THE AMERICAN

JOURNAL OF OBSTETRICS

AND

DISEASES OF WOMEN AND CHILDREN.

VOL. LXXVII. JANUARY, 1918. NO. 1

ORIGINAL COMMUNICATIONS.

CAN THE FREQUENCY OF SOME OBSTETRICAL OPERATIONS BE DIMINISHED?*

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On February 15, 1897, over twenty years ago, I began my connection with the Sloane Hospital for Women, then the Sloane Maternity Hospital. At that time women had no advice during their pregnancies, little skill in the management of their labors, and practically no care during their puerperium.

Some of the medical students saw a few cases delivered during their medical-school days, while all were totally unfit to practice obstetrics after their graduation. Of course, there were a few competent physicians to deliver women, but the rank and file were an ignorant lot, while such a man as a surgical obstetrician did not exist. The development of such men was in progress but along lines quite different from the modern ideas of to-day.

The instrument relied upon then to terminate dystocia was the forceps. Another operation frequently employed to help one out of a difficulty was a version. Physicians had to be skilful at both of these operations for a successful outcome, because in the hands of bunglers a tremendous amount of harm could be done.

Before 1897 a Cesarean section had been attempted but once in the history of the Hospital since its foundation in 1888, and that resulted in failure. High forceps operations, versions, and

* Read at a meeting of the Society of the Alumni of the Sloane Hospital for Women, October 26, 1917.

craniotomies, however, were frequent, while the complications of pregnancy, such as the various toxemias and eclampsia, abnormal presentations, difficult and prolonged labors, were of daily occurrence.

To-day there is a great change manifest. The forceps, though still our sheet anchor in most of the delayed cases, has been supplanted in the very difficult ones by the knife. Cesarean section is now an ordinary recognized procedure with definite indications. The obstetrician must be a skilled surgeon, prepared for any major abdominal work. He is often called upon to remove a fibroid, an ovarian or a dermoid cyst, complications of pregnancy and labor, but more than all he must be able to deal with a ruptured uterus, removing that organ if necessary.

To-day a high forceps is dreaded and a version avoided, because the outcome of both these operations is so uncertain. Craniotomies are only done as a last resort, while the complications of pregnancy, such as eclampsia, are now much rarer.

What are the reasons for all this progress?

(1) Women appreciate that pregnancy and labor are often far from physiological processes and seek advice early.

(2) Medical students and practitioners, even midwives, are better trained and know more frequently what to do in an emergency. They also know when they have reached the limit of their knowledge and resources and when to call in skilled assistance.

(3) More women are delivered in hospitals, where every weapon is at hand to combat any expected or unexpected complication.

(4) More physicians specialize in obstetrics.

However, with all our advances, there is still too much indifference, ignorance and bungling work among the rank and file of the medical profession who practise obstetrics. Even specialists in this branch are guilty of too many mistakes and errors in judgment.

Can anything be done during pregnancy to prevent complications? Can anything be done during pregnancy and during labor to render the delivery of a patient less difficult and dangerous?

Certainly—preventive obstetrics is the first aim of any man doing this work. There is no doubt that with proper care during pregnancy and with proper care during labor many of the dangerous complications and many of the difficult and uncertain obstetrical operations can be avoided.

The greatest advance has been in the prevention and management of the toxemias of pregnancy. As the climax of this dreadful complication is eclampsia and, as eclampsia demands many major operations in delivery, so one can easily see that if this terrible

symptom can be prevented the number of such major operations can be lessened.

How can eclampsia be prevented? By a careful diet; by a continued stimulation of all the organs of excretion—the bowels, the skin, the liver, the kidneys—not forgetting some of the ductless glands, especially the thyroid—and remembering that this toxemia is a complex condition; by finding out at once the cause of symptoms such as persistent nausea and vomiting, headaches, specks before the eyes, dimness of vision, restlessness, nervousness, sleeplessness, or any edema; by noting any rise in blood pressure; and finally by regular, frequent, and thorough examinations of the urine. This examination should be made early in pregnancy, every three weeks until the sixth month, every two weeks thereafter until the ninth month, and then every week. The urine should be examined for albumin, sugar, acetone, diacetic acid, indican, urea, and in certain cases a nitrogen partition should be made. Traces of albumin should never be overlooked. If once the faintest trace is found one should make a daily examination.

The physician should be responsible and should see that the specimen be in on time. I am often surprised by the carelessness in this respect even of some of our well-known specialists. A friend of mine stopped in to see me the other day because of daily vomiting attacks. I had already sent her to one of our best obstetricians. On questioning her I found that he had not asked for her urine and she was then over six months' pregnant!

It is not unusual to hear of a woman dying of eclampsia in the hands of a good practitioner—even a specialist in obstetrics. Their complaint has been that the patient was slack in sending in her specimens. This, I believe, is a poor excuse. It is the obstetrician's business to attend to this matter, for if the urine has not been sent in on schedule he can always get it after writing a letter or, more quickly, after a reminder by telephone. Of course, fulminating cases of eclampsia will develop without any one's fault, but most of them have the premonitory symptoms mentioned. This means that mild symptoms of any kind should not be disregarded, and if symptoms increase in severity notwithstanding treatment the uterus should be emptied long before the patient's condition becomes alarming. Following out, then, this line of treatment, the greatest toxic symptom of pregnancy—a convulsion, with its high mortality (both fetal and maternal)—will rarely occur.

In these twenty years, among my own private cases I have had only one antepartum case of eclampsia. This patient lived in

the Bronx. Her specimen was several days overdue and I could not obtain it. She also disregarded the grave symptoms of splitting headache, repeated vomiting, and edema. I was notified only after she had had two convulsions. I had her removed to a sanitarium, and although the baby was lost through prematurity I managed to pull her through by stimulating her elimination and by as prompt an evacuation of the uterus as possible.

At the Sloane Hospital in the past years the number of eclampsia cases have diminished. From January 1, 1901, to December 31, 1905, inclusive, we had 113 cases of eclampsia in 7145 deliveries, or 1.5 per cent. From January 1, 1911, to December 31, 1915, we had seventy-four cases in 9224 deliveries, 0.8 per cent. These statistics show, I think, that more patients consult their physicians early in pregnancy, and that the patients as a whole get better care during their pregnancies than formerly.

Can abnormal presentations be corrected by external manipulations, thereby preventing difficult deliveries? Often with ease.

How much trouble can be avoided by changing a transverse position to vertex? This can be done in the last month of pregnancy. To make the position permanent a properly applied abdominal binder is necessary. Also, many breech cases can be turned even within a day or so of labor. In my first 200 cases (1900–1902) I delivered ten breech cases, while in my last 200 cases I delivered only six of this presentation (1916 to date, Apr. 1, 1917).

This procedure of changing a breech presentation is sometimes impossible, however, in a primipara where the legs are extended—a frank breech. A scant amount of liquor amnii also makes the operation difficult.

Not long ago, one of our well-known New York physicians had a young primipara, as a patient. He did not discover that the child was presenting by the breech until a few days before term. Not relishing the idea of delivering the woman with this complication he immediately asked me to do the work for him. The next day I went down to see her and, under chloroform, corrected the abnormality. A few days later the patient delivered herself easily after about four hours of pain. I have probably turned 75 per cent. of my breech cases in this way.

Another possibility—of changing a brow or a face case to a vertex early in labor—is often forgotten. How much trouble can be avoided by such a procedure is appreciated only when one tries to deliver a brow or a mentoposterior position as such.

The same problem, in a way, presents itself in an occipitoposte-

rior position which promises to remain persistent. Before the head becomes wedged in this unfavorable position, a manual rotation anteriorly can be accomplished frequently, after which the head may be born spontaneously or at most delivered by an easy forceps.

Should the father and the mother be allowed to boast of unusually large children? I have not delivered a 10-pound baby in private practice for some years. In other words, does a large child with a large, hard head—overgrown and oversize—cause dystocia? At the hospital and in consultation outside I have had almost as much trouble—high forceps and craniotomies—with such cases as in cases where there has been a real pelvic deformity. It has not been unusual for a patient to be admitted to the Sloane Hospital more or less *in extremis* after failure of repeated attempts to deliver her of her seventh, eighth, or even twelfth child by forceps. This dystocia was due to too large children. I remember being called to such a case down on the lower West Side where all the physician in attendance had accomplished was to pull off the baby's head.

Can, then, the size of the baby be limited before its birth? I believe so. After the sixth month the amount of carbohydrates in the woman's diet should be cut down. This I advise as a regular rule. Some patients will obey and others will not. I try to persuade them that a 6- or 7-pound baby is born most easily and does best after it gets into the world.

The following two cases show what diet can do in this respect:

CASE I.—Mrs. R., first came to me in 1910, a thirty-two-year-old primipara. She was a short, stocky Jewess with a pelvis of a masculine type. The external measurements were good—26 cm., 28 cm., 23 cm., 23 cm., 22 cm.—but the cavity of the pelvis was funnel-shaped, narrowed somewhat at the outlet. Her menstruation occurred irregularly at intervals of three to seven months. With no early nausea, she did not suspect that she was pregnant until she felt life and noticed some abdominal enlargement. I delivered her in her first labor after sixteen hours of hard pains by a moderately difficult medium forceps. The baby, a girl, was moderately asphyxiated, but was resuscitated and did well. It weighed 7 pounds. The head was well moulded, showing a tight fit. She did not conceive again until three years later. She came to see me January 31, 1914. Although her last period was July 29th, six months past, the uterus was only about four months in size. Consequently I estimated her date of confinement roughly for June 15th. It was hard to get her to call to see me. May 10th the baby's size seemed to be normal. She did not call again until June 6th. In the meantime the child had grown considerably. The head was lying R. O. A., dipping into the brim. Fearing trouble, I ordered castor oil, oz. i, and quinine, gr. x, that night at eleven o'clock. Pains began soon

after the dose at 1.30 A. M.; 3.30 A. M. they were very strong and at 4.45 A. M. bearing down and very frequent. At 6.10 A. M. she was begging for relief. The head was R. O. A. at midpelvis. Forceps were applied and the head was delivered without difficulty at 6.41 A. M. The shoulders, however, refused to budge. It was impossible to deliver them in the ordinary way. Finally, after thirty minutes or more with the patient bearing down, with an assistant pressing on the fundus, while I was pulling for all I was worth, the shoulders entered the pelvis and were born. The baby's heart beat slowly for twenty minutes and it took a few gasps. It was a girl—weighing 9 pounds 15 ounces—very fat and broad through the shoulders.

The patient came to see me again for her third confinement, on September 20, 1915—seven months nearly in size. I suggested a Cesarean section but the operation was refused. I immediately put her on a proteid diet, almost to starvation, and advised her to walk two to four miles daily. I did not advise induction of labor as the cervix was long, high and closed, and the baby seemed smaller. Nov. 15th was her approximate date, and at 11.00 P. M. I ordered oil and quinine again. November 16th, the next day, at 9.00 A. M. the pains started but were weak until 2.45 P. M. At 3.15 P. M. they were strong and bearing down—a baby weighing 6 pounds 11 ounces was born spontaneously at 4.47 P. M. He did finely. This child was over 3 pounds less than the one which died. Last July I delivered this patient again three days ahead of the estimated date of her confinement, without difficulty, of a baby weighing 7 pounds 6 ounces. This labor was started by a dose of castor oil and quinine.

CASE II.—Mrs. D., a second gravida, twenty-four years old. The patient had lost her first child, weighing 9 pounds, after a difficult high forceps by another doctor. She came to me February 2, 1915, six months pregnant. Her pelvic measurements were 23 cm., 26 cm., 22 cm., 22 cm., 20 cm.—another pelvis of the masculine type. She was put on a proteid diet. She was also advised to wear a tight corset and to take long walks later on in her pregnancy.

October 25th, two weeks ahead of time, as the head was riding high, as the baby seemed large for her and, as the cervix had dilated somewhat, I decided to induce labor, so at 9.15 P. M. I inserted a No. 2 modified Champetier deRibes' balloon. The pains began irregularly during the night but were not strong until 12.30 P. M. At 2.15 P. M. the membranes ruptured. At 3.10 P. M. a boy, 5 pounds, 11 ounces, strong and husky, was born, weighing over 3 pounds less than her first baby. It did well. Of course, in this case the size of the baby was reduced also by shortening the pregnancy by two weeks.

There are two other measures which may make labor more easy: 1. Long walks during pregnancy. The idle and pampered hate to walk with a motor at their command. These patients lead a hothouse life. No wonder that their babies grow large, and ride high above the pelvic brim! No wonder their muscles are flabby and

when labor comes on inertia and fatigue result. With exercise, red blood, good muscular tone and endurance for the supreme test of labor, all contribute toward a more easy and successful outcome.

2. A snug-fitting corset worn during pregnancy. This support should be comfortable. By its use not only is the patient's appearance more presentable, but also being properly applied it drives the head into the brim more early in pregnancy. In this way, molding of the head is accomplished long before labor begins. What happens without this support, especially in short-waisted women? The woman looks enormous, the belly is pendulous, the head is pulled away from the axis of the brim, and often abnormal presentations result. I remember a case at the Hospital where forceps could not be applied to the head by the physician outside because of a pendulous belly in a woman weighing between 250 and 300 pounds. It looked ridiculous to see an assistant sitting on the fundus to get the head in the axis of the brim while I applied forceps from below. However, by this procedure the head was easily grasped and delivered.

All these measures should be adopted in ordinary cases with normal pelves. How much more so should we take advantage of them where the pelvis is contracted. Fortunately, small pelves are not very common in general practice. When they do occur the problem which confronts us is to estimate the relation between the child's head and the pelvis. This is far from easy. Mistakes are often made by the best obstetricians. The external measurements do not give us the whole situation. The thickness of the bones, the prominence of the sacral promontory, the axis of the plane of the inlet to the axis of the force exerted, the shape and amount of room in the pelvic cavity, the width of the pelvic outlet, the mobility of the coccyx on the sacrum, must be considered. Whether there is room enough in a given pelvis for the passage of a child is often a matter of judgment of the individual operator. There are some methods by which this is arrived at, but his long experience is of great value. Also the presentation of the child, the position of the head, its flexion, its hardness, where it lies in relation to the pelvic canal, are important points for a decision. Besides, the consistency of the cervix and the possible strength of the uterine contractions are factors of the utmost significance. To solve, then, what must be done in a given case is most difficult.

When the baby is very large, riding high above the pelvic brim, or where the pelvis is very small, the problem is simple, for one can decide on a Cesarean at once. In other cases, an induction of labor, never earlier than two weeks before term, in suitable cases

gives very satisfactory results. These are our only elective operations. The others employed are of necessity with uncertain results.

If we wait for a test of labor in a doubtful border-line case, nature often helps us out by a spontaneous delivery or by advancing the head far enough so that we can do a successful forceps operation.

Lack of progress in labor with the head high above the pelvic brim in the presence of a disproportion may make us decide for an abdominal delivery. However, we must not be too radical and recommend a Cesarean section just because the head is high, because then we will often open the abdomen unnecessarily. Late cases in which there have been many examinations and much manipulation increase many times the risk of Cesarean section, and often having once committed ourselves to the vaginal route the abdominal section may be contraindicated on account of its high maternal morbidity and mortality from sepsis.

Many articles have been written showing the powerful action of pituitrin in labor. To-day we are not so enthusiastic over this drug and have narrowed its indications to simple inertia without obstruction. There are, then, four cardinal conditions to remember before employing pituitrin: 1. The cervix must be completely dilated and effaced. 2. The membranes must be ruptured. 3. The presentation must be normal. 4. There must be a proper relation between the fetal head and the maternal pelvis throughout. Given in such cases, the drug can be used without risk, is a powerful adjuvant to labor, and will often obviate the necessity of an instrumental delivery, which is the aim of all obstetricians.

The furor about Twilight Sleep has almost died out. The notoriety of this method of allaying pain in labor, however, has brought forth the demand generally among the laity for something to control the suffering necessary for the birth of a child. Gas alone, or gas with oxygen, has been used for a year or so with varied results. This anesthesia can be used earlier in labor, in the first stage even, or at any time when the patient wants relief. Although gas is far from being a perfect anesthetic, some of the patients are greatly benefited by its use. In some, the strength of the uterine contractions is increased, while in others the relief from pain gives the patient the necessary courage to strain and to bear down during the second stage—so much so that often we are spared the necessity of applying the forceps to terminate labor. I can mention only two drawbacks to gas inhalation besides the nuisance of a prolonged administration, from which the obstetrician only suffers.

1. There is often great difficulty in controlling the advance of the

head over the perineum. This rapid advance will require a change to chloroform or ether. 2. There is an increased tendency to postpartum hemorrhage. I have had much more worry since the use of gas in this respect and have had to pack more uteri.

Nothing pleases me more in my obstetrical work than to have a baby born a week or two ahead of time, especially in a primipara, because it means usually a quick, simple labor. Any baby weighing 6 to 7 pounds is plenty large enough, and getting into the world easily, in my experience it does better than a larger child dragged out by a difficult forceps operation. Consequently it is not unusual for me to try to "shake the apple off the tree" ahead of time by castor oil and quinine. It is remarkable how often this dosage is effectual. Occasionally, as mentioned before, when the disproportion between the baby and the pelvis is slight but when one scents trouble, I start labor ahead of time or at term by means of a modified Champetier deRibes balloon.

In multipara, who have had a previous difficult labor, or who have lost a baby in a previous confinement, without marked pelvic contraction, it is my custom to insert a bag one to two weeks before term with almost invariably good results. Last year I induced twenty-four cases in this way without any fetal or maternal mortality. All patients, however, cannot be managed in this way. The cervical condition must be favorable. If the cervix is rigid and if there is present a possible uterine inertia, the whole process is slow and painful, the outcome is uncertain, and there is more risk of infection.

I have compiled some statistics to show the recent changes in obstetrical procedures:

1. In the Sloane Hospital for Women, from 1901 to 1905 inclusive, there were 7145 cases. During this period labor was induced for various indications 284 times or 3.9 per cent. From 1911 to 1915 inclusive there were 9224 cases. Labor was induced 302 times or 3.3 per cent. During the first period there were 558 low forceps operations or 7 per cent. During the second period, 380 low forceps operations or 4 per cent. Medium forceps operations increased; 176 to 449, or 2 per cent. to 4.5 per cent. High forceps operations, 81 to 138, an increase from 2 per cent. to 4.5 per cent. This is surprising.

Versions diminished, 299 or 4 per cent. to 272 or 3 per cent. There has not been an elective version done in the hospital for the last three years and possibly longer.

Craniotomies have diminished, 33 or 0.3 per cent. to 18 or 0.2 per cent.

The last symphysiotomy was done in 1902; the last pubiotomy in 1908.

From 1901 to 1905, 38 Cesarean sections were done, or 0.53 per cent. From 1911 to 1915 there were 133 cases, 67 primary, 70 secondary, or 1.65 per cent. Last year 32 Cesarean operations were performed. The greatest number for one week was 4, and for one day 3 such operations.

Humpstone reports 148 abdominal hysterotomies in 6493 deliveries at the Methodist Episcopal and Jewish Hospitals of Brooklyn, or 2.3 per cent.

2. From private practice. In my first 200 cases, I induced labor 29 times, or 14.5 per cent., losing no mothers and only one child at birth. This fetus was born dead in a case of threatened eclampsia after basiotripsy. It was very premature and nonviable. Two babies, both premature, subsequently died—one in a case of accidental hemorrhage, and the other, a second twin.

Indications.—Contracted pelvis, 12; chronic endocarditis, 2; prolonged gestation, 7; (six had lost their previous babies at birth); accidental hemorrhage, 1; toxemia and threatened eclampsia, 2; previous difficult labors or stillbirths, 5. Total, 29.

Terminations.—Seventeen cases terminated spontaneously; 4 cases terminated by high forceps; 5 cases terminated by medium forceps; 2 cases terminated by low forceps; 1 case terminated by basiotripsy on a nonviable infant in threatened eclampsia.

In my last 200 cases, I have induced labor 41 times, or 20.5 per cent. for various indications—contracted pelvis, large babies, prolonged gestation, previous stillbirths or difficult births, toxemia of pregnancy and threatened eclampsia, and accidental hemorrhage. There was one fetal death—a nonviable child in a case of accidental hemorrhage.

In my first 200 cases I delivered 10 breech cases as such, and in my last 200 cases only 6.

In my first 200 cases I did 29 low forceps, without fetal or maternal mortality, to 15 in my last 200 cases, with no fetal death. I regret to say that in the latter series a mother died suddenly without warning from a pulmonary embolus on the 15th day while sitting up in a chair.

In my first 200 cases I did 24 medium forceps, losing one child, born with the cord twice about the neck. One child died later—atelectatic. In my last 200 cases I did only 8 medium forceps. All the children did well.

In my first 200 cases I did 15 high forceps—one baby was stillborn

and one died later. Both were lost after prolonged labor and hard traction. The mothers all recovered. In my last 200 cases I did only 4 high forceps. All the mothers recovered. One baby lived ten hours and then died in convulsions. To-day patients do not expect to lose their babies, and when such an unfortunate event happens friends immediately ask who was the obstetrician and why did he not do something else, for instance a Cesarean section.

I will present the problem of this case to the Society because we sometimes learn more from our failures than from our successes.

Mrs. B., a primipara, thirty-six years old. Dr. McCosh removed her appendix in 1906. Dr. Phinney took out gall-stones and broke up adhesions about the colon in 1910. Since then she has suffered from abdominal pain, gas and constipation. "Having tried many physicians without much relief," she had been in the hands of an osteopath for two or three years.

During her pregnancy she had more or less abdominal pain and discomfort, would not take laxatives, and said she could not walk. The pelvic measurements were normal—24 cm., 28 cm., 22 cm., 22 cm., 20 cm. Until the last part of her eighth month, the child was lying as a breech, when I turned it to a vertex. After this the head remained L. O. A., but high until labor began. Four or five days before term, oil and quinine were given to start labor without success. When five days overdue pains began during the night but were infrequent. These pains continued all day but were only at half-hour intervals. At 10.00 P. M. the pains were stronger, every five minutes. As she was very tired, I ordered chloral and codeine, and she dozed between the pains. 9.00 A. M. the next morning the cervix admitted two fingers only and was still very firm. I believed that the cervix had held the head up as it had been long. The baby did not seem especially large so I decided to insert a No. 3 bag. The pains soon became strong. The bag came through at 2.00 P. M. The cervix then admitted five fingers. At 2.30 P. M. the membranes ruptured and the head settled somewhat into the brim. The pains were then frequent and less strong but the patient stood them badly as she was very tired. At 4.45 P. M. gas was started as she demanded some relief. The pains continued off and on with little if any advance. At 8.30 P. M. the patient was completely tired out and exhausted. I knew that the delivery through the natural passages would be difficult and the outcome, so far as the child was concerned, would be uncertain, but was afraid to recommend and perform a Cesarean section—the other alternative—knowing the high maternal mortality in these late cases, especially as a mother had been lost from sepsis two or three weeks previously under similar conditions at the hospital.

After conferring with the husband, I decided not to take the risk of the abdominal operation but to do a high forceps instead. After dilating manually the cervix as far as possible, I applied

the blades. Hard tractions were necessary to complete the dilatation of the cervix, mold the head, and deliver it. The baby's heart remained good throughout. The operation consumed one hour and fifteen minutes. The baby, weighing 8 pounds 5 ounces, was badly marked and deeply asphyxiated. In addition, the cord had been tight about the neck. After an hour's work of resuscitation, it breathed fairly well. Eight hours later it began to have convulsions, and after two hours more died, probably from cerebral hemorrhage. No autopsy was allowed. The cervix was somewhat torn. The mother did well, without temperature, for fourteen days and then developed a mild popliteal phlebitis.

I believe that if this patient had had good pains and a less rigid cervix the result would have been otherwise. I made a mistake in underestimating the size of the child. By abdominal examination it did not seem over 7 pounds. The head was hard and difficult to mold. These two facts added to my troubles. I believe that the patient can have a second child through the natural passages without much difficulty—an elective Cesarean section, however, must be considered.

In my first 200 cases, I performed four versions, losing one child—a transverse presentation with a prolapsed cord, seen late in labor in consultation.

In my last 200 cases, I have done only three partial podalic versions, *i.e.*, pulling down a foot in a frank breech. In my first 200 cases, I performed two craniotomies. These were cases seen in consultation where attempts to deliver by forceps before my arrival had failed and the children were already dead. I have done no such operation in my last 200 cases.

In my first 200 cases, I did two accouchement forcé operations—one for placenta previa and one for eclampsia (the latter a consultation case). I have not done one such operation in my last 200 cases.

In my first 200 cases, I did not perform a single Cesarean section. In my last 200 cases, I did three—all were successful. In one I had done a previous Cesarean for a large child in a woman with a justominor pelvis. Another had had a previous Cesarean in Morristown, N. J., after a prolonged labor and had nearly died from puerperal sepsis.

The indication for the third case was unusual.

Mrs. N. came to me in 1910 when thirty-eight years old for her first baby. The fetus died without apparent reason at about four months' gestation. I emptied the uterus between the fifth and

sixth month. Examination of the fetus and placenta, as well as a Wassermann test, proved negative.

She conceived soon again, went to term, and was delivered August 10, 1911, of a fine healthy boy, weighing 7 pounds 5 ounces, after a rather difficult high forceps. The child was asphyxiated but reacted. To-day he is a wonderful specimen in every way.

She conceived again in seven months, went between four and five months, when I emptied her uterus of a fibrous ovum, only two and one-half months in size. This occurred May 17, 1912. After the operation the patient began to be more or less depressed, still wishing for another child.

She conceived again after a two years' interval. The fetus grew nicely till the eighth month and then died without apparent cause. May 13, 1915, a macerated fetus was born.

After this disappointment her mental condition became quite alarming at times.

By accident during the following summer, she conceived again for the fifth time, when forty-four years old. During this pregnancy her management was about the same. Notwithstanding the negative Wassermann previously she had some iodide, which she could not tolerate. During this pregnancy she had a little protiodide which she could not take for more than a few days at a time.

The child grew nicely and the fetal heart remained strong until May 3, 1916, when the beat seemed more distant and muffled. In view of the patient's past history, I considered that now was the time to act. She was within three weeks of term, the child was large, and it must be born alive to restore the mother's mental balance. To anticipate antepartum fetal death, I decided upon a Cesarean. A consultant and the family physician agreed with this decision and on May 5th the operation was done. A baby weighing 8 pounds and 5 ounces was extracted. The mother did finely. The baby, however, was jaundiced and languid and even on breast milk gained very slowly. After a bad summer he is now doing well, nine months old.

In Conclusion.—I have endeavored to show how many uncertain obstetrical operations can be avoided by ordinary measures during pregnancy and labor.

The statistics show that forceps operations, especially high forceps, are diminishing in frequency, that elective versions, symphysiotomies and pubiotomies are more or less obsolete, and that craniotomies are only performed as a last resort on dead, injured, or nonviable babies.

Finally, these statistics show that induction of labor and Cesarean sections are very frequently done nowadays, and are sane and safe operations under recognized indications. A warning, however, must be proclaimed against the radicalism of many obstetricians who perform the abdominal operation too often as an easy way out of *any* obstetrical difficulty.