advised her to see some other obstetrician and obtain his advice, without telling him what mine had been. Mrs. P. accordingly consulted Dr. George Haven, who gave her the same advice. This joint decision was accepted by the patient and her last catamenia having occurred on the 5th of December, the date for the operation was set for September 10th, unless labor should occur earlier.

This did not happen, and the operation was performed shortly after 11 A. M. on that day. The abdomen was opened by an incision about eight inches in length in the median line. The uterus was lifted through the incision, surrounded by towels and the cervix grasped by the hands of an assistant. The uterus was then opened in the median line by an incision about six inches long. The arms and legs presented. The child was extracted by traction on the legs, and cried much more promptly than most Cæsarean babies do. The placenta was implanted on the fundus and left lateral wall, its edge just appearing in the wound. The placenta was calcareous and with the membranes was universally adherent to the walls, but owing to the accessibility of the uterus under these circumstances, could be very rapidly dissected off with the fingers. Half a drachm of Squibbs' fluid extract of ergot was given hypodermically. The uterus contracted well. Ten braided silk intermuscular, and six fine silk sero-serous sutures were inserted and tied, after a bit of gauze had been passed into the vagina through the cervix. Fifteen silkworm-gut, and a number of finer coaptation sutures were used in the abdominal wall. The abdominal incision and the delivery of the uterus occupied three minutes; the uterine incision and the delivery of the child, one minute; the delivery of the adherent placenta, two minutes; the total time of operation to this point being six minutes. The uterine suture occupied $8\frac{1}{2}$ m.; the abdominal suture, $20\frac{1}{2}$ m.; total time of operation $40\frac{1}{2}$ m. The recovery from ether was rapid. There was no vomiting and little or no thirst. The temperature for six days ran between 100° and 101° , no explanation of its elevation being found except that the patient was in an extremely nervous state. There were no other symptoms of any kind whatsoever. The patient was kept in bed for three weeks to secure good involution of the abdominal walls, and was discharged in first-rate condition at the end of four weeks. Her baby was a girl, weighing eight pounds and one ounce, was nursed from the start, and reached a weight of one and a quarter pounds above its birth weight during the first four weeks, weighing nine pounds and five ounces on discharge.

I heard the other day that mother and child are both in the best of health.

I report this case as another instance of the elective Cæsarean section, and in support of the position which I hold to be the proper one at the present day, that while there is still a field for the induction of labor, the Cæsarean section is to be preferred, in the interests of the child, to the induction of labor for contracted pelvis at a period earlier than eight months, and in the interests of both mother and child to an induction at eight months or a later period, under circumstances which render it likely that the induction will be followed by a difficult labor.

There are two other points which I have noticed in every Cæsarean section which I have done or seen, and which I mention in connection with this report,

only because I have never seen them referred to in any published report of Cæsarean cases:

First, I have noticed that the babies when first extracted appear sluggish, and usually require considerable stimulation before they breathe, cry, or move with any activity. It would seem probable that this sluggishness is due to the fact that their intra-uterine life is so suddenly and gently interrupted, and that a certain amount of handling, hot and cold water, and other cutaneous stimulation is needed to replace the disturbing and stimulating effects of the normal passage through the pelvic canal.

Second, it appears to be the rule that there is little or no lochia during convalescence from the Cæsarean operation. This I offer simply as an observation, and one which I should be glad to have explained.

CASE OF SYMPHYSEOTOMY.¹

BY E. H. POMEROY, M.D., CALUMET, MICH.

Mrs. C. M., mixed Indian and Canadian French blood, rachitic dwarf, age twenty-one, height four feet, five and a half inches. First pregnancy. Married October, 1895. Last menstruation last week of December, 1895. Labor commenced during the night of November 2, 1896. As this was a case of elective symphyseotomy, I had taken the following pelvic measurements several weeks before: spinous processes, $10\frac{1}{2}$ inches; crests, 10 inches; diameter of Baudelocque, 7 inches; internal diagonal conjugate, $2\frac{3}{4}$ inches; true conjugate (estimated) 2 inches.

Early on the morning of November 3d, in the presence and with the assistance of my associates of the Calumet and Hecla Hospital Staff, Drs. Niles, Simonson, Bobb, Shorts and Rees, I performed symphyseotomy. The patient was first rendered surgically clean, as for a capital operation. I regret that I cannot recall the name of the operator whose directions I followed in separating the symphysis. The principal portion of the operation consisted in a short incision, half an inch in length, directly through the soft parts covering the middle of the anterior aspect of the symphysis; the section with a tenotome of all the symphysis excepting about three-eighths of an inch of the upper portion; then the insertion of a probe-pointed bistoury beneath the soft parts and close to the symphysis, until it could be made to hook over the upper, unsevered portion of the latter, meeting the end of the finger of the left hand, which finger has been thus far held constantly and steadily as a guide and guard against the inner aspect of the symphysis; with this knife the remaining portion of the symphysis was separated. The forceps were then applied and traction made until the pelvic bones separated and the fetus, a large and vigorous male, was delivered. During the delivery, although the ilia were supported strongly by an assistant pressing from each side, the pubic bones separated a distance of fully two and a half inches, and both sacra-iliac articulations gave way with sounds perceptible, if not alarming, to all the physicians present.

The child had the appearance of having grown nearly ten months *in utero*. I regret that no accurate mensuration of the fetus was made. It was weighed by Dr. Bobb, and the weight was slightly more than

¹ Reported, by invitation, before the Obstetrical Society of Boston, February 16, 1897.

twelve pounds (twelve and a half pounds including the cloth in which it was suspended; the subsequent weighing of the cloth made no impression on the small spring-scale used).

A small tear in the perineum was immediately repaired; a warm sublimated intra-uterine douche given; the original incision, as well as a tear half an inch long near the fourchette, dusted with boric acid and iodoform; a voluminous padding of sterilized dressings applied; broad bands of rubber adhesive plaster encircling the pelvis; the knees and ankles padded and bandaged to their fellows, and a broad obstetric binder applied. The bandage of adhesive plaster was soon found to be inefficient to hold the pelvic bones in proper position, and a belt of surcingle web, with strap and buckle, was added, and found to retain the bones in position admirably.

These dressings, and the horizontal position, were insisted upon for three weeks, although lying on either side was allowed. Recovery was uneventful, excepting for an occasional rise of temperature, which would yield immediately on the use of a boiled-water or mild sublimate douche.

At the end of three weeks, firm union was found to have taken place at both sacro-iliac junctures and at the pubic symphysis. The patient has been wholly free from restraint since the fourth week (present writing March 11, 1897); lactation has been free and normal from the beginning; and the child is a typical specimen of vigorous health.

This is the only case of symphyseotomy I have ever seen. The only Cæsarean section I ever saw was before the era of asepsis. The results of my symphyseotomy have been very pleasing. The union of the pelvic bones remains firm and strong. The patient leads a laborious life as a miner's housewife, walks long distances in deep snow, apparently without fatigue, and expects to raise a large family of children.

Cæsarean section, however, as described in the report of Dr. Reynolds's case, and in Dr. Worcester's approved comments, is a better surgical operation, cleaner, simpler, gentler; and listening to the report certainly gives me a more pleasing impression than I ever experienced from my own case of symphyseotomy, although I believe the record of statistics to be more in favor of symphyseotomy. In due time I expect to attend my patient in a second delivery, which I purpose shall be a Cæsarean section, and in a third which shall be an elective operation, based upon the experience of the first and second.

Reports of Societies.

THE OBSTETRICAL SOCIETY OF BOSTON.

CHARLES W. TOWNSEND, M.D., SECRETARY.

REGULAR Meeting, February 16, 1897, the President, DR. FRANCIS H. DAVENPORT, in the chair.

DR. EDW. REYNOLDS reported

A CASE OF CÆSAREAN SECTION.¹

DR. G. J. ENGELMANN offered

REMARKS ON SYMPHYSEOTOMY.²

¹ See page 35 of the Journal.

² See page 34 of the Journal.

DR. E. H. POMEROY of Calumet, Mich., reported

A CASE OF SYMPHYSEOTOMY.³

DR. J. P. REYNOLDS referred to the importance, in collecting statistics of the two operations, of comparing only those that are done by experts. It is manifestly unfair to compare the operation of symphyseotomy, for example, performed by an expert, with Cæsarean section done by a general practitioner.

DR. A. WORCESTER said that as a general practitioner he felt strongly the ease with which Cæsarean section could be done, as compared with symphyseotomy. He believed that the latter operation required more surgical skill to avoid complications.

In our statistics all deaths from septicemia, which are avoidable, should be thrown out.

DR. E. REYNOLDS, in closing, said that the keynote was struck by Dr. Engelmann when he said that symphyseotomy did not compete with Cæsarean section at the time of election, but that it was the operation to be used at the latter part of a long labor, where the patient was exhausted and the soft parts lacerated. In these cases Cæsarean section often proved very fatal.

He would agree with Dr. Worcester that Cæsarean section was the simpler operation for the inexperienced surgeon, but this operation should never be done by the man who did not appreciate thoroughly the meaning of asepsis. For the dirty-fingered man craniotomy was the only operation.

He mentioned two observations he had made in his experience with Cæsarean section. One was that if the operation was done before the onset of labor, the cervix would dilate and stay dilated on the removal of the child. This overthrew the bugbear that one could not get good drainage unless labor had started up. The other observation was that the lochia were of very small amount and duration after Cæsarean section.

THE AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

ELEVENTH ANNUAL MEETING, WASHINGTON, D. C.,
May 4-6, 1897.

FRANCIS S. WATSON, M.D., President, occupied the chair.

FIRST DAY. — TUESDAY.

REPORT OF POST-MORTEM EXAMINATIONS IN SOME CASES OF MOVABLE KIDNEY.

DR. FRANCIS S. WATSON, of Boston, read a paper on this subject. It consisted of a report of the post-mortem findings in eight cases of movable kidney. Four of these subjects were females, four males. In four of them both kidneys were movable; the right kidney alone was movable in three cases; the left kidney alone in one case. The perinephritic fat was greatly diminished in five cases and slightly diminished in two; it was not noted in one. Hydro-nephrosis was absent in all of the cases. There was ptosis of one or more of the other abdominal organs in six cases; none in two. The peritoneal coverings of the kidney were greatly relaxed in four cases; in four they were moderately relaxed. In two of the first four cases, those in which the peritoneum was greatly