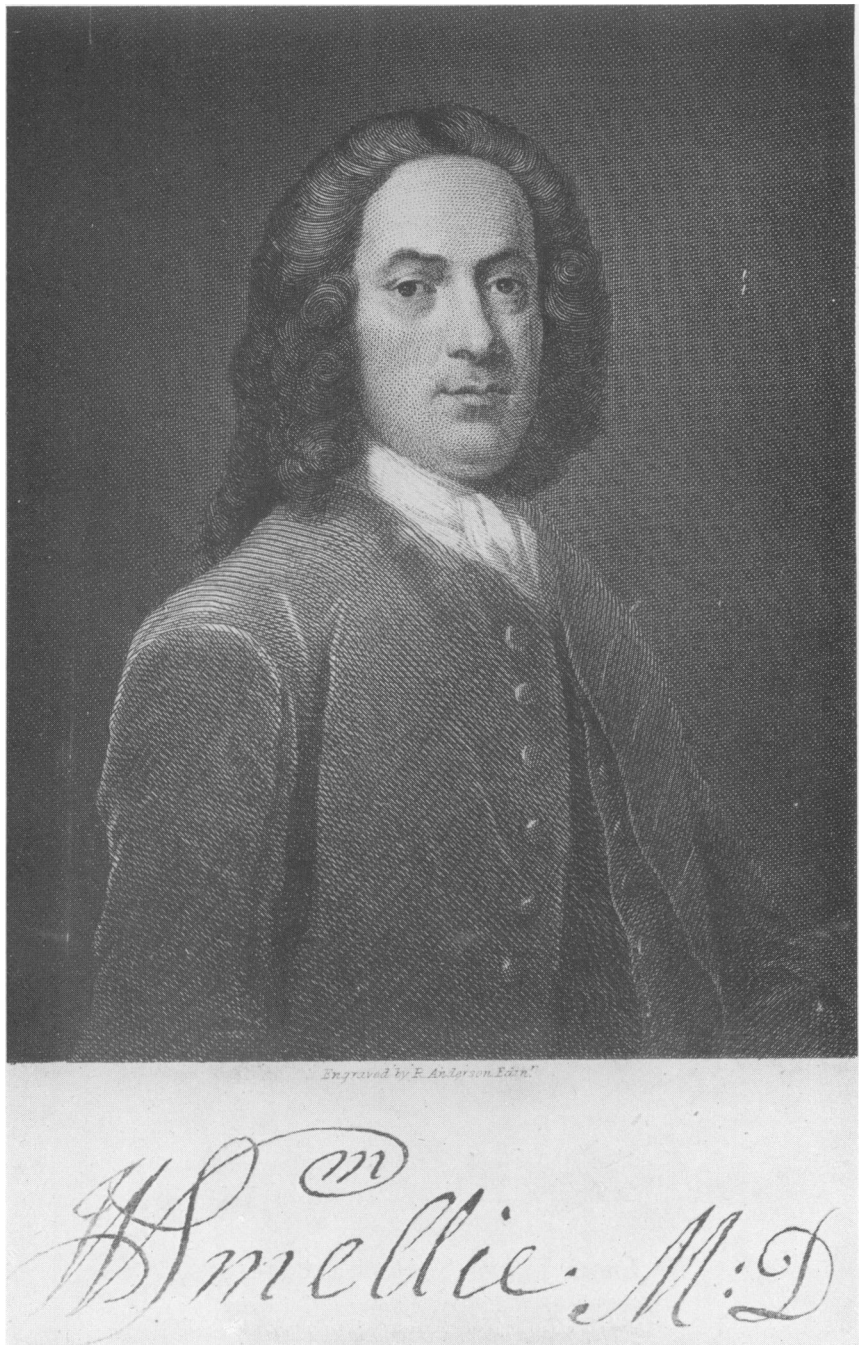

William Smellie (1693-1763)
Pioneer in the use of Obstetric Forceps and Pelvimetry

appropriate. In the majority of cases the lower segment operation can be performed and, taking the long view of future pregnancies, is preferable. There are, however, cases where the lower segment is narrow or inaccessible and in such cases the classical operation is safer. If a subumbilical incision is made initially either operation may be performed with ease. If haemorrhage has occurred during or following the vaginal examination a blood transfusion should be started simultaneously with the Caesarean section.

The group of patients in which the haemorrhage has been more than moderate or has persisted presents a difficult problem. These cases as a rule occur in the groups of second or third degree placenta praevia, and in many of the cases the baby is immature or already dead. In the writer's experience these cases account for the greatest number of foetal deaths (see Table 5).

If the baby is alive and not too premature a Caesarean section should be performed. When it is immature or dead a podalic version will usually control the haemorrhage.

In most cases the latter method of treatment is possible as the cervix will be found to admit at least one finger, and usually two, allowing a foot to be extracted.

Table 7 shows the results associated with the various methods of treatment. It has been suggested that the increased use of Caesarean section as a method of treatment may result in difficulty and danger at future confinements. The practice of doing the lower segment, in preference to the classical operation diminishes the risk of uterine rupture at a subsequent confinement.

In 15 cases in the personal series where lower segment Caesarean section was performed, 12 cases were delivered per vaginum at their subsequent confinements and three had Caesarean section, one for another placenta praevia and two on account of contracted pelves.

TABLE 7

RESULTS OF VARIOUS METHODS OF TREATMENT

	No. of Cases	Still-Births or Died	Per Cent.
Artificial rupture of membranes	74	11	14.9
A.R.M. and Willetts forceps	25	10	40
Version	25	18	72
Caesarean section ..	127	9	7.1
Breech	8	7	87.5
None	16	1	6.25

While there has been an improvement in the results of the treatment of placenta praevia, there appears to be a limit to what one can attain as far as the baby is concerned, and it is possible that the foetal death rate cannot be reduced below 12 to 16 per cent.

To maintain or improve the results requires constant vigilance and the full use of every assistance one can get from blood transfusion, paediatric and nursing services.

REFERENCES

1. JOHNSON, H. W. (1945), *Am. J. Obst. Gyn.*, **50**, 248-254.
2. MIELS, W. G. (1948), *Brit. Med. J.*, **2**, 896.
3. MACAFEE, C. H. G. (1945), *J. Obst. Gyn. Brit. Emp.*, **52**, 313.
4. MACAFEE, C. H. G. (1945), *Proc. Roy. Soc. Med.*, **39**, 9.
5. STURROCK, J., STIRLING, H., TENNENT, R. A. (1947), *Edin. Med. J.*, **54**, 496, 504, 510.
6. BROWNE, F. J. (1946), 'Antenatal and Postnatal Care,' 6th ed., Churchill, London.

WILLIAM SMELLIE

William Smellie was born in Lanark in 1697 *of 'substantial people.' He was educated in the local Grammar School, to which he subsequently left his books. He first set up practice in Lanark in* 1720 *having served his apprenticeship in Glasgow. In* 1739 *he travelled to London (with letters of introduction from Professor Monro in Edinburgh) and later studied under Gregoire in Paris. He then settled in London to teach midwifery in his own house, using a model made of pelvic bones covered in leather, and rapidly became well known in spite of a somewhat uncultivated bearing. His great contributions to obstetrics were the introduction of curved forceps with rules for their proper application, and the introduction of pelvic measurement in the identification of contracted pelvis. He became the close friend of Smollet and William Hunter was one of his pupils.*

He died in Lanark whilst awaiting the publication of the third volume of his case notes in 1763.