Chloral is a hypnotic of such long usage that everyone is familiar with its effects. It has been used much too little of late years and combined with the three bromids is often very serviceable.

Chloralamid is too unreliable to be found helpful, only in a few isolated cases. It seems desirable, in all cases where a hypnotic is necessary, to change frequently as less harm is thus done than where a patient is kept on the same one continuously, even though the new drug may produce fewer hours of sleep.

Clinical Report.

AN EMERGENCY CASE OF CESAREAN SECTION UNDER THE POSITIVE INDICATION, WITH TERMINATION IN RECOVERY.

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CHICAGO.

Mrs. X. was admitted to the Englewood Union Hospital on the night of July 25, 1901. She had been in labor for 24 hours. The following history was elicited: Bohemian, age 30; ii-para; 5 ft. 4 in. in height; weight 120 pounds. At the birth of the second child the cervix was severely lacerated and the perineum ruptured through the sphincter ani. For a period of six weeks she suffered from septicemia. Seven months after the birth of this child she entered a hospital and underwent an operation for the repair of the cervix and perineum. This was afterward shown to be an ablation of the cervix well into the lower uterine segment, and almost complete obliteration of the os uteri.

Diagnosis: An almost normal pelvis. The osseous system showed no signs of rachitis. There was no spinal curvature and the long bones were perfect in shape and conformation. A digital examination revealed a normal head presentation of a full-term child. The os uteri could not be demonstrated. The cervix was absent; its former site being occupied by an extensive mass of scar tissue which extended back to the fornix; the tissues imparted a rough parchment-like sensation to the touch.

Notwithstanding the fact that the pelvis was quite normal, the history of former deliveries showed that some cause rendered the birth of the child difficult, that forceps were employed and unusual force was used to extract the child and produce such extensive laceration as this case exhibited; that she had been in labor for twenty-four hours with absolutely no dilatation of the opening representing the os. This was found under anesthesia to be 1/8 in. in diameter, and was located in unyielding scar tissue from which amniotic fluid slowly exuded. Finally the severe uterine contractions, intensified by some ecbolic mixture, administered by a midwife, threatened to rupture the body of the uterus.

The question naturally presented was: Can this opening, surrounded as it is by pathologic tissue, be dilated sufficiently to allow the passage of the fetal head without producing an uncontrollable tear or hemorrhage? Or if that proposition is feasible, can a living child be born? We decided in the negative for the reason that it placed both lives in jeopardy: 1, in the mother's case, from fatal hemorrhage, due to a ruptured uterus; 2, the child's, from asphyxia. The patient was prepared for immediate laparotomy. There was no option as to a selected time for the operation. It had to be done at once. The woman was much exhausted, pulse 98, temperature normal.

Assisted by my associate, Dr. Arthur Werkmeister, an incision was made through the linea alba, above the umbilicus, two inches in length and rapidly enlarged to within an inch of the pubes, with strong scissors; no omentum or intestines presented between the uterus and abdominal wall. The uterus was forced from the abdominal cavity and covered with hot compresses, the abdominal wound being carefully covered with hot towels. I was unable to locate the site of the placenta from palpation or inspection before incision. The uterus was

opened by a vertical mesian incision in the fundus and enlarged to the extent of six inches with the scissors, through the fundus and anterior uterine wall. The thickness of the uterine wall was three-eighths of an inch. The placenta was adherent to the posterior wall, the membranes were torn through with the fingers and the fetus, which lay R. O. P., rapidly delivered by the feet. It did not breathe, but was soon restored by artificial respiration. The placenta was easily removed and the uterus contracted nicely, the walls increasing by this time to one and a quarter inches in thickness. Ergot was used after the evacuation of the uterine contents. Hemorrhage was slight after the contraction of the uterine musculature and was fully controlled by digital compression and hot sponges. Neither the elastic ligature nor a single hemostatic forceps, except the one used to clamp the cord, was employed in the operation.

Ten buried interrupted silk sutures were used to approximate the uterine muscle, followed by eight interrupted silkworm gut sutures, which included all the tissues down to the mucosæ. When the two rows of sutures were drawn tight the uterine wound was accurately closed and perfectly dry. The Lembert suture was impracticable on account of the tension due to active congestion of the organ.

The toilet of the peritoneum was brief, as no fluid had escaped into the abdominal cavity. The abdominal incision was closed by silkworm gut sutures.

The duration of the operation was thirty minutes. The uterine sutures were placed with unusual care, and that is the time-consuming step of the operation. There was scarcely any shock. She reacted nicely and her convalescence was uneventful. The prevailing temperature was 98.8; on the fourth day it reached 100 F., but subsided in a few hours. On the morning of this day she got out of bed and walked about the room. She repeated this endeavor on the tenth day, with no apparent ill effects, except a slight gastric disturbance. Her bowels were moved on the second day. The lochial discharge was odorless and ceased in two weeks. Lactation was not established. The only after-treatment she received was an occasional vaginal douche. The abdominal sutures were removed on the thirteenth day and the patient left the hospital "feeling fine," as she expressed it, three weeks from the time of entrance.

The child was a mature female, weighing seven and a half pounds, well formed and robust. It has done very well. Examination on December 12 revealed the uterus normal in size and limited motion; the parametrium was nearly free from infiltration; the sutures in the uterine wall could not be felt; the uterus was well up in the pelvic cavity, but could be made to descend with ease. There are probably some adhesions between the uterus and abdominal wall. The abdominal wound is firmly united.

REMARKS.

1. The continuous suture should not be used, as the involuting organ rapidly loosens it.
2. The buried suture possesses the advantage that after it is firmly tied the upper half of the wound can be thoroughly cleansed of blood, thereby giving ideal wound surface, with no interposing material.
3. Silkworm gut was used because silk occasionally acts as a syphon drain. If this occurred, one cavity would drain into the other.
4. The fetus should be rapidly delivered; otherwise the contracting uterus may grasp its head.
5. A satisfactory method of preventing fluids from entering the abdominal cavity will be found by having a rubber dam of such weight as is used by dentists, about one yard square, which should be kept ready for use in hospitals. Through a central circular opening from one and a half to three inches in diameter it can be slipped over the uterus and will effectually prevent fluids from entering the abdominal cavity.

The results obtained in this case answer in a measure the objections to the removal of a woman in this stage of labor, in an ambulance, over rough streets, or that the patient should be prepared the regulation time in advance in order to secure a favorable termination.

Reliance Building.