and then upon patients with the natural disease treated under proper conditions in respect of control and observation. Only then was it presented to the profession. Within a few months its benefits were everywhere apparent. It had "come to stay" in every country in the world. It satisfied alike the credulous and the sceptical.

Minot's demonstration of the value of liver therapy in pernicious anaemia was partly dependent on earlier animal experiments by Whipple with artificial anaemias and then on careful clinical trials checked at every stage. Its refinements have depended equally on close clinical observation and intimate haematological study. As a consequence an intensive study of the blood diseases has followed and the value of massive iron therapy in microcytic anaemia has also been proved. As with insulin, so with these treatments acceptance was inevitable; the treatments were studied eagerly and employed actively but critically in the teaching hospitals from the first, and rapidly revolutionized practice throughout the world. In each case prognosis was at once and subsequently improved.

The experimental method of originating new therapeutic measures does not preclude the occasional empirical discovery like quinine and digitalis and prostigmin, but even such discoveries require and have received, sooner or later, what may be called "adequate clinical trial" or scientific assay, or both. The Therapeutic Trials Committee of the Medical Research Council does valuable work in arranging for proper trials of any new remedies which the manufacturing chemists are prepared to submit to it, but we are daily confronted with the advertisements of treatments launched as a commercial speculation and with no such scrutiny. I believe that our profession would gain nothing but respect and increased allegiance from the public if it were to insist on more frequent and judicial inquiries into all therapeutic innovations.

My remarks are not uttered in a censorious spirit, nor are they intended to apply to any one section of our fraternity. They are the expression of a mental discontent which I believe we all share in some degree. I put them forward alike for the consideration of the general practitioner, the consultant, the clinical and laboratory specialist, and the manufacturing chemist.

In addressing your old and honoured Pathological Society I may appear to have wandered too far afield and to have touched upon matters of conduct in practice which might, at first thought, be held to be remote from pathology. But, in fact, all I have asked for is a better appreciation of all that pathology, using the word in its broadest sense, implies. Only by the study of disease and its natural origins, processes, and progress can we learn how to influence its prognosis for the better, whether by active intervention or refraining therefrom. In the next stage of medical evolution the actions and uses of remedies, in common with other biological phenomena, must be determined not by advertisement or opinion, but by observation and experiment.

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SOME METHODS OF ANALGESIA DURING LABOUR*

BY

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Relief of pain during the second stage of labour has now become a fairly well-accepted practice, though even now, I regret to say, there are still some practitioners who consider the use of analgesics unnecessary for the normal case. Relief at this stage is usually obtained by the administration of an inhalation anaesthetic given intermittently with the pains, so that an analgesic effect is obtained. This method has much to recommend it, for the co-operation of the patient is retained and she is able to make voluntary efforts and so hasten delivery.

Inhalation Anaesthesia

Of the inhalation anaesthetics, chloroform and gas in combination with either air or oxygen are the most commonly used. Each has its adherents, and circumstance usually decides which is used. It is obvious that chloroform is often the only possible anaesthetic for use in domiciliary practice, more especially in country districts. Its cheapness, portability, and ease of administration account for its popularity.

The use of gas and air and gas and oxygen is steadily increasing, and rightly so, for wherever possible it should be chosen as the least toxic of the anaesthetics. In hospitals or nursing homes where portability is not a consideration gas and oxygen or gas and air is most certainly the anaesthetic of choice, and Dr. Minnitt has done a great service by the introduction of his ingenious gas-and-air machine, which is now making it possible to use gas much more widely in domiciliary practice. Though I consider gas and oxygen and gas and air to be of the greatest value throughout the second stage of labour, I am not fully convinced that either of these alone is, in many cases, really sufficient for the actual delivery. The addition of a small amount of ether or chloroform for the crowning of the head adds very much to the ease and comfort of delivery, both to patient and to obstetrician.

Relief from pain in the second stage does not really present a very difficult problem now where adequate assistance and instruments are to hand. I wish, at this time, to draw particular attention to the relief of pain during the latter part of the first stage of labour. This is often described by the patient as being the most wearisome and painful part of her whole labour. The cervix is dilating, often very slowly, and the patient can do nothing to help herself as she can in the second stage by her voluntary efforts. The form of relief which we should give her at this time differs essentially from that given for the second stage, in that an intermittent form of relief, such as is obtained by inhalation anaesthetics, is, to my mind, inadvisable.

It should be borne in mind that if an inhalation anaesthetic has been begun it must be continued until the time of delivery. It is obviously unwise to use chloroform in this way, for its toxic effects are most often seen in those cases which have received it over a long period, even in very small doses. Gas and air, or gas and oxygen, is sometimes used before full dilatation, but I do not approve of its prolonged use in the first stage, for the intermittent form of relief is often inadequate and very tiring to the patient. Though she may get relief with each pain, she

* Read in opening a discussion at a meeting of the combined Sections of Pharmacology and Therapeutics, with Anaesthetics, and Obstetrics and Gynaecology at the Annual Meeting of the British Medical Association, Oxford, 1936.

lies in apprehension waiting for the next contraction, and may thus become very much exhausted. Some form of drug which will give her a real rest and continuous ease from the pain should be administered at this stage.

Sedative Drugs

No drug gives such adequate relief from pain as morphine, and an injection of 1/6 or 1/4 grain at this stage will frequently be sufficient to tide the patient over the latter part of the first stage until the cervix is fully dilated, permitting an inhalation anaesthetic to be begun. Obstetricians who avoid the use of morphine lest delivery should occur within two hours of its administration generally use other drugs such as scopolamine or one of the barbiturates, usually nembutal or sodium soneryl. The use of such drugs in the first stage greatly facilitates the administration of gas during the second stage.

For the straightforward case very satisfactory results are obtained by the use of sedatives such as potassium bromide and chloral hydrate, or one of the barbiturates, in the earlier stages followed by morphine, scopolamine, or the barbiturates again later on, an inhalation anaesthetic being given during the second stage. There are, however, a number of cases which for one reason or another have a long, wearisome first stage. This may be due to such complications as persistent posterior positions, slight disproportion, rigidity of the cervix, etc. I wish to draw special attention to the analgesic measures useful in such cases of a prolonged first stage.

We have, at the Royal Free Hospital, for the last three years been using rectal methods of analgesia for these cases. The rectal anaesthetics which may be employed for obstetric purposes are avertin, paraldehyde, and ether. We have used only the two latter in our series, and the accompanying tables show the results obtained in fifty cases which have received rectal ether and fifteen which have received paraldehyde. These are unselected cases taken from our records of approximately 130 administrations of rectal ether and 40 administrations of paraldehyde. The numbers are small because rectal methods are mainly reserved for those cases in which the usual analgesics are inadequate.

Rectal Ether

The numbers given rectal ether are greater than those given paraldehyde, as the choice has been left to the resident anaesthetists in charge. The results obtained from the rectal ether have been, in their opinion, very much more satisfactory than from paraldehyde. We have had a certain amount of restlessness with the paraldehyde cases after injection, and also the smell of the drug is not popular in a general ward. The patient herself does not appear to notice either smell or taste.

ROUTINE FOR RECTAL ETHER

In the early stages drugs such as potassium bromide, 30 grains, chloral hydrate, 30 grains, in 6 oz. of glucose lemonade are given, mainly for their sedative effect. When the pains increase in strength and frequency and the patient becomes distressed 1 c.cm. opoidine in 2 c.cm. magnesium sulphate is given intramuscularly in the gluteal region. In twenty to thirty minutes, if real relief is not obtained and the patient is still distressed, the rectal injection is given; this may be delayed for one to one and a half hours after the morphine has been given, but the best results are obtained when it is given about half an hour after the morphine. The time to start the routine of the rectal method is best decided by the severity of the pains rather than by any degree of dilatation of the cervix. The obstetrician may not wish to examine vaginally, and in any case dilatation occurs at such differing rates in differing patients that it is not really a reliable guide.

The important point to note is that the pains should be really well established, or even the administration of morphine alone may delay the progress of labour.

PREPARATION AND ADMINISTRATION

The rectal ether is prepared according to the formula of Gwathmey, and consists of:

Quinine alkaloid	...	...	...	...	gr. xx
Alcohol	...	...	...	...	m xl
Ether...	...	...	...	...	3 ijss
Olive oil	...	...	...	...	to 3 iv

An ordinary funnel and catheter, size 10-12, are used for the administration, an enema having been given some time previously to clear out the lower bowel. The anal region is well greased with vaseline, the funnel is filled with an ounce or so of warmed olive oil, and the attached catheter is inserted six to eight inches into the rectum. The warmed mixture is then poured in and a further ounce of olive oil is given, making about 6 oz. in all to be retained. The injection usually takes about ten minutes and should not be done hurriedly, as the patient may become excited if it is run in too rapidly. If a pain occurs during the instillation the catheter should be nipped and the patient instructed to breathe in and out and not push down. She should be watched for about fifteen minutes after the catheter has been removed and if necessary a pad pressed over the anus to assist her to retain the injection. This is much better retained than might be expected, and as soon as the analgesic effect is established all desire to expel it is lost.

Excellent amnesia and analgesia is obtained, usually for three to four hours. The patient generally sleeps soundly, but often turns over and groans as the contractions occur. In domiciliary practice it may be difficult to convince the relations that she is not suffering, but she usually has no recollection of events after the injection. The length of amnesia and analgesia may be increased by two more administrations of 2 c.cm. magnesium sulphate intramuscularly; at intervals of an hour or so. This prolongs and increases the effect of both morphine and ether. If the second stage has not begun when the effect of the rectal analgesia has passed off the whole procedure may be repeated after an interval of not less than four hours, using only 10 grains of quinine in the mixture.

Rectal Paraldehyde

Much the same routine is adopted with paraldehyde with the omission of the magnesium sulphate injections and occasionally the use of scopolamine in the place of morphine, about one to one and a half hours before the rectal injection. The paraldehyde is kept as a stock preparation of 1 oz. of paraldehyde to 4 oz. of olive oil, 3 to 4 oz. being used according to the weight of the patient. We have had no trouble with rectal complications after the injection, this being due, I think, to the rather lavish use of olive oil.

In some cases very little additional anaesthetic is necessary for the second stage. Gas and oxygen or gas and air is used in the hospital, with the addition of a little ether if necessary for the final delivery. Latterly we have been using vinyl ether with good results. A very small quantity is needed, and in its rapidity of action it very much resembles chloroform. Our numbers are, however, too small as yet to quote.

Advantages of Rectal Methods

The points to which I should like to draw especial attention in this rectal form of analgesia are:

1. It is possible to obtain three to four hours' excellent analgesia, which, even if mistimed so that it does not tide the patient over till full dilatation is

Rectal Ether in Oil

Case No.	Type of Case [P=Primipara] [M=Multipara]	Delivery	Length of Labour			No. of Hours between Rectal Injection and Delivery	Condition of Baby	Haemorrhage	Amnesia and Analgesia
			1st Stage	2nd Stage	3rd Stage				
1	P	Spontaneous	28 hrs. 25 mins.	1 hr. 35 mins.	30 mins.	16½ hrs.	Satisfactory	Normal	Very fair
2	P with mitral stenosis and aortic regurgitation	"	16 hrs. 20 mins.	35 mins.	10 mins.	5 hrs.	White asphyxia	"	Very good
3	P	"	56 hrs. 55 mins.	1 hr. 55 mins.	15 mins.	7½ hrs.	Satisfactory	"	Good
4	M ¹	"	24 hrs.	25 min.	35 mins.	5½ hrs.	"	"	Very good
5	P	"	23 hrs.	1 hr. 40 min.	15 mins.	1st Inj.: 13 hrs. 2nd Inj.: 6 hrs.	"	"	Good
6	P	"	2½ hrs. 20 mins.	55 min.	10 mins.	1 hr. 50 mins.	"	+	"
7	P with mitral stenosis	"	21 hrs. 30 mins.	1 hr.	25 mins.	5 hrs.	Drowsy	Normal	Very fair
8	P	Forceps (for delay in 2nd stage)	22 hrs.	1 hr. 45 mins.	1 hr.	10 hrs.	Very drowsy	"	Very good
9	M ¹	Spontaneous	45 hrs. 30 mins.	2 hrs. 55 mins.	15 mins.	12 hrs.	Slightly shocked	+	Fair
10	P with mild toxæmia	Forceps (for foetal distress)	12 hrs. 15 mins	2 hrs.	15 mins.	6 hrs.	Blue asphyxia	Normal	Good
11	M ³	Spontaneous	45 hrs. 55 mins	45 mins.	35 mins.	6 hrs.	Satisfactory	"	Very good
12	P	"	52 hrs. 20 mins	1 hr.	30 mins.	9 hrs.	"	"	Good
13	P	"	20 hrs. 45 mins.	1 hr. 15 mins.	15 mins.	11 hrs.	Blue asphyxia	"	Very good
14	P	"	26 hrs.	50 mins.	15 mins.	17 hrs.	Satisfactory	"	Very fair
15	P	Forceps (for persistent posterior)	38 hrs.	2 hrs.	15 mins.	15 hrs.	"	"	Good
16	P	Spontaneous	8 hrs.	1 hr. 45 mins.	10 mins.	3 hrs.	Blue and limp	"	"
17	P	Forceps (for delay in 2nd stage)	45 hrs. 30 mins.	2 hrs. 20 mins.	10 mins.	11 hrs.	Blue asphyxia	"	"
18	M	Spontaneous	19 hrs. 45 mins.	15 mins.	10 mins.	1½ hrs.	Satisfactory	"	Very good
19	M with mitral stenosis	"	11 hrs. 10 mins	2½ mins.	20 mins.	1½ hrs.	"	+	"
20	P	"	21 hrs. 45 mins.	15 mins.	20 mins.	7 hrs.	"	+	"
21	P (trial labour)	"	27 hrs. 30 mins.	45 mins.	30 mins.	6 hrs.	"	Normal	Good
22	P	"	16 hrs.	45 mins.	30 mins.	3½ hrs.	Drowsy	"	Very fair
23	P	"	7 hrs. 10 mins.	50 mins.	7 mins.	4 hrs.	"	"	Good
24	P	"	55 hrs.	35 mins.	55 mins.	30 hrs.	Satisfactory	"	Fair
25	P	Forceps (for delay in 2nd stage)	42 hrs.	1 hr. 30 mins.	25 mins.	17 hrs.	Drowsy	"	Fair
26	P	Spontaneous	10 hrs. 50 mins.	35 mins.	7 mins.	2 hrs.	Satisfactory	+	Good
27	P	Forceps (for disproportion)	12 hrs. 30 mins.	2 hrs. 30 mins.	15 mins.	5½ hrs.	White asphyxia; baby died	Normal	Good
28	P	"	32 hrs. 20 mins.	2 hrs. 50 mins.	20 mins.	7 hrs.	White asphyxia	+	Very good
29	P	Spontaneous (breech)	11 hrs. 50 mins.	45 mins.	10 mins.	1½ hrs.	Drowsy	+	Good
30	M ³	Spontaneous	30 hrs.	30 mins.	10 mins.	8½ hrs.	"	Normal	Very fair
31	P	Forceps (for persistent posterior)	17 hrs. 20 mins.	1 hr. 10 mins.	20 mins.	9 hrs.	Satisfactory	"	Fair
32	P	Spontaneous	49 hrs. 30 mins.	3 hrs.	15 mins.	1st Inj.: 14½ hrs. 2nd Inj.: 6 hrs.	"	+	Good
33	P	"	20 hrs.	30 mins.	8 mins.	6 hrs.	"	Normal	Fair
34	M ¹	"	18 hrs. 40 mins.	27 mins.	8 mins.	5 hrs.	"	"	Good
35	M ⁵ with toxæmia	"	25 hrs. 25 mins.	10 mins.	10 mins.	1½ hrs.	Shocked	"	Fair
36	P	"	20 hrs. 30 mins.	1 hr. 10 mins.	5 mins.	1st Inj.: 10 hrs. 2nd Inj.: 4 hrs.	Satisfactory	"	Good
37	P	"	24 hrs. 45 mins.	1 hr. 5 mins.	5 mins.	1 hr.	"	"	Very good
38	P with double mitral lesion	Forceps	23 hrs. 45 mins.	1 hr. 8 mins.	8 mins.	1st Inj.: 15 hrs. 2nd Inj.: 7 hrs.	Blue asphyxia	"	"
39	P	Forceps (for delay in 2nd stage)	22 hrs. 30 mins.	3 hrs. 15 mins.	20 mins.	6 hrs.	Satisfactory	+	"
40	P	Spontaneous	24 hrs.	1 hr. 5 mins.	15 mins.	14½ hrs.	Slightly shocked	Normal	"
41	M ⁵ with mitral stenosis	"	25 hrs.	30 mins.	10 mins.	4½ hrs.	Satisfactory	+	Good
42	M ⁴ : twins	Forceps	49 hrs. 10 mins.	45 mins.	20 mins.	1st Inj.: 17½ hrs. 2nd Inj.: 10 hrs.	Macerated foetuses	+	"
43	P	Spontaneous	40 hrs. 30 mins.	1½ hrs.	10 mins.	12½ hrs.	Satisfactory	Normal	Very good
44	P	"	9 hrs. 25 mins.	30 mins.	15 mins.	5 hrs.	Limp; cyanosed	+	Good
45	P	Forceps (for foetal distress)	59 hrs. 45 mins.	—	35 mins.	3 hrs.	Cyanosed	Normal	"
46	P	Spontaneous	14 hrs. 30 mins.	45 mins.	10 mins.	6 hrs.	Satisfactory	"	Fair
47	P	"	10 hrs. 30 mins.	3 mins.	5 mins.	6 hrs.	"	"	"
48	P	Forceps (for delay in 2nd stage due to narrow pelvic outlet)	43 hrs.	4 hrs.	40 mins.	11 hrs.	Stillborn	"	Good
49	P	Spontaneous	32 hrs. 30 mins.	3 hrs. 30 mins.	10 mins.	15 hrs.	Satisfactory	"	Very fair
50	P	"	21 hrs. 50 mins.	1 hr. 55 mins.	10 mins.	3½ hrs.	"	"	Good

Rectal Paraldehyde in Oil

Case No.	Type of Case [P = Primipara] [M = Multipara]	Delivery	Length of Labour			No. of Hours Between Rectal Injection and Delivery	Condition of Baby	Haemorrhage	Amnesia and Analgesia
			1st Stage	2nd Stage	3rd Stage				
1	P.	Forceps (for foetal distress)	20 hrs. 35 mins.	1 hr. 25 mins.	20 mins.	5 hrs.	Drowsy	Normal	Fair
2	P.	Spontaneous	28 hrs.	1 hr. 40 mins.	10 mins.	5 hrs.	Satisfactory	+++	Good
3	P.	Forceps (for persistent posterior and foetal distress)	13 hrs. 30 mins.	1 hr. 45 mins.	30 mins.	18 hrs.	Limp and blue	Normal	Poor
4	P.	Spontaneous	10 hrs.	2 hrs.	30 mins.	4 hrs.	Blue asphyxia	++	Good, but restless
5	P.	"	62 hrs.	1 hr. 20 mins.	40 mins.	18 hrs.	Satisfactory	+	Fair
6	P.	Forceps (for delay in 2nd stage)	27 hrs.	3 hrs.	15 mins.	8 hrs.	White asphyxia	Normal	Very fair
7	M.	Spontaneous	39 hrs.	20 mins.	5 mins.	12 hrs.	" "	+	Good
8	P.	Forceps (for foetal distress)	18 hrs.	35 mins.	15 mins.	12 hrs.	" "	Normal	Very fair, but restless
9	P.	Spontaneous	25 hrs.	1 hr. 15 mins.	15 mins.	3½ hrs.	Blue asphyxia	"	Very good
10	P.	"	8 hrs. 20 mins.	30 mins.	10 mins.	1½ hrs.	Satisfactory	"	"
11	P.	Forceps (for persistent posterior)	13 hrs.	2 hrs. 10 mins.	10 mins.	3½ hrs.	"	"	Very fair
12	P.	Spontaneous	46 hrs.	1 hr. 30 mins.	10 mins.	4 hrs.	"	"	"
13	P.	Forceps	34 hrs. 15 mins.	1 hr. 22 mins.	13 mins.	8 hrs.	Blue asphyxia	"	Very fair, but restless
14	P.	Spontaneous	24 hrs.	1 hr. 40 mins.	10 mins.	5 hrs.	Shocked	"	Good, but very restless
15	P.	"	32 hrs.	2 hrs. 15 mins.	40 mins.	7 hrs.	Satisfactory	"	Good

reached, gives a complete rest to a tired patient and gives her time for recuperation.

2. The drugs are safe, cheap, can be obtained anywhere, and can be kept as stock mixtures.

3. There is no elaborate administration. Any skilled person can give the rectal injection.

4. The method can be used for cardiac, toxæmic, or chest cases.

We do not claim to have discovered anything new, for American observers have quoted thousands of cases in which the Gwathmey technique has been used as a routine. In this country, however, rectal methods have not won any considerable popularity, and it is for this reason that I wish to show that there is a very definite field for this form of analgesia.

The incidence of forceps deliveries for the rectal ether cases is two and a half times greater than the average for the year, and for the paraldehyde cases three times greater than the average. I must, however, draw attention to the fact that the cases quoted in the tables are unselected groups which have received this form of analgesia for the very reason that they are the more complicated cases of labour, so that it should not be concluded that these methods lead to more instrumental deliveries. The number of lacerations including episiotomy cases in these groups are also 20 per cent. and 8 per cent. higher than the average, but again for the same reason I think it cannot be proved that these are attributable to the analgesic methods.

The resident medical officers have volunteered the information that the rectal methods seem to produce a marked relaxation of the perineum.

In the tables I have reserved the comment "very good" for those patients who have either had no recollection of events after the injection or have made such remarks as "It was wonderful." From our records there is no evidence that these forms of analgesia increase the stillborn rate or the neo-natal rate. The amount of haemorrhage has been tabulated as: normal; + indicating loss slightly above the average; ++ loss considerably above the average; +++ a definite post-partum haemorrhage. There is no evidence to suggest that these methods lead to increased post-partum haemorrhage.

I am much indebted to Professor Fleming for her permission to produce these results.

PROGNOSIS OF CARCINOMA OF THE CERVIX

BY

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In a paper published in the *British Medical Journal* Fletcher Shaw and Dougal¹ remarked on the scarcity in this country of statistical reports on the results of radium treatment of carcinoma of the cervix over a five-year period. The following analysis of 497 consecutive cases treated at St. Thomas's Hospital between the years 1918 and 1930 inclusive may be of interest. In selecting the cases all patients who had previously received treatment elsewhere have been excluded, and only those whose entire care was undertaken by St. Thomas's Hospital are considered.

Follow-up Clinic

After discharge from the hospital all patients suffering from malignant disease of the genitalia are encouraged to attend a special "follow-up clinic," usually at intervals of three months, but more often if the condition of the patient makes this desirable. In this way the progress of each case can be noted, and further treatment given if necessary. Not all patients are able or willing to attend this clinic, for some live in distant parts of the country and others drift away from the hospital after a few years have passed without recurrence of symptoms. The almoner's department makes every effort to trace these patients, but unnotified changes of address make the loss of a certain proportion inevitable. The ill patients nearly always keep in touch with the hospital, and probably only a small number of deaths are missed; it is usually the fit and healthy patient who becomes tired of attending the clinic, and who does not trouble to communicate her change of address. For example, in the present series of cases the majority of patients lost sight of had been progressing favourably when last seen, and a few had been free from recurrence for four years or longer. Of the 497 patients treated in the years under review 458, or 92.2 per cent., were followed for at least five years or until death. In recent years it has been the practice