do it, because they do not tolerate the stomach tube well.

Dr. Urban Maes, New-Orleans, La. (Closing).—Inflammation of the peritoneal membrane is only dangerous in so far as it is capable of producing intestinal paralysis. With the paralysis comes an early thrombosis in the terminal radicals of the mesenteric vessels in the wall of the intestine, causing ulceration and necrosis in the mucosa, liberating a toxic protein substance from the mucosa, which is the cause of symptoms.

We are familiar with thrombosis of the large mesenteric trunks, but have not been accustomed to thinking of the possibility of thrombosis in the terminal capillaries caused by pressure from gaseous distention, which in turn may be caused by handling the plexus of Auerbach and Meisner in the wall of the intestine.

AUTHORS' ABSTRACTS

Surgery, Gynecology, Obstetrics and Genito-Urinary Diseases.

Surgical Operations During the Pregnant State.

By Francis Reder, St. Louis, Mo. *The American Journal of Obstetrics*, January, 1916, p. 66.

The author believes that an imperative major operation, of whatsoever nature, performed during the pregnant state, does not influence the progress of pregnancy other than to favor its continuance, provided no septic process with its continued high temperature results in the death of the fetus and causes abortion.

The author's experience with appendicitis as a complication leaves for him but one choice in dealing with this disease, and that is to operate as soon as the diagnosis is made. He even goes so far as to demand an exploratory operation in all cases where there is a strong suspicion of the existence of appendicitis. Through such a procedure very little harm, if any, can occur, and a far more serious trouble may be anticipated and the patient's life saved. Surgical intervention for appendicitis during pregnancy is not a matter of election and should be performed regardless of any accepted ruling as to the most propitious time for operation. Of five cases of appendicitis during the pregnant state, between the fourth and the seventh month, where pus was encountered, three aborted—all within five days. The other two went to full term, having a normal labor.

Of twenty-eight cases of appendicitis during pregnancy between the second and the fifth months, where no pus was encountered, there were no abortions. Two cases of appendicitis, one occurring during the sixth month and the other during the seventh month of pregnancy, suffered no untoward results from the operation.

The cause of abortion in the pus cases must

not be attributed wholly to the operative measure. The author is disposed to believe that the continued high temperatures and the drainage material used are equally important factors.

Cervical myomata grow rapidly during gestation and usually prove a decided barrier to delivery. Vaginal enucleation or amputation of the tumor should be done at the earliest date possible. The operation is often followed by severe hemorrhage and difficult of control. Many surgeons militate against this risk by resorting to more radical measures. Should a cervical myoma prove too great a risk for removal, on account of the size it has attained, it would be advisable to follow the same rule as in the other varieties of uterine myomata, namely, to wait for the viability of the child, and then perform Cesarean section, followed by hysterectomy.

Cases of myomata complicating pregnancy coming under the author's care were nine sub-peritoneal tumors, all sessile. Four cases were subjected to myomectomy on account of rapid growth and incarceration between the third and fifth months; no abortion. Of the other five cases, three went to full term, and two miscarried at the fifth and seventh months, respectively. All recovered. In the three cases, where myomectomy was successfully performed, the uterine balance was quite disturbed, as was evidenced by pain that presaged an impending abortion. With the aid of opiates, the organs regained their normal equipoise within a few days. The other case of myomectomy progressed most favorably and gave no evidence of the surgical infliction. In one case of interstitial tumor operation was refused. Patient miscarried in the seventh month and perished from sepsis two months later. In two cases of intraligamentous tumor, operation was refused. One case aborted in the third month and the other in the fourth month. Both patients recovered. They were operated successfully later. One cervical myoma the size of a hen's egg was removed during the second month. No abortion. The author had a few cases of myoma where hysterectomy had been performed and the discovery of pregnancy was made after operation.

Conclusions

The author's conclusions gleaned from the studies of a limited experience with surgical lesions complicating or co-existing with pregnancy are as follows: 1. A woman expecting to become pregnant should be thoroughly examined for any physical defect. 2. Such a defect should be corrected, if possible, before pregnancy takes place. 3. No operation that can be deferred should be performed upon a pregnant woman. 4. Any operation that will contribute to the safety of a pregnant woman should be performed without hesitancy.