supra condyloid ridge is above the centre of motion at the elbow-joint, similar to that of the flexors. As soon as the shortest direct line between their point of origin and insertion came in front of the centre of motion at the elbow-joint, their action as extensors would cease. They would then virtually be flexors, and assist in producing the same deformity as that produced by the flexors.

Professor Packard, of Philadelphia, says the method of putting the arm in extension, with the normal lateral angle maintained, and keeping the limb in this posture by means of some immovable apparatus, is a very sound one in theory, and no doubt has given good results. But he thinks the same results may be attained in the flexed position, and with more comfort to the patient. I think I state without fear of contradiction that it is very difficult, or next to impossible, to know whether we have the arm at the proper angle when in the flexed position, and as to the comfort of the patient, I think no method can surpass the extended position. The experience of the surgeons who have used this is that when dressed the patient is perfectly comfortable. A patient with the arm extended and the lateral angle perfectly maintained by one or two straight splints, goes about with the arm hanging by the side, or supported with the other hand, complaining of no pain whatever.

The results of this method of treatment by the surgeons whom I have mentioned have been perfect in every instance. My own observations are limited to four cases, three children and one adult, with perfect results in each case. In consideration of these encouraging results, I think I will be sustained by all who have used this method, in making the broad statement that where the same care, tact, and judgment are used in dressing these fractures in the extended position as are used in dressing them in the flexed position, the results in the former will be better. I would therefore recommend this method of treatment to those who have had imperfect results in the treatment of these fractures by the old method.

TWO CASES OF LABOR COMPLICATED WITH FIBROID TUMORS, WITH REMARKS.¹

BY W. E. BOARDMAN, M.D.

CASE I. Nora C., octopara, was admitted to the Boston Lying-in Hospital during my service, August 1st, 1882, at the request of her attending physician, with the view of having labor induced artificially, on account of the presence of a fibroid tumor which, it was feared, would become a serious complication to the process of labor if pregnancy was allowed to continue until the full term. She was then in the seventh month of pregnancy.

Upon examination after admission, there was found a sessile, interstitial, or rather submucous tumor the size of a fetal head, in the anterior wall and projecting within the cavity throughout its whole extent, apparently, or at least as far as the examination permitted its exploration, and soft to the touch. The fœtus appeared to be small, though living. The os was patulous, and readily admitted two fingers, so that the tumor could be reached.

Upon consultation it was decided, in the interest of the child, to postpone interference as long as possible, consistent with due regard for the safety of the mother. On the following day, however, at 11 A.M., labor began, the breech presenting, and was completed at 5 A.M. on the next day, without any abnormal incident. The child was stillborn. The following brief extracts from the records are given to illustrate the subsequent history of the case:

August 4th, the day after delivery, A.M. pulse 100, temperature 101.7°, and P.M. pulse 104, temperature 103.5°. Following the custom then prevailing in the hospital, vaginal carbolized douches were given, and also ergot and quinine were administered. The patient continued to be nervous and weak, slept and ate poorly. The pulse and temperature varied but little from day to day until August 7th, when the record states the A.M. pulse 68, temperature 98.3°, P.M. pulse 78, temperature 102.2°, and the lochial discharge became very offensive. The pulse and temperature again rose, and on August 9th, A.M. pulse 104, temperature 101.2°, when, upon examination, the tumor was found to be protruding from the external os. Gradually it came down so as to occupy the vaginal cavity, and on the 13th, the general symptoms became so threatening that, during my absence from the city, Dr. Richardson was summoned, and he removed the entire mass, which was exceedingly foul, and thoroughly cleansed the uterine and vaginal cavities. On the following day, peritonitis developed, and shortly after collapse occurred, and death ensued.

CASE II. During my service in January, 1886, N. M., single, primipara, was admitted to the hospital. She stated that, having previously menstruated every two weeks, she was exposed in July, since which time the catamenia had not appeared. About this time she began to suffer with abdominal pains, to relieve which she soon contracted the opium habit, and shortly after consulted Dr. C. P. Strong in regard to some "lumps" in the abdominal cavity. He diagnosticated multiple fibroids, but declined to consider the subject of operation for their removal, chiefly because he suspected associated pregnancy, which subsequent observation proved to be the condition.

January 21st, she complained of symptoms which pointed to the coming on of labor, and, by his advice, she was sent to the hospital on the following day, when, upon examination, a very loud and distinct souffle over the whole lower abdomen, but no fœtal heart, could be heard. By palpation the fundus was felt, reaching just above the umbilicus, irregular in outline. Upon either side of this were several fibroid masses. Per vaginam there was found a retro-vaginal fibroid mass, which filled posteriorly the excavation, obviously with a high attachment to the uterus, and could not be dislodged by pressure with the fingers. In front, and very high up, behind the symphysis, the cervix was found, with the os soft and patulous, admitting more than the finger tip, and the posterior lip notably elongated. It was decided to wait until the pains should become more frequent and regular, in order to ascertain what nature would accomplish before attempting interference in any way. During the day, January 22d, it was found that the cervix gradually came down lower in the pelvis, though to a slight degree, and the fœtal heart could be heard, but not counted at the right of and below the umbilicus.

On the following day, in the morning, the pains

¹ Read before the Suffolk District Medical Society, Section for Obstetrics and Gynecology, Nov. 17, 1886.

became nearly constant, but slight, the cervix was taken up; the os, the size of a twenty-five cent piece, was easily reached, and found distended by a fluctuating tumor. The membranes obviously had ruptured at 12 M., on the day before. The os continued to dilate gradually but slowly until 3 P.M., when it was fully dilated, and the fluctuating tumor, which was then recognized as an encephalocele, presented at the vulva. In the meantime, the retro-vaginal fibroid had gradually ascended until finally it was entirely above the brim. Soon after this the child was born, having been delayed somewhat in the passage of the head beneath the pubic arch. The fœtus was stillborn. The uterus contracted firmly after the expulsion of the placenta and there was no hæmorrhage. Convalescence was uninterrupted, and she left the hospital February 4th. Upon examination before her departure, the cervix was found to be lacerated bilaterally, and the uterus was anteverted and lying prone beneath the mass of fibroids.

In connection with the relation of these cases it may not be out of place to give a brief *résumé* of our present knowledge concerning fibroid tumors in their relation to conception, pregnancy, parturition, and the post-partum period. It is a well-recognized fact that these tumors predispose to sterility, the subserous variety primarily on account of the uterine displacements which they induce, the interstitial for the same reason, and, if these tend to become the third variety, or submucous, on account of the changes which they induce in the lining membrane of the uterus, and which lead to hæmorrhage and other discharges that ordinarily prevent conception. Still sterility is by no means the absolute rule with either variety, and especially is this true of the subserous form. Another fact is observed, which is notably true of the submucous variety, but not confined to this class, that abortion or premature labor is likely to ensue.

In some cases, however, pregnancy is uninterrupted until the period of normal labor arrives. Meanwhile, it is the common observation that during pregnancy these tumors develop rapidly, and, as a rule, undergo a change in consistence, becoming softer, and at times are transformed more or less into colloid or cystic masses. It is a frequent occurrence, too, that abnormal positions and presentations of the fœtus are occasioned by all varieties of these tumors, and it may be added there appears to be a notable disposition, with the interstitial and submucous varieties, to placenta prævia, or to the implantation of the placenta over the locality of the tumors.

At the time of labor, these tumors may or may not interfere with the normal processes of parturition, according, in the main, to the variety, to the size of the tumor or tumors, their location and mobility, to the existence and extent of adhesions, and to the period of pregnancy.

In the earlier months, the process of abortion or very premature birth very likely will not be complicated to an unusual degree, except, possibly, by hæmorrhage, which, however, ought not to become a source of danger in these cases.

In the later months, and at term, either variety may become a serious obstacle to delivery, and a source of danger either to the mother or to the child, or to both, and in various ways, of which the following will serve as illustrations:

Uterine fibrous polypi may be the occasion of hæ-

orrhage, or interfere with delivery, from occupying so much of the cavity of the body or cervix as to delay or prevent the passage of the fœtus, or from presenting in front of the fœtus.

Submucous fibroids, if situated above the body and in the fundus, will offer no impediment to delivery, except, perhaps, they occasion irregularity in the uterine contractions, or give rise to hæmorrhage. Situated in the body, however, from their size, which is increased largely during pregnancy, they commonly become a serious impediment, acting in a like manner with the polypi similarly situated.

Interstitial tumors obstruct delivery, as a rule, only when, in their rapid growth during pregnancy, they become more or less submucous in character, or are located in the body or cervix, and attain sufficient size to obstruct mechanically the progress of the fœtus. If they develop outwards, tending to become subserous, they commonly afford no serious obstacle, provided they remain, or can be kept above the brim of the pelvis. Similarly, too, extra-uterine or subserous, or subperitoneal tumors may not seriously complicate labor, provided they do not encroach upon the parturient canal to a degree which will prevent the passage of the fœtus.

If such a tumor is connected with the body of the uterus, and is not tied down by adhesions, the longitudinal contractions of the uterus will serve to elevate or keep it above the brim, but if it originates from the cervix, in some cases it will permanently occupy the pelvis, becoming retro-vaginal; and if it attains to a great size, it will afford an impassable barrier to the expulsion of the fœtus, constituting, in fact, a shortening of the pelvic diameters.

The treatment of these cases, in the light of comparatively recent experience, which has been based upon modern advances in gynæcological, obstetrical, and surgical practice, offers a very wide and interesting field for discussion, which the scope of this paper will not permit me to enter upon, except in a very brief manner.

There is a general consonance of opinion as to the treatment of the polypoid variety of tumors. During pregnancy, hæmorrhage sometimes becomes a dangerous symptom, and in these cases, the ordinary rules of surgical procedure should, and may safely be applied, and the tumor should be removed.

At the time of labor, the general practice is to await the proper dilatation of the os, and then, in the intervals between the pains, to push up the tumor, and allow succeeding pains to expel the presenting part in front of it. Failing in this attempt, or if the tumor already is pressed down in advance of the head, and is too large to admit of the passage of the child without endangering its life, or the mother's soft parts, the only proper method appears to be to remove the entire tumor by means of the *ecraseur* or the knife, if the pedicle can be reached; otherwise, as much of it as possible should be taken away. Fortunately, in these cases it is quite the rule, I believe, that the pedicle is within reach, attached to the cervix, or just above it. If the pedicle is very small and thin, nature, in her efforts to expel the child, would, without doubt in many cases, rupture the attachment, but at the expense of time and strength, which might be saved to the mother and child to their mutual advantage.

With the submucous variety of fibroids, including the interstitial forms, which, in their development

during pregnancy, tend to become submucous, the practice has been to await the results of nature's efforts, and when these have failed, to resort to some artificial means of delivery; and, as a rule, until lately the child has been sacrificed in the interests of the mother; but, as a rule, too, in these cases the mother has succumbed, sooner or later, to hæmorrhage, exhaustion, shock, or septicæmia.

Even in cases where there has been no serious impediment to delivery, the tumor, softened by the processes incident to its rapid growth during pregnancy, is subjected to so much pressure after the rupture of the membranes and by the uterine contractions, that sloughing and gangrene ensue, and the patient is overwhelmed with septicæmia or pyæmia, as, for instance, in the case which I have reported.

The older obstetric records furnish little but fatal results in these cases, when left to the natural efforts, or where craniotomy or Cæsarean section, either alone or combined, were performed. The study of the details of reported cases appears to disclose one salient fact, namely, that many, if not most, of the immediately fatal results have been due to delay; and bearing in mind that where delivery has, in a surgical sense, been safely accomplished, while the patient subsequently died with septicæmia, the deduction seems clear to me that the safety of both mother and child, in these cases, suggests the following methods of practice, namely: If the tumor is not so large as to offer a serious obstacle to delivery, I should avoid, as much as possible, the compression of it by manual or instrumental delivery directly after the rupture of the membrane, employing artificial dilatation of the os, if required.

In case the tumor is so large as to block the passage of the presenting part so as to form an impassable barrier and is accessible, it would seem to be the best practice, in suitable cases, to employ enucleation, as has been successfully done by Mundé of New York and others. With regard to a resort to version, forceps or craniotomy, similar rules apply as in cases of deformed pelvis, except that with fibroids we must, on the one hand, endeavor to appreciate with considerable accuracy their position, mobility and consistence, and, on the other, the liability to subsequent septicæmia, to which reference has already been made.

Whenever delivery appears to be impossible per *vias naturales*, either under nature's efforts alone or with the intelligent assistance of art, or when there is good reason to believe that these efforts will not only destroy the child, but very likely the mother also, respect for the obstetric art, and more than this, humanity, seems to me clearly to indicate an early resort to laparotomy in some of its forms.

In the light of modern success in abdominal surgery and from a critical study of the cases in recent years which have been the subjects of Cæsarean section, Porro's, Müller's, or Sanger's operations or of laparotomy, it seems to me to be evident that the timely resort to one of these methods will, in the future, result in the saving of many maternal and foetal lives.

If the tumors be interstitial, but tending to the subserous variety, it is probable that delivery will not be interfered with to any great extent, except from the delay sometimes occasioned by irregular contractions, provided the tumors are above the brim of the pelvis. The same is true in general of the subserous tumors.

In many cases, however, as in the second one I have related, there is a tumor occupying the retrovaginal space. If this be not too large or adherent, it may sometimes be pushed above the brim and held there until the foetus engages or occupies the excavation. If this cannot be done, I believe the essential point to be determined, if possible, is whether the tumor has its origin in the body or above, or in the cervix of the uterus.

If the former is the case and it is not tied down by adhesions, the longitudinal contractions of the uterus will gradually lift it out of the pelvis, as occurred in the case reported, and in this effort nature may often be assisted, and labor will then go on without dangerous obstacles so far as the tumor is concerned. When, on the other hand, the tumor arises from the cervix the contractions are not sufficient to effect this result, and in this case similar rules will apply as with the submucous variety, that is to say, one ought to resort, if it seems necessary on account of the size of the tumor, to version, forceps or craniotomy, and in some of these cases the timely employment of laparotomy, especially, would seem to be demanded with the view of affording the best chances to both mother and child, though it is to be kept in mind that with these subperitoneal tumors, while there is a liability to a subsequent peritonitis, there is not the danger of a supervening septicæmia so common after labor complicated with the submucous fibroids.

The question of the advisability of the induction of premature delivery in these cases is one of great importance and calls for the most careful scrutiny in each instance. The consistence of the tumors, their locality and mobility, their size and rate of development during pregnancy, the occurrence or absence of hæmorrhages, the general physical condition of the individual, possibly the history of a previous labor in the same woman with similar complications, all these should be taken into consideration in estimating the probable results of labor at term or in the latest months.

Reasoning from the large fatality incident to the care of most cases which have been recorded in former years, it would appear that an early induction of labor would result in the saving of maternal life, but, on the other hand, in recent years, the desire of obstetricians to save the children has been favored by the knowledge and experience gained in successful abdominal and vaginal surgery, so that we may not err in venturing to assert that in the future the obstetric literature may reverse the direful record with which, so to say, it has been stained in former years, in connection with the treatment of those cases of labor complicated with fibroid tumors, by a resort to the induction of labor after the completion of the seventh month or by laparotomy in some of its forms.

It only remains for me to add a few words concerning the relation of these tumors to the post-partum period.

It is a common experience that most of them rapidly become smaller after labor, sometimes, indeed, they seem to disappear entirely or nearly so, and this is true of the polypoid, intramural and subperitoneal forms. Occasionally the polypoid variety will slough, but it is then quite amenable to treatment.

The submucous variety, however, and too, the interstitial which during the hypertrophy incident to the period of pregnancy, has tended to become submucous,

commonly soon begin to soften more, to slough and become gangrenous, as did the one in the first case I have related. My error then, I believe, was in delay. Possibly an earlier interference with the view of removing the mass, by the curette or otherwise, would have made no difference in the final result, but upon general principles of uterine surgery, it appears to be eminently proper to attack such tumors at once, to remove as much of the sloughing material as we can, and to employ disinfecting agents with the utmost freedom.

Following this method in these cases of submucous tumors, we shall, at least as far as lies in our power, remove the source of systemic poisoning.

The danger from hæmorrhage with such treatment is overstated, for if the necrotic mass be removed quickly you will soon reach healthy tissue, which will not bleed very freely, just as is the case with similar treatment of malignant disease.

Another objection has been made, that by the exposure of such a large freshened surface to the lochial discharges, the chances of septicæmia would be largely multiplied, but I cannot appreciate the justice of this criticism, for surely the lochia cannot be so infectious as the sloughing and gangrenous material of the tumor, and too, the employment of the intrauterine disinfectants, if they serve any good purpose, certainly will tend to render the lochia innocuous.

Clinical Memorandum.

A CASE OF HÆMATOMA OF THE PANCREAS: DEATH IN THREE DAYS.

BY R. W. AMIDON, A.M., M.D., OF NEW YORK.

IN a recent number of the JOURNAL (October 28, 1886), Dr. F. W. Draper narrates five cases of extreme interest, in which pancreatic hæmorrhage coincided with inexplicable sudden death. It may interest those who read his paper to learn of a case in which death was *not* sudden, but in which pancreatic hæmorrhage was the only noteworthy lesion found. The case occurred in my practice several years ago.

A laboring man had been in perfect health until 10, A. M., June 23d. At that hour he was seized with nausea, vomiting, and slight diarrhœa. That evening, attacks of severe pain and cramps in the abdomen and stomach set in, which increased in frequency and force until the next evening, when I first saw him. He was then suffering severely. Countenance pale and haggard, body emaciated, and skin cold. Vomited matter was greenish; later, blackish (did not contain any blood-corpuscles). Frequent cramps run from abdomen into arms, and down legs, causing great muscular rigidity, and making patient cry out with pain. There was intense thirst. The urine was slightly albuminous. The treatment consisted in the free hypodermic use of morphia.

June 25th. The condition was unchanged; no movement from the bowels had occurred. A hypodermic injection of ether (3iss) raised the temperature from 97.6° to 99° F.

The patient died rather unexpectedly June 26th.

The pancreas was enlarged and hard. A hard, disk-shaped tumor, four centimeters in diameter, lay seemingly between the head of the pancreas and duodenum,

and adherent to both. It presented, on section, a hard, blackish surface. On more minute examination, the tumor was found to encroach upon the substance of the head of the pancreas. The microscope proved the tumor unquestionably a hæmatoma.

New Instruments.

A NEW EAR-SPECULUM.

BY E. D. SPEAR, M.D.

AN ear-speculum, designed by the writer, was presented to several of the aural surgeons of Boston a year or more ago, was noticed by an aurist of another city in his "Treatise upon Diseases of the Ear," and has been of such service, that a description of it is here offered, that its usefulness may be further extended. Made more especially for an operative instrument, it serves equally well as a demonstrating speculum, fulfilling the object for which aural specula are intended; namely, the straightening of the auditory canal, the turning aside of hairs, bits of cerumen, or epidermal scales, and the removal of obstructing parts of the auricle, as the tragus.

As it is easily retained in position by the elasticity of the cartilaginous canal, and does not, therefore, require holding, the surgeon is enabled by its use to perform the usual operations without the aid of an assistant.

In reality, the instrument consists simply of those portions of an ordinary speculum actually in use during an examination of an ear. It is a short, flattened funnel, with a triangular flange projecting from, and forming one of its sides.

It need only be stated, in directions for its use, that this flange should be placed anteriorly, where it will be found pushing aside the tragus to allow light to enter the canal.

It is manufactured by Tiemann & Co., of New York, and may be obtained of them, or through Messrs. Goldthwaite & Co., in Boston.

Reports of Societies.

SUFFOLK DISTRICT MEDICAL SOCIETY. SECTION OF OBSTETRICS AND GYNÆCOLOGY.

ROBERT B. DIXON, M.D., SECRETARY.

NOVEMBER 17, 1886, DR. JAMES R. CHADWICK in the chair.

DR. W. E. BOARDMAN read a paper entitled

TWO CASES OF LABOR COMPLICATED WITH FIBROID TUMORS, WITH REMARKS.

DR. DRIVER, in opening the debate, mentioned a case of pregnancy in a woman about thirty-eight years old, complicated with a fibroid, apparently interstitial, filling the posterior *cul-de-sac*, the size of a small child's head, which he had sent to Dr. William L. Richardson, at the Boston Lying-in Hospital, for his opinion, Dr. Driver, seeing no way but to induce