diagnosis is the more difficult in that it is so frequently associated with other abdominal lesions. Its presence, however, should be suspected in cases presenting a somewhat indefinite cycle of upper abdominal symptoms, chief among which are loss of appetite, vomiting, and emaciation.

As pancreatic lymphangitis is usually secondary to disease in some other organ its treatment must essentially consist in measures directed to the cure of the primary focus of disease. Thus whilst in one case the removal of a chronically diseased appendix may be indicated, in another, appropriate treatment for gastro-duodenal catarrh or duodenal ulceration may be called for. As, however, clinical experience has shown that the majority of cases of early pancreatic inflammation are closely related to disease of the biliary tract, drainage of that tract is the sheet-anchor of our treatment of chronic pancreatic disease. In cases of pancreatitis associated with jaundice the latter is usually accounted for by pressure of the pancreatic tissue on the common duct where it courses through the head of the pancreas. Deaver, however, believes that in many of these cases there is an associated spasm of the sphincter of the papilla of Vater such as is seen at other sphincter-guarded orifices, and that improvement will follow measures, such as dilatation, which will at least temporarily destroy the sphincteric function.

D. P. D. W.

**OBSTETRICS AND GYNECOLOGY.**

**UNDER THE CHARGE OF**

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**PLACENTA PÆVIA.**

Can we improve upon our results in the treatment of central placenta prævia? Dr. Francesco Valtorta thinks we can. He has been working under Professor Mangiagalli in the Obstetric Institute of Milan, and has been analysing the cases of placenta prævia which occurred there between January 1890 and June 1912 (*Ann. di Ostetricia*, ann. xxxiv. vol. ii. pp. 362-368, 1912). There were 12,591 confinements in these years, 245 of which were complicated with placenta prævia, and of these, 100 were instances of the central or total variety; the maternal death-rate for the 245 was 12·28 per cent. and the foetal 53·7 per cent., whilst for the central cases alone it was 20 per cent. and 64 per cent. respectively.

The percentage of placenta prævia therefore was nearly 2 (1·94 per cent.), and something like three out of every seven of them were centrals.

Now, Dr. Harold Clifford's *Clinical Report of the Maternity Department of St. Mary's Hospital, Manchester* (for 1911) has just come in, and it is interesting to compare the statistics of Milan and Manchester. In connection with St. Mary's there were 4662 confinements in the
year, and amongst them there were 38 cases of placenta praevia. This works out at 0·81 per cent. There were three maternal deaths, one of these being from post-partum haemorrhage following the placenta praevia, so that the mortality was 7·8 per cent. This was less than that which was noted at Milan; unfortunately in the Manchester report central cases are not distinguished, so that we cannot carry the comparison further. The results for the child were worse in Manchester, there being 17 of the infants stillborn, whilst 10 others died later, giving a foetal and infantile death-rate of 71 per cent. Again, there is no distinction drawn between the children in cases of central and those in the lateral variety of placenta praevia.

Whether, however, we take the Milan death-rates of 12 (maternal) and 53 (foetal), or the Manchester ones of 7·8 and 71, it is quite obvious that placenta praevia is still one of the most dangerous of the complications of labour. Can anything further be done? Dr. Valtorta would first of all unify the definitions used in connection with the subject, so that there may be a fair chance of contrasting the results of different methods of treatment. No definition of placenta praevia is adequate, he thinks, which does not contain the anatomical as well as the clinical factor, and he prefers what he calls the Barnes-Mangiagalli definition, viz., "the insertion of the placenta upon the distensible zone of the lower uterine segment." Further, in order to distinguish between the central, marginal, and lateral varieties we must have the cervix uteri dilated to what is regarded as a sufficient extent; for, obviously, we cannot be sure that it is a central case when the os only admits the tip of the little finger. The sufficient degree of dilatation he fixes at 4 cms., a little less than 2 inches. Speaking generally, then, we are not to arrive at a diagnosis of the variety of placenta praevia till the os is half dilated.

Can anything be done to prevent some of the worst features of these central placenta praevia cases? Dr. Valtorta points out that in only one of all the 245 patients did the haemorrhage supervene in great amount without a previous warning. There ought, therefore, to be a possibility of taking precautions in time, and so avoiding operations on women already exsanguine, and in some instances infected with sepsis. Bleeding in pregnancy, even when slight and transient, should be reported by the patient to her midwife or doctor, and where it is possible she should be examined by an obstetric specialist, who, from the haemorrhages, but also from some finer diagnostic characters (such as displacement of the cervix, absence of engagement of presenting part, boggy sensation given by the cervical tissues, etc.), may be able to recognise the anomaly before labour begins. Such a patient ought then to take greater care of herself; she ought not to do hard manual labour in the later weeks, but should rest a good deal, and she ought to be within easy reach of the best treatment. Even if operative
interference becomes necessary, such a patient will have a much better chance of a good result, and will in all probability escape infection. Dr. Valtorta is really arguing here in favour of the strict medical supervision of pregnancy; but before that is possible, patients must be instructed to recognise anomalous symptoms in their pregnancies, and to report on them to their medical attendant.

Even when the hæmorrhage is going on and the labour in progress, Dr. Valtorta is of opinion that we can lessen the mortality by putting a check upon the tendency which exists to employ surgical measures, and by trusting more to obstetric means. He sums up against vaginal Cæsarean section on account of the great friability of the lower uterine segment, and the tendency it has to bleed when torn; he is convinced that cases of central placenta praevia calling for the ordinary Cæsarean section are extremely few, for he thinks that the rigidity of the cervix, advanced often as a reason for doing this operation, is not a true rigidity, but rather an apparent one caused by lack of engagement of the presenting part of the child; and he is also opposed to accouchement forcé (either manually or instrumentally with Bossi's metallic dilator). He uses Bossi's dilator, however, in cases in which the os is not sufficiently dilated and rapidity of intervention needed; but even then he only dilates up to 3 or 4 cms., in order to make other manoeuvres possible. If the os be not dilated and the symptoms slight, or at any rate not urgent, vaginal plugging should be employed as a temporary measure, preparatory to operative means to be used later. Here Dr. Valtorta speaks strongly (and wisely so) of the insufficient packing often introduced into the vagina by the person who is first called to the case. A few pieces of cotton-wool lying loosely in the canal is not vaginal plugging. Indeed, one feels deeply impressed (when one thinks of it) with the tremendous responsibility which rests upon the first person (be it midwife or doctor) who gives treatment to the placenta praevia patient; in his or her hands there really lies the ultimate fate of the woman and her infant; and there is more than a little ground for the statement that if one is able to operate in good conditions no woman ought to die from hæmorrhage in placenta praevia.

But to return to obstetric measures. If the os be sufficiently dilated and the placenta central in position, Dr. Valtorta asks us to choose between Braxton Hicks's combined version and the use of the Champetier de Ribes's bag. In both cases the placenta is perforated; in the former a foot of the child is drawn down through the opening made; in the other the dilating bag is pushed up through it. He himself prefers the second method, and he has reason for his preference, because he has treated 14 cases of central placenta praevia with the bag, and has lost none of the women on account of hæmorrhage (one died at the end of the first week from septic infection, but then she had been plugged in her own home before coming to hospital). He emphasises
the technique, however. The left hand is to be introduced into the
vagina, and one or two fingers are to be placed in the os; the placenta
is then to be perforated with a narrow pair of curved forceps; then
(with a finger in the opening) the operator grasps the bag with the
forceps and pushes it into the interior of the uterus; finally the blades
of the forceps are disarticulated and removed one by one, leaving the
bag, which is next to be distended, *in utero.* Three advantages are
claimed for this method: these are the small loss of blood which is
caused, the fact that it can be carried out without anaesthesia, and the
greater safety for the fetus thus obtained. The bag is applied intra-
ovularly, and therefore the risk of infection is very slight. Slight
traction can be made on the bag, and before long the canal is sufficiently
dilated for delivery of the child.

On the other side of the Atlantic Dr. Henry Schwarz of St. Louis
holds views which are very similar to Dr. Valtorta’s (*Amer. Journ.
Obstet.*, vol. lxvi. pp. 974-980, 1912). With regard to Cæsarean section
they are even stronger, and he discusses all varieties of placenta
prævia, not merely the central ones. He says: “No form of placenta
prævia, as such, ever offers a justifiable indication for Cæsarean section.”
He condemns version too: “Version after Braxton Hicks, in the presence
of a viable child, deliberately sacrifices the life of that child, and has
no place in modern obstetrics.” He bases his opinion on the physi-
ology of the mechanism of labour in the first stage, and he maintains
that by proper packing of the cervix and the vagina the bleeding can
be stopped. As soon as the cervix is sufficiently dilated he introduces
the Champetier bag, but, unlike Valtorta, he pushes the placenta up
in front of it, and does not perforate it. The case may be finished by
podalic version, forceps, etc. Dr. Schwarz has treated fifty cases of
placenta prævia in this way, with one maternal death (2 per cent.).

The discussion which followed the reading of Dr. Schwarz’s paper
—it took place at the annual meeting of the American Association of
Obstetricians—was spirited; indeed, the remarks made by some of the
speakers in debate showed signs of considerable excitement. One
obstetrician, for instance, in arguing for the use of Cæsarean section,
closed his remarks with the following alarming, albeit cryptic, state-
ment: “We were all babies once, and if we do not take care of the
babies, we will never have any more mothers.” It goes without saying
that Dr. Gustav Zinke pled energetically for Cæsarean section in
certain selected cases of placenta prævia (*e.g.*, when the musculature
of the uterus is diseased, or when there is incipient malignancy in the
cervix); he had advocated it eleven years previously, and he main-
tained that there were “cases which could only be saved by Cæsarean
section, all the arguments to the contrary notwithstanding.” In his
reply Dr. Schwarz seems to have felt the electricity in the controversial
atmosphere, for he closed the discussion with the following words,
which had been used by Dr. Newell of Boston: "The advocates of Caesarean section have not recognised that their personal limitations furnish the great indication for abdominal delivery and not the exigencies of the case."

Professor Paul Bar (Arch. mens. d'obstétr. et de gynéc., ann. i. No. 10, pp. 162-176, 1912) discusses the question of surgical interference in placenta prævia in a much calmer manner than our American confrères. Since 1897 he has dealt with 153 cases of this complication of labour, first at the Saint Antoine and later at the Clinique Tarnier; the total number of confinements in the same period would be about 20,000. In Paris, therefore, placenta prævia would seem to be rarer than in Milan (where there were 245 cases out of about 12,000 labours). The deaths were 14 mothers and 50 infants, or 9·2 per cent. and 51·63 per cent. respectively. Various plans of treatment were employed: in 10 cases labour was rapidly ended by forceps, version, or basiotripsy; in 8 the haemorrhage was treated by vaginal plugging, alone or along with rupture of the membranes, version, or the bag, and in the first of these groups there was one maternal death, and two in the second; in the great majority of the cases (120) rupture of the membranes without vaginal plugging, but sometimes with version, the Champetier bag, or forceps, was the method used, and there were nine maternal deaths; in 2 cases the placenta was perforated and immediate version performed, with no maternal but with two infantile deaths; in 6 cases manual dilatation of the cervix was carried out (followed by version or forceps), with one maternal death; and in 3 cases the cervix was dilated by the Bossi instrument, with no maternal fatality. But in respect of the maternal mortality Professor Bar has this to tell us: in 10 out of the 14 deaths the cause was infection; in only 4 was it to be ascribed to the acute anaemia produced by the haemorrhage. But another thing is still more striking: in the Saint Antoine no special effort was made to persuade patients with morbid conditions in pregnancy to remain in the hospital, whereas in the Clinique Tarnier pregnant women often came for advice, and nearly always remained in the hospital if so advised; of the 45 cases of placenta prævia treated in the Clinique Tarnier there was not a single death from infection. This is a most remarkable testimony to the value of providing ante-partum beds in connection with our maternity hospitals.

Professor Bar thinks there is a place for purely surgical treatment in placenta prævia, but it is a very restricted place. In cases in which there is reason to fear infection and in which the cervix can be dilated without fear of tearing it, then obstetrical means (rupture of the membranes, use of the bag, combined version) are indicated; but if the cervix is not dilatable or cannot be safely dilated, and if there is the need for rapid interference, then he inclines to try the vaginal Caesarean section. But the vaginal Caesarean section may be contra-
indicated, viz., when the placenta is situated very low and in front (for then there might be danger of cutting into it); under these circumstances the abdominal route may be tried, only it would be, not a classic Cesarean section but a hysterectomy that Professor Bar would recommend. If, again, there be no risk of infection, and if the cervix is dilatable, obstetric measures are to be preferred; but if the cervix be undilatable, and there is a call for haste, the classic Cesarean section is to be chosen. It will be seen, therefore, that Professor Bar regards the sphere of surgical treatment in placenta praevia as very limited. Perhaps when the pregnancy is at full term and the infant vigorous there is supplied another reason for preferring the Cesarean section, for it cannot be denied that the ordinary obstetric means give rather a poor chance to the child.

It is rather like passing from one end of the therapeutic scale to the other to speak of pituitrin in placenta praevia after Cesarean section, but E. Hauch and Leopold Meyer (of Copenhagen) have given this new organic extract a trial in association with the obstetric device of rupture of the membranes (Arch. mens. d'obstét. et de gynéc, ann. i. No. 10, pp. 177-183, 1912). They found it helpful (given subcutaneously) in four cases of lateral placenta praevia, but in three other cases (central variety) it was disappointing. It can only act by strengthening the uterine contractions, and it must therefore be looked on as no more than an auxiliary in the big contest with placenta praevia.

We come back, therefore, to the question with which we began: How can we reduce mortality in placenta praevia, and especially in the central variety? The answer seems to be that, in the first place, the unification of our nomenclature by giving a sure basis for comparison of different methods of treatment will be a help. In the second place, and in view of the risks of infection and of additional haemorrhage from tearing the cervix, the advantages of early recognition of the abnormal situation of the placenta before labour comes on and of the adoption of aseptic precautions from the very first are very great. The diagnosis of placenta praevia in pregnancy and the supervision, during their pregnancies, of patients suffering from this complication, either in their own homes or, preferably, in pre-maternity wards in the hospital, are means which may confidently be looked to for a marked reduction of mortality. In the third place, the sphere of the purely surgical operations (vaginal Cesarean section, hysterectomy, classic Cesarean section) is a very limited one, but these procedures may in carefully selected cases save some lives, both maternal and infantile. For the general practitioner the essential thing to bear in mind is the extraordinary importance of the early stages of interference in cases of placenta praevia; defects in aseptic technique in the first applied plans of treatment may have the most serious effect upon the ultimate result.

J. W. B.