all dressing is now tinged more or less with the Listerian mode; whether it be in increased carefulness, or cleanliness, or washings with antiseptic fluids—they are all based on getting rid of a danger ever lurking about the patient. Even Mr. Savory is the practiser of a method, not Listerian in its details, it is true, but Listerian in its principles. If he would have a true comparison, let him dress his wounds with one of the “best antiseptics”, clean water, side by side by those done under the antiseptic dressings, and a twelve months’ observation will show on which side success will stand.

Mr. Savory is liberal in his admission, when he regards a carbolised spray as “better than a pestilential atmosphere”. I should like to know how he determines when the atmosphere is not pestilential, as regards an open wound. He admits that there are germs in the air so small as to be beyond the powers of the microscope. By what means is it made clear that the atmosphere coming in from London or other streets is pure, though all the sides of a ward be windows or the walls be burrowed with chimneys. Is it quite certain that this special ventilation will sweep away all the exhalations from other patients, and that the eddies caused by opposing currents of air will not carry troops of vigorous poison germs upon the wound at the very time we deem the ward to be purest? May not the very “pestilential atmosphere” of which Mr. Savory speaks, however small in extent, be actually present at the wound surface, with great potency for mischief? If, then, it be impossible to determine this point, if we cannot know at what moment a tear may occur in the granulation tissue and expose the patient to risk, is it not reasonable, even on Mr. Savory’s own showing—nay, are we not bound on every ground—to use a spray which he admits to be “preferable” to such a condition?

Read in this light, Mr. Savory’s address will not do so much harm as might at first appear. It is a testimony to principles which he has adopted, but which he has hesitated to follow in their logical leading. That he must do so, I do not doubt. His address has only strengthened my own convictions. Like hundreds of others, the trammels of my old teaching held me back from trying a method over which I heard much scepticism talked; but I cannot refuse the evidence of my senses, and I have adopted it because it has relieved surgery of much of its terror, and given a sense of safety which, so far as I am aware, no other system affords.

A BRIEF RECORD OF TWO THOUSAND TWO HUNDRED CONSECUTIVE CASES OF MIDWIFERY.

By W. WHALLEY, M.D., etc., Bradford.

IN reviewing 2,200 consecutive cases of midwifery taken from my obstetric register, I find that out of that number there were thirty-nine breech-presentations, of which seventeen infants were still-born. Footling cases occurred seventeen times; ten of these infants were still-born. The arm presented twelve times; five of these infants were still-born. The face presented five times; one infant was still-born. The funis associated with either head or breech presentation occurred seven times; one infant being still-born. The funis and arm presented in one case; the infant was still-born. The funis and shoulder presented once; the funis, feet, and head once; the funis and foot once; the shoulder once; the foot and head twice; the hand and face once. There were two complete and three partial placental presentations. The placenta was retained or adherent in twenty-seven cases, requiring the introduction of the hand for its removal. Accidental hæmorrhage occurred in twelve cases. In three instances, the funis was coiled three times round the neck of the child. The long and the short forceps were applied in fifty-one instances; in which seven infants were still-born. Craniotomy was resorted to in eleven cases. Podalic version was performed in about twenty-one cases; and the Cæsarean section in one case.

There were twenty-eight cases of twins, of which eleven infants were still-born. In thirteen cases, the head presented in both children; in seven cases, in the first child the head presented, and in the second the breech; in four cases, the head of the first child and the foot of the second; in one case, the arm of the first child and the head of the second; in another, the breech of the first and the head of the second; in one case, the head of the first child and the hand of the second; and in another, the hand of the first child and the head of the second. In half the number of cases, the second child followed the first at intervals varying from twenty minutes to two hours; in the remainder, the intervals varied from two to six hours. In twelve cases, the children were both males; in seven cases, they were both females; in five cases, male and female; and in four cases, the sexes were not registered.

Rupture of the perinæum requiring surgical interference happened in six cases. All were successfully treated with the quilled and interrupted sutures. Spontaneous evolution occurred in three premature cases. Five cases were complicated with convulsions. Deformity of the pelvis was met with in seven cases. Premature labour happened spontaneously twenty-eight times, and was artificially induced five times.

In one patient, seven years had elapsed since her last confinement; in another, eight; in two others, nine; in another, ten; in another, eleven; in another, twelve; in another, fourteen; and in two others, fifteen years.

Among the primiparæ, six patients were aged respectively 32, 34, 36, 37, 39, and 45 years.

Of the total number delivered, seven mothers died.

The abnormalities met with in children were the following. Three possessed supernumerary thumbs; in two of these cases I amputated the redundant thumb, and in the third applied the ligature; all did well. One child had webbed fingers, another hare-lip with cleft palate; the latter I operated upon successfully at the eighth week. One child was born with talipes calcaneus, and was successfully treated by the aid of a boot without division of tendons. There was one case of spina bifida, the tumour being situated in the lumbar region; and, notwithstanding every care was taken to protect it from injury by a properly arranged apparatus, the child only survived a few months, ultimately dying from convulsions. There were twelve or fourteen cases of nævi. Two were cured by vaccination, one with nitric acid; but the ligature was found most successful. One child had malformation of both ears; each pinna or external ear consisted merely of a small flap of loose skin, and there was complete absence of the meatus auditorius externus; the child did not survive many days. In another child, there was an absence of a portion of the abdominal parietes in the umbilical region, the deficiency being supplied by a purple-coloured membranous structure; the child died before the funis separated. Lastly, there was one acephalous child.

The foregoing cases—viz., 2,200—have been attended in private practice, and comprise the whole of my midwifery practice from August 28th, 1860, to January 21st, 1878. It will be observed from the above figures that, of the abnormal presentations, the breech was the most frequent. The management in the greater number of these cases has been to let the breech pass doubled, and not to allow the legs to escape until after the knees were born. In the twelve cases of arm-presentation, podalic version was successfully performed in all, so far as the mother was concerned. Out of the five cases of face-presentation, one infant was still-born, and another died in a few hours after birth, from injury to the larynx during labour. In the cases complicated with prolapsus of the funis, the “postural method” and turning the child and delivering by the feet were found to be the most successful plans of treatment.

The first case of complete placental presentation was met with in a multipara, about six months advanced in pregnancy. She stated that during two months she had lost blood eight or ten times; it had appeared in gushes without any apparent cause, and subsided as unaccountably. In this case, plugging succeeded well for about thirty-six hours, after which the discharge became excessive, and the uterine action strong; the os uteri was found dilating, the placenta was detached from the inner surface of the uterus, and removed; the breech was then readily brought down, and delivery speedily accomplished. The patient made a good and rapid recovery. The second case of complete placental presentation occurred also in a multipara, aged 35, the mother of ten children, pregnancy being advanced almost to the full term. When called to this case, at 3 A.M., I was informed that the patient had been flooding excessively at intervals since the afternoon of the previous day. I found her fainting, cold, gasping for breath, and the uterine action very feeble. The os uteri was dilated to the size of a crown-piece, and possessed that degree of unresisting flabbiness indicative of the most urgent danger. Brandy was administered by the mouth and in the form of enemata combined with infusion of ergot. In an hour and a half, the patient had fairly rallied. Podalic version was decided upon, and was performed without much loss from hæmorrhage, after which the uterus contracted firmly. The child was still-born. Although the patient appeared to bear the operation remarkably well, she sank four hours after delivery. The death of this patient was unquestionably attributable to hæmorrhage carelessly allowed to take place before sending for assistance, the patient having unfortunately being placed under the care of an old, ignorant, and very deaf nurse.

Only one of the cases of partial placental presentation caused trouble or anxiety. This occurred in a primipara at the full term of gestation. I found flooding was and had been going on profusely for some time, the membranes were ruptured, and a portion of the fleshy fibrous placenta was readily recognised. I proceeded at once to plug the

vagina, but it proved ineffectual; the hæmorrhage continued to be poured forth copiously, so that the patient's life remained in imminent danger. Version was performed with difficulty. She made a good recovery, but the child died. The remaining cases of partial placental presentation, as well as the majority of the twelve cases of accidental hæmorrhage were treated, *i. e.*, after labour had commenced, by puncturing the membranes early and administering ergot, which invariably increased the uterine action, the head being quickly forced down upon the open orifices, almost completely plugging them, putting a stop to the hæmorrhage, labour progressing rapidly and satisfactorily to the end. In short, this treatment proved eminently successful.

The forceps has been much more frequently employed in my practice of late years than formerly, from the fact that patients have learnt to appreciate its utility. It was formerly the custom here as elsewhere for medical practitioners to remain with their parturient patients for several consecutive days and nights, rather than employ instruments. I have invariably used the long forceps with the pelvic curve, and have found it to answer every purpose, whether the head has been engaged at the brim of the pelvis, or in the cavity, or at the outlet. In a paper like the present, it would be impossible to particularise the conditions which indicated in every case the necessity for the employment of the forceps or for having recourse to craniotomy.

Of the five cases of convulsions, three only presented any features of interest. They all occurred in primiparæ, either during labour or immediately after delivery. In one case, I delivered with the forceps, after which the convulsions ceased. In two other cases, the convulsions continued after delivery for twelve or sixteen hours, threatening congestive apoplexy. The administration of chloroform and other treatment having failed, I performed venesection in both cases; in one about twenty, and in the other about thirty ounces of blood were drawn, after which the convulsions subsided. Both the patients made rapid and good recoveries.

The first case of pelvic deformity occurred in a primipara. On examination, both the child's hands were found presenting; the insertion of the funis was recognised; the head was felt resting on the promontory of the sacrum. The latter projected so far forward as to considerably narrow the inlet of the pelvis. The legs of the child were directed up towards the fundus of the uterus. The membranes were ruptured, and the uterus was contracting strongly upon the body of the child. Chloroform was administered, and several unsuccessful attempts to turn were made; it was then resolved to eviscerate, but this was found impracticable. It was finally determined to decapitate the child *in utero*. This was done with considerable difficulty by piercing the neck with a pair of long sharp forceps, and then dividing the spinal column. The trunk was then removed, and the head afterwards extracted with the long forceps. This patient has since had five children; four were delivered with the forceps, one of which was still-born, and one a female child, being unusually diminutive, was born naturally.

The subject of the second case was a multipara, who had always experienced tedious lingering labours. All her children, with one exception, were either still-born or soon died. When summoned to attend, I learnt she had been in labour since the previous evening. On examination, I found she possessed that rare deformity, which has been termed by M. Nægele "the obliquely distorted pelvis". I applied the forceps, but found the space insufficient to admit of extraction with safety to the mother. I then determined to turn; this was effected with great difficulty. After bringing down the breech and shoulders, profuse hæmorrhage ensued; and, finding it impossible to bring the head through the brim, I perforated behind the ear. The patient lost about a quart of blood, from the effects of which she died the following day.

The third case was met with in a multipara. It consisted of a diminution of the conjugate diameter of the pelvis, complicated with extreme obesity of the patient. She had borne several children, and, rather than allow premature labour to be produced artificially, had exposed herself to all the dangers of craniotomy three times. Her consent to have premature labour induced by means of the uterine douche having at last been obtained, it was brought on at the seventh month. Unfortunately for the fetus, the funis and foot presented, and it was born dead. The patient has been confined twice since; once she was delivered by craniotomy, and the last, a very diminutive female child, was born alive without instrumental aid.

The fourth case occurred in a primipara, and in most respects resembled the one just described, except that the tubera ischiorum were more closely approximated. The patient presented many of the characters indicative of deformed pelvis, the result of rickets in early life. On inquiry, it was found that, when a child, it was a long time before she could walk unsupported. She was with considerable difficulty delivered by craniotomy. She was urged to have her second labour artificially induced at the seventh month, but obstinately refused, and was

again delivered by craniotomy, but with much greater difficulty than on the first occasion. She died from exhaustion on the third day.

The fifth case was met with in a multipara, and resembled the third case. This patient has been delivered four times with the forceps; only one child survived.

To the sixth case, I was called at 2 A.M., and found she had been in labour two days, under the care of an ignorant midwife, who pronounced "all right". The membranes were ruptured; the funis, neck, chin, and foot of the fetus were recognised with great difficulty, owing to the extreme contraction of the brim of the pelvis. The patient having been brought under the influence of chloroform, version was several times attempted by myself and three other medical gentlemen, but all signally failed. As it was found impossible to pass the hand through the brim of the pelvis, after repeated but ineffectual attempts to eviscerate the child, all agreed that the only means remaining was to perform the Cæsarean section. This I did without the aid of chloroform. The patient bore the operation remarkably well, but gradually sank the following day from exhaustion.

The seventh case occurred in a primipara aged 25. She, like the fourth case, presented many of the characters frequently associated with distortion of the pelvis, the result of rickets in childhood. She was of diminutive stature, had a shambling gait, a very prominent chin, the joints of the hands and feet were thick, and there was curvature of the lower extremities. She was nearly three years old before she could walk alone. At her first confinement, I found that the promontory of the sacrum projected considerably forward; the symphysis pubis was flattened and pushed towards the former, the lateral diameter being increased; the bulk of the head of the fetus remained above the brim. The forceps were applied, but it was found impossible to effect extraction with impunity. The case was terminated by craniotomy. Her second labour was induced at the seventh month by means of the uterine douche. It lasted ten hours. The child was born without operative interference, but only lived ten hours. In her third pregnancy, the patient was persuaded by her friends to go to the full term of gestation. I had again to perform craniotomy; and on this occasion I found the cephalotribe of signal service. In her fourth pregnancy, I again induced premature labour at the seventh month by the gradual dilatation of the os uteri, separation of the membranes, and the introduction of a long elastic male catheter (without stilet) between the membranes and the uterus. This soon brought on uterine action; the child was still-born. The fifth labour was prematurely induced by the introduction of Dr. Barnes's bags. It continued eighteen hours; the child was delivered alive by the forceps, but only lived two days. The mother suffered from a sharp attack of peritonitis, from which she soon recovered. Her sixth and last labour was brought on at the seventh month in the same way as the fifth, and in every respect resembled it; the child lived three hours and a half.

The first of the seven mothers who died was a primipara, and resided in a very insalubrious locality. She was delivered by craniotomy, and died at the expiration of a week from septicæmia. The second patient began in labour when convalescing from an attack of small-pox. She was very depressed in spirits, her brother having just died from small-pox, and her husband had been removed to the hospital suffering from the same complaint. She died from septicæmia. The third was the subject of pelvic distortion, and died, as has already been stated, from accidental hæmorrhage. The fourth died from exhaustion, the result of a prolonged instrumental labour with deformed pelvis. The fifth died after the Cæsarean section. The sixth, aged 39, a primipara, was extremely delicate, was delivered by craniotomy of a putrid fetus, and died on the fourth day from septicæmia. The seventh was a primipara, extremely feeble and anæmic; her labour was natural, diarrhoea supervened, and carried her off on the seventh day.

The foregoing brief reports are in many respects very imperfect; however, I have endeavoured to detail the most essential and interesting features of the cases met with in my obstetrical practice.

WHITECHAPEL.—During the first quarter of this year, 753 births, and 647 deaths, were registered in this district. The death-rate is about the same as that for the corresponding quarter of last year, and is equal to an annual rate of 28 per 1,000. The deaths from infectious diseases were reduced from 73 to 38; but the diseases of the respiratory organs were, chiefly on account of the low temperature that prevailed during the whole three months, increased from 225 to 280. The chief infectious disease of the quarter was whooping-cough, which caused 23 deaths. As usual, the report contains some interesting remarks on questions of a general kind, such as the comparative mortality in the different infectious hospitals of the Metropolitan Asylums Board; the relative proportion of deaths occasioned by the more or less constant epidemic diseases; and the advantages of preserving open spaces.