## THE CONDUCT OF NORMAL LABOR.

*By D. L. Maguire, M. D., Charleston, S. C.

A PAPER on the above subject seems so commonplace and hackneyed that perhaps I should offer some apology for it. I am perfectly sensible of the fact that I am unable to tell you anything new concerning Labor, and I do not intend to promulgate any new doctrine in regard to its management. I know quite well that a baby is born in the same old way. However, my reasons for bringing such a topic before you are two: First, to stimulate the writing of papers on obstetrics; and secondly, to elicit a free discussion, so that each of us may benefit by the opinion of the other, because no two of us conduct a case in exactly the same manner.

When a physician receives his call to a labor case, it should be answered at once, no matter what the engagements or obligations of the physician may be. This call takes precedence over all others. If at the theatre or some social function at a time when a case of labor is expected, he should always leave directions how he can be found, and should respond at once. At times this may be very inconvenient, but nevertheless, the practice should be followed rigidly. If he is in attendance upon another case of labor, it is perfectly permissible for him to leave that case, if her condition be not such as to demand his actual presence, and after having seen the second case, he can return to the first. In this manner, it is easily possible to manage two cases at the same time, but there should always be a substitute within call. According to the best authorities, the patient first beginning labor has the right of priority, and if a substitute has to be called, he should be sent only to the second case. Others believe that the duties of the obstetrician are with the woman, who is more seriously ill, and the substitute should attend the easier case.

If the obstetrician is obliged to leave town about the time that a delivery is expected, he should by all means notify the patient and arrange for a competent substitute to

*Read before the South Carolina Medical Association, Florence, S. C., April 16, 1914.

take his place. He should always bear in mind that the proper care of such cases requires a great deal of time, and frequently, no small amount of personal sacrifice, and if he is not willing to place himself at the disposal of his patients, as far as may be necessary, he should, from the first, refuse to attend them. Undue haste is the most frequent cause of unsatisfactory results in this branch of medicine.

The first duty of the physician on entering the obstetrical room is to find out whether or not the patient is in labor. This he should do, not by making an immediate and hasty Vaginal examination, but by sitting down and watching the patient to see if the pains recur at regular intervals. In the meanwhile, the physician should dispel any possible fear on the part of patient, and assure her, by his kindly manner, of the successful outcome of the case. Many ludicrous mistakes have been made by eminent obstetricians in their early practice in discovering whether or not a patient was in labor. One noted physician states that as a student, he watched throughout an entire night, only to find when in the morning, he sent for the demonstator of obstetrics of the Medical College to apply forceps —that the patient was not in labor. Such mistakes do happen, and perhaps many of us can recall similar instances.

The three signs indicating that labor has actually be gun are: (a) Recurrent pains of characteristic duration, situation, and nature; (b) The escape of a small quantity of blood-tinged mucus from the vagina show; (c) The dilatation of the Os. The "show" may be absent in the early stages of labor, but usually I ask soon after my entrance into the room, whether or not the "show" has occurred.

To an experienced obstetrician, the appearance of the patient's face and her manner may suffice for diagnosing whether or not the patient is in labor. But to my mind, the physician should always make a vaginal examination to discover the condition of the Os before deciding in the negative and leaving the house. If, upon examination, he finds the cervical canal obliterated and dilated to a dollar or larger, it is his duty to remain with the patient—particularly if there is a marked bulging of the bag of water through the Os, which indicates strong pains.

Vaginal examination during labor should be made only with the strictest antiseptic precautions. It can not be too emphatically stated that a parturient woman can be fatally infected by a single careless vaginal examination. *Utmost scrupulousness then should be maintained in examining a woman.* Although I am not of the opinion that Potassium Permanganate and Oxalic Acid should be in the obstetric bag, and that the hands and arms should be immersed in solutions of these drugs, I do believe that the obstetrician's hands and forearms, up to the elbows, should be washed well and placed in solution of Bichloride of Mercury. Furthermore, a physician is never justified in making a vaginal examination on a parturient woman without a rubber glove which has been boiled for five minutes. No matter how uncertain we may feel about the sterilization of the hand, we can always feel safe with a rubber glove. I can not then too strongly urge the use of sterile rubber gloves as a routine measure in confinement cases.

During the first stage of labor, the

points to ascertain by vaginal examination are the condition of the membranes and the degree of dilatation of the Os. We find, therefore, whether the membranes are ruptured or not, and so whether we will have a normal or dry labor. By the feel of the membranes also, we find out the character of the pains by noting if there is a strong or weak protrusion with each uterine contraction. By vaginal examination we discover likewise the dilation of the Os, which assists us somewhat in giving a prognosis as to the duration of labor. Remember, however, that the length of labor depends on the uterine pains.

After he has made the examination, the physician will be asked his opinion by the expectant family as to the probable duration of labor. Here it is always well to be guarded and deliberate, and he should make the somewhat ambiguous statement that the "duration of labor will depend on the strength and frequency of the pains." If the operator bears in mind the average duration of labor in primipara and multipara as being seventeen and eight hours, respectively, from the onset of pains, he will be greatly helped.

During the first stage, it is not necessary for the patient to remain in bed. On the contrary, she should be encouraged to walk around the room or sit erect in a chair. We find that in prolonged labor, especially in primipara, sitting erect or walking around the room is of advantage in assisting dilatation of the Os and fixation of the head. During this stage also the patient may be allowed any liquid food and this should be encouraged in prolonged labors. Simple broths, coffee, and tea can be given with impunity. No solid food, however, should be given on account of the fact chloroform narcosis may be subsequently demanded.

In those cases where the cervix remains hard and unyielding, there is no better drug to use during this stage than morphine grain ¼, Hypodermically. Morphine seems to act as a stimulant for the uterine contractions and at the same time it softens and dilates the cervix. Chloroform also has been used a great deal but when used, only enough to deaden the pain should be administered. Profound narcosis is not desired because this will stop the uterine contractions. Again enemas of Chloral gr. XX and Bromides dram 1, have been used with very happy result.

To my mind, an obstetrician can do a great deal towards assisting the woman by dilating the cervix with his vaginal fingers (between pains). By this, I do not mean that his entire fist should be introduced into the uterus, but that the cervix should be gently stretched with the index and middle fingers after a pain. Although this is not recommended in any text books, and although I may be severely censured for it, I am candid to say I have never seen bad results from the method and have found that it materially shortens the first stage of labor.

Again, I have found that the unruptured membranes delayed the onset of the second stage. In several cases, the cervix has been fully dilated, and although with strong pains, the membranes remained intact.. Of course, too early rupture of the bag of water should be discouraged and frowned upon, but I do believe that after the cervix has become fully dilated, and hence after the membranes have performed their function artificial rupture should be

speedily performed. I am of the opinion that unruptured membranes after complete dilatation of cervix will delay labor.

After the cervix has fully dilated and the membranes have ruptured, the patient has entered upon the second stage of labor. During this stage she should be placed in bed and kept there, the bed pan being used for evacuations from the bladder and rectum. Both bladder and rectum should be emptied because when these organs are full they frequently interfere with the progress of labor.

The physician should be at the side of the woman, his duties during this stage being to protect the perineum and to encourage the woman to use her voluntary forces until the head reaches perineum. A great deal can be accomplished, particularly in a protracted labor, by instructing a woman to hold her breath and bear down as a contraction reaches its height. If the contractions are very severe and painful and the patient does not bear them well she may be induced to bear down by being allowed to inhale a few drops of ether or chloroform at the beginning of each pain. Encouragement should be the watchword during this stage and the woman should even be coaxed to use her pains in the right way. The most important duty, however, for the obstetrician in this stage is the prevention of perineal tears. These perineal tears are in a number of cases hard to prevent, and a lacerated perineum will result even after the utmost care on the part of the obstetrician. The great importance of avoiding rupture of the perineum can not be over-estimated. It is scarcely an exaggeration to state that one-half of the gynecological cases owe their condition directly or indirectly to rupture of the muscles of the pelvic floor during labor. *The main point to remember is that the perineum should stretch and not tear.* The causes of the perineal lacerations are three in number. (1) Relative disproportion in size between the presenting part and the pelvic outlet. (2) Too rapid expulsion of the head. (3) Faulty mechanism of labor whereby a larger circumference of the presenting part than necessary passes through the outlet. All of these—particularly the last two causes—are under the control of the obstetrician and abundance of time must be given to the muscles of the pelvic floor to stretch sufficiently, without tearing, to permit of the passage of the foetus. This can be accomplished by allowing the head to remain sufficiently long within the vulva and not be too hastily or quickly expelled. Also the obstetrician should remember to produce extension of the head just as it is passing over the perineum. The occiput then should be pushed well up under the pubic arch.

There is a very ingenious device which has been recently recommended by Dr. Geo. H. Noble, by which the perineum is supported by means of three adhesive straps—1½ inches wide, and 18 to 24 inches long. When the head distends the vulva, the end of one strap is applied in the vulva femoral crease, while its other end runs diagonally downward across the opposite buttocks. A second strap is applied in the same way on the other side, and the third running directly transversely about one-half inch below Posterior Commissure. Noble has used this method in six forcep deliveries, in which laceration seemed imminent, with perfect satisfaction. I personally have had no experience with this method. A possible objection is the difficulty

of obtaining sterile adhesive plaster.

After the delivery of the head, the obstetrician should wait for the expulsion of the shoulders. I think in the majority of cases, the shoulders are too rapidly delivered. The birth of the head seems to be the signal that the rest of the body of the child should be pulled out as quickly as possible. This, of course, is a mistake, as the obstetrician should wait for the natural forces to deliver the shoulders—except in the face of some serious complication. After the head is born it should be gently supported in the palm of the hand—flexing the neck slightly upward—so as to allow for the birth of the posterior shoulder. A word of warning, however, should be given in regard to too marked flexion of the head of the child. There is a possibility of injury of the spinal accessory nerve. Remember that when the shoulders are too quickly delivered there is danger of further and more seriously tearing the perineum. As was said above, the posterior shoulder should be delivered first when occasion demands, but in delivering it, the utmost gentleness must be used.

After the delivery of the shoulders the body is, as a rule, rapidly expelled. Should there be delay, the thorax may be grasped with the hands and gentle traction made, or better, the foetus may be expelled by pressure of an assistant on the fundus. In the delivery of the shoulders and body of the foetus, the general principle—namely, to make use of all the available space of the pubic arch is followed. To accomplish this, the shoulders and body are not permitted to press too closely against the perineum, but are rather pushed carefully under the pubic arch. During the expulsion of the foetus the fundus is followed down, by the hand of an assistant, and this pressure should be maintained for at least an hour.

As soon as possible after birth, the eyes, mouth, and nose should be wiped clear of mucus. Into the eyes also should be instilled two drops of 2 per cent solution of silver nitrate. This is strongly recommended and should be done in the case of every new-born baby. A two per cent solution of nitrate of silver should be in every obstetrical bag. Immediately after the installation, the eyes are to be washed with Boric Acid. Respiration of the child being established, the ligation of the cord should be delayed until pulsations in the cord cease, unless there is some positive indication to the contrary. I take advantage of this delay in having the nurse wipe out the nose, mouth, and eyes of the child and instill the solution of Silver Nitrate. The reason that immediate ligation is not recommended is because it deprives the foetus of about three ounces of blood. When pulsations have ceased and I am ready to ligate I usually employ a hemostatic forcep on the placental end of cord and a ligature of bobbin on foetal end, and cut between. The reason of using hemostat is that there is a saving of bobbin and time. The hemostat remains clamped on cord until placenta is expelled.

A good plan to follow before ligating cord is to strip back the jelly of Wharton before applying the ligature. This will insure a more decided ligation and less chance of hemorrhage from the umbilical cord. Always after cutting the cord, the obstetrician should touch the severed end of the stump with a piece of cotton saturated with Bichloride solution. This is not only for its anti-

septic effect, but also to be sure there is no active hemorrhage going on.

In addition to my other instruments, I always sterilize two hemostatic forceps. These are used when coils of the umbilical cord are wrapped around the neck of the child. This complication occurs in 25 per cent of cases, and the great danger is asphyxiation of the child. Just as soon as I find that this condition is present, I clamp the cord in two places with the hemostatic, and cut between them. This, I believe, is safer and quicker than untwisting the cord around the head.

After ligation and section of the cord, while the obstetrician is waiting for the delivery of the placenta, I can entertain no valid reason why the perineum should not be sutured if such is necessary. Immediately after the birth of the child, the perineum is numbed and anesthetized, partly on account of pressure of the foetal head, and partly on account of the anaesthetic. Hence a much more satisfactory examination can be made and repair performed without giving patient very much pain. Even if the sutures are not tied, they at least, can be inserted and tied after the delivery of the placenta.

In my judgment there is a great temptation during the delivery of the presenting part, and also in examining the perineum of placing the finger in the rectum. We find so often that the head is pushed by a pain almost to the vulva opening, and then recedes to its original position. There is great temptation here of inserting the finger in the rectum and by intra rectal manipulations of attempting to deliver the head. These manouveres are mentioned only to condemn them, and an obstetrician is never justified in performing any intra rectal "coups."

The delivery of the child completes the second stage of labor, and usually within twenty to thirty minutes after the birth of the child—the placenta is expelled. An obstetrician should wait for at least thirty minutes before performing any method of placental expulsion. As was mentioned before, the nurse or some other person, should make pressure on the fundus for at least one hour after the birth of the child. This will materially assist in contracting the uterus and expelling the placenta.

Just after the birth of the Placenta, the patient should be given Ergot. My preference is for Ergotole for the reason that it can be given hypodermically, as well as by mouth. I always carry Ergotole in my obstetrical bag, and administer it hypodermically, immediately after the expulsion of the Placenta. This drug should never be given during labor until after the birth of the Placenta. After giving my first dose of Ergotole I write out a prescription for F. E. Ergot, with directions, one dram every three hours, for the first twenty-four hours. This is for the purpose of obtaining firm contraction of the uterus, and hence as a prophylactic against post partum hemorrhage.

I have purposely neglected to mention pituitrin in the conduct of normal labor, because I feel that it should not be used in normal deliveries. I am candid to admit, however, that I believe it a wonderful drug and that it does a vast amount of good in Uterine Inertia. But in normal cases as a time saver, we are never justified in using it.

In conclusion I want to sound a note of warning as to the danger of manual extraction of the placenta, or, in fact, of any intra vaginal or

intra uterine manipulations during the third stage of labor. When examinations are made in the first or second stage of labor, they are made, so to speak, inside of the amniotic cavity, which entire cavity is cast off. On the other hand when examinations are made in the third stage the hand comes into direct contact with the abraded placental site, and hence the danger of infection is greatly increased. The manual removal of the placenta should be considered, for this reason, one of the most dangerous of obstetric operations, and should never be resorted to until all other measures have utterly failed, and only then, after thorough re-disinfection and sterilization of the hand.

## DISCUSSION.

Dr. W. J. Burdell, Lugoff, S. C.:

Mr. President, I did not hear any of the papers distinctly, and the part that I did hear I do not like to discuss, except to commend them very heartily. I would like to just run over a few of the principles that I would like to put into practice in the management of the obstetrical cases that occur in my practice. I think a good many of us are inclined to pay very little attention to the mother until the time of labor. I think that we should keep a general supervision over the pregnant woman from as near the very beginning of pregnancy as we can. I know a good many cases in my practice that I think I have been able, by advising the mother, and sometimes having to almost force her to take the proper precautions, to prevent a good many abortions. Where we have the so-called habit of abortion established, or about to become established, we can do much to prevent. I also make a careful antepartum examination early in pregnancy of any primipara. I do not think it necessary to make such an examination, perhaps, of the multipara as of the primipara.

There are some other points that I desire to carry out in the preparation for labor. I take my typewriter and make several copies of some instructions, and as soon as I am engaged to attend a woman in labor I either mail them to her, or give them to her husband or some one in the family. I do not claim they are original with me. I have culled them from literature, but they are precautions for the examination of urine, frequently, during pregnancy, and especially during the latter end of pregnancy, and the necessity of taking repeated blood-pressure tests during pregnancy, which I think important. Also, I give, in this written leaflet, some of the symptoms that we consider premonitory symptoms, or symptoms that would lead us to suspect possibly that we might have convulsions. I do not know that I put much faith in the mere presence of finding albumen in the urine as one of the indications of coming puerperal eclampsia, in my experience. I have found albumen that had run by the Esbach test, .5 and .6 of 1 per cent, and I would be scared to death, and probably the family would be, too, and have no trouble, and have had those convulsions come on in the cases where we did not find but very little—in some cases no—albumen. Where I have been able to watch the cases closely enough, those that I found had high blood-pressure, both systolic and diastolic before labor. We should try to treat these by eliminative methods. We should look after the diet. We should also instruct the woman how to prepare the bed for labor. Also give her instructions about having plenty of water. I instruct her to get lysol, bichloride tablets, absorbent cotton, gauze, and I also have her, in the last month before labor is expected, to use (I have been using for sometime), a preparation of glycerole of tannin, applied to the nipples twice a day. It hardens up the nipples and lessens the tendency to fissues. They have to protect the underclothing from it, and it makes a dirty stain, but I think the use of it repays for anything of that sort. I instruct them to have plenty of water that has been boiled and cooled in pitchers, as we can not get the pitchers in many of my families, they use buckets or anything, but they have boiled water and water on the fire all the time in case we should need it. The woman is instructed that as soon as she feels the first pain that she knows is a labor pain, that she should take a full bath, and especially the genital region and the thighs, from the waist to the knees, and, better, from the waist down. If they have not a tub that they use a bichloride solution for bathing off the parts that are most likely to be touched.

The baby also, I have a regular little ceremony that I preach in those houses. I have gotten the thing so that I can get it off like a stump speaker, almost, when the nurse is washing the baby, and that is in regard to the value to putting the baby to breast as soon as you can conveniently do so, after it has been dressed, and the mother has been dressed. I think we have decidedly less trouble if the milk comes when the breast is emptied thoroughly. I think, too, that colostrum has a little less effect on the baby's bowels than a little piece of fat bacon. In my country they tie a piece of fat bacon, as soon as the baby is born, across the baby's mouth, if it will not stay there any other way, and then, next day, a sugar teat, tied up in an old rag. The people realize that the baby will starve to death if it does not get fed before the milk comes, and they feed it on butter and sugar, tied up in a rag.

I use a preparation of the German pharmacopea, a talc powder with starch and salicylic acid. I cut the cord about three-fourths of an inch, for I am sure there is no danger, if the cord is normal. Tie it, then put a piece of sterile gauze around the cord, put on a good, heavy dusting of this powder containing salicylic acid. I have learned from these obstetrical experts to always turn the cord straight up, if it is a boy. If it is a girl, if you turn the cord to the right side the children of this girl will be principally boys, and to the left side principally girls. These are important points to bear in mind. (Laughter). If you do not turn the cord up in a boy the boy will be sterile when he grows up.

The cord dries and comes off with this salicylic acid powder in about twenty-four to thirty-six hours less time than it does by any other method that I have used. And the point I have tried to impress upon the mothers is that a baby crying does not always mean colic or catnip tea, but I do think if you make a little examination sometimes you will find the band has slipped, and you have the dressing tugging on the cord, and very often just a little changing of the band stops the colic, if the baby has it.

I am old-fashioned enough, when a baby has colic, to think there is nothing much better than assafetida. It has plenty of smell to satisfy the grandmothers, and it is a pretty good old-time remedy. In those cases in which I am so unfortunate as to lose a child and we have to dry up the mother's breast, I have found that the best thing I could do for that is a stunt I got from Williams of Johns Hopkins—simply to do nothing. I was taught to go ahead like you were working with a cow, to do everything you could to keep that breast secreting milk. I think if you let that breast alone, and you don't get any cracks of the nipples, and you don't have a painful breast, they get over it much quicker than if you go to tampering with the breast. I don't keep my parturient woman lying down as long as I once did. I keep them confined to the bed as long as the lochia is red, but after, say, the third day, for the micturition and for the passage of the bowels, I let them get up and sit on the commode by the side of the bed. I think it gives us a better drainage from the vagina in getting rid of clots. I find when we give the third day dose of castor oil; it is an excellent thing for certain conditions in children, and it is a good thing for the parturient woman, too. As a member of our profession said, a good lubricant for baby ankles, and also a good lubricant to clear out the intestinal canal. Of course I try to impress on the mothers and nurses of various degrees of ability that I have, the necessity for cleaning the child. We see so many children having sores behind the ears and about the joints in the different parts of the body—due to improper first cleaning up of the baby. The text books advise different things, I think, but I have not been able to get over the belief that there is nothing better to grease a new baby with than pure old country-made hog lard. I like it better than vaseline. Of course, the baby's eyes should be attended to, regardless of what baby or whose baby it is, or where it is. Use nitrate of silver. That I don't think should be neglected in any instance. You get some case of sore eyes in the new born that is not due to gonococcus and I think that the silver salt is a good thing for the non-specific opthalmia.

Another thing that I impress upon the mothers is that a rash, under the various names they have for it, is an evidence of neglect and filth, and I always give boric acid. I give her enough boric acid to make a solution of about 10 to 15 grains to the ounce. The baby's mouth is washed before and after nursing, and the nipples, also.

Another of my fads is I like to hear the babies squall good and loud and keep it up

for awhile when they are born, but the method of artificial respiration of swinging the baby, I do not like—I was a little excited when I did that once; it was in a negro cabin and there were cross joists, and the baby's feet hit against the joist. I like this method better. Hold the shoulders in one hand, steadying the head, take the buttocks in the other hand, baby's abdomen up. By pronating the hands you flex the baby's body, compressing the chest and abdomen.

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Dr. C. W. Kollock, Charleston, S. C.:

Mr. President, there is one examination of the pregnant woman which is not usually made but which is of the greatest importance, especially when there is a tendency to edema of the limbs and headache: I refer to the examination of the nerve head (?) and fundus, with the opthalmoscope. A swollen nerve head (?) may be present for some time before the vision becomes affected and if this were known by the obstetrician he would naturally be better fortified for the prevention of more serious trouble—such as convulsions. I believe it is the general opinion that when albumen and choked disc co-exist that premature labor should be brought about.

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Dr. J. S. Rhame, Charleston, S. C.:

I would like to make a few remarks in regard to Doctor Burdell's not having a definite time about having his patients confined to bed. We know it takes about six weeks for the process of involution, and I still think a great many cases of retroversion of the uterus are caused by the patient rising too early from bed. I would rather be too conservative and keep the patient in bed ten days to two weeks. I advise my patients to assume a position of lying on the abdomen two or three times during the day for a period of twenty to thirty minutes. We know the condition of the uterus after delivery, so of course, it is very well to watch the discharge; but I think the indiscriminate use of allowing women to get up too early after confinement has this evil, and although fully aware that certain classes are up on the third day, and in some instances in the kitchen, yet, in a highly nervous woman I think we should still adhere to our principles and maintain a proper period of rest after confinement, rather than endanger congestion, uterine displacements, and subinvolution, etc.

Dr. J. C. Sosnowski, Charleston, S. C.:

The Doctor spoke of keeping the patient in bed longer than necessary. About five years ago I delivered a woman one morning, and cautioned her carefully to stay in bed for nine days, that she was supposed to stay in bed according to the teaching I had received. I told her to be very certain not to move for nine days. That afternoon I went back and found that woman up, cooking supper, I said, "Young woman, you are up against my directions, and you will have to take the consequences. If you die you will be responsible for it." But I never had an obstetrical case get along better than she did. In a few weeks I had a similar experience. So from then on I have told them to get up as soon as they want to, unless badly lacerated. I did not know why that woman did not die of hemorrhage or sepsis or something else, if the text books were right. But I figured that the proper position for drainage was the upright posture. If you get a woman with a bad infection of the pelvis and put her at an angle of 45 degrees, you will have her in a position that will drain as well as possible, after delivery the uterus is heavy with its attachments, lax, on the erect position it will fall forward in a normal position which will allow free drainage and not fall backward, lying down on the rectum obstructing the latter. If you allow them to get up the drainage becomes more natural. Since that time I have allowed these cases to get up on the first day if they wanted to, and have had them get up as early as the same afternoon and sit up in a chair, and I have not had any ill effects from it.

In regard to albumen: I think that Doctor Burdell's experience has been that of most of us, that the amount of albumen in the urine is not, by any means, the measure of danger to be expected.

Edgar, in his chapter on the toxaemias of pregnancy, in his book on obstetrics, gives a good picture of the condition that exists: that the chief trouble lies with the liver, and the kidney danger is only a minimum affair in these cases. When convulsions start, the quickest thing I have found to control them has been venesection. I remember cutting into a woman's vein once to stop a series of convulsions that nothing else would control, and when I went through the left median cephalic vein the blood shot across the bed and hit the nurse, standing behind the bed. It shot at

least four or five feet, which showed it must have been under pretty high tension in those veins.

As to the midwife: I am mighty glad Doctor Kollock has stated this thing, because I don't know of anything more disagreeable than sitting up all night and hearing a woman grunt, and many times I have toiled all night with these women and hoped I had caught nothing, because they were so septic or so dirty; and I would prefer having some one else take the chances rather than me..

I substituted for the nitrate of silver, a few years ago, a 20 per cent argyrol solution, finding it less irritating and just as efficacious. Even if Caesar's wife is above suspicion, Caesar never is himself, and that is one of the safest things to prevent ocular sepsis following delivery.

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Dr. B. M. Badger, Dillion, S. C.:

Another thing about this antiseptic dressing of the toilet for the cord: I have almost abandoned the use of the antiseptic powders, because I have had, on one or two occasions, long retention. Not long ago, in one case it was retained fourteen days. Lately I have just been asking the nurse what was her plan, and if there was no objection to it I let her work that part of it, it coming off in four or five days or longer, very much to my relief, that is by anointing it, with pure, good, lard, and while it is not very pleasant—it becomes offensive, but in from one to three, four or five days that cord drops off by antiseptic dressing.

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Dr. W. P. Timmerman, Batesburg, S. C.:

I got the remark from some one that the lying-in woman was lying in bed all the time, on her back, for a week or ten days. I do not know that Doctor Maguire said what position she should be in in bed. I tell them to lie in just such position as is most comfortable to them. Some of the old doctors always apply a band to the parturient woman because of overstretched muscles. It keeps the enlarged uterus from falling from one side to the other, which it does when not supported correctly.

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Dr. G. B. Edwards, Darlington, S. C.:

In regard to the question of lying in bed: It would seem to me that it is one of the most serious questions in regard to obstetrical work. I am a great believer in staying in bed, and the more experience I have the more I think it is the proper thing to do; and my experience has been in examining the woman and finding defects that we have to so frequently send them to the hospital for, just from not taking the proper care of themselves at the time of the births of their children, and I feel like expressing myself in regard to their staying in bed.

I do not like my patients to get up earlier than ten days, and some, I think, should stay longer than that. I think it depends entirely upon the strength and the class of your patient, how long they ought to stay in bed. I do not believe some of the working classes of people should stay as long as two weeks, because they have greater vitality and greater resisting powers.

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Dr. W. J. Burdell, Lugoff, S. C.:

In regard to keeping the women in bed: I hope the Association did not understand that I advocated letting the woman get up on the third or fourth day, and let her be about her usual work, not at all. I do confine her to bed lying flat, lying on her back. I did not say I thought that necessary. I said I would let her get up to stool on the third day. I encourage her staying in bed, but let her get up for stools and the calls of nature, and I let them turn about in bed, so that they are comfortable.

I know that the uterus is large and heavy and I think as Doctor Sosnowski said, unless I am mistaken in the anatomy of the pelvic organs, that you are more apt to cause a retroversion certainly by making the woman stay on her back. It seems to me the pressure of the abdomen always would press it right back, while, if you get the woman up, the normal position is almost horizontal, and the intra abdominal pressure on the fundus of the uterus holds it in that position. If the woman gets up and walks, of course, with lacerations, it is different, we have got to modify these cases. I have had some awful lacerations, but other cases not lacerated.

Another point: a binder for the woman. I do not put that binder on so much for the effect on the figure of the woman, as to help to hold up the relaxed abdominal muscles, but I think it has its effect principally on the sacro iliac joints. I think the majority of the backache in women is not attributable to uterine displacements and other uterine disorders, but due to the fact that those sacro iliac joints have not been properly supported, when relaxed from

pregnancy. I think that is one of the most common causes of backache in women. With the modern woven wire mattress there is an awful strain on the sacro iliac joints on anybody where they sag down in the middle, and I think the binder will help as to that.

As to the cord dressing, my experience has been (and this based on, I think, my last case that I have notes for is something over 400 cases of obstetrics) that the average for the time of coming off of the cord, left alone, or with castor oil and bismuth, is about eight days. Take a piece of old-fashioned flannel and singe the nap with a match and put that on, especially if you are in the country; but the dressing with the salicylic acid and talcum powder—that seems to have adesicating effect on the cord. I cut a square of gauze—cut a hole in it, so that the gauze fits closely about the base of the cord, then put the salicylic powder on it. I do not change that dressing until the cord comes off. That baby is given a sponge bath every day, but the nurse is instructed to let that cord alone.

Another thing I preach against is a new-fangled binder, they use for the babies, I prefer a straight plain piece of muslin pinned with three pins. Answering Doctor Stiles' question as to the percentage of women of South Carolina having doctors attending them in labor, I do not think, just from my experience in small towns and country districts, and in larger towns, while I was a student, I would say not over 25 to 35 per cent have doctors. I believe over 50 per cent by all means are attended by the most ignorant kind of midwives.

As to the method of inflation of the babies' lungs, I have used that method. I have taken the tube and I have put my lips to the baby's mouth and blown into its mouth. I think that causes a reflex of air in the back of the throat. I have used the tube and inflated the child's stomach beautifully, too, and I have quit that method. It might rupture those little air vesicles in the lungs. I do not like to use that air inflation method. I think we can get satisfactory results another way. I have used them all, and if I could not do one thing I would do another. I have used the 2 per cent silver nitrate solution. I have had a little irritation but no trouble with the babies that seemed to amount to much.

One other point: We some times, in obstetrics, run across a case of retained placenta. I don't know why it is, but that is getting to be very common in my section of the country, and I think there is too great a tendency to put the hand up into the uterus and get it out. I think that is all right in many cases where you have got things reasonably clean and have got a glove. I would lots rather use the pressure method above and sometimes I let my patients—a certain class of them—use a very effective remedy of letting the mother blow into the mouth of a bottle. It works fine.