Original Communications.

NOTES FROM AN OBSTETRICAL CASE-BOOK.

By J. G. BLAKE, M.D., Boston. Read before the Boston Society for Medical Observation, Dec. 3, 1870.

The patient, Mrs. M., a strong, healthy woman, of Irish birth, has been delivered of four still-born children—three with forceps, and the fourth by craniotomy. Having been her medical attendant for some years, I have been with her three times at her labors—once forceps, once craniotomy, and the case of induced labor.

My first experience, from the great difficulty in effecting delivery by forceps after waiting thirty-six hours, satisfied me that it would be impossible for a child of the average size, at the full term, to pass alive. This was not on account of any special deformity of the pelvis, but from a general narrowing of the natural diameters. With the assistance of Dr. B., and after two hours' hard work, a still-born child was delivered—with long forceps.

The mother made a good recovery, and after the lapse of fifteen months, I was summoned to attend her again. On this occasion, the labor progressed slowly for a time, but after several hours it became evident that the head could not enter the brim of the pelvis without assistance. Long forceps were applied, and all the force deemed justifiable used, but without effecting the slightest progress. Finding assistance needful, I sent for the gentleman who so kindly lent his aid on a former occasion, but he was unable on account of illness to come. Dr. C. came instead, and after etherizing the patient, again applied the long forceps, but without any result.

Before resorting to craniotomy, podalic version was tried, but without enabling us to deliver the head. After pulsation in the cord ceased, nothing remained but perforation, which was done under some disadvantages. If unfortunate enough to have another case requiring craniotomy, I should hesitate about attempting to effect delivery

by podalic version after a fair trial with forceps. By it, the head becomes immovably wedged into the pelvis, while the vagina is completely filled by the child's neck. Besides this, the head must be pierced at the most difficult part—the occiput.

Our instrument bag not containing a cephalotribe, and the woman's condition not admitting of postponing delivery sufficiently long to obtain one, Dr. C. introduced Smellie's scissors, and pierced the head through the occipital bone; then separating the blades, broke up the substance of the brain. Efforts to evacuate the brain were now made, and attempts at extraction by means of the forceps and traction of the legs, but without success. The blunt hook was also repeatedly used, but every point to which it was applied yielded, and after four hours continued effort, the patient remained undelivered. She seemed sinking fast; pulse weak and fluttering, respiration slow and gasping, and with every indication of approaching dissolution.

Dr. C. and myself were by this time very much exhausted, and summoned Dr. K. to our assistance. He came, and after an hour and a half finally succeeded in delivering the child's head.

The woman made a good but slow recovery. During the after treatment, I told her that if she became again pregnant, it would be absolutely necessary—in order to save her own life and afford her a chance of having a living child—to induce labor at the seventh month. To this she agreed.

Soon after, she became pregnant again. With the hope of somewhat diminishing the size of the child, I gave her, after the third month, large doses of iodide of potassium, and continued this treatment up to the seventh. When this period was reached, premature labor was induced in the following manner:—

A sponge tent was introduced into the os, and allowed to remain all night. It was withdrawn in the morning, and the parts not being sufficiently dilated, a larger one was inserted, and allowed to remain six hours. After this was removed, the os was found fully opened. A dose of ergot was

given, which had the effect of producing several strong pains, and the membranes having been ruptured, in a short time the head could be felt presenting at the brim.

The pains died away, and after a lapse of six hours, ergot was again given in a full dose. This was soon followed by strong uterine contractions, but without advancing the head. So long a time elapsed without making any progress, that I feared being again obliged to resort to craniotomy, but resolved first to try the forceps.

I did so. After considerable force, and assisted by the expulsive efforts of the uterus, I succeeded in extracting a living child, much to my own satisfaction and the delight of the mother.

Everything has since gone on in an entirely satisfactory manner. Milk appeared in the breasts on the fourth day, and continued to be secreted in abundance. The child, which was well formed, but small at birth, is now growing rapidly, and promises to be as strong and vigorous as if it had reached the full term.

ASTHMA BRONCHIALE. BRONCHIAL SPASM OF CHILDREN.

By Dr. L. M. POLITZER. Translated from the *Jahrbuch für Kinderheilkunde und Physische Erziehung*. Neue Folge, III. Jahrgang, 4 Heft, by C. P. PUTNAM, M.D., Boston.

DURING the last few years a disease of the respiratory organs has come several times under my observation and treatment, which, by reason of its unusual form, its peculiar nature and course, has shown itself to be so different from the diseases of childhood hitherto observed and described, that I think it worth while to make the following communication, in order to complete the observations of others:

To the appearances of the disease to be described I shall give the name of Asthma Bronchiale, or Bronchial Spasm.

Although perfectly well known as a disease of adults, yet not sufficiently well understood, it is, as far as I know, nowhere mentioned as occurring in the case of children, at least in the characteristic form in which I have met with it, or at any rate nowhere recognized as a special form of disease.

I am inclined to consider this asthma bronchiale as an idiopathic, essential disease of the bronchial muscles and of the nerves which regulate their contractions, although, according to the observations hitherto made, it always appears as a sequence of bronchial catarrh, as will be seen

hereafter. Whether and to what extent this opinion is justifiable, will be learned from the description of the disease in question, drawn from the observations within my reach.

I will first describe the cases, of which only the more marked and characteristic will be given in detail; others less important will be but hastily sketched.

CASE I.—Peter G., 16 months old, fed from the breast of a nurse, suffering from chronic eczema of head and face, anæmic, rachitic, frail, of very strong but obese parents, had had up to this time no acute disease. This sickness made its appearance in midsummer, in a healthy mountain region, free from dust, in the neighborhood of Vienna. In the beginning there were to be found only symptoms of ordinary bronchitis of the greater and smaller tubes—fever, high temperature, accelerated pulse, hurried respiration—on auscultation coarse and fine vesicular râles, percussion normal, movement of the diaphragm indicating nothing unusual, but such as is found in every dyspnoea caused by bronchitis. The respiration continued in the same state for some days, but gradually returned to its normal condition, for, as the fever diminished under quinine, the bronchitis and the symptoms belonging to it disappeared also.

After some days of undisturbed convalescence, I was called in urgent haste and found the child again attacked with excessive dyspnoea, so that, at the first moment, I thought there was a return of the bronchitis. On more careful examination, however, I was struck with the contradiction between the severe dyspnoea, and a normal temperature. Percussion was as before normal, but auscultation showed complete absence of all râles except a high fine whistling, heard during the whole respiratory act. Beside this was a marked state of sopor, also difficult to reconcile with the absence of fever. The peculiarity of the dyspnoea consisted in the fact that with respiration of 50 or more there was a prolonged, whooping, whistling inspiration and expiration audible at a distance, and excessive drawing-in of the epigastrium during inspiration, also expression of great distress in moments of consciousness, with lividity and coolness of face. What was also striking was the very infrequent cough, which had a dry, whistling sound, much resembling laryngeal cough. I confess that in the beginning I was not able to reconcile these contradictions, as I could not place this, to me, unknown disease, in any recognized class. But when I returned in