Treatment of Contracted Pelves.

The *Lancet*, in an interesting review of the medical year, gives the following summary of the most modern methods of treating contracted pelves:—

With the gradual lowering of the death-rate after the operation of classical Cæsarean section, together with the development of pubiotomy and the introduction of supra-symphyseal Cæsarean section, our methods of treating cases of contracted pelves are gradually, but surely, undergoing a change. At the same time it must be remembered that increasing experience is again bringing to the front the teaching of some of the greatest masters of obstetrics, teaching which of late years there has been a great tendency to forget—namely, the extreme importance of allowing, whenever possible, spontaneous labour to occur in a case of contracted pelvis. In a most interesting paper read before the Glasgow Obstetrical and Gynæcological Society Professor F. Schauta laid great stress upon this point, and showed that in his clinic, considering labours at full term only, nearly 80 per cent. in cases of contracted pelves ended spontaneously. Not only did they end spontaneously, but this termination gave better results for the mother than any other, and better results for the child as compared with any other method of treatment, with the exception of Cæsarean section. In cases of contracted pelves where labour took place in a lying-in hospital under the best possible surroundings he recommended the following lines of treatment. With a conjugate of above 8 centimetres (3 $\frac{1}{5}$ inches) there is a possibility of spontaneous delivery and therefore expectant treatment should be adopted. In cases with a conjugate under 8 centimetres (3$\frac{1}{5}$ inches) Cæsarean section should be performed, and in cases with a conjugate of 8-8½ centimetres (3$\frac{1}{5}$—3$\frac{2}{5}$ inches) hebosteotomy is to be considered. This operation with a conjugate of 8-8½ centimetres (3$\frac{1}{5}$—3$\frac{3}{5}$ inches) would be an alternative to spontaneous labour, with a conjugate of 7½-8½ centimetres (3—3$\frac{1}{5}$ inches) an alternative to Cæsarean section. The choice would be determined by the size of the head, the character of the labour pains, and the general condition of the patient. These methods should be regarded as typical, and all other methods, such as the induction of premature labour, craniotomy, version, and the application of forceps to the head above the brim, as atypical, and only to be undertaken in special circumstances. These conclusions will be received with some hesitation by many English practitioners, but they are interesting as the matured views of an obstetrician of great experience and of much eminence, and as indicating the trend of modern treatment in these cases. Even in this country at the present day the indications for Cæsarean section are becoming wider and wider, and while hebosteotomy has made but little headway obstetricians are returning to the teaching of Smellie and Hunter, and are at last abandoning the dangerous method of applying forceps to the head above the brim. The induction of premature labour still holds its own in England, but there are not lacking signs that among the more enterprising Scotch and Irish schools of obstetricians it is losing the favour it once had in the treatment of contracted pelves. We may well anticipate for the future the more widespread adoption of hebosteotomy and Cæsarean section, the abandonment of craniotomy, except on the dead child, and the much more frequent performance of Cæsarean section when it can be performed as an operation of election.

Why Not?

One would imagine that there was a "corner" in midwives in London, to judge from the evident and ill-disguised spirit of opposition to the formation of a Midwives' Union upon the part of a certain class of midwife who prefers to be represented on the Midwives' Board, and otherwise, by a medical practitioner. This reminds one of the intolerant R.B.N.A. days. Surely the midwives are not to be herded and hustled in the same unbecoming manner as were the nurses in the naughty nineties? The temper of the times is changed—vastly so, and we hope Mrs. Robinson will not be discouraged, but will call her meeting at a convenient season—at a convenient place—when we feel sure it will be largely attended. A British Midwives' Union is urgently needed, and should be organised with as little delay as possible. *The Midwives' Record* already exists to voice its needs.

The Prevention of Infant Mortality.

The Conference on the Prevention of Infant Mortality recently held at New Haven, U.S.A., was, we learn from the *Johns Hopkins Nurses' Alumnæ Magazine*, one of unusual interest. All sides of the question were exhaustively discussed—medical prevention, philanthropic prevention, and institutional prevention. All the speakers emphatically protested against artificial feeding, and the general opinion seemed to be that with proper care—"proper care" embodying an enormous range of possibilities, medical, philanthropic, and connected with the state regulation of labour, trades, etc.—ninety-nine per cent. of women could nurse their children.

The prepared foods were left without a leg to stand upon when discussion concerning them was ended. The opinion expressed concerning Milk Depôts was that "the educational *possibilities* of a milk depôt should be the only limits to its educational *responsibility*." The chief function of a milk dispensary should be to become a centre of education, not to supply a milk for infant feeding, with the possibility of making mothers depend on that, instead of nursing their children. It was suggested that there should be classes and demonstrations for mothers, and "little mothers," and that the real element of pride in a milk dispensary should be the large attendance of *nursing mothers*, not the number of babies supplied with modified milk.

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