rapid—about 130. No examination of the fetal heart was made. Dr. Grube gave the anesthetic,—ether,—and Dr. H. L. Green assisted me. The abdomen was hastily opened, after having been prepared by shaving, washing with green soap, then a solution of permanganate of potassium, followed by a solution of oxalic acid, and, finally, with mercury bichloride, $\frac{1}{1000}$, and then alcohol. Similar solutions were used for the hands. No vaginal douche was given, and the tampons not disturbed for fear of exciting further bleeding. An incision was made in the median line, a rubber cord slipped quickly over the fundus of the uterus, around the cervix, and firmly tied; and now the patient was absolutely safe from hemorrhage. The abdominal incision was enlarged sufficiently to permit the uterus to be brought outside the abdominal cavity, and an incision made into it across the top from horn to horn, in hopes of thus retaining as much blood for the patient as possible, if perchance the uterus could be saved. The child, a seven and a half pound male, evidently near full term, was rapidly delivered, apparently anesthetized. It was placed in the hands of Dr. Becker, to whose skill in resuscitating it I have no doubt we owe its life. The cord was clamped at once and cut. Attempts were now made to induce the uterus to contract and free the placenta. Though it seemed to make feeble attempts to do so, yet they were feeble indeed. After waiting as long as was deemed wise, with reluctance I peeled the placenta from its attachments. It could not by any possibility have been more centrally placed over the cervix. Suspecting that the constriction of the neck might have some influence in preventing the desired contractions, after a few moments I loosened the rubber cord, but was compelled to tighten it at once; for as soon as loosened blood would well up from about the cervix in such quantities that, in the condition of the patient, it would no doubt soon have proved fatal.

Becoming convinced that the uterus could not, or would not contract firmly—and I understand it often will not when there has been great loss of blood—I amputated it above the rubber cord, passed two old-fashioned hysterectomy pins through the stump, washed out the abdominal cavity with normal salt solution, stitched the peritoneum with catgut about the stump, and closed the abdomen with buried catgut and interrupted silk-worm gut sutures. The time of operation was about thirty minutes; ten minutes was wasted in vain attempts at saving the uterus. I did not do the more modern hysterectomy, dropping the stump after separately ligating the arteries, for I did not feel that the interests of my patient warranted me in taking the extra time necessary.

The patient was placed in bed with a pulse that had suffered nothing from the operation, and it soon began to mend. No salt solution was injected subcutaneously, but an enema of one quart was administered soon after she was placed in bed, which was repeated again in an hour.

No stimulants were given at any time except $\frac{1}{30}$ gr. of strychnia sulphate just before the anesthetic was started.

The patient went straight on to recovery, the stump and rubber cord came away at the end of two weeks, and the opening left by them in the abdominal wall rapidly and firmly healed. She returned home at the end of four weeks; the only evidence of the fearful ordeal through which she had passed was her extreme pallor from loss of blood and anemic headaches, intense in character. She had no milk to nurse the child, but though artificially fed he has grown well, and is now, after about four months, a big healthy lusty baby.

The only other Porro done for placenta previa to my knowledge was by Lawson Tait, Dec. 21, 1898, and reported by him in the *Lancet* for Feb. 11, 1899.

FORCED FLEXION AND ADDUCTION IN CASES OF EXTREME SENSITIVENESS OF THE HIP-JOINT.¹

BY E. H. BRADFORD, M.D., BOSTON.

In a girl of seven years of age, at the Boston Children's Hospital, of acute hip disease with persistent night cries, which lasted without check for several months, various methods had been tried; namely, incision of the joint, traction as high as fifteen pounds (with additional lateral traction), fixation with plaster spica and the usual bed treatment. All these methods of treatment failed to fix the hip-joint absolutely, and failed also to counteract completely the resulting spasm of the muscles about the hip-joint. The injurious jamming of the head of the femur against the acetabulum, the cause of night cries, is not prevented, though it may be sufficiently checked to answer for successful treatment in all but exceptional cases. If the muscles connected with the spasm causing night cries could be put out of action by the position of the limb, and the limb fixed in this position, would not the night cries stop?

The child was etherized and a plaster-of-Paris bandage applied to the limb, forcibly flexed and slightly adducted, with a complete cessation of night cries. A month later the limb was again fixed in a straight position with traction, and a recurrence of the night cries took place. These were again checked by fixation in a position of forced flexion and adduction without traction.

In a second case, a child of three, with thirteen night cries each night, the effect of fixation in a flexed and adducted position of the thigh was equally marked.

The procedure seems applicable to such cases of an extreme type in which other measures fail. In how many instances it will be advisable is yet to be determined, but they are probably few. The measure is, of course, a temporary one, and is only successful when applied with care. The child is secured upon a bed-frame lying on the back, to prevent rolling, and the flexed and adducted thigh and leg, secured in a plaster spica, is slung

¹ Read by title before the American Orthopedic Association, 1901.

so that the weight may not be an inconvenience.

The measures mentioned have the merit of following the indications to be found in the pathological conditions of hip disease in Nature's attempt to protect and relieve the joint.

Medical Progress.

REPORT ON PEDIATRICS.

BY THOMAS MORGAN ROTCH, M.D., AND JOHN LOVETT MORSE, M.D.,
BOSTON.

MOVABLE KIDNEYS AND PALPATION OF THE KIDNEYS IN INFANCY.

WILHELM KNEPFELMACHER¹ speaks of the difficulty of palpating the kidneys in infancy, as the irritation of palpation often causes strong contraction of the abdominal walls. In artificially-fed children the length and distension of the intestines also often make it difficult to reach the retroperitoneal organs. For these reasons some other method for palpation of the kidneys is necessary. He finds that in young infants, and sometimes in older infants, the kidneys are palpable by the rectum. He puts one hand on the lumbar region and introduces the forefinger of the other hand into the rectum. According to the age and size of the child, and according to the course of the sigmoid flexure, either one or both kidneys may be palpated. As a rule, the right kidney is felt more easily than the left. This is due to the fact that the right kidney is situated somewhat lower than the left. By this method the lower third, and often the lower half of the kidney may be felt. The method is simple. Palpation is best performed with the child on its back, but sometimes the side is better. He found that the kidneys in infants were always movable, and that they also moved with respiration.

He found two cases of floating kidney in infancy. One was in a child of nine months, the other in one of four months. In the first case, he thinks the motility was acquired, as the spleen and liver were also low. In the second case, he thinks that there was congenital dislocation of the kidney, and hence that it was movable.

MYOTONIA IN INFANTS AND ITS RELATION TO TETANY.

Hochsinger² claims in early infancy there is a slight rigidity of the flexors of the extremities and a tendency to assume a position of slight flexion in the fingers and toes, even in perfect health. But little psychical excitement is sufficient to produce a tonic spasm, which doubles the hand into a fist and strongly flexes the toes. Prolonged pressure on the brachial plexus produces, according to the degree of muscular irritability, either partial or complete flexion of the fingers, and this "fist phenomenon" may be produced in all forms

of pathological myotonia. The ease with which the fist phenomenon may be produced during the first few weeks of life is explained by the absence of inhibitory impulses arising in the cortex of the brain, which restrain reflex action of the cord, and by the tonic spasm peculiar to infancy.

In the lightest forms of myotonia there appears, in addition to this phenomenon, an increase of the physiological hypertonia of the flexors, even without any exciting cause. During the first few weeks of life a little digestive disturbance may cause this mild degree, but it is rarely found after the second month.

In the first form of myotonia in infants are found intermittent tonic contractions of the muscles of the extremities. The position of the hand peculiar to tetany is also found frequently in this variety, but, according to Hochsinger, these spasms must be distinguished from those of tetany. They differ from the latter in showing no hyperexcitability of the muscles and nerves, either on mechanical or galvanic stimulation. They are painless, while the contractions in tetany are usually painful. Tetany affects children between the fourth and twentieth months of life; this form is found almost exclusively during the first three months. Myotonia affects children suffering from some other grave disturbance. These disturbances are most commonly gastro-intestinal diseases and congenital syphilis. Hochsinger considers these spasms an exaggeration of the physiological hypertonia of the muscles of newborn infants, which is present during the first three months of life.

The second form, or persistent spastic myotonia, is characterized by persistent symmetrical spasms of the flexors of the hands and feet, and stiffness of the flexors and adductors of the extremities. These persistent spasms may continue for six months without noticeable change. This second form is especially frequent during the first weeks of life, and relatively infrequent after the third month.

In a third form the myotonia extends to the muscles of the trunk and neck, and even to those of the face, producing a condition resembling tetanus. It is distinguished from true tetanus by the absence of increased excitability of the muscles and nerves.

Marchi and Nissl have demonstrated by their staining methods, changes in the anterior nerve roots and cells of the anterior horns of the grey matter of the spinal cord, in specimens obtained from children dead of septic or intestinal diseases. These changes, Hochsinger believes, form the anatomical basis of the conditions of myotonia described by him, and although they affect only the nutrition of the parts, they are probably sufficient, in connection with the absence of inhibitory impulses, to produce the muscular contractions.

THE LEUCOCYTES IN THE DISEASES OF THE GASTRO-ENTERIC TRACT IN INFANCY.

Japha³ made many counts of the white corpuscles in 22 normal children under ten months of

¹ *Jahrb. f. Kinderheilk*, 1901, p. 298.

² *Wien. med. Woch.*, 1900, Nos. 7-12.

³ *Jahrb. f. Kinderheilk*, 1901, p. 179.