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AGENTS.—DAWSON BROS., Montreal; J. & A. MCMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

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PLACENTA PRÆVIA.

One of the most difficult and trying positions in which the young and inexperienced accoucheur can be placed, is at the bedside of a woman from whom the life-blood is rapidly escaping through separation of a portion of the placenta, when attached to the lower third of the uterus, and generally caused by the expansion of the neck, and dilitation of the os.

If his attention has not been previously especially directed to this fortunately rather unfrequent occurrence, he finds himself at no little disadvantage in deciding what course to pursue, and extremely liable to error in practice, or becomes totally inadequate at the very time when his knowledge and skill should be effective in saving the life of the mother, and possibly the child.

Within the last thirty years the fatality attending placenta prævia has been reduced from 30 per cent. to 5 per cent. by the early removal of the uterine contents, the improved methods adopted in inducing premature labor, and the general antiseptic treatment, during and subsequent to delivery. It has long been a question among experienced accoucheurs whether it is advisable to postpone delivery till labor sets in spontaneously, if at all possible to control or stop the hæmorrhage from time to time, or to induce labor and deliver as soon as any considerable flowing has occurred, and placenta prævia is clearly diagnosed.

In later years the general concensus of opinion among most experienced authors is, that we should, rather than assume the greater risk of the expectant plan, proceed at once to induce labor and empty the uterus, no matter at what point of pregnancy hæmorrhage from this cause supervenes. The methods available to restrain or stop the flowing, all depend on pressure, by the trampon primarily till the os is sufficiently dilated, if not already large enough to admit one or two fingers. Then the placenta should be separated from the uterus as far as can be detached by one finger; expansion of the os should be induced by the fingers, thereby bringing on contractions of the uterus. If now the uterine action is ineffective to produce sufficient pressure of the head, and the forceps cannot be applied to keep the pressure continuous by moderate traction, so as to stop the flowing, the medical attendant should at once press up the hand either at the margin of the placenta or through the placenta, if centrally located, and resort to version, drawing down the leg, and making a breech presentation. If the os be too small to introduce the hand, turning by combined version must be attempted. With a leg through the os, and the breech well down, flowing is effectually prevented. Then we can safely wait for the natural contractions of the uterus to expel the child, and secundines, assisted possibly by gentle traction on the leg.

In this connection the following rules recently laid down by Braxton Hicks, as embodying the ideas of the most practical and skilful accoucheurs of our day, will be important.

1. After diagnosis of placenta prævia is made, proceed as early as possible to terminate pregnancy. 2. When once we have commenced to act, we are to remain by our patient. 3. If os be fully expanded, and the placenta marginal, we rupture the membranes, and wait to see if the head is soon pushed by the pains into the os. 4. If there be any slowness or hesitation in this respect, then employ forceps or version. 5. If the os be small and the placenta more or less over it, the placenta is to be carefully detached from around the os; if no further bleeding occur we may elect to wait an hour or two, but should the os not expand, and if dilating bags are at hand, the os may be dilated. If it appears the forceps can be admitted easily, they may be used, but if not, version by the combined external method