Article V.—*On the Management of Natural Labour.*

By Alex. Baird, M.B., Perth.

Very frequently, even in primiparæ, we find that labour has been begun and finished in such a short time, that the patient herself feels agreeably surprised that foundation for her dread has been but slight. She recovers without any bad symptoms consequent on the rapid dilatation and contraction of the uterus. This is the condition of affairs which pleases alike patient and attendant; and hence it behoves us to consider how in most cases it can be brought about, so rendering unnecessary long hours of suffering to the patient and of waiting to the busy practitioner.

In most, if not all, of our text-books we are told that in ordinary cases of midwifery the less done by the medical attendant the better for the patient, and that our duty as a rule is quietly to wait until the membranes are ruptured, then perhaps to give a little support to the perineum and receive the child. Generally, when called to a case we find the os uteri of a size at least equal to that of a florin, and oftener larger; so that we may, leaving nature to effect delivery, wait for a few hours before being permitted to tie the cord.

It is in these cases, and when the os is somewhat dilatable, that I fancy much can be done by a gradual but continuous dilatation of the os by means of the examining finger and *between* the pains. The patient complains but little of such treatment, and it will be found that, the process being continued, more especially towards the pubic half of the circle, the occiput has more room to descend and the pains become more regular and efficacious, so that labour is assisted materially, much time being saved.

Dilatation of the os, and that part of the cervix which can be reached by the examining finger, is a practice which has been objected to by some eminent writers; but in most text-books no reference is made to the procedure. I have found it useful in saving time, and, further, it seems to me to be a distinct assistance in the natural process of parturition.

Women often will make some objections to the slightest movement of an examining finger, except during a pain, and this seems to show that it is during the continuance of the pain that our interference is expected. It can scarcely be expected, however, that much good can be effected by attempts to dilate the rigid and contracted circle.

During a pain, the uterus, as it were, attempts to draw itself up over the head of the child, and possibly this may be assisted by gently pushing the cervix in the required direction; but during the interval not only can this be effected, but the relaxed circle can be made so much larger as to give both the longitudinal and circular fibres a much better chance when they are again brought into

action. Another decided advantage resulting from the more rapid dilatation of the os is, that pressure of the cervix between the descending head and the brim is much less likely to occur. This is of great consequence during protracted labours, and especially after premature rupture of the membranes, as, no doubt, continued pressure will tend to cause a pulpy and degenerated condition of the parts, liable to end in rupture, or at least apt to set up sloughing and consequent septic mischief.

At present, too, when we so often get inert preparations of ergot placed in our hands, we anxiously look for some means whereby ergot will be more seldom required. In several cases I have patiently waited the effect of two good doses of the liquid extract of ergot given at an interval of twenty minutes, and carefully noted the frequency of the pains, which are often not at all accelerated. In similar cases I have found that by gradual manual dilatation, the pains have regularly increased in frequency and in effect, so that labour has been finished in a much shorter time than in the cases left to nature, even when assisted by ergot.

When the head has reached the perineum, we frequently find that expulsion is so much delayed that the short forceps are brought into use. This I find can be often obviated by a very simple expedient, not referred to in text-books. When the occiput is fixed against the pubes and the face is known to be in the hollow of the sacrum, we can give nature much assistance by introducing the index finger per rectum, and, as if with a hook, catching the chin or mouth, we easily bring about the final turn which the head requires to complete its delivery. In resorting to the above expedients in practice I have had nothing but the best results.

ARTICLE VI.—*On the Human Voice.* By C. RUMNEY ILLINGWORTH, late Assistant-Demonstrator of Anatomy, University of Edinburgh. (*Continued from vol. xxii., page* 541.)

The action of the crico-thyroid muscles. — The view generally accepted is that these muscles take their fixed point at the cricoid, and draw downwards and forwards the anterior part of the thyroid cartilage by rotating it about an axis passing transversely through the inferior pair of crico-thyroid joints, thus stretching the vocal cords by increasing the distance between their anterior and posterior attachments. But, as Schech has demonstrated, this cannot be their action, for the cricoid cartilage is not fixed; and even if it were, the crico-thyroid muscles are not strong enough to oppose, much less overcome, the thyro-hyoid muscles, which are put in action at the same time, as is proved by the simultaneous narrowing of the thyro-hyoid and crico-thyroid intervals, as the voice rises in the scale.

The thyro-hyoid muscles, taking as their fixed point the hyoid