

two last mentioned conditions exists, manifestly one may readily have hemorrhage following simple inversion of the appendix with the ordinary purse-string suture.

To avoid this possibility I have devised the following technic: After tying off the meso-appendix with one or two ligatures, as may be indicated, a double-needed fine chromic catgut suture is passed through the mesenteric border of the appendix at its base, taking a good bite through the muscular coat. This is tied. Then proceed with one needle to introduce the usual purse string suture to the side opposite the mesenteric attachment; or, in other words, half way around the appendix. Then do likewise with the second needle, when one is ready to invert and tie after using clamp and cautery. The second purse-string suture is inserted as usual.

I am well aware that some surgeons prefer linen or silk to catgut, but I can not feel justified in using nonabsorbable suture material for ordinary appendix work, until I shall have been convinced of a single accident occurring by reason of the inefficiency of absorbable suture material. That silk or linen may cause irritation or suppuration later can be corroborated by every surgeon of experience, who can readily recall numerous fishing excursions for the recovery of infected stitches.

## RUPTURE OF URINARY BLADDER FOLLOWING FORCEPS DELIVERY.

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The peculiar circumstances attending the following case make it of more than passing interest, and worthy of report.

*History.*—Mrs. C. R., Italian, aged 40; husband living; vi-parâ; no miscarriages; instrumental delivery with last child, Oct. 23, 1907. Last menstrual period about nine months ago. No definite history of previous menstruation obtainable. Family history negative.

It was very difficult to elicit a definite history of the development of the trouble. Her family physician claimed that he was called to attend the woman in labor on the afternoon of Oct. 23, 1907. Her pains continued strong up to about 4 p. m., when they suddenly ceased. As no further progress seemed to be made, he examined the woman and found the membranes ruptured, and "one of the child's arms over the head." This arm he attempted to replace, and then applied forceps. No mention was made as to the dilatation of the os uteri. After working very hard with the forceps, the doctor finally succeeded, toward morning, in extracting a large baby. He reported the child stillborn.

There was considerable bleeding after delivery. The woman passed no urine, and had no movement of the bowels afterward. Her doctor tried to pass a catheter, but claimed he could obtain only a few drops of urine. Various cathartics and enemas failed to relieve the bowels. Next day her abdomen became distended and tender. Vomiting began and was persistent. She had some chills and a rise of temperature. Her physician said he thought she had an acute obstruction of the bowels and so sent her to the hospital.

Patient was admitted to the Charity Hospital at 4 p. m. Oct. 25, 1907, complaining of generalized abdominal pain, especially tender on pressure, marked distension of abdomen; persistent vomiting (greenish-yellow, sour smelling vomitus); constipated for four days; no urine passed for over four days; chills and fever.

*Examination.*—When the woman arrived at the hospital, it was thought, from the history and distension of the lower abdomen, that the bladder was greatly distended with urine. The woman claimed she had passed no urine for over four days. She was very anemic; tongue dry and heavily coated;

temperature 101; pulse 120. There was a general distension of the abdomen, with a trifle more fulness over the lower part and in the flanks. Abdomen throughout was extremely tender. On percussion there was a semilunar area of dullness extending about three fingers' breadth above the symphysis pubes and out toward the flanks. Relative dullness extended almost above the umbilicus. The fundus of the uterus could not be felt on account of the great distension and tenderness. The vaginal outlet was relaxed and there was a recent tear through the sphincter ani. The vulva was contused and edematous. Vagina roomy, abraded, contused and edematous. There was a laceration in the vault, extending about the base of the bladder, and the neck of the bladder felt as though it had been torn loose and retracted. There was also present a bilateral laceration of the cervix, extending on the right side up into the broad ligament and on the left to the vaginal vault.

Acting on the assumption that there was a full and distended bladder, numerous attempts were made to pass catheters of various kinds and sizes. With every attempt the catheter seemed to slip into some false passage. Finally, with a small glass catheter directed backward and upward, and a finger in the vagina as a guide, it was felt that the tip of the catheter was separated from the finger by only a very thin mucous membrane. The catheter, however, was passed in completely, but only a few drops of bloody, ammoniacal urine were withdrawn. A suprapubic puncture was then made in the median line, about one inch above the symphysis. On manipulating the trochar point it seemed to grate on a firm irregular organ. When the trochar was withdrawn a few drops of bloody, ammoniacal urine came from the cannula. Thinking that the bladder had become detached at the neck, and was pushed up by the enlarged uterus, another puncture was made about an inch and a half above the former one. The trochar felt as though it first entered a hollow viscus, and then encountered the firm body as before. On withdrawing the trochar about half an ounce of bloody ammoniacal urine flowed from the cannula. When further withdrawn, some yellowish-green fluid fecal matter came out. There was then little doubt that a loop of gut had also been punctured.

*Operation.*—Dr. C. A. Hamann was called in to see the case, and after careful examination, advised immediate operation. Operation at 8:30 p. m. by Dr. Hamann; ether anesthesia. Patient had a chill fifteen minutes before going under the ether. A median incision, about three inches long, was made above the symphysis. On opening into the abdomen the bladder was found to be ruptured. Difficulty was experienced in finding the posterior bladder wall. It was found to be torn off above the neck, and retracted from the urethra, with only a very thin mucous membrane between neck of bladder and vaginal vault. There was bloody, ammoniacal urine in the lower abdomen and in the flanks. An acute generalized peritonitis was evident. The uterus was firm and the fundus reached almost to the umbilicus. A loop of small intestine was found adherent to the upper anterior surface of the uterus, which showed a puncture wound of the trochar, with a small amount of fecal matter about the puncture. The puncture wound of the bowel was closed with a fine silk Lembert stitch. A soft rubber catheter, guided with two fingers in the vagina, was passed up through the urethra and brought into the lower posterior part of the ruptured bladder for drainage. No attempt was made to repair the bladder wall itself. Several iodoform gauze strips were left in the bladder and passed out through the abdominal incision. The wound was closed with through-and-through silkworm gut sutures.

Just as the operation was nearing completion, the woman collapsed on the table. The pulse became very rapid, then much slower, and finally imperceptible. Breathing ceased and cyanosis ensued. The pupils were dilated and rigid. All efforts failed to restore the patient. Operation lasted about thirty minutes, and five ounces of ether were used.

*Traumatic Neurosis.*—W. H. Axrell, in *Northwest Medicine*, states that the symptoms of a traumatic neurosis are usually those of neurasthenia or hysteria. There is loss of energy, with listlessness, slow mentality, simulation of the particular injury alleged to have been received, and indefinitely located pains.