of the placenta from the interior of the uterus. When such a separation takes place, *two* surfaces are exposed, namely, *first*, a part of the inner surface of the uterus, and, *secondly*, the corresponding part of the outer, or maternal surface of the placenta. Both of these exposed surfaces present a number of open vascular orifices left by the laceration of the utero-placental vessels which formerly connected them. From which set of open vascular orifices—the uterine or the placental—does the resulting hæmorrhage principally proceed?

Most accoucheurs seem to believe that the blood effused in those hæmorrhages which occur before or during labour, comes from the exposed *uterine* orifices. "It is (observes Dr. Lee) from the great semi-lunar, valvular-like, venous openings in the lining membrane of the uterus, which you have seen in various preparations, and of [from] the arteries which are laid open by the separation of the placenta, that the blood *alone* flows in uterine hæmorrhage."—(Lectures on Midwifery, p. 361.)

But arteries, particularly when they are so long and slender as the utero-placental arteries are, do not give rise to any marked degree of hæmorrhage when they are lacerated or *torn* through; and bleeding does not readily occur from the venous openings exposed on the interior of the uterus, because venous hæmorrhage by *retrogression* (which the blood escaping backward into the uterine cavity would be) is here prevented by a variety of anatomical and subsidiary means, which I have elsewhere taken occasion to describe at some length.

In the passage that I have quoted above from Dr. Lee's published Lectures, Dr. Lee does not allow that the blood, in uterine hæmorrhage, proceeds in any degree from

the open venous orifices existing on the surface of the separated portion of placenta, the discharge proceeding, in his opinion, from the exposed *uterine* surface "alone." But I know of no reason, anatomical or otherwise, for alleging that the open *placental* orifices do not bleed; and, on the contrary, I believe with Dr. Hamilton and others, that the discharge issues principally or entirely from the vascular openings which exist on that exposed placental surface. These placental orifices are not, like the uterine, surrounded by contractile fibres capable of constricting them; they are in free communication with the general vascular system of the mother through the medium of the maternal vascular, or cavernous system of the placenta; and the blood in that cavernous system escapes readily from the exposed venous orifices on the surface of the placenta—that being, in fact, so far, its natural and *forward* course.

In cases in which the placenta is partially and repeatedly detached before labour begins (as happens frequently in placental presentations), before each attendant attack of hæmorrhage is arrested, the vascular system of the separated portion of placenta seems to require to become blocked up and impervious, with coagulated and infiltrated blood. This obliteration of its vascular cells prevents the further circulation of maternal blood through the detached part of the organ, and hence prevents also the further escape of it from its exposed surface. Each new detachment gives rise to a renewed hæmorrhage, which again ceases on the sealing up of the vascular system of the detached part. A few cases of placental presentation are on record in which there was *no* attendant hæmorrhage when labour supervened, the tissue of the placenta having, throughout the whole organ, previously become so morbidly changed, obstructed, and impervious, as not to have any quantity of blood circulating in it and ready to escape, when at last its surface was separated from the interior of the cervix uteri under the occurrence of the uterine contractions.

In common cases of unavoidable hæmorrhage, the amount of the attendant flooding seems to be as much regulated by the quantity of placental surface *still* remaining attached to the uterus, as by the quantity *already* separated from it—the degree of flooding depending as much, or more, upon the extent of the means of supply of blood as upon the extent of its means of escape. And in proportion as we approach nearer and nearer a *total* separation of the placenta, the number of its *afferent* utero-placental vessels is diminished, till at last we find that when the one organ is once completely separated from the other, the flooding is instantly moderated, or entirely arrested; for the placenta ceases to yield any discharge of maternal blood as soon as its own supplies from the maternal system are thus cut off by the disseverment of all its organic and vascular attachments with the uterus.

Some years ago, I happened to see two cases of unavoidable hæmorrhage, in which the placenta was spontaneously expelled for some hours, before the child itself was born. In both cases the attendant hæmorrhage moderated, or entirely ceased, as soon as the whole placenta was completely detached. These instances, and others with which I was previously acquainted, forcibly suggested to my mind the idea that, under some complications in unavoidable hæmorrhages, we might here (as in many other obstetric operations) adopt the principles of treatment at times successfully acted upon by nature herself, in her own unassisted management of such cases. I knew the fearful maternal mortality accompanying placental presentations, and that it was as great, or even greater, than the fatality among patients attacked with yellow fever, or subjected to lithotomy. In order to ascertain if the *total* and complete detachment of the placenta afforded a greater chance of life to the mother, I collected and published in Dr. Cormack's Journal of Medical Science for March last, notices, which at that date I had brought together, of 141 cases of placental presentation in which the placenta was expelled or extracted before the child. The deductions which I ventured to draw from an analysis of these 141 cases were to the following effect:—

1. The *complete* separation and expulsion of the placenta before the child, in cases of unavoidable hæmorrhage, is not so rare an occurrence as accoucheurs seem usually to believe; and it is not by any means so serious and dangerous as (according to the commonly received doctrines of uterine hæmorrhage) might *à priori* be expected.

2. In 19 out of 20 cases in which it has happened, the attendant hæmorrhage was either at once altogether arrested, or became so much diminished as not to be afterwards alarming.

3. The presence or absence of flooding after the complete separation of the placenta, does *not* seem in any degree to be regulated by the extent of the interval intervening between the detachment of the placenta and the birth of the child.

4. In 10 out of the 141 cases, or in 1 out of 14, the mother died after the complete expulsion or extraction of the placenta before the child; whilst, as we shall see immediately, about 1 in every 3 of the mothers dies under turning and extraction of the child in unavoidable hæmorrhage.

5. In 7 or 8 out of these 10 natural deaths, the fatal result seemed to have no

connection with the complete detachment of the placenta, or with consequences arising directly from it; and if we did admit the 3 remaining cases, (which are doubtful), as leading by this occurrence to a fatal termination, they would still only constitute a mortality from this complication of 3 in 141,—or of about 1 in 47 cases.

These facts tend strongly to shew that the artificial and complete detachment of the placenta would in all probability be in some cases and varieties, at least, of unavoidable hæmorrhage, accompanied with much saving of maternal life. I know further, that in several instances recorded by Collins, Ramsbotham, Lowenhardt, &c. this treatment had been followed with success, when perchance it had been had recourse to by midwives, and others, under supposed mismanagement, and in ignorance and defiance of all the established rules of practice in this special complication.

I subjoin in a foot-note* the details of a case of this description very kindly forwarded to me, some time since, by Mr. Cripps of Liverpool. I insert it as, at one and the same time, illustrative both of the preceding remark, and of some of the other observations which I have already offered.

Exactly a year ago, I had an opportunity of putting, for the first time, to the test of experience, the practice which the foregoing remarks all lead to suggest, of *detaching, and, if necessary, extracting the placenta and not the child* in unavoidable hæmorrhage. The lady (a patient of Mr. Hill of Portobello), was taken in labour between the 7th and 8th month of pregnancy, and, in consequence of the severity of the discharge, was blanched and prostrated when I first saw her. The vagina was filled with coagula, and the os uteri was, in consequence of its small size and great height, reached and passed with difficulty, so as to ascertain fully the presentation of the placenta. Anterior to it I was able after a short time to reach and rupture the membranes. Notwithstanding this, however, along with the exhibition of ergot, &c., the discharge and sinking continued to go on. It seemed very difficult and dangerous to attempt to turn in consequence of the state of the os, and as the edge of the after birth was offering to protrude through it, I separated and gradually extracted the whole placental mass. From the time that this was accomplished all hæmorrhage ceased. The cord was cut, and the placenta removed from the bed. The infant came down slowly, and was safely expelled about two hours afterwards. The mother made a perfect and speedy recovery.

Similar cases of the successful adoption of the same practice have, since the period at which my paper appeared in Dr. Cormack's Journal, been published by Mr. Wilkinson, Mr. Greenhow, Mr. Jones, and Dr. Maclean. In all these instances the mothers were saved, and rapidly recovered. Dr. Lever and Dr. Bird have informed me within the last week, of two other recent successful instances of the same practice. In the course of a short time it seems not unreasonable to expect, that we may have a sufficient number of cases recorded, to enable us to judge with greater certainty and precision of the merits of this plan of treatment, and of the particular placental complications to which it may be specially applicable.

The proposal of the practice of separating and extracting the placenta before the child in unavoidable hæmorrhage, and thus (to use the expressions of Dr. Robert Lee), "departing from the rule (of turning the child) which has been established in the treatment of cases of placental presentation for the last two hundred years," and "subverting the established rules of practice in the treatment of cases of such vital importance," has, as might naturally be expected, given rise to considerable discussion and difference of opinion. In the MEDICAL GAZETTE for September 19th, I find that Dr. Lee has entered his present dissent against the proposed treatment. The tone and character of Dr. Lee's remarks might save me from the necessity of offering any answer to them; but, for the sake of the practice under dispute, I shall correct in de-

* "I was sent for—Mr. Cripps writes me—a few days ago, about 8 P. M., to see a poor woman who supposed herself to be at the early part of the last month of pregnancy with the third child. She had had occasional flooding to no great extent for a week previously. On the morning of the day on which I saw her, a surgeon had been sent for in consequence of the occurrence of several labour pains, together with a good deal of hæmorrhage. This gentleman being out of town, his assistant went; he remained with her during the day, and in the evening, finding things not going on so favourably as he wished, he sent for a friend of his employer's, who, soon after his arrival, sent for me. On making an examination, I found an arm down, which was much swollen, and the pains very severe. I immediately gave one drachm of laudanum, and on their subsiding, turned without much difficulty. The funis was divided, only about four or five inches remaining, and appeared as though it had been cut. On expressing my surprise at this circumstance, I was informed that it was cut when the after-birth was taken away, about 10 in the morning. Not believing it possible that such could be the case, there *having been no hæmorrhage whatever from that hour until the period of delivery*, I searched for the other portion of the navel-string, but not finding it, and being again assured that "the after-birth had come in the morning," I introduced my hand into the uterus, and made a most careful examination; it was contracting satisfactorily, but was perfectly empty. I watched her strictly until her complete recovery. I had every portion of discharge saved for my inspection, and am therefore perfectly satisfied that this is a case in which the placenta presented, and was removed 10 hours previously to the birth of the child, and that, in the meantime, *there was no hæmorrhage whatever.*"

tail some of the more prominent mistakes which his observations appear to me to contain.

First.—Dr. Lee appears to see no reason to depart from the practice which has been followed in placental presentations from the days of Ambrose Paré to the present time. The usual practice in these cases is well known to all. "The operation of turning, is (Dr. Lee observes), required in all cases of complete placental presentation," but "is not necessary in the greater number of cases in which the edge of the placenta passing into the membranes, can be distinctly felt passing through the os uteri," (Lectures, p. 372). In these last, rupture of the membranes is sometimes sufficient.* In his paper in the GAZETTE, Dr. Lee has given the following tabular view of eight late cases of placental presentation, in illustration of the success of the ordinary mode of treatment.

No.	Complete. or Partial.	Treatment.	Child.	Mother.
36	Complete.	Turning.	Dead.	Recovered.
37	Complete.	Turning.	Alive.	Recovered.
38	Partial.	Membranes ruptured.		Recovered.
39	Partial.	Craniotomy.	Dead.	Recovered.
40	Partial.	Craniotomy.	Dead.	Recovered.
41	Partial.	Craniotomy.	Dead.	Recovered.
42	Complete.	Turning.	Dead.	Recovered.
43	Uncertain.	Perforation of Placenta.	Dead.	Recovered.

If the above table afforded a correct idea of the success of the common practice in placental pretentations, I should never have attempted to change it. But unfortunately, turning, "which is required (according to Dr. Lee) in all cases of complete placental presentation," is followed in this complication with very fatal and disastrous results. Among Dr. Ramsbotham's reports of the Maternity Charity and Dr. Lee's previously published cases, I find 61 instances in all reported, of placental presentations, in which turning and extraction of the child were had recourse to. The following table shows the results.

A tabular view of the results of 61† *cases of Turning in Placental Presentations.*

Reporters.	No. of Cases operated on.	No. of Mothers saved.	No. and proportion of Mothers lost under this treatment.
Dr. Lee . . .	24	14	10 or nearly 1 in every $2\frac{4}{10}$.
Dr. Ramsbotham.	37	23	14 or nearly 1 in every $2\frac{7}{10}$.
Total . . .	61	37	24 or nearly 1 in every $2\frac{1}{2}$.

Hence, 24 out of the 61 mothers sunk under this treatment. More than 1 out of every 3 was lost. Or, in other words, under this practice about 65 per cent. of the mothers were saved, and 35 per cent. of them died.

The great mortality resulting from the treatment of turning in placental presentation, may be more strongly shewn to some minds if the fact is stated in another form. In order to ascertain the fatality of the Cæsarean section abroad, Dr. Churchill collated with much care the histories, from foreign authorities, of 371 cases of the operation. Out of these 371 cases, 217 mothers recovered, and 154 or nearly 1 in every $2\frac{4}{10}$, died. (Midwifery, p. 318.) This is exactly, and to a fraction, the degree of maternal mortality accompanying turning in placental presentations, in the cases reported by Dr. Lee in his Clinical Midwifery. *In other words, the success of turning in unavoidable hæmorrhage, in Dr. Lee's private and consultation practice* (as reported in that work) *has not been greater than the reputed success of the Cæsarean section upon the continent of Europe.*

When we see that the results of turning the child in placental presentations are so

* Some years ago the common practice of rupturing the membranes in partial placental presentations appears not to have been recommended by Dr. Lee. "It may be laid down (he states), as a rule admitting of *no exception*, that when hæmorrhage occurs from the placenta being situated over the os uteri, artificial delivery must be performed;" and he goes on to show it is performed by turning and extracting the child. (Researches on Diseases of Women, p. 207.)

† To prevent error, it may be proper to repeat that these 61 instances include *all* the cases of turning in placental presentation, which I find reported in the returns of Dr. Lee and Dr. Ramsbotham. Dr. Lee's returns are those of his private and consultation practice. Dr. Ramsbotham's returns are those of the practice in his own district of the Royal Maternity Charity.

very mortal in the hands of two such distinguished accoucheurs as Dr. Ramsbotham and Dr. Lee, what degree of success can we expect to follow it in the hands of the general mass of medical men?

Last year Dr. Lee most truly and justly remarked of turning in placental presentation, "*At best it is a dangerous operation*, and you can never tell with certainty whether or not the patient will recover after its performance, however easily it may have been effected." (*Lectures*, p. 373.)

Secondly.—Dr. Lee seems to argue as if I recommended the artificial detachment of the placenta in *all* forms of placental presentation in which turning is at present adopted. On the contrary, I have explicitly mentioned it as a mode of treatment to be adopted when rupturing of the membranes is insufficient, and turning is either inapplicable or unusually dangerous. I believe it will be found, for instance, the proper line of practice in severe cases of unavoidable hæmorrhage complicated with an os uteri so insufficiently dilated and undilatable as not to allow, with safety, of turning; in most primiparæ; in many of the cases in which placental presentations are (as very often happens) connected with premature labour and imperfect development of the cervix and os uteri; in labours supervening earlier than the seventh month; when the uterus is too contracted to allow of turning; when the pelvis or passages of the mother are organically contracted; in cases of such extreme exhaustion of the mother as forbid immediate turning or forced delivery; when the child is dead; and when it is premature and not viable.

As an illustration, I shall take the first set of cases I have adverted to: "There is not unfrequently (says Dr. Lee) most profuse and alarming flooding from complete placental presentation, where the os uteri is so thick, rigid, and undilatable, that it is impossible to introduce the hand into the uterus without producing certain mischief. In 13 (he adds) out of the 36* cases contained in the following table, the os uteri was rigid and undilatable." Hence, this complication occurred as frequently in Dr. Lee's practice as in about one out of every three of his placental presentations. In his Clinical Midwifery, out of 35† cases alleged to be reported, in 11 there had been more or less rigidity of the os uteri with dangerous hæmorrhage. From the mode in which the individual reports are drawn up, it is by no means easy to determine exactly and with perfect precision, the "eleven‡" cases which Dr. Lee himself classes under this remark, but I believe I have correctly given them in the following table:—

Table of Eleven Cases of Placental Presentation, from Dr. Lee's Clinical Midwifery: shewing the combination of "more or less rigidity of the os uteri, with dangerous hæmorrhage."

No.	Complete or Partial Presentation.	Treatment.	Child.	Mother.
266	Not stated.	Turning.	Alive.	Died.
267	Not stated.	Extraction by foot.	Not stated.	Recovered§.
271	Complete.	Turning.	Not stated.	Died.
272	Partial.	Membranes ruptured.	Dead.	Died.
274	Partial.	Membranes ruptured.	Not stated.	Died.
277	Complete?	Turning.	Alive.	Died.
282	Complete.	Extraction by feet.	Not stated.	Died.
283	Complete?	Craniotomy.	Dead.	Died.
284	Complete.	Extraction by feet.	Dead.	Recovered.
285	Complete?	Turning.	Not stated.	Died.
287	Complete.	Extraction by feet.	Not stated.	Recovered‖.

* Dr. Lee has here committed a statistical error in regard to the number of placental presentations occurring in his own practice, and reported in his Lectures. The number should be 38, and not 36.

† Another statistical mistake of Dr. Lee regarding the number of *his own* cases. His Clinical Midwifery contains 36 and not 35 cases of placental presentation. See other of Dr. Lee's inadvertent errors on this head mentioned in a subsequent note respecting the number of children lost in these and other placental presentations.

‡ Probably the number 11 is indicative of another error in Dr. Lee's reports. Dr. Lee, in his Lectures, adverts to 13 such cases; in his Clinical Midwifery, he limits the number to 11. If the cases were 13 in number, then the number 11 is wrong; or the reverse; for although he has reported 38 cases, in all, in his Lectures, and 36 in his clinical work, yet neither of the two *additional* cases reported in the Lectures presented any difficulty on the part of the os uteri. In one case (Case 37) it was "little dilated *but* dilatable;" in the second (Case 38) the report is, "os uteri dilated to size of a crown-piece, dilatable." If we admit 13 instead of 11 cases, we must, I believe, include Cases 260 and 289 of the Clinical Report. In both of these cases the mothers died. This would give us in the text *a proportion of ten maternal deaths out of thirteen mothers operated on.*

§ "A violent rigor (Dr. Lee states) followed [the delivery] which threatened for a time to destroy the patient. Bottles of hot water were applied to the feet and pit of the stomach, the whole body was covered with hot blankets, and brandy was freely administered. She slowly recovered from the effects of the immense loss of blood."

‖ "The pulse could scarcely be perceived for

Here we have only three mothers saved out of eleven operated upon; and two of the three saved evidently made a very narrow escape from death. I doubt if the most fatal of all human diseases—the plague itself—be found to destroy so large a proportion of those attacked. At all events, the operation of turning and artificial delivery, in unavoidable hæmorrhage, with the os uteri imperfectly dilated, would, from these and other cases, appear to be more deadly than any operation that is deemed justifiable in the whole circle of surgery. It is more mortal even than Ovariotomy.

I believe, on the other hand, that in the above and similar cases, by the introduction of a finger, or of a common sound or bougie, (such as Dr. Hamilton employed when the os uteri was still shut, and in order to separate the membranes for some inches from the cervix*, in order to induce premature labour), the placenta might be readily and completely detached—the attendant bleeding in this way arrested—and the labour subsequently allowed to proceed to a natural and safe termination, if it were a head or pelvic presentation. And if the child were placed transversely, a more safe and proper period could be waited for and selected for the version of it.

Would the strength of the natural organic adhesions of the placenta to the uterus prevent the easy separation in this way of the one organ from the other? I believe not. Speaking of the mere anatomical fact, Dr. William Hunter, in his celebrated work on the Gravid Uterus, observes, that the separation of the placenta from the uterus is "commonly practicable *with the least imaginable force.*" In his paper on the Structure of the Placenta, published in the Philosophical Transactions for 1832, Dr. Lee, whose intimacy with Dr. Hunter's work is well known, curiously uses not only a similar, but exactly the same quaint expression and words, telling us that generally after labour the placenta is detached from the uterus "with the least imaginable force."

Thirdly.—Dr. Lee argues against the practice of extracting the placenta before the child, because it was not followed by "Guillemeau, Mauriceau, Portal, Levret, Giffard, &c. &c." If the argument were true, it would be one of no weight, because, on exactly the same ground, nothing novel should ever be allowed to be introduced into practice. Dr. Lee has fallen into some curious mistakes† in the two or three different histories which he has attempted to give of placental presentations. I shall leave it to my professional brethren whether the following misrepresentation is to be referred to the same category of mistakes, or is capable of—a more direct and simple explanation.

Dr. Lee has given in his published "Lectures on the Theory and Practice of Midwifery" a special and detailed account of the *individual* cases of placental presentation recorded by Portal, and had therefore taken evidently very great pains to study minutely that author's views and practice in this complication. In his late paper in the MEDICAL GAZETTE, Dr. Lee strongly asserts that Portal is one of those great practical accoucheurs who never "attempted in a single instance to tear away or detach the placenta from the neck of the uterus, when it was so undilatable as to render it impossible to pass the hand to turn the child and deliver, nor in any other condition whatever of the part, before the birth of the child." p. 895.

In describing his 43d case, Portal observes "Je glissay ma main dans l'entrée de la matrice, où je sentis l'arriere-faix qui se presentoit. L'ayant *separé*, afin de me frayer le chemin, je sentis les membranes des eaux que je perçay, et les eaux s'estant écoulées, *je tiray l'arriere-faix le premier*, afin qu'il ne m'incommodast point à la sortie de l'enfant." Here Portal distinctly states that he separated and extracted the placenta *first*, and before trying to extract the child. He states the same thing in his 69th case, and, if possible, still more explicitly*. Dr. Lee, who, on the present occasion, so strenuously asseverates that Portal did never, in a single instance, follow this practice, *actually quoted and printed* last year in his published Lectures, and from the French edition of Portal's work the first half of the above sentence†, in which Portal himself so circumstantially declares that he did follow this practice. (See the quotation in Dr. Lee's Lectures, p. 366.) I feel assured that any additional comment of mine will be here excused, as entirely superfluous.

Fourthly.—Dr. Lee states that the practice which I have ventured to recommend in placental presentations "was performed two hundred years ago by an ignorant and audacious impostor, on a lady who died in Paris, whose case is related, with denunciations of the practice, by Guillemeau."

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many hours after, but the circulation in the extremities was gradually restored, and she recovered."

* Dr. Lee himself seems to have met with no difficulty of any kind in following this practice. See Lectures, p. 319; and Clinical Midwifery, Cases 142, 145, &c.

† "We are *solely* (says Dr. Lee) indebted to Levret for the discovery of every important fact relating to the causes, the symptoms, and the treatment of this (the unavoidable) variety of flooding in the latter months of gestation."—(Researches on the Diseases of Women, p. 209.) In his late Lectures, p. 368, Dr. Lee adduces a variety of evidence to shew that Levret on this point only "undertook to prove (to use again Dr. Lee's own words) what, it appears, had *previously* been demonstrated"—by Portal, Mauriceau, Giffard, Smellie, &c.

* Je separay tout doucement cet arrière-faix, et je tiray dehors; ensuite je glissay ma main dans la matrice, &c. &c.

† Dr. Lee's quotation terminates at the word "perçay."

It is a singular fact, and shows how differently two men *may* interpret an author's meaning, that in the discussion to which the proposed practice has given rise, Guillemeau should have been now twice brought up in evidence against me, in order to prove directly contrary allegations. In the Provincial Medical Journal for April, Dr. Blenkinsop published Guillemeau's rules of treatment in placental presentations, in order to show that Guillemeau had actually long ago recommended the artificial detachment of the placenta before the child. Now Dr. Lee appeals to Guillemeau's writings to show that Guillemeau actually long ago denounced the practice in question. I have elsewhere taken occasion to show that Dr. Blenkinsop's mistake was an inadvertent error of judgment. Dr. Lee's mistake consists in simply misrepresenting the facts of the case he alludes to. I recollect the results of Guillemeau's case well. In an instance of accidental (?) hæmorrhage the midwife pulled at the ruptured membranes, and dragged away them and a *part* of the placenta. If she had separated the *entire* placenta, as has in ignorance been repeatedly but safely done by other midwives since her time, the flooding would in all probability have ceased. As it was, Guillemeau states that she separated only a *part* of the placenta, and consequently the mother almost inevitably died. Surely Dr. Lee understood Guillemeau so far as to know that it was hence an instance not at all in point, or bearing in any degree upon the subject, inasmuch as it was *in truth* not an instance of detachment of the whole placenta.

Fifthly.—Dr. Lee objects that the child would inevitably be lost by the mode of practice which I have described. The objection which has been often urged against my views is stronger in appearance than in reality. For, without insisting upon the principle generally acknowledged by Dr. Lee and other British accoucheurs, that we should sacrifice the child in those cases of extreme danger in which that sacrifice adds greatly to the chances of the safety on the part of the mother,—there are various other considerations, connected with the life of the child itself, which destroy the apparent force of the argument.

The fact is, that in cases of placental presentation treated under the present acknowledged rules of management, a very large proportion of the children are lost. I have previously stated that in his Clinical Midwifery Dr. Lee has detailed and reported thirty-six, and not, as he himself inadvertently but erroneously reckons them, thirty-five* cases of unavoidable hæmorrhage. In 13 out of these 36 cases Dr. Lee does not state the result to the child, though the context leaves no doubt that in several of these cases the infant perished during delivery. In 23 cases he mentions the condition of the child at birth. In 8 out of these 23 cases it was born alive; in the remaining 15 it was born dead. Hence *nearly 2 out of every 3 of these children died* under this complication, or 65 per cent. of them were lost.

Besides, in exactly those varieties or complications of unavoidable hæmorrhage in which I have ventured as yet to recommend the practice of detaching the placenta, the child is already in most instances inevitably lost, or almost certain to perish under any of the established modes of treatment; that is, it is either too weakly or premature to be viable, or it is almost sure to perish if forced delivery is attempted (as when the os uteri is imperfectly dilated or the pelvis contracted), or it is actually dying or dead when interference is required. On the other hand, the child is not always lost when the placenta is detached before it. Out of 106 cases in which the placenta was expelled before the child, and the result to the latter noted, the infant was born alive in 33 instances (see Dr. Cormack's Journal for March last); or 31 per cent. of the children were saved. In most of these cases the child was expelled within a few minutes after the complete separation of the placenta. When the interval is longer, and we require, after the detachment of the placenta, to wait for a length of time, is there no hope of making the child survive by continuing either its placental or pulmonary respiration during the intervening period? Dr. Lee tells us that in some cases of pelvic presentation, acting upon the suggestion of Dr. Bigelow and "older accoucheurs," he has, before the head could be extracted, pressed back the maternal parts "that the air may gain admission into the mouth of the child and the respiration go on, when the circulation in the cord has been arrested. I have seen (he adds) from twenty minutes to half an hour elapse in some cases after the cord had ceased to pulsate. . . . If the head be low down, the fingers alone can give the necessary assistance; but if it is high in the pelvis, and reached with difficulty, the assis-

* In his late paper in the GAZETTE, Dr. Lee commits the same mistake in summing up the number of *his own* cases of placental presentation. Hence, there is an error in *all* the eight numbers which he has affixed to his cases in the table printed at p. 895 of his paper. In his Clinical Midwifery, in reporting his placental cases, he has committed another numerical mistake in passing from Case 289 to Case 291, omitting altogether 290. I mention these mistakes as liable to mislead us in some calculations, and not with the view of showing any desire to impute blame or offer serious criticism for errors of such a caste, and which it is so difficult always to avoid. In the number of the GAZETTE containing Dr. Lee's late paper, the Editor has shown (p. 917) that the Registrar-General himself, whose very profession consists of statistical calculations, has published a very "serious error" of a numerical kind, in one of his late official returns.

tance of a tube may be required." (Lectures, p. 335.) Is it hopeless to suppose that the same principle, or other means, may yet be successfully employed to keep the child alive, after the placenta is extracted in unavoidable hæmorrhage, and in some cases give it even a greater chance of life than under the continuance of the flooding, or the operation of forced delivery?

Lastly.—Dr. Lee seems to believe that one of my tables gives an erroneous view of the common degree of maternal danger attendant upon placental presentations, when it shows that about 1 out of every 3 mothers perishes under this obstetric complication.

Some years ago Dr. Churchill endeavoured to ascertain statistically the number of mothers that died under placental presentations, and from a variety of data calculated that the mortality amounted to about 1 in 3.

In his own Lectures on Midwifery, published in 1844, Dr. Lee quotes, and so far adopts from Dr. Churchill, the fact that "out of 174 cases of placental presentation recorded by different authors, 48 proved fatal, or nearly 1 in 3." (Dr. Lee's Lectures, p. 371).

We have already seen that in Dr. Lee's own recorded cases of turning in unavoidable hæmorrhage, the maternal mortality was greater than 1 in 3.

The table of maternal deaths printed in my essay in Dr. Cormack's Journal, is in perfect accordance with these results of Dr. Churchill and Dr. Lee. The principal difference is, that it contains a much larger number and more extensive foundation of statistical data. In collecting its materials I proceeded rigidly upon the principle of only entering upon it the results of the practice of those individuals or institutions upon whose records I could find ten or more cases of unavoidable hæmorrhage. In this way I believed I would be more certain to arrive at an accurate statistical result, than if I made my calculation upon the collection of cases of a smaller number scattered throughout our medical journals. I noted down all the lists of instances I could detect in which ten or more cases were reported. Latterly, I have found that I erroneously omitted Paul Portal, because I relied on Dr. Lee's accuracy, when, in his Clinical Midwifery, he stated that Portal's work contained an account of "eight" cases only of unavoidable hæmorrhage, while it contains notices of the results of fourteen. In drawing up the table I am not at all further ashamed to own, that, harassed as I was at the time with abundance of other professional occupation, I fell, in working up the data, into some other inadvertent errors, which will be found rectified in an extended essay on the whole subject, the printing of which is now nearly completed. Seeing that Dr. Lee and Dr. Ramsbotham have both committed numerical errors of the same kind in summing up, and calculating upon, the results of *their own* limited number of placental cases, it will perhaps be considered the more excusable that in searching out and reckoning up the results of far more numerous returns and reports of a similar description given by others, and, for the most part, scattered in a disjointed and unarranged form throughout their published works, I should have committed some similar errors. I did not, for example, discover some additional instances of death of the mother in placental presentation in Smellie's works, in a section (where I did not expect them) upon the Cæsarean operation; and I have corrected one or two errors of the same kind by the more careful collation of the writings of Giffard, &c. But these corrections do not alter, in any practical degree, the *statistical result* regarding the degree of mortality among mothers in placental presentations. More extensive data than I had access to *may* alter that result, but probably not to any marked amount. And, indeed, the actual total fatality of the complication may possibly be even higher than such calculations can prove, because they demonstrate the consequences of the complication and its treatment in the hands of the highest members of the profession, while they afford us little or no insight into the number of deaths produced by it among the patients of less experienced practitioners. As to the special mistake in my table of cases which called forth the animadversions of Dr. Lee in his late paper in the GAZETTE, I beg, in exculpation, to submit to the readers of that journal, some letters, explanatory of its nature, and illustrative of the difficulties attendant upon all such inquiries.