own medical attendant will be precluded from any supervision at all. I cannot too strongly urge that every doctor should fit himself for being an ante-natal clinician.

Too often, also, these clinics are supervised by public health officials with very little clinical experience, or by persons who never conduct a confinement at any time. Do not think that I am depreciating too harshly the good work done by many of these centres, as undoubtedly they have their place in the welfare of the community, but I consider they should be more in the nature of consulting clinics to which any medical man can refer his cases after he has made a preliminary ante-natal examination which he wishes amplified, or where he wishes for advice in the conduct of the labour. Each of these centres should have adequate facilities for the confinement of those women whose housing conditions are unsuitable or where the medical aspect of the case demands suitable convenience for major operations, and patients should be under the care or direction of the same person from start to finish.

If adequate ante-natal supervision was provided, I believe that a large number of these cases of failed forceps would disappear. But the keynote of success is the word "adequate." I have just said who, in my opinion, should exercise that supervision—the medical attendant who is to conduct the labour, guided, if need be, by advice from a consulting centre. Unless, however, the information gained at the preliminary examinations is acted on, then no reduction in the number of cases of failed forceps can be expected by ante-natal supervision. With this proviso, I think all will agree that most of those cases of failure could have been prevented where the etiological factors were dystocia due to disproportion, or tumours obstructing labour, or faulty presentations.

There remains, however, the group where failure to effect delivery was not the result of any condition present at the beginning of labour, and could not, therefore, have been prevented by ante-natal care—those 47 cases, for example, where an undilated cervix was responsible for the non-success. That many of these misfortunes should not have happened must be conceded. In some, the state of dilatation of the cervix had not been recognized, and possibly better teaching facilities will get over that to some exent—for example, when a student's three months' obstetrical practice is replaced by a six months' course.

In others of this group the fault often lay in a humanitarian desire on the part of the obstetrician to get a painful physiological process over as rapidly as possible. I am not saying this in a spirit of criticism, as I know how much greater are the difficulties under which the practitioner works than the consultant, and the consultant, too, is unduly influenced at times by this consideration to adopt measures which his considered judgement tells him are unwise. I hardly see how occasional mistakes of judgement can be prevented in this way, unless all patients are removed from the sphere of family influence, and better anodynes for use in labour are discovered.

I close with words of advice from the great Sydenham, about whom it was said that, when in doubt, he consulted his own reputation and the patient's safety by doing nothing, and it is certain that of all the aids we possess in the safe delivery of woman in labour, none is of greater value than the practice of the art of patience.

THE TREATMENT OF SECONDARY HAEMORRHAGE AFTER SUPRAPUBIC PROSTATECTOMY

BY

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Primary haemorrhage after prostatectomy can be easily and safely controlled by the various methods in vogue for arresting haemorrhage during and after this operation. The operation of Thomson-Walker, in which bleeding vessels are secured by ligature and oozing stopped by packing the prostatic cavity, and, as an alternative, the use of the haemostatic bag, are certain preventives. Secondary haemorrhage, however, is not so easily dealt with as primary, on account of the narrowing of the suprapubic wound, which takes place rapidly after the drainage tube has been removed. Those who have attempted packing the cavity in these circumstances will agree with me that it is a very difficult procedure involving a great deal of pain to the patient and trouble for the surgeon; besides, it may fail to accomplish its object unless an anaesthetic is administered and the suprapubic wound widely opened up.

For some time past I have been using a haemostatic rubber bag (see Fig. 5) which differs from the Pilcher bag in being spherical instead of pear-shaped. One objection to Pilcher's bag is that it enters the membranous urethra and stretches the compressor urethrae muscle, causing temporary or permanent incontinence. The improved bag, being spherical in shape, can be made to fit accurately into the prostatic cavity, and cannot enter the membranous urethra. It was first made for me by Messrs. Mayer and Phelps, and has stood the test of many trials in the prevention and treatment of primary and secondary haemorrhage.

I need not enter now into the preventive treatment of secondary haemorrhage after prostatectomy, which is due to sepsis and sloughing, and may take place from any of the raw surfaces left after operation, particularly from the margins of the mucous membrane at the entrance to the prostatic cavity and from the cavity itself. Rigorous aseptic technique during and after operation will, no doubt, lessen its incidence, but a wound communicating with the surface easily becomes contaminated, and an aseptic course is impossible. Efforts will, of course, be made to render the raw surfaces as clean as possible, but, notwithstanding all precautions, secondary haemorrhage will occur in a certain proportion of cases. During the years I have been in practice I have had cases occurring from time to time, and in the last few months I have had two: one commencing on the thirteenth day and one on the fifteenth. Both patients were poor risks, and quite unsuitable for any prolonged procedure, either at the primary operation or subsequently. In both the haemorrhage was immediately arrested with very little discomfort by the method I am about to describe, and both have made good recoveries.

It is better to anticipate trouble in these cases by inserting the bag at the very first appearance of haemorrhage, before the bladder has had time to fill with clots, and before much blood, that can ill be spared, has been lost. There are generally several prodromal attacks of slight haemorrhage before the ultimate burst appears. It is well to be forearmed.

METHOD OF ARRESTING SECONDARY HAEMORRHAGE

A catheter is first passed into the bladder—a soft rubber by preference—but if this does not enter easily a gum elastic may be used. Through the suprapubic wound a

light forceps, such as Desjardin's gall-stone forceps, is then introduced, and the catheter gently felt for. As a rule the latter can be easily seized by the forceps and brought out of the wound (see Fig. 1). It may be necessary to introduce the finger to locate the catheter, but this should be avoided, if possible, as it causes a good deal of pain. The urethral tube of the haemostatic bag is then pushed over the end of the catheter and secured by tying round both a piece of linen thread or any available substitute (see Fig. 2). The tube and bag are then smeared thickly with melted sterile vaseline to facilitate withdrawal of the urethral tube and to prevent the bag from becoming unduly embedded. The catheter is then withdrawn through the urethra, bringing the bag, which is thin and collapsible, into position (see Fig. 3). The bag is then distended by filling it with water. When distended it bulges over the edges of the prostatic cavity and makes contact with the walls of the latter, so that pressure can be exerted on both by light traction at the urethral end (see Fig. 4). This pressure is kept up by attaching a weight to the tube emerging from the urethra by a piece of cord, which can be brought over the foot of the bed. The bag must not be over-distended, otherwise it will not fit snugly into the prostatic cavity, but press on the base of the bladder, and may even, if large, exert injurious pressure on the ureteric orifices. The bag is kept in position for two or three days, but is not finally removed until it is judged that all risk of haemorrhage has ceased. It may be allowed to collapse and remain in the bladder as a precautionary measure. Meanwhile, the urethra is irrigated by the side of the tube now acting as a tied-in catheter, using silver nitrate, potassium permanganate, or other suitable solution. This minimizes the risk of urethritis from the presence of a foreign body.

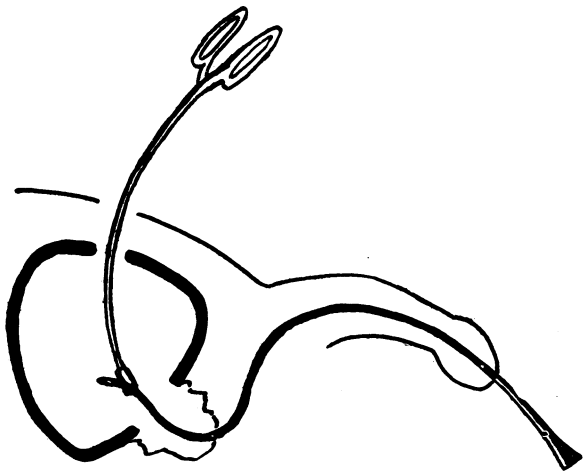

FIG. 1.—Catheter introduced into bladder and grasped by forceps.

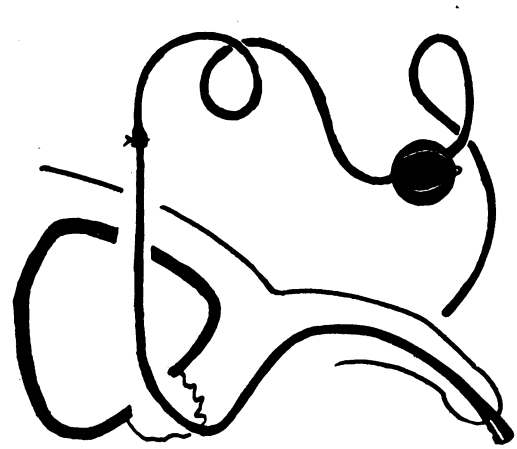

FIG. 2.—The urethral tube of the haemostatic bag is attached to the catheter.

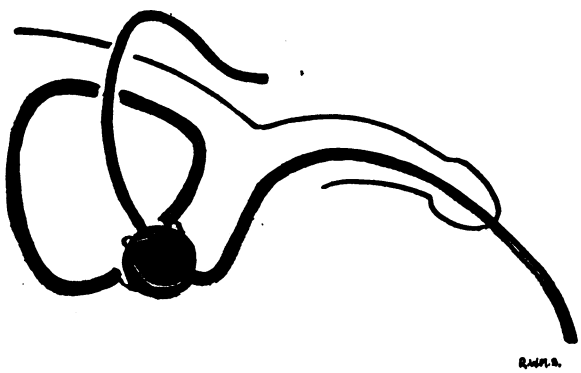

FIG. 3.—The bag in position before inflation.

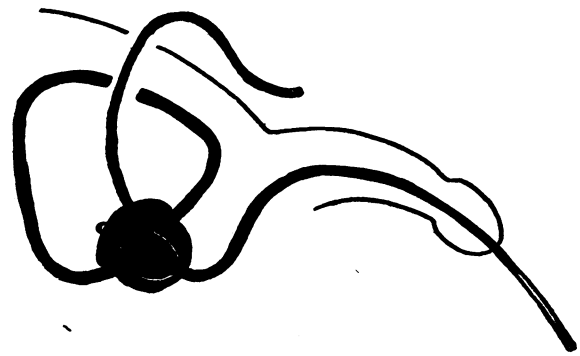

FIG. 4.—On distending the bag with water, pressure is exerted on the cavity and its margins.

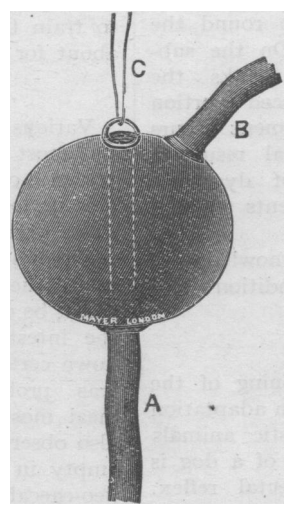

FIG. 5.—Haemostatic bag.

This precaution I always adopt when using the in-dwelling catheter. When it has accomplished its purpose, the bag may be removed easily through the suprapubic wound. To prevent infecting the bladder by drawing the exposed part of the urethral tube, which may be contaminated, back through the urethra, the bag may be cut off close to the meatus before removal.

COMMENTARY

This method of arresting secondary haemorrhage is comparatively painless, is simple and efficient, and I have yet to see any deleterious effect. The same method may be used for reactionary haemorrhage. The haemostatic bag, being globular in shape, fits snugly into the prostatic cavity, and is superior to the pear-shaped Pilcher bag commonly in use. The bag is made in three sizes. For a very large prostatic cavity it might be advisable to have outsizes made. With this apparatus in his possession the surgeon need have no anxiety about his ability easily and rapidly to arrest haemorrhage after prostatectomy, either primary or secondary, and, from my own experience, I am satisfied that he need not anticipate any untoward after-effects.

I am indebted to my former house-surgeon, Dr. R. W. M. Strain, for the illustrations, and to Messrs. Mayer and Phelps for the blocks of Figs. 3 and 5.