DELAYED UNION OF FRACTURE OF THE LEG IN THE CASE OF A PREGNANT WOMAN.

BY JOHN R. HAM, M.D., DOVER, N. H.

SURGEONS are divided in opinion as to the influence of pregnancy in the repair of fractures.

Bryant does not mention it as a cause of delayed union; Gross says pregnancy has been accused of preventing union, but he has seen no such result, and is strongly inclined to think the influence has been greatly magnified, if indeed it is not wholly chimerical; Holmes enumerates it as a cause of non-union, but qualifies it by stating that it is only in cases of unusual debility that it can delay the union, and he states that some authors deny its influence even in such cases; Packard, in the "International Encyclopedia of Surgery," mentions the fact that some writers have assigned pregnancy a prominent place among the causes of delayed union, but he says "Against the cases adduced in favor of this view must be set a great many in which the cure has been rapid."

In the case reported below no other cause can easily be assigned for the delay in the cure.

Mrs. H., American, thirty-five years old; the mother of two children, the younger of which was four years old; was in excellent health at the time of her injury and had no sickness since childhood.

On March 20, 1896, she fell on an icy sidewalk and fractured both bones of the right leg at the junction of the middle and lower thirds; the fracture was simple, but the case was complicated by a pregnancy of the fifth month.

The leg was put into a Bryant splint, and suspended so that it did not lie upon the mattress. At the end of the sixth week there was no union whatever; nor was there any evidence of induration, or of callus, at the point of fracture. A plaster-of-Paris splint was then applied and the patient was allowed to go about on crutches. In the eleventh week there was quite free motion at the point of fracture and it was not till the end of the twelfth week that the splint was discontinued. The removal of the splint at the end of the twelfth week was hardly justifiable; but the patient was one who could be trusted, and urged its discontinuance, and no harm came from it. The pregnancy was not disturbed by the injury.

Medical Progress.

PROGRESS IN GYNECOLOGY.

BY EDWARD REYNOLDS, M.D.

(Concluded from No. 12, p. 293.)

NEW OPERATION FOR PROLAPSUS UTERI.⁹

J. M. BALDY describes a modification of the technique of hysterectomy for uterine prolapse. The ligature which surrounds the ovarian artery is made to include the round ligament on each side. A second ligature secures the uterine artery on each side and no intermediate ligatures are used. The uterus is then amputated as far down on the cervix as possible. A suture is then passed on each side through the stump of both uterine and ovarian arteries, care being taken to place it deeply and well back of the

ligatures. On tying these sutures the cervix and vagina are drawn high into the pelvis by the approximation of the amputated surface to the stumps of the round ligaments and ovarian arteries. The peritoneum is then approximated by catgut sutures from the stump of the cervix and along the edges of the incision through the broad ligaments. Any plastic vaginal work which may be indicated is then performed.

The author reports eight successful cases and asserts that the firmness with which the stump is held high in the pelvis is very surprising. [The operation is, of course, open to the objections which apply to all forms of hysterectomy for a disease which, like prolapse, is in itself not fatal.]

GENITAL TUBERCULOSIS IN CHILDREN.¹⁰

Maas calls attention to the rare occurrence of genital tuberculosis in children in comparison with its frequent appearance in other regions. In a careful search through the literature he was able to find only seven cases, to which he adds an eighth. In the autopsy upon a girl five years old, who died of general tuberculosis, he found tubercular ulceration of the mucosa of the uterus and tubes. The muscular wall of the latter was filled with tubercular nodules, but that of the uterus was not affected. The ovaries were normal. There seemed to be no doubt that the internal genitals were the original seat of the trouble. The cause of the infection was most obscure. It seemed improbable that bacilli could enter the vagina, as the hymen was intact and the ordinary causes (coitus, unclean instruments, etc.) could be positively excluded. Moreover, the vagina was healthy. The presence of a line of old fibrous tubercles along adhesions extending inward from the umbilicus to the parietal peritoneum led the writer to infer that the infection entered through the navel, a fact of considerable interest to the obstetrician.

SALPINGOTOMY.¹¹

Gersung reports a case in which, after removing the adnexa of the left side, the right tube was found to have an occluded abdominal end and to be distended with fluid blood.

Gersung opened the abdominal end of the tube, washed out its contents and stopped the wound by sewing the corresponding ovary into the slit. The woman conceived two months later.

This case certainly proves conclusively that a hemato-salpinx may be so far recovered from as to permit the restoration of the function of the tube.

FIXATION OF THE PROLAPSED OVARY.¹²

Sänger reports two cases in which he practised "pelvic fixation" of the ovaries. With the patient in Trendelenburg's posture, ventro fixation of the retro-displaced uterus was first practised. The prolapsed ovaries were attached to the pelvic brim in one case by passing two fine silk sutures through each mesosalpinx near the ampulla of the tube, and then through the parietal peritoneum just in front of the attachment of the ovarian ligament. In the other case after ventro-fixation the ovaries (previously freed from slight adhesions) were drawn upward, ignipuncture of several follicular cysts was performed and the organs were

⁹ Archiv für Gynäkologie, Band li, Heft 2.

¹¹ Centralblatt für Gynäkologie, No. 2.

¹² Loc. cit., 1896, No. 6.

⁹ American Journal of Obstetrics, Vol. xxxiii, No. 222, April, 1896.