MEETINGS OF SOCIETIES.

Edinburgh Medico-Chirurgical Society.

A meeting was held on 5th January, Dr. Byrom Bramwell, President, in the chair.

Dr. C. W. MacGillivray opened a discussion on syphilis and marriage. He referred to the importance of the question in view of the facts that the disease was not merely infectious, but was transmissible to the offspring, and was a common cause of abortion and of degeneration of the race. The public was very ignorant regarding venereal disease, and it was left entirely to the medical man to cure the disease, to prevent contagion, and prevent transmission. The task was both difficult and thankless. The question when it was safe for a syphilitic to marry was a difficult one. His own view was that four years from the chancre was a sufficient interval if the treatment had been efficient, and there had been no further symptoms. A question must be treated as a sanitary, and not as a sentimental, one. The subject of malignant syphilis was unsuitable for marriage at any time, but the problem was usually forestalled by death. Tertiary syphilitics should be advised not to marry. A large number of interesting cases were quoted.

Dr. Clouston said that congenital syphilis might show itself as a form of epileptic idiocy and defective development. General paralysis was also syphilitic. In general paralysis of adults there was precedent syphilis in the great majority of cases, but a causal relationship was not established. It was the routine treatment to give antisypophilitic remedies in general paralysis, but the small number of cases which recovered were most probably brain syphilis.

Dr. Haultain said that, as regards paternal syphilis, he was sceptical about the truth of Colles' law. Many women married to syphilitic men aborted regularly, but the women were not syphilitic, and were not immune. After a woman had a series of abortions, and was then treated, the foetus might live. The benefit of the mercury was wrought on the foetus through the placental circulation, and not on the mother. He cited cases where women with syphilitic husbands had several abortions, and after remarriage to healthy men had healthy children, and quoted one case where a woman with a syphilitic husband had a series of abortions, and after re-marriage to a second syphilitic got a chancre on the cervix.

Professor Caird deplored the absence of statistics in this country, but believed that the greater efficiency of modern treatment had done a very great deal to save many lives.

Dr. Cranston Low quoted the experiments of Metchnikoff and Roux,
which showed that vigorous treatment cured the disease, and made early re-infection possible. The Wassermann reaction should be tried when old syphilis was alleged or suspected.

Dr. Allan Jamieson said that a difficulty arose in the treatment of syphilis, since as soon as symptoms disappeared, the patient suspected whether advice to prolong treatment was disinterested.

Mr. Hodsdon quoted a case in which, after very thorough treatment, a second infection occurred two years after the first.

Mr. Miles said that the advice to delay marriage for more than two years was a counsel of perfection. He doubted whether tertiary syphilitics need be advised not to marry. All humanity was liable to some fatal disease.

Dr. James Ritchie thought there should be two years' treatment, and one year without symptoms before marriage.

Drs. Lundie and Blaikie read a paper on the "Treatment of Phthisis and other Conditions by Injections of Arylarsonates." The drug chiefly used had been soamin. Doses of 10 grs. on two successive days were given at intervals of a fortnight. In one-third of the cases there was pain twelve hours after injection, and in one case blindness had resulted. In specific cases the benefit had been very great. In some tubercular cases there had been immediate and striking improvement.

Dr. Boyd made some remarks on metabolism under the influence of these bodies.

Dr. Berry discussed the nature of the optic lesion in blindness resulting from the use of such drugs.

Dr. W. G. Aitchison Robertson gave a lantern demonstration illustrating the advantages of cremation over earth burial.

Edinburgh Obstetrical Society.

The second meeting of the session was held on Wednesday, 8th December 1909, Dr. F. W. N. Haultain, President, in the chair.

Dr. Haig Ferguson and Dr. Fordyce showed specimens.

Dr. J. W. Ballantyne read a paper entitled "The Rational Puerperium." He referred to Dr. Haultain's paper read before the Society in July, in which it had been claimed that recumbency after the third day and in an ordinary case was unnecessary, and that it was rational management to allow the puerperal woman to sit up in bed on the second day and to rise on the third day. The morbidity in 100 hospital cases so treated was 3 per cent.

The question of early rising had been much discussed on the Continent during the last ten years, but in Britain it had received little attention. Early rising, even on the day following labour, had been advocated as early as 1874-5 by Dr. William Goodell of Philadelphia,
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who gave as reasons in its favour that labour was a physiological and not a pathological process, that the upright position excites uterine contractions and lessens the amount and duration of the lochia, the absence of uterine diseases among the nations whose women practise early rising, and his own experience that early rising made the convalescence after labour more prompt and sure. This position was adversely criticised in his own country by Garrigues (1880) and apparently found no support in Europe. The subject was actively revived by Küstner in Berlin (1899), who thought that for strong healthy puerperal patients who had come through a normal labour, and had neither been infected nor suffered lacerations, a rest in bed for several weeks was not only needless but actually harmful, and that they ought to rise on the third or fourth or even on the second day after delivery. In cases with lacerations, previous infection, or gonorrhoeal discharge, and in operative and unusually tedious cases, however, the longer rest in bed was enjoined. In cases which rose early he claimed to find freedom from prolapse or retroversion, hastening of involution, greatly improved digestive functions, and absence of difficulty in micturition. Küstner's method met with a good deal of criticism and little support. Of late years, however, it has found numerous advocates, and excited animated controversy and literary activity. So far Dr. Ballantyne found most of the reports to have been favourable to the new departure, and they seemed to show that after normal labours there is no need for prolonged rest in the horizontal position.

Amongst results quoted were:—Karl Mayer: patients allowed up when they liked; 4 rose on the third day, 40 on the fourth, 100 on the fifth; morbidity lower by 10 per cent. than in patients under old rule. Von Alvensleben: of 100 cases 3 rose on the first day, 61 on the second, 19 on the third, 18 on the fourth; morbidity 10 per cent. as opposed to 17 per cent. in the general clinic. Opitz reported favourably, but found difficulty in preventing women leaving hospital too soon, and anticipated difficulty in private practice where the puerperal patient was under less constant observation. Krönig still further shortened the resting period, allowing some patients treated by scopolamine and morphine to get up 8 to 10 hours post-partum. His published results were good and show no cases of thrombosis or embolism. Simon allowed rising for increasing periods from the fourth day, insisted on wearing a binder, and instituted gymnastic exercises to strengthen the abdominal muscles. On the other hand, Gellhorn has adversely criticised the method, and found that patients discharged from hospital as in perfect condition had required weeks of rest and treatment for disturbances which had come on after their return home. The case of the women of Java had also been brought forward as an argument against the practice. These women, of exceptional physique, are compelled by an old law of
their country to get up immediately after confinement and walk about, although not to attend to their domestic duties, and amongst them embolism and prolapsus uteri were of frequent occurrence. Fromme recorded a death from thrombosis and embolism in a patient who got up for an hour on the second day.

Dr. Ballantyne then reviewed a modified method carried out by himself in the Edinburgh Royal Maternity during the autumn quarter of 1909. He was convinced that the horizontal position in the early days had distinct advantages, but believed that the advantages claimed for early rising, viz., the strengthening of the abdominal and pelvic muscles, the improved digestion and better appetite, improved regulation of the bowels, and more ready escape of the lochia, could be attained by other methods without the possible risks of early rising. The escape of the lochial discharges was encouraged when desired by elevation of the head of the bed on blocks, and by giving regularly a pill containing sulphate of quinine and ergot, sometimes with digitalis. An amplified system of early exercises in the lying position (Liegegymnastik) as advocated by Krönig was carried out. These were not forced on the patients, but were quite voluntary and were directed by the sisters or nurses. They consisted in turning movements of the body, drawing up the knees, movements of the arms, and breathing exercises. In most cases they were begun the first day after labour—in no case later than the fourth day—and lasted for 10 minutes the first day, 20 minutes the second, 30 on the third, which was never exceeded. The patients enjoyed them, and in most cases the tone of the abdominal muscles at time of leaving hospital was above the average. No marked effect on the action of the bowels was observed.

Accurate observations were made by the house-surgeons in the 122 cases treated, as regards effect on muscular tone, pulse-rate, blood-pressure, and general progress in convalescence. Patients who, from various circumstances, could not have been allowed to rise early, were able to engage in the exercises at an early period. The treatment was contra-indicated and was not practised in a number of patients, including cases of eclampsia, serious heart disease, sepsis before admission, influenza, albuminuria, pneumonia, craniotomy, &c. As regards the date of rising in these cases treated by exercises, 43 rose on the seventh day, 38 on the eighth day, 19 on the ninth day, 4 on the tenth day, 1 each on the sixth, eleventh, and twelfth day. There was a marked absence of the usual weakness and dizziness on rising.

Dr. Ballantyne arrived at the following conclusions:

1. That it is permissible to reduce the period of rest after labour for the ordinary hospital patient to 8 or 9 days.

2. Systematised exercises in the horizontal posture during the early days helps to keep the muscles in good tone, saves the patient from ennui, and facilitates return to the normal after rising.
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3. When these exercises are carried out it may be safe to allow rising on the seventh day.

4. In coming to any conclusion about the proper day of rising in the puerperium the effects on the various phenomena of the period—pulse-rate, blood-pressure, temperature, &c.—must be strictly scrutinised, and the result shows that rising even on the seventh or eighth day causes distinct rise in the pulse-rate and a fall of blood-pressure.

5. The necessity for earlier rising, with its possible risks, will disappear when its advantages are gained in other ways as by the methods advocated.

6. Normal cases must be clearly distinguished from morbid ones, and the treatment adapted to the circumstances. Many cases in which early rising is contra-indicated can engage safely in the Liege-gymnastik.

7. In private practice some shortening of the lying-in period might be adopted, the strict maintenance of the dorsal posture not insisted upon, and the patient allowed to turn freely about in bed.

Dr. James Ritchie, in opening the discussion, said that although in many women maternity might be described as a physiological process, in very many, especially those of the better classes, the process was dangerously near the pathological, even in uncomplicated labours. Such patients were not good judges of the amount of liberty which they might take. Formerly, patients had been kept too long and too strictly at rest, and that to their disadvantage. The use of an abdominal binder was physiologically correct because it gave to the abdominal contents that support which the lax parietes could not afford under the suddenly changed conditions. Most women expressed themselves comforted after its application. The use of a pad was indefensible. If the uterus was not contracted and retracted the woman should not be left. For some years he had allowed patients to move freely from side to side immediately after confinement. If they could not use the bedpan they were allowed to sit in bed to empty the bladder. He allowed the patient an increased liberty in bed in proportion to the rate of involution of the uterus. He did not approve of routine douching of the vagina. Douches were necessary in special cases. For a cleansing douche he preferred sterilised water to antiseptics, because he believed that the latter diminished the natural protective power of the vaginal secretion. He thought that the principles advocated by Dr. Ballantyne were founded on a more scientific basis than those recommended by Dr. Haultain, whose paper he had read with much interest. Although he had no actual experience of the gymnastic movements he felt inclined to give them a trial in his private practice. Dr. Barbour said there could only be one opinion as to the importance of the paper, and of the subject with which it dealt. In the preceding quarter at the Maternity he had steered a middle course, letting patients rise about the fifth day, and had been well satisfied with the results.
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Owing to the great interest of the subject full discussion was postponed until the next meeting of the Society.

Dr. B. P. Watson and Mr. H. Wade described and illustrated by lantern slides the Histological Changes Associated with an Early Abortion and the Anatomy of the Ovum. The specimen was obtained from a patient aged 24, who had borne two full-time children, of whom the first was alive and healthy and the second had died nine days after birth; then a series of abortions occurred at different stages in the first half of pregnancy. Each abortion was preceded by continued haemorrhage. Antisyphilitic treatment had had no effect, but syphilis could not be rigorously excluded. Curettage also had been tried without avail. The menstrual losses were always profuse. The specimen consisted of a complete decidual cast of the uterus, containing in situ a pea-like ovum 1 cm. in diameter. Pregnancy had not advanced beyond the third week. On section the vessels of the decidua vera, serotina, and reflexa were found to be surrounded by a definite wall, composed of a fibrous tissue deposit and an endothelial proliferation, which reduced the size of the lumen. The changes were comparable with the sclerosis of uterine vessels occasionally found about the climacteric period. At one part thrombosis in a narrowed vessel had led to the necrosis of a lobule. The same pathological condition was found in the vessels of the resting mucosa, obtained from a previous curetting. The glands showed a degree of enlargement and proliferation. From the history and the changes in the resting mucous membrane and decidua, it was suggested as probable that the vascular change was causally related to the series of abortions. Whether it was primarily due to syphilis, or to a localised toxic absorption from the uterine mucous membrane, was left undecided. Serial sections, almost exactly transverse, of the embryo and its membranes were shown. They demonstrated with diagrammatic clearness the structure and relations of the early embryo. Dr. Barbour, Dr. J. W. Ballantyne and Dr. Young made remarks on the paper.

The third meeting of the session was held on 12th January, Dr. Haultain, President, in the chair.

The following specimens were shown by the President:—(a) Twisted pedicle subperitoneal fibromyoma of uterus with double fibromata of ovary. (b) Suppurating dermoid with intra-pelvic uterine fibromyoma. (c) Foetus, showing achondroplasia, and median and probably lateral encephalocele.

Dr. J. W. Ballantyne showed (a) small uterus with fibroids removed for pressure symptoms. (b) Ectopic gestation of one side, with haematosalpinx of the other. (c) Copy of Mercurio’s La Commare, alleged to be the first edition of 1601; also a copy of the 1642 edition. A point of interest was an illustration in this old work showing the
obstetric position now known as Walcher's position; also a copy of Raynalde's _Byrth of Mankynde_, edition of 1545.

The adjourned discussion on Dr. Ballantyne's communication on "The Rational Puerperium" was resumed.

Dr. Lackie referred to the risk of chill to the patient performing the exercises advocated by Dr. Ballantyne, and thought these exercises too limited to do any good. He considered massage preferable. He supported the plan of early rising which he had seen give such good results in Dr. Haultain's hands, and from which he had also obtained gratifying results in private practice.

Dr. Fred Porter made a plea for more thorough criticism before deciding definitely about the proper time for rising. He thought Dr. Ballantyne's charts showing blood-pressure, pulse-rate, &c., should be compared with similar observations in cases treated by the old method. He referred to the occurrence of embolism, phlebitis and prolapse, even in cases carefully treated by long rest in bed.

Dr. Armour thought the principle of not interfering with normal processes observed in our conduct of labour might with advantage be extended into the puerperium. If we could arrive from historical facts at a conclusion as to what women inclined to do of themselves before they became guided by medical men, he thought it would give us the normal period for women to "lie up." This would probably come nearer the "third-day" than the "eighth-day" method.

Dr. Oliphant Nicholson referred to the good results obtained in dispensary patients, who got up when they chose, and said he had found these results better than in private practice. This he attributed to the satisfactory drainage of the lochia that took place from the erect position. Whilst agreeing fully with the principle of early rising, he found in private practice that not one in ten or twenty wished to get up earlier than a week at least, and he did not see the need to change in private practice unless patients desired it.

Dr. Keppie Paterson said it was good to be shaken out of the ruts of custom in practice sometimes. He still believed thorough asepsis in midwifery an utter impossibility, and gave regularly a perchloride douche immediately after completion of labour, frequently flushing out the uterus at the same time. As to the puerperium, for some years he had allowed turning in bed and sitting up in bed to pass water the first day; encouraged sitting up in bed on the third or fourth day, and allowed of rising to have the bed made often as early as the fifth day. He had ventured on still earlier rising lately, but as yet did not feel quite justified in urging it generally.

Dr. Haig Ferguson expressed himself as quite satisfied with the existing method of treating the puerperium if carried out rationally and the patient not stagnated by disallowing movement. Free drainage for the lochia was the crux of the whole matter, and this was best
promoted by allowing of movements and sitting up in bed. He thought the present departure in favour of early rising a mistake, not because of immediate results which were much the same in both methods, but because of the remote results such as displacements, prolapse, cystocele. These were much more common amongst the poorer classes than in private practice, and he attributed their greater frequency mainly to getting up too soon. The patient's desire to rise early should not come into the matter at all, and the question should be decided entirely by the opinion of her medical attendant. Gymnastic exercises in bed would do less harm than early rising.

Dr. Haultain said the crux of the situation lay in the way we looked upon pregnancy, labour, and the puerperium; whether we regarded them as pathological or physiological. Unfortunately the teaching in the past had taught us to regard these processes as pathological. If physiological, as he believed, why should we condemn a woman to 14 to 21 days in bed? In his experience he had not found women to desire the long rest; on the contrary they were only too keen to rise. Whilst he certainly did not defer entirely to the patient's wishes in the matter, he had been in the habit of asking them on the third or fourth day if they wished to get up, and allowing them to do so if they chose. He now went further and urged those to get up who did not wish to do so.

In 25 private cases occurring since he read his paper 20 got up on the third day; all did well, and those who had had previous confinements expressed an unusual feeling of well-being and regret that they had rested so long on previous occasions. Of the others, 2, relations of doctors, refused to rise. Two were severe complicated labours. One had a foetus weighing 11 lbs., and in consideration of the unduly stretched ligaments and weakened pelvic floor he decided not to let her up. It was interesting to note that now after three weeks in bed she had a prolapse. He could not agree at all with Dr. Haig Ferguson's opinion that prolapse, &c., were more common in hospital than in private patients, but thought that impression was gained because one saw so many more of the former class in one's work. He had had no case of phlebitis or thrombosis since he started early rising, and he thought the stimulation given to the circulation probably even prevented their occurrence. He thought the performance of exercises in bed not so good as early rising, as, in the recumbent posture, they would tend to force the uterus backwards. He recognised that it was difficult for medical men to carry out early rising in private practice at the present time, because any bad results whatever would be put down to it, but personally, he was so convinced of its rightness that he was determined to go on with it.

Dr. Ballantyne, in replying to the criticism, referred to the difficulty of getting a nurse to massage every case. When he came on duty at
the hospital he found two cases of phlebitis in patients who rose about the fifth day. He strongly deprecated the discussion being regarded as in any sense a duel between himself and Dr. Haultain, as both were attacking what was hitherto the customary mode of treatment during the puerperium; and if his own paper had preceded that of Dr. Haultain instead of following it, the views expressed by him might have been regarded as radical and those of Dr. Haultain as conservative. Whilst the puerperium was not pathological it was still a period of stress and strain following the stress and strain of labour. In private practice one felt some diffidence in attacking an old-established custom, but he thought this would be less if the change were less radical as in the method he advocated than it would be if we jumped still further at once to that of very early rising.

Dr. Hugh S. Davidson read a communication on "Ovarian Epilepsy," with a report of two cases successfully treated by operation, which appears on page 125.