G. Dr. J. showed it to the Society for Medical Improvement, and he and Dr. Coolidge gave subsequently the following description:—

"The mass was of an oval form; 8½ inches in length, 6½ inches in width, and 5 inches in thickness; weight, 5 lbs. 3½ oz. Upon one surface there were the remains of the kidney, about two inches in extent; and, including this, was a somewhat defined, oval, superficial patch, about 6½ inches by 2½ inches in extent, and that strongly suggested the idea of a connection with the original outline of the organ. Around this patch the surface was lobulated, and radiated in appearance, but upon the opposite surface it was much more even. The irregularity was much more apparent after a fibrous envelop had been stripped off that was quite marked for the most part, and moderately adherent by a lax tissue, though less so to the patch above referred to than to some other parts. Towards the surface where the patch was, and throughout nearly one half of the whole mass, the structure was white, not vascular, had a pearly transluency, and was softer than fetal brain, with an appearance as if it were infiltrated with a ropy fluid. The remainder was much firmer, and evidently contained more or less connective tissue, the softer and firmer portions passing gradually into each other. This last was also stained by blood, and in some parts quite deeply, though no free clots were found. There was also a small serous cyst in this firmer portion. The portion of kidney above referred to was perfectly healthy in appearance; and, on incision, there was found, within, a well-marked pelvis that could be traced for three or four inches, and infundibula arising from it, with portions of the renal substance that had undergone more or less the cancerous transformation. There were also found in distant parts, but upon the surface of the mass only, several small, insulated remains of perfectly healthy renal substance, about three or four lines in diameter.

Under the microscope, the soft substance which constituted so large a part of the disease consisted of innumerable, roundish cells, not varying much in size or form. They had large nuclei, and were embedded in a soft, streaky, ropy mass. At the end of a week, the specimen not having been preserved in any way, the nuclei alone were visible; the substance of the cells having become indistinguishably fused with the mass in which they were."

TEDIOUS LABOR; INCISION OF OS AND CERVIX UTERI.

By JOHN L. SULLIVAN, M.D., Malden.

Mrs. F. D., aged 25, primipara, well formed, muscular. Labor pains first felt on the evening of 10th inst. When examined, at 9, P.M., of the 11th inst., os was found too small to admit the point of the fore-finger; presentation probably cephalic; pains light, but regular, recurring at intervals of fifteen minutes; passages moist, cool; perineum relaxed.

12th, 9, A.M.—Pains all night, preventing sleep; os unchanged. During the day slight, bloody show; membranes ruptured; waters discharged.

11, P.M.—Os dilated so as barely to admit fore-finger; head presenting; pains every five minutes, and severer; patient fatigued and somewhat despounding. Opium (grs. iiij.) administered.

13th, 9, A.M.—Slept "by snatches" during night; pains every three or five minutes; slight thirst; no appetite. Warm hip bath, enema per rectum, tartar emetic ad nauseam; warm vaginal douche proposed, but objected to.

10, P.M.—Pains increasing; head descending through pelvis, driving uterine neck before it; no farther dilatation; os very rigid. With difficulty, a No. 1 Barnes's dilator introduced and inflated. Pains very severe; dilator removed after an hour. Os dilated to about the size of half a dollar, still rigid; presentation readily diagnosticated r. o. c. Largest sized dilator introduced, followed by very frequent and severe uterine contractions. Dilator removed in half an hour. Os two inches in diameter; edge like whip-cord.

14th, 1, A.M.—Dilator introduced and fully expanded. Pains violent and almost uninterrupted.

12, A.M.—Dilator removed. No permanent increase in dilatation of os, which seemed to contract like India-rubber on removal of dilator. Patient's condition still good; passages moist; tongue ditto; abdomen not tender; uterine contractions regular and quite forcible. Determined to leave the case to nature until symptoms of constitutional irritation should supervene, rendering farther assistance indispensable to the safety of mother or child, or of both.

10, P.M.—No progress towards delivery. Os rigid and undilatable as ever; uterine neck swollen and edematous, pitting deeply on pressure; pains frequent, powerful and agonizing; passages dry and hot; abdomen tender on pressure; tongue dry and
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burning;thirsturgent;pulsefrequent
andhard.Oneounceofdark-lookingurine
drawnbycatheter.

Itwasclearthatthesafetyofmotherand
childdependeduponspeedydelivery,and
thatthiscouldnotbeeffectedwithoutassistance.
Forcepsorincisionoftheosuteri
weretheoperative measures which suggested
themselves.Inviewofthecomplexity
ofdrawingtheheadthroughtheswellen
andunyieldingcervix,andthefatal conse-
quences that might ensue from failure in
theattempt,thelatteralternative,incision
of the os, was chosen. The blade of a her-
nia knifewascarefully introducedbetween
thefetallandandthecervixuteri,inthethe-
tral interval between the pains. As soon as
theuterine contraction occurred, an inci-
sion was made upon the anterior lip through
theosandcervix,todepthofaboutan
inch and a half, care being taken to carry
the division of the uterine fibres deep
enough to insure the ready passage of the
head, and thus obviate in some degree the
dangeroflaceration.Thisprocedure
was followed by a discharge of somefluid
blood and several large coagula, which relieved
the edematous condition of the neck.
Several short and hesitating pains succeeded,
asif the womb, startled by some
occasional occurrence, had paused to reconnoitre;then came a prolonged,expulsive effort,
and thechild’s head passed fairly through
the os, distending the perineum.

The termination of the labor was easily
accomplished, and in less than half an hour
a full-term male child was delivered. Un-
fortunately it had cyanosis, and in conse-
quencedidnotsurvivefortwenty-four hours.
The mother experienced no untoward symp-
toms, either from the tediousness of the
labor or the means employed for her relief,
and is now (March 31st) convalescent.
Duration of her labor, 102 hours.

In a few minutes after the birth of the
child, the uterus, aided by very moderate
pressure over the fundus, contracted firm-
lly, expelling the placenta. The binder hav-
ing been applied, a vaginal examination
was made, to ascertain the condition of the
cervix. A shallow notch marked the place
where the incision had been made. There
was no subsequent hemorrhage, the lochia
being even less profuse than usual.

With reference to the foregoing opera-
tion, Dr. Murphy, in his Lectures on the
PrinciplesandPracticeofMidwifery(Se-
ccondEdition),pages246and247,observes:
"If these means fail, it becomes a question
whether we should wait for the death of
thechild, inorder to removemby the

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cient. It seems to us that, when practicable, a single incision should be made sufficiently free to ensure the easy escape of the head. If this be done, it is difficult to conceive why a consequent laceration should occur. Indeed, both experience and reflection have convinced us that, when the incision is properly made, the danger of such an accident must be very small, if not purely hypothetical.

On the other hand, if the incision be not carried deep enough to accomplish per se the desired object, viz., the liberation of the head, it is difficult to understand why laceration should not take place, especially if the subsequent pains be violent and prolonged, as they naturally would be, excepting in cases of exhaustion, either general or of the uterus alone.

If the uterus were contracting vigorously, a laceration of greater or less extent would be very likely to ensue, when the obstacle to the advance of the head had been only partially removed by a timid and inefficient use of the knife. It is easy to comprehend how a slight cut or nick in the cervix might weaken its power of resistance at that point, and thus become the point of departure of a dangerous, if not fatal laceration. This is certain—the depth to which an incision is carried is wholly within the operator's control; the extent to which laceration may take place lies wholly beyond it.

It seems to us, therefore, that if the knife is to be used at all, it should be used freely, so that when the uterus again contracts forcibly it may meet with little or no resistance from its own tissues to the descent of the foetal head. Should it appear that a sufficiently free incision could not be made through one lip only without endangering the integrity of the intra-uterine or of the abdominal structures, we are aware of no anatomical nor surgical reason forbidding the division of both the anterior and posterior lips, either at corresponding points of their respective segments, or at whatever point in each the greatest impediment seems to exist.

Such is the method, founded, as it appears to us, on rational and obvious principles, which we would submit for the guidance of the practitioner, or commend, at least, to his attentive consideration whenever it is proposed, in the language of Dr. Murphy, "to cut through this Gordion knot of difficult labor."

In the case we have detailed, we are persuaded that had we waited for "the death of the child in order to remove it by the crocheth," the mother would probably have perished also. Nearly equal danger to both would have attended the use of the forceps; and, had these failed, there would have remained no alternative but craniotomy, performed under circumstances highly unfavorable to the mother.

It remains to notice the possibility of dangerous hemorrhage occurring as a consequence of the free incisions we have recommended, let it be understood, in exceptional cases only. We can conceive that such an accident might result, 1st, as a very rare coincidence, from the patient's possessing the hemorrhagic diathesis or idiocy. 2d. Inertia uteri, spontaneous, or following anesthesia from ether or chloroform, might give rise to flooding dangerous in itself, and rendered more so by the additional loss of blood to which incisions under these circumstances might give rise. As a precaution, therefore, just before the operation is performed a full dose of ergot might with propriety be administered, unless the patient were a primipara, or the medicine otherwise contra-indicated. And even in a first labor, should the uterine contractions have become feeble and infrequent, or have ceased altogether, and an evident necessity existed for stimulating the womb, ergot in small and tentative doses might be resorted to. It should be borne in mind, however, that ergot in such a case would be inadmissible unless it were evident that delivery could be effected before there had been time for its absorption. An attentive examination of the perineum and external parts will enable the experienced practitioner to determine with sufficient accuracy the probable duration of this stage of the labor. If ergot is contra-indicated, opium, given in small and repeated doses, will prove a uterine motor-stimulant, to the good effects of which we can testify from long experience. Small as the danger probably is of any considerable hemorrhage arising from incision of the cervix, our own judgment would be decided against the performance of this operation unless the uterus were contracting regularly and with power sufficient effectually to close the divided vessels.

New Editors of the St. Louis Medical Reporter.—Drs. W. M. McSheeters and G. M. B. Maughn succeed Dr. O. F. Potter in the editorial management of the St. Louis Medical Reporter. In future this Journal will be published monthly, instead of twice a month, as in the past.—N. Y. Med. Rec.