THE LANCET.

VOL. II.] LONDON, SATURDAY, MAY 17. [1827-8.

LECTURES

ON THE

THEORY AND PRACTICE OF MIDWIFERY,

DELIVERED AT GUY'S HOSPITAL BY

DR. BLUNDELL.

LECTUR XXVIII.

Of the means of superseding the Cæsarian Operation.

THE Cæsarian incisions, it seems, from the remarks of a former lecture, are attended with much danger, and hence it has been asked, whether we have not the means of superseding it? May not an operation, so formidable in its nature, be rendered altogether unnecessary by measures of a different kind?

If the pelvis be contracted in so high a degree, that parturition, by the natural passages, is impossible, I need scarcely tell you, that the shortest way to avoid the necessity of the operation, would be by abstinence altogether from intercourse with the other sex. The most solid resolution, however, may sometimes thaw; and when a woman is married, she may be placed under those circumstances, in which it is not very easy to adhere to this advice; her life perhaps falling a sacrifice to her neglect. My friend Dr. Hull, of Manchester, once transmitted me the case of a woman whose pelvis was contracted in a high degree; she knew her situation, remained in a state of abstinence for many years, but afterwards became pregnant, and died. Now is there any other mode in which, when the obstruction of the pelvis is insuperable, the formation of a fœtus may be prevented? In my opinion there is: for if a woman were in that condition, in which delivery could not take place by the natural passage, provided she distrusted the circumstances in which she was placed, I would advise an incision of an inch in length in the linea alba above the symphysis pubis; I would advise further, that the fallopian tube on either side should be drawn up to this aperture; and, lastly, I would advise, that a portion of the tube should be removed, an operation easily performed, when the woman would, for ever afterward, be sterile. All this, after due consideration, circumstances not forbidding. But the abdominal incision—that is bad. True; but the Cæsarian incision, that is worse. Is not that true also. Again.

If a woman, in the earlier months of pregnancy, is known to have a pelvis contracted in a high degree; is there nothing which you may then do to prevent an ultimate need of the Cæsarian operation? Why, yes; abortive medicines might, in this case, be thought of; or these failing or rejected, if you could feel the os uteri, you might introduce a female sound, or any other instrument of that kind; and passing this sound into the uterine cavity, you might completely break up the structure of the ovum, so as to prevent the progress of generation. In doing this, there would always be a risk of hæmorrhage; but where you are endeavouring to avoid the necessity of the Cæsarian incisions, this risk would be justifiable. The substitution of the smaller evil for the greater, is frequently the principle of the healing art. But what, if the os uteri be inaccessible, is there, in such case, any other expedient to which we may have recourse? In a case like this, were my opinion consulted, I should incline to reply—as a substitute for the Cæsarian operation, let an incision be made as before above the symphysis pubis, then let some small instrument, a trocar or canula, be carried into the cavity of the uterus; let this instrument be sufficiently stiff to enter the cavity, and retain its form there under pressure; and then, let it be resolutely moved about in the uterus, so as to break up completely the texture of the ovum. The whole instrument need not be much thicker than a bell-wire; the process is allied to that of acupuncture: the point of the trocar, on entering the uterus, should be withdrawn within the canula; a finger should be carefully placed on the uterus, so as to guide

the instrument, and guard against injury of the intestines or the bladder. Scribblers had better content themselves with sneering at the operation—surgeons had better perform it—artem quisque suam. To produce future sterility, the tubes might be rendered impervious.

But suppose the gestation has reached the end of nine months, is there then nothing which may then be done, to supersede the Cæsarian operation? Why, if the patient can be delivered by having recourse to perforation, by all means this should be adopted. Observe, it is a rule—an axiom in British midwifery, that we are never to deliver by the Cæsarian operation, provided we may, in any way, deliver by the natural passages. Difficult and dangerous as the delivery is, in some cases, when effected by the natural passages, I feel persuaded that women might sometimes be more safely and more easily delivered by the Cæsarian incisions, than by the passages of the pelvis; but if, acting on this persuasion, we were once to establish the principle, that the Cæsarian delivery may be used as a substitute for delivery by the perforator, there would, I fear, be too many cases in which it would be needlessly adopted, and men would now and then, not to say frequently, perform this operation under circumstances in which it ought never to have been dreamed of. Where, therefore, the embryotomic delivery is practicable, let this be preferred. But then, you may reasonably ask here, how are we, in any case, to decide clinically—at the bed-side I mean, whether the delivery be practicable or not? To this query I wish it were in my power to return a satisfactory reply. Much must depend on the dexterity, and other qualities, of the operator; for one man may be able to succeed in the delivery, when another may not. Much again must depend upon the instruments which we employ; to the operative midwifery of Dr. Davis, I must refer you for an exposition of these different contrivances, together with a description of his own inventions and improvements. Much must depend, too, upon the size of the aperture; and it seems, from the researches of Hull and Burns, that the smallest aperture through which a full grown fœtus may be abstracted by the embryotomic operations, under circumstances the most advantageous, must be, at least, three inches in its length, and an inch and three quarters in its breadth. To justify embryotomy, therefore, there must be a clear passage through the pelvis, of these diameters at the least. From the consideration of all these particulars must emanate the determination, whether you will, or not, embryotomize. Before you come to a decision, procure the best advice within reach. With these suggestions, I must commit you to the waters; I wish the compass were less perplexing in its indical tions. Happily, these difficulties are rare.

Section of the Symphysis Pubis.—Laborious Labours.

With a view of enlarging the capacity of the pelvis, in cases of labour more or less laborious, it has been proposed to make a division of the symphysis pubis, an operation which is easily performed. In executing this operation, the surgeon or accoucheur cuts down upon the joint, and carries the scalpel between the extremities of the ossa innominata, so as completely to detach from each other, taking care that no injury be inflicted upon the urethra or bladder.

The simple division of the symphysis pubis, however, enlarges the pelvis but little; and, therefore, in order to secure the full benefit of the operation, it is proposed further, that the surgeon should separate the ossa innominata from each other, to the extent of one, two, perhaps I may say of three or four inches. It seems to be ascertained pretty clearly, by observation made on the Continent, that in the mere division of the symphysis, pain, not very intense, and no incurable injuries of the part are to be expected; but if the joint be not merely divided, but if, moreover, the bones be separated from each other to the extent of two or three inches, then in consequence of the injury done to the sacro iliac synchondrosis, and the lesion of the sciatic nerves, and the straining of the softer viscera, which are connected with the pelvis, the operation becomes one of considerable pain, and is, perhaps, scarcely less dangerous than the Cæsarian incisions themselves, even in the present condition of that mode of delivery.

The section of the symphysis pubis was proposed originally as a substitute for the use of the perforator and the Cæsarian operations. There seems, however, to be no reasonable doubt, that as a substitute for the Cæsarian incisions, this operation is exceedingly inadequate; for the pelvis, being distorted in a high degree, if you were not merely to divide the symphysis pubis, but to separate the bones to the extent of two or three inches from each other, you would have a great deal of difficulty in getting away the child; very probably you would be compelled to lay open the head, and at the same time you would inflict great injury on the pelvis, and the softer parts generally, more especially the bladder, so that I conceive the operation would be as dangerous and painful to the mother, and far more dangerous to the child, than the Cæsarian delivery itself. Add to this, the difficulty of performing the operation at all under the higher distortion of the pelvis.

But although the operation is not a substitute for the Cæsarian, some may think, that, in many cases, the section of the symphysis might supersede the necessity of the perforator, and this I believe to be true. Generally, where there is a narrowing of the pelvis requiring the use of the tractor forceps or perforator, the contraction lies between the promontory of the sacrum and the symphysis. There is a want of room between the front and back, which a division of the symphysis pubis is calculated in a measure to remove. In common and ordinary contraction of the pelvis, it may then be said, why is not the section of the symphysis pubis substituted for the operation of embryotomy? Why! for this valid reason, because it is an axiom in British midwifery to sacrifice the child to the safety of the mother, and, in these cases, without injury to the parent, the child may be brought away by laying open the head. Remember too, what has been stated already, that in narrowings of the brim, the fœtus may often be saved with little risk to the mother, by the induction of delivery in the seventh or eighth month. On both these accounts, therefore, because we may deliver by the perforator, and because, too, we may altogether supersede the need of this instrument by the indication of premature delivery; the division of the symphysis pubis is unjustifiable as a general practice, when the pelvis is slightly contracted. Not to add to these objections, that if we were to allow of the division of the symphysis, in those cases where there is merely a narrowing of the pelvis between the front and the back, such is the present imperfection of obstetric diagnostics in general, that there would be many cases in which it could be performed, where it was not at all necessary.

One case there is in which I conceive the section of the symphysis pubis might be justifiable, that I mean in which the perpetuation of a dynasty or ..... but it is unnecessary to enter further into this topic.

And thus much, then, respecting laborious delivery in the general; we will now, if you please, proceed to the consideration of the different varieties of laborious parturition, together with those modifications of the general practices which these varieties require.

The laborious labours which are giving rise to the more formidable difficulties during parturition, may be divided into three species or varieties; those labours, I mean, in which the difficulty arises from the rigidity of the softer parts; those in which the difficulty arises from a deficiency of room between the bones, and those in which the difficulty is produced by an unfavourable position of the fœtus, and more especially of the cranium; not to add, that we sometimes meet with cases in which the difficulty may be ascribed from these causes mixed.

And first, then, with respect to the laborious labours resulting from an unfavourable position of the cranium. Where a labour proceeds naturally, the presentation is of the vertex, the face in the beginning of the delivery lying towards the one, and the occiput towards the other side, in the way here demonstrated; but as parturition advances, the head descends, and the face takes place in the hollow of the sacrum, and the occiput under the arch of the pubis, and the sagittal suture lies along the perineum, and thus the head emerges. It is not always, however, that the fœtal head, in passing, assumes these favourable positions; for sometimes when the presentation is vertical, the face is lying forward throughout the labour; and sometimes, instead of a vertex presentation, we have a presentation of the forehead, or of the face; difficulties being in this way produced, as may be seen from the apparatus here exhibited. Thus, then, it appears, that there are three varieties of the laborious labours produced by unfavourable positions of the fœtal head; that, I mean, in which the vertex presenting the face lies forward on the symphysis pubis all through the labour; that variety again in which the face is lying over the centre of the pelvis; and, lastly, that position of the head, not without its difficulties, though less important than the former, in which the presentation, instead of being vertical, is frontal.

When it is found, by examination, that the child's head is lying unfavourably for transmission, an accident, understand, which is by no means very uncommon in its occurrence, the accoucheur begins to consider what steps become proper, in order to facilitate the delivery. Now, there seem to be four different ways in which the difficulty may be alleviated; by turning I mean, by rectification of the position of the head, by the use of instruments, and by the natural efforts. And here I wish you to understand clearly at the outset, that when the child is lying unfavourably, it does not, therefore, necessarily follow, that you must immediately have recourse to artificial means of delivery; for, under presentations of the face or forehead, or in vertical presentations, with the face lying forward on the symphisis pubis, by the mere efforts of the uterus, if the pelvis be large and the head small, the child will not unfrequently be expelled. It sometimes happens, however, that the natural efforts fail us, more especially if the pelvis be contracted or the head be large, and, in such cases, we may be compelled to have recourse to some of those instruments, which I laid before you on a former occasion. The tractor or forceps be-

ing first tried, and these failing, the perforator.

By some it has been observed, that where the child lies unfavourably, it may very readily be brought away by the operation of turning. Now, in some cases, as, for instance, where the pelvis is large and the softer parts are lax, and the hand of the accoucheur is dexterous, so that the feet may be seized without difficulty, the operation of turning might, perhaps, be desirable. I must entreat you, however, to look upon this method of delivery turning as an exception to the general rule; for although now and then, perhaps, the child may be with advantage withdrawn by the feet, when the head lies unfavourably, yet, as a general practice, turning is improper, because it requires the introduction of the hand into the uterus —because that operation should never be performed without there exist an absolute need for it—and because, by the natural efforts, or the use of instruments, abstraction of the child may be very generally accomplished. The more I see of midwifery, the more I feel the necessity of evading the operation of turning; wherever to avoid it is practicable. Speak! you who have witnessed the ruptures of the uterus, is this caution necessary or not?

In some cases, again, where the head is lying unfavourably, its position may be rectified. The pelvis is large, the parts are lax, the hand may be easily introduced, and, with the action of the hand, the position of the head may be altered. Suppose, for example, the child present by the face, you may insinuate the hand into the pelvis without violence, and bring down the vertex. Suppose, again, I make an examination, and, discovering a frontal presentation, I pass my finger over the occiput; by the mere action of the finger, or by the play of the lever, I may, in this manner, rectify the presentation of the cranium. Nevertheless, though this rectification is, in itself, highly desirable, yet, as a general practice in these cases, it is scarcely proper; for it cannot be easily accomplished without carrying the hand along the vagina, and some little way into the uterus, and, in my opinion, the risk of rupture constitutes a valid objection to this method of operation. To an adjustment of the head by the lever I have less objection, and this may be sometimes accomplished as here shown.

Instead of rectifying or turning, therefore, in these cases of unfavourable position, unless circumstances are highly favourable, the more wholesome practice is, either to commit the woman to the natural efforts, or to have recourse to the lever, forceps, or perforator, according to the nature of the emergency.

But here, perhaps, you may ask, how are we to decide whether, in any given case, we ought to resort to the employment of instruments, or to confide in the natural powers of the system. Let me remind you then of the rule which has been already so often prescribed; if the woman have not been in strong labour for four-and-twenty hours, and if no dangerous symptoms are apparent, then you are not to interfere; but if dangerous symptoms are manifesting themselves, referable to the prolongation of the delivery, or, if the woman have been in strong labour for four-and-twenty hours, the head making little or no progress, then the embryospastic instruments become justifiable. Further, if the embryospastic instruments have been fairly tried without success, and if dangerous symptoms are manifest, or if the woman have been in labour for six-and-thirty or eight-and-forty hours, the head not descending—notwithstanding the dreadful nature of the operation, you are justified in embryotomising.

Face presentations may, sometimes, be rectified by the fingers, or the tractor, as now shown. Forehead presentations may spontaneously become facial, or vertical; by the fingers, or the tractor, rectification may be accomplished in this manner. The face, when lying on the symphysis pubis, may be, in three different ways, thrown into the side of the pelvis: by grasping the cranium, when above the brim; by the action of the short forceps, when it is below the brim; or, when the head is in the cavity, by making pressure, during pain, with two fingers, placed on the side of the cranium near the face, the face being carried, by little and little, first into the side of the pelvis, and then into the hollow of the sacrum behind. Observe the demonstration.

Of Laborious Labours, arising from deficiency of room in the Cavity or Apertures of the Pelvis, superior and inferior.

In the preliminary lectures, I took occasion to observe to you, that from fractures, mollities ossium, or rickets, more or less of distortion and contraction of the pelvis may be produced; and, in a view to practice, we may divide these distortions into two kinds, namely, those of slighter degree, and which are more frequent in their occurrence, and those contractions in which the coarctation is very considerable, specimens of both kinds of contraction are laid on the table before you. Again.

Contractions of the pelvis, in the *higher degrees*, are divisible into two varieties—the *elliptical* and *angular*, here shown. For a description of these two varieties, I must refer you to my former observations on the deviations from the standard pelvis; for these

greater distortions are so rare, in ordinary practice, that I deem it unnecessary to treat respecting them again. When you meet with the *slighter* contractions of the pelvis, (in their occurrence not uncommon,) these contractions may lie in any part of it—brim, cavity, or outlet; but, in that degree, which gives rise to laborious labours, they are most frequently met with at the brim, between the front and back of the pelvis, interposed sometimes between the promontory of the sacrum and the symphysis pubis; and sometimes between the promontory of the sacrum and acetabulum. In the specimen here exhibited, the contraction lies between the symphysis pubis, and the promontory of the sacrum; and here is another specimen of coarctation, in which the contraction is seated between the acetabulum and the promontory.

By different practitioners and operators, those contractions of the pelvis, in a slighter degree, may be differently ascertained; my own method, I formerly explained to you. If a woman have had a number of children with difficulty, all still-born, for example, or all requiring the use of instruments; if, on making examination, you feel the promontory of the sacrum with unusual facility; if your patient have been in labour for a length of time, the waters being discharged, and the parts relaxed, and the head not descending; if the cranium, on examination, be found to be intumescent, the margin of the one parietal bone lying over the margin of the other, you may then be pretty well satisfied, that the pelvis is too small. By the difficulty of previous labours; then, by the unusual facility with which the promontory may be felt; by the failure of the descent of the cranium after strong efforts, and by the swelling of the scalp, and the overlapping of the parietal bones, coarctations may, in general, be detected, without the help of those pelvimeters which were formerly exhibited, though these instruments are not to be despised.

The laborious labours, which thus result from deficiency of room among the bones of the pelvis, are usually divided, in my own practice, into *three* varieties; the first consisting of those cases in which the pelvis is so highly contracted and distorted, that the head does not descend into the pelvis at all; the second, comprising those more frequent cases, in which the head comes down among the bones of the pelvis, and is there incarcerated, so as neither to advance nor recede; the third, comprehending those cases which are of all the most common, and where there is just that degree of contraction, which prevents the descent of the head into the pelvis, the cranium dipping down but a little way within the superior aperture.

You may be in practice for a length of time without meeting with a single instance of the first variety of laborious labour; namely, that case in which you have the highest degrees of contraction, so that the head cannot enter the pelvis at all; now and then, however, such cases must occur to you, and one or two have fallen under my own notice. In the extremer difficulties, the pelvis may be so much contracted, that even the os uteri cannot be reached by the finger. Should it fall to your lot to operate in laborious labours of this kind, in order that you may decide rightly, I would advise you, by all means, to procure the best advice in the neighbourhood. Now, should it appear on consultation, that delivery by the natural passages is impracticable, and that the Cæsarian delivery is required, in accordance with principles already explained, it is obvious, that the sooner the operation is performed, the better; for where it is performed early, there is a fairer chance of saving the child, and for the woman herself, there are better hopes of recovery.

Again, in those cases of higher distortion, provided embryotomy be thought of, and the child is to be abstracted by the use of the perforator, averse as I am to an operation so dreadful, I must still maintain, that the sooner we perforate the better; nay, in the very commencement of the labour, if it be perfectly obvious that embryotomy must at last be adopted, the operation becomes justifiable. By embryotomising early, you secure the advantage of operating, while you are yourselves fresh, and not exhausted from long attendance, the woman herself being in full spirits and vigour; besides which, you have it in your power to leave the head in the pelvis for hours after it has been laid open by the perforator, so that it softens and putrifies, and readily separates into different pieces; a condition which materially facilitates the delivery.

But here it may be asked, "In these cases of extreme difficulty, how is it that we are to decide whether the Cæsarian operation, or the operation of embryotomy should have the preference, for the two practices are very different?" Recollect yourselves, and you will remember, that I have already met this interrogatory, and to these remarks, comprised in the preceding lecture, I must again refer you.

There is yet a second variety of laborious labours which you must now and then meet with in your practice, I mean that variety in which the head, pushed down among the bones of the pelvis, becomes impacted there, so as to constitute that kind of case which is familiarly denominated the *locked* head. In these cases where the head is incarcerated, great danger arises in consequence of

the strong and permanent pressure which it makes on the softer parts, and contusions, inflammations, suppurations, and sloughings of the mother, not to mention the death of the child, may all of them be the result. Here, too, I may notice especially, that owing to this pressure on the pelvis in front, the bladder may be injured, great accumulations and disruption ensuing, a specimen of which accident is on the table before me. Under these accumulations of urine, too, even where no rupture occurs, acute inflammation, or chronic disease, may be the result, and the patient may be irrevocably injured, or perish in consequence. Left to themselves, therefore, I look upon these incarcerations as properly ranging among the most dangerous deliveries with which we have to contend, and yet (though dangerous) when thoroughly understood, they may be managed with perfect facility.

If you find the head among the bones of the pelvis, and firmly impacted there, you will be led to consider what are the steps to be taken, in order to render the delivery secure. Now, in cases of this kind, women are sometimes delivered by the natural efforts, and sometimes by the operation of the tractor, forceps, or perforator. So that it comes to be a point of consideration whether we ought to have recourse to the use of the instruments, or whether we ought to rely upon the natural efforts? In deciding this question, I should myself be guided principally by that general rule, or canon, which I have already so often prescribed; and if the woman had not been in labour for four and twenty hours, and if no dangerous symptoms were manifesting themselves, I should then commit her to the natural efforts—for a meddlesome midwifery is bad; but if, on the other hand, I found that dangerous symptoms were appearing, or, independently of these symptoms, if the patient had been four and twenty hours in strong labour, the head making no progress, I should then make trial of my tractor and forceps; if, lastly, these instruments failed, or if dangerous symptoms were appearing, or if, independently of these symptoms, the patient had been in labour six and thirty or eight and forty hours, I should then deem myself justified in having recourse to the perforator.

There are some practitioners, who are guided by a very different principle, too valuable to be neglected; I mean, the degree of compression which the head is making on the softer parts: and if the head is among the bones, and if, upon examination, it appears that it is very firmly locked there, so that the finger may not be insinuated between the cranium and the symphysis pubis, a prompt delivery is recommended; but, on the other hand, if, on examination, it is obvious that the fingers, though not without difficulty, may be passed between the bones and the cranium, they wait for two, four, or six hours, a longer or shorter term, according to the degree of pressure. Now, I could wish this rule to operate influentially upon your practice, though you may still adhere, in the main, to the general maxim prescribed. If you find that the head is but loosely incarcerated, you may wait with more confidence; but if it so happen, that the head is more firmly impacted between the front and back of the pelvis, you must watch more vigilantly for the symptoms indicative of contusion; and you must, too, promptly have recourse to delivery, as soon as the first marks of injury appear. There is, I suspect, little ground for apprehension, while the pulse remains below 100; a pulse more frequent, though not necessarily dangerous, ought, in all cases, to awaken and alarm. Beware of overlooking the indications of injury from compression; beware of delaying the delivery too long.

There is yet a third variety of laborious labour, arising from want of room, of all others the most common in its occurrence, and which requires some little dexterity in its management; the case, I mean, in which you have a slight narrowing of the brim, and where the head is prevented from thoroughly entering the cavity, being pushed a little way only into the superior aperture. Now, in deliveries of this kind, it not unfrequently happens, that the child is expelled by the natural efforts, notwithstanding the coarctation, and therefore these efforts ought to be fairly tried; for it does not follow, because you have a narrow pelvis, that you are officiously to interfere with instruments, without further consideration. But it not infrequently happens, when the natural efforts are fully and fairly tried, that these efforts are inadequate to the expulsion of the fœtus, and in such cases the tractor or forceps become necessary, or, these failing, the perforator.

In these cases, by some practitioners, turning is recommended—a practice which I must reprobate in a decided manner. It is true, that where there is a narrowing at the brim of the pelvis, a skilful operator might, now and then, introduce his hand, and bring away the fœtus by this undesirable operation; but to me, as a general practice, it seems to be highly improper; first, because in performing it, you must carry your hand into the uterus, an operation always to be deprecated, and, secondly, because when you have turned and brought down the fœtus, as to its limbs and trunk, the abstraction of the head and shoulders must still be attend-

ed with difficulty, for the narrowing of the brim remains, and by endeavouring to extract the cranium in this manner, you may detach the head from the body.—Turning, therefore, I cannot approve. In narrowings at the brim, it is better, as a general practice, either to suffer the woman to be delivered by the natural efforts, or to have recourse to the instruments already enumerated—the tractor, forceps, or perforator.

Again, it may be asked, granting that these two modes of delivery are to be preferred, how are we to decide whether we ought to commit the delivery to the natural efforts, or have recourse to the embryospastic instruments? Why, to this, as to many other emergencies, the general rule will apply; and, if the woman have not been in labour for twenty-four hours, and if no dangerous symptoms are appearing, it is better not to interfere; but if, on the other hand, the woman have been in labour for twenty-four hours, or, if dangerous symptoms are manifesting themselves—the pulse rising, the bladder closing, inflammation of the abdomen appearing—then we may, properly, have recourse to the lever or the forceps; and further, if these instruments fail, or if dangerous symptoms appear, or, independently of any dangerous symptoms, if the woman have been six-and-thirty, or, at any rate, eight-and-forty hours in labour, we are again justified, though unwillingly, in having recourse to the perforator.

What I stated to you in a former lecture is well worth remarking here, namely, that in those instances where you have laborious labour, from a narrowing of the brim, the head will sometimes mould itself, and thus come away. In the morning you apply your forceps, but cannot extract the cranium. Well! no dangerous symptoms manifesting themselves, you wait till evening, and then try the forceps again; and now the head moulded by compression and the pains, so as to adapt it to the passage, on this second application of the forceps, a living fœtus is abstracted. Thus much, then, with respect to those laborious labours which arise from the second cause, namely, a want of room among the bones of the pelvis. Of the labours with rigidity, we will treat at our next meeting.