

contractions to (if possible) expel the child. I have attended about 800 obstetric cases as a general practitioner. I have had one woman die from the late effects of *post-partum* haemorrhage, due to her getting out of bed to micturate an hour and a half after the birth; and I am thankful to say I have had no case of puerperal septicaemia, and no death of the infant due to protracted second stage of labour.

I desire, therefore, to epitomize the main principles on which those labours have been conducted, and in doing so I would define natural labour as one in which the mother could by "pains" expel the infant head first into the world if unlimited time were allowed her to endure those "pains." The main principles I have acted upon are three, and I believe that the vast majority of successful obstetricians act on these principles. They are: (1) Rigid asepsis for the doctor, and as much cleaning up of the patient as is possible in each case; (2) timely and skilful aid by forceps, and by "timely" I mean the unhesitating use of forceps when the os is dilated or dilatable and the head is making no appreciable descent to the perineum, or, having arrived there, comes no farther; (3) waiting patiently with the left hand on the uterus for the placenta, only expressing it when either the placenta is in the vagina or haemorrhage sets in from its partial detachment. I am fully convinced that the early and judicious use of the forceps in lingering though normal labour saves, in some cases, the life of the child, and in all cases preserves the strength of the mother, thereby removing one of the common causes of haemorrhage. I am further convinced that complete anaesthesia, the chloroform being given by a second medical man, during the early stage of the delivery, followed by partial anaesthesia, as the head is very slowly and by intermittent pulls drawn through the vulva, is less likely to result in severe tears of the perineum than if the patient is left to expel the head by her uterine contractions.

I have, at any rate, found that these three principles are safe and efficient in practice, comforting to the patient, and satisfactory to oneself. I was educated as an intern student of the Rotunda Hospital in the "leave-everything-to-Nature" principles advocated by Dr. Horrocks. I quickly found in working a general practice that it was necessary, in order to have any obstetric work to do, to evolve the above method of conducting labours, which is, I claim, as safe as the methods adopted by Dr. Horrocks, and also much more pleasant for the woman in labour.

I repeat, then, that the frequent use of the nail-brush with soap and hot water, the expediting of a lingering second stage, and the slowing of the third stage of labour, constitute the three legs of a tripod on which a safe and scientific obstetric practice can rest.

Just a word on occipito-posterior positions. They are met with, I believe, far more frequently than the textbooks allow, and the condition, in my experience, is the commonest cause of a lingering second stage in those disappointing cases where, though everything else seems favourable, the head does not descend. I find that Nature will not right the majority of cases of this malposition. Forceps with anaesthesia are generally required, and it is advisable, if during extraction the head rotates either to the lateral position or to the occipito-anterior position, to take the forceps off and put them on again before completing the delivery. The lateral position I have referred to, neither occipito-anterior nor posterior, is not uncommonly the difficulty to be overcome.—I am, etc.,

King's Norton, April 23rd.

BERT. JORDAN.

SIR,—I am glad to find that medical men of experience are adding their testimony to the safety and humanity of the advanced method. May I add a word or two of argument?

1. Every experienced obstetrician knows that with the aid of chloroform and the forceps he can with perfect safety deliver women in bad high forceps cases where he has to pull for all he is worth. Why deny the privilege to other women, and save them hours of pain when no great obstruction exists?

2. To dilate the cervix in a non-pregnant uterus is not a difficult nor dangerous matter. Why should there be any difficulty or danger in the educated hand stretching an already dilating os in labour?

On looking at my records for the last fifteen months I find I have used chloroform and the forceps in 80 per cent.

of those cases where I have been present at the birth of the child, and each case has done perfectly well—better, in my opinion, than if Nature had been left to accomplish the task unaided. The usual proportion of these cases have been occipito-posterior, and when the hand has been introduced into the vagina and the os fully dilated, nothing is easier than to slip the hand over the child's head like the blade of the forceps, and with a turn of the wrist correct the position. The forceps then being applied will save hours of pain and difficulty.—I am, etc.,

North Shields, April 22nd.

F. C. MEARS.

ANGINA PECTORIS WITHOUT APPARENT DISEASE OF THE HEART OR BLOOD VESSELS.

SIR,—I am greatly indebted to Professor Clifford Allbutt for his lengthy notice of my communication of April 14th. It is very difficult to produce convincing evidence of the intracardiac origin of angina pectoris, because pain in the heart and in the first portion of the aorta is referred to practically the same area. The following points in support of the intracardiac origin of an attack may be worthy of consideration. I do not think the pathological conditions present in calcareous degeneration of the aorta are favourable to the production of a profound nervous explosion for the following reasons: For the generation of visceral pain, the sensory nerves supplying the part must be subjected to considerable stretching either from within or without the particular organ implicated, and when from any cause the sensory nerve endings are destroyed or protected from strain or movement, referred pain ceases. For example, the pain of appendicitis ceases with perforation of the appendix; acute perforating gastric ulcer is said to be free from pain, except perhaps in its early stage, because the nerve endings are destroyed in the ulcerative process; there is an absence of lung pain in pneumonia because the movement of the diseased portion of the lung is arrested. The aorta is no exception, for a small aneurysm of that vessel which excavates its inner wall may at first be very painful, resembling an anginal attack, and subsequently, owing to the destruction of its sensory nerves, or by throwing them out of action by large fibrinous deposits, pain both local and referred may disappear, or it may retain only a dull local character unless by pressure on surrounding structures. From the analogy between the aorta and other viscera in respect of pain, I think I may infer that an extensive calcareous deposit, converting the aorta into a rigid tube, rather protects the subjacent sensory nerves from undue stretching, and therefore removes the essential conditions for either local or referred pain. These are also the cases in which attacks of angina come on with increasing frequency and intensity, and in which the heart also becomes weak—degenerate from interference with the coronary circulation, either by extension of the morbid deposit along the coronary arteries or by encroaching upon their orifices. Assuming that there was in my case extensive disease of the aorta, the coronary vessels would probably share in the disease, with a corresponding effect on the heart muscle.

I will not enter into the conditions within the heart in cases of aortic valve disease beyond remarking that in aortic regurgitation, and more particularly if accompanied by stenosis, the left ventricle in addition to working at high pressure is being constantly jogged by a backward flow when the muscle is not toned to receive it. It consequently becomes fatigued and liable to pain, both local and referred.

Kernig¹ reports important changes following anginal attacks:

"There are fever with increased area of cardiac dullness as compared with the heart before the attack." The fever he attributes to "softening or inflammation of the myocardium." "The second group comprises cases in which dilatation of one or other cavity makes its appearance. In the third group are cases in which acute pericarditis develops in sequence to an attack of angina pectoris attributable to invasion of the pericardium by bacteria from areas of myocardial softening or infarction, or abnormal perviousness of the smaller vessels. Mural endocarditis secondary to areas of myomalacia has likewise been reported. Symptoms of functional derangement, such as diminution of urine and oedema, also make their appearance."

Professor Clifford Allbutt, in his Cavendish Lecture,

¹ Kernig, *Medical Record*, March 14th, 1905.