

## 153.—ON DELIVERY BY TURNING AS A GENERAL RULE.

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[The following paper may startle some timid surgeons, but ever since the paper of Dr. Simpson on this subject was published, we have often thought that turning in preference to the forceps (where it could be done before impaction took place) would be a much safer and easier process. In more than one case of contracted pelvis, through which, in a previous labour, the head could with the greatest difficulty pass, we have found that when the breech presented and we could extract by the feet the labour was quite different and comparatively easy. Dr. Figg recommends the right hand in turning: we differ from him in this respect. The left hand accommodates itself better to the axis of the pelvis in the usual obstetric position, and also grasps the feet easier they being to the back of the mother: with the left hand, the head above the brim and the os dilated or dilatable, turning is a very easy and very safe process, and we think the day is not far distant when its use in labour will be greatly extended, but only or chiefly as a substitute for the long forceps or craniotomy. Dr. Figg begins by saying:

Let me suppose that you are summoned by a midwife to a patient, by whose side she has occupied a seat for eight hours consecutively, while a repetition of vigorous contractions at intervals of four minutes has not advanced the os into the pelvic cavity. An examination reveals a glove-like process of the membranes extending towards the concavity of the sacrum, or if the liquor amnii has escaped the substitution of a large caput succedaneum in the axis; the pulse beats at 110; the muscles are strained, as if the sufferer had been just laid on the rack of the middle ages; the mouth is viscid with thirst, the throat hoarse with crying; and thus the patient, corporeally exhausted, and mentally excited, awaits your verdict of her state.

Does reflection indicate the long forceps, considering the circumstances previously to their application. The swollen scalp, obliterating the sutures, the caput succedaneum almost inducing the impression of a nates presentation, the difficulty of introducing the ponderous blades from the impeding bedclothes, the difficulty of attaching them when introduced from the mobility of the head, the probability of their not locking when attached, or their liability to yield on traction, from the lambdoidal region of the cranium being alone encompassed are all so many obstacles.

Add the long and violent concussion of the patient's frame, and the infant motionless, lacerated, and contused, when produced, and you have an array of evils requiring no small amount of professional fortitude to encounter.

Is the picture too highly coloured? Ask the Accoucheur of the anti-chloroform era, in whose memory it is vividly portrayed, coupled with the shrieks of agony or nervous excitement, rending the still air in the still midnight.

Perhaps your guardian angel suggests turning—Simpson's expedient in lieu of the use of instruments in such cases.

The patient's anxiety, and that of her friends, is at once soothed by the information that the hand alone is to be the medium of extraction. The administration of chloroform to the extent of perfect anæsthesia, relaxes the uterus, abdominal, and perineal muscles, and renders torpid the vaginal and utero-cervical nerves.

The infant seized by the feet, and drawn in the axis of his own abdomen, effects an evolution with little if any effect on the part of the operator.

Why? Because there is nothing abnormal in the movement. The foetus by the law of gravitation or other cause, had actually a month or so antecedently transformed a breech into the present cranial presentation, and often in the descent of the arm or shoulder. Nature rectifies the error, by substituting the feet in spontaneous evolution. Again, the ordinary position in *utero*, the arms crossed on the chest, the chin in close opposition to the sternum, the legs flexed on the abdomen, and the back describing the segment of a circle in its external periphery, offers extraordinary facilities for the ex-

execution of the project, which are actually increased by the nature of the womb itself in which the infant lies, as in an elastic bottle sufficiently flexible to admit of transverse occupation of the revolving foetus, but antagonistically contractile to co-operate with the practitioner in instantly reducing it to the longitudinal axis.

The right hand (which I prefer to the left for introduction) is an instrument the perfection of mechanism; one that is not only exquisitely adapted for prehensile action, but furnished with nervous sensibilities, so as to discern by contact the character of the objects in its vicinity. I never use the long forceps without a fear, lest the flattened extremity of the blade being insinuated externally to the os uteri, and internally to the bladder, should pierce the peritoneal process, investing the fundus of both, and run riot in the region of the intestines. Impossible, you exclaim, if you make the index finger of the left hand the pilot for conducting the instrument. Quite possible, I assert, as was once demonstrated at a post-mortem to Drs. Keiller, Zeigler, and myself, the catastrophe having occurred in the hand of a really intelligent young gentleman.

With the hand there is no such risk. The vaginal avenue conducts into the large uterine cul-de-sac, the calibre of the fingers precluding an admission into the abdominal cavity by the course referred to.

Methinks I hear an exponent exclaim, The train of events is not quite so propitious as you represent it. Allowing that with a pulsating cord and unbroken arms you produce the trunk, it is but a mere inversion of the order of difficulties. We of the forceps school direct our first effort to the extraction of the impacted or incarcerated head. You prefer making it the last measure; it alone constitutes the obstacle in delivery, and in either case physical force on the part of the accoucheur is imperatively necessary.

Let me afford the objector all the weight that his argument deserves, its essence being, that under every circumstance a head is inadequate to the dimensions of the pelvis occupies a position above it. The forceps by causing an imbrication of the frontal, parietal, and occipital bones, reduces the head to dimensions exhibited by the closed blades, quite irrespective of its capacity of diminution to a greater extent, and preclusive of all possibility of the cranium adapting itself, in making the exit, to peculiarities in the pelvic shape. It matters not whether the pelvis be infundibuliform, oval, cordate, or laterally capacious, the unvarying ellipse of the blades is compelled "*vi et armis*" to run the gauntlet of obstructions.

Instead of compliance with an arbitrary law, delivery by turning is morely an artificial accomplishment of the suggestion of nature, who, with the view of obviating the impediment, assumes every available space to force the pliant cranial bones into while expediting their passage.

Who has not felt the parietal within the pelvis yielding and springing on pressure, like the side of a tin can? Or, who has not heard the exclamation of astonishment from assembled relatives at the length of an infant's head, the product of a protracted primiparal accouchement, a length out of all symmetry, and attributable to the elongated condition of the bones, and not merely the caput succedaneum? A short time rectifies the evil, the cranium reverts to the contour possessed before subjection to the ordeal of labour, and which it had only abandoned to pass through the pelvis.

Again, if the maternal tissues could be insured from injury in the operation, the forceps possess a power of leverage admirably adapted for the removal of an impacted head. But civilized midwifery ignores such an application, for the objection which applied to, and almost rendered the vectis obsolete, bears here with double force, inasmuch that in the case of the vectis, on one side of the pelvis becomes alone the fulcrum. In that case either blade of the forceps would be alternatively used. The forceps, however, possesses a twofold legitimate function, a power of traction and ability to oscillate the head between the sacroiliac synchondrosis and the obturator foramen.

With regard to the former, natural philosophy emphatically denies that the force in traction is increased in the ratio of the distance, the principle of

leverage is excluded in this case. The muscular power of the practitioner antagonized by the resisting head, is neither increased nor diminished by the intervention of instruments.

In the rival operation of turning we can at all times increase the forceps traction in a double proportion, by enlisting the services of an assistant at the limbs of the infant, while your own efforts are directed to the liberation of the arms, protection of the cord, and oscillation of the head by the aid of the finger in the mouth.

But some one may sceptically exclaim, Dare you exhibit the power of two athletic men on so frail a structure as the body of an infant, without risk of decapitation, that calamity of which the older writers in obstetrics have given so many instances? I reply, that though the circumstances involving the necessity be rare, you may exercise such force with impunity. I have seen some of the most judicious men, inclusive of Simpson, exercise it without injury to mother or child. And, while I avoid a breach of professional courtesy, by not treating the cases of Denman and the authorities of his age as purely apocryphal, I meet the difficulty by asserting that the art of procreation is keeping pace with the advancement of science in the nineteenth century. Our children's necks are more substantial in character than those of our ancestors, a fact which any one may verify by experiment, if he try the amount of force requisite to dislocate the neck of a still-born infant.

In one respect, I think all practitioners will coincide with me, viz., that chloroform to complete anæsthesia is only indicated till the forceps is attached or the infant inverted, subsequently to which events a state of semi-consciousness is preferred, inasmuch as it renews the uterine action suspended by the perfect influence of the anæsthetic.

We may form a just idea of the value of this immutual ally, by considering the amount of exertion we have been called on to expend in the removal of a head from its confinement between the tuberosities of the ischia, by the aid of a forceps of medium power. Yet the uterus alone would have effected the expulsion, by the effort of two or three hours duration.

In what degree, then, it may be inquired, is either operation assisted by the vis a tergo of uterine contraction? The information is at once afforded by considering the rationale of production in an ordinary unassisted labour. The uterus at first contracts at intervals of half-hours, and with a single faint impulse. Why? Because it resembles a hand attempting to grasp a ball too large for its compass or constriction. The whole of the vigour of the organ is diffused over the membranes, distended with liquor amnii, and the included fœtus, and this power is consequently less manifest.

Matters, however, improve with the lapse of a couple of hours. The contractions occur at intervals of four minutes, and with a double impulse. Why? Because the head has descended into the cavity of the pelvis, and the efforts of the uterus are solely appropriated by the trunk, which remains within its circumference: thus proving that the power of the organ in its proportion to the bulk of the object on which it acts. In extraction by forceps we secure the assistance of the uterus by an equal diffusion of its power over the foetal body. In turning we have that power concentrated on the comparatively small superficies of the head, which it closely invests. Without reference to assistance artificially by forceps previous to or manual traction after turning, the uterine power in either case may be thus arithmetically stated:—If the expulsive capacity of the organ be represented by the number six, the foetal power of resistance at the commencement of parturition being also six, the latter on a liberal calculation will have reduced one-third, on the head partially or completely entering the pelvic cavity. The expelling agency will then rate at six against four, two-thirds of the original resistance. But if the body of the fœtus be external to the uterus, and the head alone within its cavity we have an arithmetical as well as a physical inversion of circumstances. The expelling influence will still be six, but the object of resistance two.

It is almost superfluous to attempt proving that the uterus reduces its dimensions and increases its functional power in the proportion of the child's

expulsion. Every student who has watched its gradual declension from the central point, between the scrobiculus cordis and umbilicus, the locality of the fundus at the commencement of labour, will testify to the latter. And every practitioner who has introduced his hand for the removal of an adherent placenta will testify to the latter, from his recollection of the firm pressure of the cervix on his forearm, which, like a tourniquet, rendered torpid the nerves of the hand and congested the part by arresting the venous circulation.

We repeat, then, the question, how far does this uterine power assist an artificial delivery? In a forceps case it does so imperceptibly. In case of version most evidently; I append one out of many instances of experience.

In company with another medical man I obeyed the summons of a midwife to a case three miles distant from my home, a contracted pelvic brim had set her at defiance. We placed the patient under complete anæsthesia, turned the infant with ease, and extracted all but the impacted head. We pulled alternately and pulled conjointly without progressing in any appreciable degree. To my horror my companion announced the exhaustion of the chloroform, under which the patient during our efforts had insensibly slumbered: consciousness was gradually established, and with it her uterine contractions, the second of which with very little co-operation on my part completed the expulsion. The ideal danger of rupture is another conjuration of the professional mind with regard to this operation. The uterus is sometimes ruptured, so is the heart, and their organs present many points of similitude. But the heart never ruptures, save when there is something morbidly abnormal in its structure; neither does the uterus.

When consulted respecting the gymnastic performances of some young Titan, who for three months antecedently to his exit threatens the perforation of his mother's sides, and banishes sleep from her eyelids, do we ever dream that the uterine parietes will prove inadequate to the retention of their charge, though elbows, knees, head, and nates consecutively effected the assault? I fancy not: but yet with marvellous inconsistency we predict rupture as the calamitous consequence of artificial foetal evolution, the most gentle process in the whole catalogue of midwifery tactics, one that I have sometimes performed without anæsthetics, and without eliciting from the patient a single intimation of pain.

The impropriety of introducing the hand into the uterus was vividly and early impressed on my imagination by my instructors. But how in consistency with reason do they define the danger? Is it that the introduction of a foreign body, in which light we will view the hand, interferes with an organic function requiring instant performance, as in the air-passages, or circulatory apparatus? Experience says not. The uterine function may be suspended without injury, and in its state of quiescence the introduction takes place. Is it that the passage of the hand by the side of the head, as it lies *in situ* within a well-dilated os uteri, would effect a perilous laceration of the latter from its inability to expand? Experience says not. In the normal progress of the labour it must assume a circumference double the one it now exhibits to emit the foetus. Is it, that the extreme sensitiveness of the locality would render it liable to lesion in the act? Experience says not. No other organ but the heart presents such a contrast between its powerful action and its nervous supply, almost inducing the opinion that it owes its function to some other besides a nervous source. In the absence of chloroform some little pain might be experienced in the passage of the vagina and os, but the interior of the uterus is as torpid to manipulation as the cavity of a gutta-percha bottle. The muscular structure and internal aspect of the gravid uterus may, in one sense, be designated the connecting link between the maternal and foetal organisations, though I confess its relationship to the former to be of course closer than to the latter; yet, hæmorrhage excepted, I believe the mother's system to be as free from liability to shock on manipulation or abrasion of the internal surface of the uterine cavity as from injury to the foetal portion of the placenta. This opinion is corroborated by the consideration of the natural progress of events

in unassisted labour. How rarely is the structure of the organ or its lining membrane injured by the violent and incessant efforts of twelve hours duration! The peritoneal investment, the abdominal or lumbar muscles may suffer derangement, varying from simple pain to active inflammation. Decomposing animal matter may lie in contact with its internal surface, and by absorption into the circulation, produce ruinous results in distant localities. But a post-mortem examination of the uterus itself after a death from any of these agencies, presents no appreciable morbid peculiarity. Metritis is an extremely rare disease.

[In the extraction of a child by the feet, it is astonishing what force may be used without injuring the child. But we should advise that each limb should be surrounded by a fold of the napkin, and that extraction be made with the limbs thus well padded. The bare hand of the surgeon is not a good instrument.]

[Dr. Figg relates a case which remarkably illustrates his views:]

The sudden illness of a medical man, placed me as his substitute, by the bedside of a parturient patient, where for the twenty-four hours previously he had been stationed. The waters had long escaped, the swollen scalp bent low between the sacral promontory and symphysis, above which, notwithstanding vigorous uterine effort, the cranium itself was incarcerated; and to darken the prospect I was informed of her delivery by perforation on three previous occasions. I at once applied the substantial long forceps left by my predecessor, and for twenty minutes the patient's frame vibrated under all the strength I could enlist on the occasion. From a conviction of absolute failure I desisted, and despatching a request for Dr. Simpson's attendance, inactively awaiting his arrival. *Ad interim* a third party appeared, Dr. P., a gentleman called in by one of the officious relatives, without consulting me or informing him of my possession of the superintendence. We compromised the matter by acting conjointly, that is to say, we postponed all measures until Dr. Simpson's arrival, with whom a deliberation was held as to further procedure. Dr. P., an accomplished midwife, thought the long forceps indicated; I, from the fact of my recent discomfiture, deemed them inadequate to the emergency. Dr. Simpson, without affording a decisive opinion as to the practicability of delivery by the long forceps, preferred turning. However, Dr. P., at the Professor's request, attached the instruments a second time, and worried the patient, *secundum artem*, for some minutes; when, concluding the resistance insurmountable by that means, he agreed to an attempt by Dr. Simpson's alternative of turning.

The patient was placed under chloroform, the infant was turned and delivered by Dr. Simpson in about four minutes, crying vociferously a minute or two after.

The triumphant termination of this case imperatively demanded a verdict in favour of version, and naturally suggested to me the following query on the following premises,—If delivery could be effected so rapidly, easily, and safely, under such formidable circumstances, how much more easily, safely, and rapidly, could it take place by the same means under normal circumstances?

With so many excellent manuals of midwifery in the hands of the profession, it would appear almost impertinent of me to offer my observations as to the mode of carrying this measure into execution; however, for the benefit of my junior brethren I will offer a few directions.

Place the patient on her left side transversely in the bed, so that her body form an angle of 45 degrees with the longitude of the bed, over the side of which let her nates nearly protrude, whilst her knees are drawn up in the direction of the abdomen. Let the covering be a single blanket or sheet; two or three pillows may be placed under the head, while a hot and cold water bath ready for the infant are in close vicinity. Never attempt the operation till the os uteri acquire the diameter of three inches, nor defer it till it ceases to be tangible in its whole circumference to the examining finger. Avoid, if possible, rupturing the membranes, but do not imagine the version impracticable if they be ruptured. Administer chloroform to perfect anæsthesia.

Place an assistant sitting in the concavity formed by the flexure of the patient's body, desiring her to elevate the right knee. Throw off your coat, and anoint the arm and back of the right hand, avoiding the palm. Throw the fingers of the right hand into the form of a cone, introduce them in the axis of the pelvis outlet, not being deterred, if in the case of a primipara, this require a little force, pass them internally to the posterior uterine lip, and into the cavity of the uterus. Grasp the feet, contemporaneously with which you must of necessity rupture the membranes. In doing this the feet must be carefully discerned from the hands of the foetus, and seized, by passing the heels between your fingers.

Should you by mistake bring down an arm, do not esteem it of any consequence, but repeat your search for the feet; draw them in close vicinity to the child's abdomen, and thus throw up its arms and head tangent to the uterine fundus, while the feet enter the pelvis.

The left hand may be now employed on one leg, while the right acts on the other, drawing the infant's body in the direction of the mother's rectum, in effecting which a towel placed between your hands and the child's limbs will afford a firmer attachment. If the child originally present with its face towards either synchondrosis, which will be the case in seventy per cent. of parturient patients, the evolution will, of course, transform it into a public presentation, a circumstance of no material consequence, as you can turn it the quarter circle to the right or left, into the first or second Naegele, when the body is drawn down till the os encircle the axillæ and chest of the infant, its arms being at this stage tangent to the side of the head in the uterine longitudinal axis. Having turned the face posteriorly, when required resume traction till you experience a sense of resistance to a tolerable amount of effort on your part. Now gently draw down two or three inches of the cord; hook the fore-finger of your right hand over the infant's arm lying posteriorly to the right ramus of the maternal pubes, carry it to the bend of the elbow, and press the arm down perpendicularly to the side and external to the vagina.

Repeat the measure with the other arm; encircle the cord without pressure beneath the thumb and fingers of the left hand; carrying the same hand into the vagina, and placing the fore-finger in the infant's mouth, therewith press the chin close to the sternum, at the same time exercising traction in the direction of the mother's rectum, with the right hand spanning the child's loins. If the resistance require a greater amount of traction than this attachment affords, encircle the neck with a towel, the ends of which grasped opposite the breast will form a better hold.

When, however, the head has reached the floor of the pelvis, bring the body of the infant directly forward, between the femora of the mother, turning the face downward, and clearing the vagina.

If you experience any difficulty in bringing down the arm next the maternal pubes, at once attempt the extraction of the posterior one.

If that be also immovable, pull the child's body laterally in the direction of the mother's right acetabulum, thus causing a depression of the arm adjoining the sacro-iliac synchondrosis, and placing it within your reach. A relaxed undilatable os uteri, with thickened edges, frequently accompanied with flooding, ante partum, is a more serious obstacle than ordinary contracted pelvic passage. For if you succeed in introducing the hand and turning the child, the os encompasses the neck, and confines the head with almost the same tenacity that the capsular ligament exercises over the head of the femur.

I am not aware of any remedy instantaneously counteracting this evil, which imparts considerable tedium to the delivery, presenting, however, one redeeming trait, viz., if the os and cervix be defective of tone, there is no pressure on the cord, and therefore little risk to the infant.

It may occur that on the introduction of the hand into the uterus, one foot only may be within reach, the opposite leg being in all probability ligatured by two or three circles of the cord, and thus maintained perpendicularly parallel

to the long axis of the womb, instead of the flexed position favourable for the operation.

The first attempt to secure both feet proving abortive, do not waste your time by further efforts, but proceed in accordance with previous directions with the single foot, when the traction will cause a rotation and version of the foetal body, and consequently the liberation of the opposite one, which can then be easily extracted.

Perhaps neither feet are tangible; the near leg being encircled with the cord, the distant one is beyond reach. Or the foetus may present in the third Naegle, forming the curvature of the body anteriorly. The cause of difficulty is immaterial, the mode of rectification being the same, viz., making the foetus to revolve like a wheel on its axis, and when the segment of a circle is effected, the feet will fall within reach. The instant the infant is secured, remove the placenta, and press externally over the uterus.

In the greater proportion of cases, I have found it partially detached, and consequently effusing blood from the lacerated vessels, along the line where its uterine adherence remained. It may have been forcibly removed by contact with the child's body in the act of turning. It may have been acted on by tension of the cord. Whatever the cause the precaution of early removal obviates the danger.

With regard to the children they are generally still from two to five minutes, and in some cases half an hour's duration. In many instances the first arm brought down is a little painful when moved for a day or two. I confess with humility that I have even broken four arms, which, though they occurred in cases of great pelvic contraction, were attributable to my own mismanagement in pressing over the shaft of the os humeri instead of following its line to the elbow. Should you commit the same error, with similar result, be not too candid to the relatives, but at once by your dictum transubstantiate the injury into a slight sprain received by the infant striking his shoulder against the backbone of the mother while actively prosecuting his uterine gambols. It will pass current, more especially if you appeal to her experience, when it is sure to be corroborated by a quotation of the day and hour of occurrence. Two slips of pasteboard applied, with a strip of calico a yard long, remedies the evil in ten days.

In establishing a comparison between the advantages derivable from turning in primiparæ, and multiparæ I believe there is a preponderance of argument in favour of the former. In a primipara the os uteri is more in the axis of the pelvic brim, the body of the organ being more inclined to the perpendicular, and not projecting anteriorly, as in the frequent parturient; hence, in the former case, the uterine efforts of the last month previously to labour lodge the os and cervix inclusive of the head low in the cavity of the pelvis, not only assuring the practitioner by tangible proofs of the perfect capacity of the brim, but also presenting the best arrangement for the co-operation of the uterus with his extensive efforts. In the latter case from the yielding of the abdominal muscles in former labours, the fundus bearing forwards, throws the os in the direction of the spine, rather than pelvic cavity. Hence until the contraction of these muscles in some measure restore the proper axis, no advance can take place.

The advantage in the second particular is briefly explained, by stating that in a primipara the antagonistic force is directly in line with the extractive. In a multipara it is entrenched round a corner.

Again, in a primiparal case you have good grounds for the conviction that, in obviating the perineal stage, you limit the labour considerably; while in the latter patient an hour's suffering might conclude the case.

Be they right or wrong these are the sentiments which have guided my conduct at a large majority of my cases latterly, experience appearing to justify in happy results what theory dictated on sound reasoning. I hope I shall soon lose all mental impressions of a head lingering on the perineum, or stationary from falling pains for hours. My primiparal patients are up in four days without swelling of the vaginal muscles, nymphæ or labia; and

what to me is perfectly unaccountable, with very slight laceration of the perineum.

I have had but one maternal death where the infant was turned, and that occurred five days after the event, by inflammation of the peritoneum of a patient who, with contracted pelvis, had submitted to the ordeal to produce her sixth full-timed dead child.

If I be entitled to any credit at all, it is for the candid avowal of a practice, that some under fear of professional censure, would have adhered to but concealed.

The operation was ancient, but nearly obsolete, and its revival by Dr. Simpson in particular circumstances, led to my adoption of it in general cases.

P.S. Since writing the above observations some months ago, I have attended sixty labours, three of which alone have been conducted as head presentations. Of the remainder two were breech presentations, and the other fifty-five were conducted according to the principles advocated in the above communication, viz., the children were all delivered by turning.—*Med. Times and Gaz.*, Nov. 13 and 20, 1858, pp. 493, 522.

[One great objection to this practice, as a rule, would be the danger to the child. It could only be justified in severe cases of obstruction at the brim of the pelvis; and, in these cases, we think Dr. Simpson's views are correct.

Both Dr. Robert Lee and Dr. Ramsbotham seem to be very much against Dr. Simpson's views. The opinions of these eminent men must always have great weight. We agree with Dr. Simpson, but dissent from Dr. Figg's views, which we think dangerous, and the practice uncalled for.

Dr. RAMSBOTHAM in the following letter to Dr. Robert Lee, expresses his opinions upon the practice inculcated by Dr. Figg in the preceding paper. He says:]

That paper in my mind resolves itself into two points each of the utmost importance in obstetric surgery: the first, the propriety of turning the child, in cases of deformed pelvis, instead of delivering it by the forceps, or by craniotomy, or inducing premature labour—that to which indeed you have particularly called my attention; the other (which you have not noticed in your note to me) the turning and delivering by the feet every child, though presenting naturally by its head, even although the patient possess a pelvis of ordinary size, and whether she be bearing a child for the first time, or have had a family before.

My opinion on the first of these cases has already been clearly expressed in each of the four editions of my work on 'Obstetric Medicine.' My words are: "I cannot find language sufficiently strong in which to deprecate this mode of proceeding as a general principle;" and in the last two editions, I have given my reasons for this anathema at length; having been induced to do so by Dr. Simpson's then recent advocacy of the practice.

The second kind of case I have adverted to has received no notice from me, because I never dreamed that any man in his senses would have the hardihood to recommend that all natural cases should be artificially converted into footling cases, or to announce that such an interference with nature's ordinances had become in his practice an established rule. Dr. Figg tells us that since he penned his paper, some months before its publication, he had attended sixty labours, of which three only were conducted as head presentations. Of these cases, in two instances the breech presented; the remainder, fifty-five in number, were head presentations; and all these children were delivered by turning. He acknowledges that the children thus officiously dragged into the world, are generally still for from two to five minutes after their birth, and sometimes for half-an-hour; and he confesses also to have broken an infant's arm four times during its extraction.

The practice advocated by Dr. Figg appears to me so mischievous and dangerous in its tendency, that I consider you will be doing a service to the cause of humanity, if you will notice it publicly with that reprobation which I am convinced, you, in common with all well-judged obstetricians must entertain towards it.

[Dr. Figg's opinions have been severely commented upon by various writers in the journals, with many of whose views we agree. We think it only right, however, that he should have the advantage of any opinions given in his favour. Mr. W. H. BORHAM writes as follows:]

In publishing my opinions and practice on version as an accoucheur to the profession, particularly as they hear out, and agree with the obstetric experience of Dr. Figg, as published in his papers in the 'Medical Times' of November 13th and 20th, I am prepared to encounter the frowns of the aristocracy of accoucheurs, as now constituted in London, nay, to be considered as inculcating "atrocious" doctrines bordering on "insanity," or perhaps may be "practising a hoax," or that my mode may be "corrupt" and "cruel," or "revolting," to the refined experience of obstetricians; but notwithstanding all this, I am prepared to establish by practical experience, that most of the doctrines inculcated by Dr. Figg are not to be entirely disregarded in certain cases. In giving these my views, I have a firm conviction in their being tenable and right, as much so as those of Dr. Figg's opponents; and with all due courtesy to my talented and respected examiner, Dr. Aldham, I must beg to be at issue with his opinions on the subject of Dr. Figg's paper. The case in which I first performed turning, was one of that very rare form of labour complicated with a vaginal cystocele, when the vagina and bladder protruded from the os externum like an adult male testicle. (Dr. Lever, I think, only mentions one case in 33,000.) By this prolapsus the head was prevented descending; it would have been imprudent to have used traction with the forceps, as probably a vesico-vaginal fistula would have been the result; so I decided upon turning, by which means, I was enabled to replace the protruding bladder, while revolving the child to a footling case. The mother and child did well, she has since been attended by me in a natural labour. This case occurred about three years ago; and the facility by which it was accomplished led me to resort more frequently to the practice of version.

The next cases I have had are those of placenta prævia, arm, epigastric, or dorsal presentations. Turning in these cases requires no comment. Then come those of the natural presentation, with limited contraction of the pelvis; here I have turned six times, with the loss of only one child. And now lastly, I come to those cases which bear more immediately upon the subject, viz., such as have the head presenting, and where the labour is protracted beyond the usual time, either by a want of the expulsive uterine power, or by an increased resistance from some mechanical cause.

In such cases I have turned twenty-five times, all successfully, and without losing a single child. There was, of course, as little time as possible allowed to intervene after the feet were secured till the full delivery of the child.

I have experienced no difficulty in turning the above cases, and the mothers have not complained of much pain; my hand and arm are not large. Some were primiparæ, some multiparæ. The capacity of the pelvis, as adapted for the exit of the head, can be easily ascertained by the hand when in the uterus; and the decapitation of the child by force as mentioned by Dr. Hancox, could be easily prevented by this ordinary precaution.

I might here mention that I have never given chloroform in any case; and for the last seven years never a dose of ergot. During this period I have attended about 1800 cases, and three only of the mothers have died, one lately from puerperal fever, one from flooding after version in a case of placenta prævia, and the other from scarlet fever a few days after delivery.—*Med. Times and Gazette*, Nov. 27, and Dec. 25, 1858, pp. 561, 665.

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154.—*Turning in Natural Labour.*—By Dr. H. HANCOX, Wolverhampton.—On reading over the paper 'On Delivery of the Child,' &c., by Dr. Figg, I at one time entertained the same opinion as that gentleman, that "two athletic men" would have some difficulty to pull the body from the head of an infant; but during the last few weeks, I am sorry to say my opinion has

been changed, in consequence of a surgeon, who after making a natural presentation into a preternatural one, endeavored to deliver the head, both by manual efforts and by means of the vectis, when the body separated from the head, leaving the latter undelivered, in which condition the poor woman lingered for nearly two days, when death put a stop to her sufferings. This case I think will not bear out Dr. Figg's theory, "that the act of procreation is keeping pace with the advancement of science in the nineteenth century." I should be inclined to think, judging from this case, that science is not keeping pace with the advancement of procreation, and also that the neck of this child could not have been any "more substantial in character than those of our ancestors," by which Dr. Figg meets the difficulty of the cases, similar to the above, related by Denman,—or if the contrary, the amount of force used in this instance by the disciple of *Æsculapius* was more powerful and rash than justifiable.—*Med. Times and Gazette*, Dec. 4, 1858, p. 587.

155.—*Turning versus Craniotomy.*—By Dr. T. H. WARDLEWORTH, Lowestoft.—During my stay with a medical practitioner of Rochdale, I was requested, during his absence from home, to attend to a Mrs. S., who lived about two miles in the country. On my arrival, I found her in labor with her seventh child. To my surprise and astonishment, on inquiry, I was informed that craniotomy had been performed in all her previous labours by that gentleman. On an examination per vaginam, I found a foot presenting, and that the promontory of the sacrum lessened to some considerable extent the antero-posterior diameter of the pelvis. I experienced no difficulty in the extraction of the head, the chin being well pressed on the chest. A fine child was born alive: they both did well.

Two years afterwards I was summoned again to attend Mrs. S. On examination, I found the head presenting above the pelvic brim, os uteri fully dilated, membranes unruptured. From the facility with which I succeeded in her previous confinement, I unhesitatingly determined to turn, which I did without much difficulty, and delivered her of another living child. Mother and child did well.

In all subsequent cases which have come under my notice during the past twenty years of a like character, I have always adopted the same practice, with the most satisfactory results. This practice is only applicable when the os uteri is dilated or dilatable, and the membranes intact. If the membranes are ruptured, and the foetal head advancing to fill the pelvic cavity, to turn, under these circumstances, would be attended with considerable difficulty, and danger to both mother and child. In all cases where the antero-posterior diameter of the pelvis is only three inches or even two inches and a half, I would, if the os uteri were fully dilated, and membranes unruptured, prefer to turn, and take advantage of one of the diagonal diameters, rather than allow the head of the child to become impacted in the distorted bony cavity. Even should the head become impacted, there would be no greater difficulty in extracting it after the perforator had been used than if the vertex had been the presenting part. I am satisfied, from ample experience, that more lives would be saved by turning in such cases, and also that the soft parts of the mother would be less liable to injury.—*Lancet*, March 5, 1859, p. 219.

156.—*Podalic Version.* By T. M. PARROTT, Esq., Stamford-le Hope.—Is it a fact that the head passes more easily through the pelvis when extracted last? The following is a case in point:—

I was requested to attend Mrs. A., in what I believed to be her first confinement. I had not been in attendance many minutes, however, before I was informed that craniotomy was resorted to at both her previous labours on account of deformity of the pelvis. On examination, I found an arm presenting, and, without much difficulty, turned and delivered her of a very fine living child. Some time after, she again became pregnant, and was attended by a practitioner in London. The presentation was natural, and the head

was again perforated. Had she been under my care on the last occasion, I should have taken the hint, and turned, whatever the presentation might have been.

This case will, in some measure, prove that the head may be dragged through a moderately deformed pelvis—one through which the uterine contractions could not force it with perfect safety to the child.—*Lancet*, Feb. 26, 1849, p. 219.

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157.—*On Rigidity of the Os Uteri in Labour, Menstruation during Pregnancy, &c.* By Dr. J. HENRY BENNET.—In the interesting essay of Dr. Gilmour, 'On Rigidity of the Os Uteri during Labour, published in a recent number of the *Lancet*, the causes and conditions usually admitted by accoucheurs are carefully enumerated. Dr. Gilmour has, however, omitted to mention a cause hitherto unnoticed, to which I drew the attention of the profession many years ago—viz., induration and hypertrophy of the cervix uteri, the result of chronic inflammatory disease. I then stated that I believed this pathological condition to be in reality the most frequent cause of rigidity of the os during labour, and subsequent experience has confirmed this view.

Inflammatory induration of the neck of the uterus is now universally acknowledged to be of frequent occurrence in child-bearing women, and would, even more frequently than is actually the case, be the origin of rigidity in labour, were it not that, as pregnancy advances, the morbid induration usually softens. It would seem that the nutritive changes which so profoundly modify the structure of the healthy uterus during pregnancy extend to the indurated hypertrophied tissues of the neck, and thus prepare them for the final dilation. Should, however, this softening not have thoroughly taken place when labour commences, we have, as a necessary sequela, rigidity of the os and cervix.

The practical deductions which may be drawn from this important pathological fact are two fold: Firstly, as the existence of inflammatory induration of the cervix may, in cases of pregnancy, prove a serious complication of labour, it ought to be treated and removed on this ground as well as on others; secondly, whenever decided rigidity complicates a labour, we may suspect the pre-existence of cervical disease; and, on the recovery of the patient—say six weeks after the confinement, the condition of uterine organs should be ascertained, and, if any disease is discovered, it should be treated and removed. I may add, that the treatment of rigidity of the os during labour, from chronic inflammatory disease, is the same as that of rigidity from other causes. Patience and time are, however, still more necessary. Tissues indurated by chronic inflammation must dilate slowly and painfully.—*Lancet*, Dec. 11, 1858, p. 618.

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