taken effect. The fascia and peritoneum are now infiltrated in turn and divided. The uterus presents under the incision and is approximated to the abdominal wall by the method already described. One ampoule of pituitrin is now injected into the uterine muscle. The uterine peritoneum and muscle are insensitive, so it is not necessary to inject any local anaesthetic. The uterus is incised, the incision being carried down to the membranes first in its lower portion to avoid encountering the placenta and is then completed with scissors. The membranes are now ruptured, the operator's hand cautiously inserted into the ovum and the anterior leg gently grasped. The child is slowly and carefully extracted and the cord clamped and cut. All tearing of tissue or rough handling must be avoided. Speedy and spectacular operating is most out of place here. Both the abdominal and uterine incisions must be amply large to allow the easy extraction of the child.

Having disposed of the baby the operator inserts his fingers into the upper angle of the uterine wound and gently delivers the uterus through the abdominal incision. Then and not before the assistants are allowed to remove their hands from the patient's flanks. One or more sterile towels are wrapped around the lower portion of the uterus and secured with clamps. The placenta and membranes are removed and the uterus sutured in the usual manner. If it is desired to sterilize the patient the proximal $1\frac{1}{2}$ inches of the mesosalpinx is infiltrated with local anaesthetic just below the tube. The tube is tightly ligated $1\frac{1}{2}$ inches from the uterus and the proximal portion excised, including its uterine insertion. The distal cut end is now buried between the folds of the mesosalpinx, which are brought together with a running stitch. The elliptical incision in the uterine cornu left by the excision of the tube is closed by sutures. The same process is repeated on the other side and the uterus returned to the abdominal cavity. Suture of the abdominal wall is carried out in the usual way. One should, however, avoid picking up the parietal peritoneum in hemostats or pulling upon it in any way, as such traction causes intense pain and is sure to arouse the patient. Packing of gauze into the peritoneal cavity will produce the same effect. It may be necessary to inject more local anaesthetic into the skin before it is sutured.

In the cases operated on by the writer according to this technic or in those which have come under his observation there has been an entire absence of operative shock. The patients have been returned to bed in no worse condition than when they left and there have been no maternal deaths. All have either been entirely unconscious of what was going on at the time of operation or else have had a very hazy idea of it. With the exception of one child, which was dead at the time of operation, there have been no foetal deaths. The full term infants have cried promptly at the time of delivery, more vigorously, in fact, than after Caesarean under ether anaesthesia. The premature infants have required considerable resuscitation. The method is doubtless applicable to other conditions than those mentioned. In eclamptic primiparae with rigid cervixes it may have a distinct field of usefulness.

SUMMARY.

(1) Caesarean section under local anaesthesia combined with morphine and scopolamine narcosis is a useful and successful method of delivery in some of the graver complications of pregnancy. Among these are cardiac disease where one or more attacks of decompensation have occurred, diabetes, nephritis and cardio-renal disease, pulmonary tuberculosis and bronchial asthma.

(2) In general, it finds its application in those cases where we wish to avoid the pain and physical exertion of labor, the possible shock of an operative pelvic delivery, and the danger of general anaesthetic.

(3) Plenty of time must be allowed for both the general medication and the local anaesthetic to act.

(4) Deliberate operating, with studious avoidance of roughness, is essential to success.

SOME SURGICAL ASPECTS OF SYPHILIS.*

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THE seed of our present day knowledge concerning the surgical aspects of syphilis comes from the work of three great Old World scientists, Virchow, Alfred Fournier, and Sir Jonathan Hutchinson.

* Read at a meeting of the Out-Patient Staff of the Massachusetts General Hospital, March 12, 1920.

With all the recent intensive study of syphilis which has been carried out during the past few years, and which through refined methods of diagnosis has brought to light the great amount of unrecognized syphilis in communities, it is indeed strange that the surgeon, excepting in a few instances, has not realized how much bearing these facts may have on his own problems of diagnosis and operative treatment.

If the surgeon receives a negative Wassermann report before operation, the factor of a possible syphilis is often dismissed. Often the Wassermann test is not even done, because the patient does not have any glaring manifestations of the disease, and denies any previous infection. We must realize that a negative Wassermann reaction means nothing, as far as the possibility of syphilis goes. The fact that many patients are infected, innocently or otherwise without their knowledge, is not realized as often as it should be.

Surgical syphilis has to do with the lesions of syphilis which require surgical treatment, either conservative or operative, in conjunction with specific medication. Also we must include those cases where manifestations of the disease simulate surgical conditions demanding operative intervention. In a case demanding operative surgery in a syphilitic, the operation wound may take on the characteristics of specific ulceration, but this is not necessarily so, and does not happen in the majority of cases.

In cases of suspected syphilis with negative Wassermann reactions, we have in skeletal radiography, a most valuable method of detecting at times a silent syphilis. This, of course, does not mean that the trouble the patient is to be operated upon for is necessarily syphilis, but that the old infection is there, and may light up after operation. Probably about 15 or 18% of those applying for surgical treatment at large hospital clinics, have been infected some time or other, with the *spirochaeta pallida*.

In considering this subject more in detail, we find that there are certain diseases and certain parts of the body where we find syphilis masquerading as a surgical condition, or complicating a surgical case. From a study of such cases we find many unrecognized specific infections, and can draw some definite conclusions.

Cervical adenitis, due to tertiary syphilis, a gummatous infiltration of the glands, is not so very uncommon. It has been mistaken for tuberculous cervical adenitis, and for Hodgkin's disease, more than once. Deep seated syphilitic mediastinitis is sometimes mistaken for hopeless malignant disease, and a fatal prognosis given, when the patient has been subsequently relieved of symptoms and symptomatically cured by recognition of the real cause of the trouble and vigorous specific treatment.

Obscure conditions simulating ordinary bursitis or synovitis, are sometimes treated for a long time with a mistaken diagnosis, and months afterward, when the diagnosis of a luetic bursitis or synovitis is made, they are quickly symptomatically cured. This is true of both those cases which have been treated conservatively and those which have been operated upon, and have not healed.

Syphilitic bone disease at times underlies varicose veins of the legs and varicose ulcers. The veins are operated upon but the ulcers return. When the true cause of the condition is recognized, cure quickly follows in many cases. Not infrequently specific ulcers of the leg are diagnosed as varicose, because the patient has varicose veins. A true syphilitic phlebitis is rare, but exists.

In the question of non-union and delayed union of fractures we must always have in mind the possibility that syphilis is at the bottom of the trouble. Routine Wassermann tests should always be made in these cases, and when they are negative, x-rays of the other bones should be taken to see if they show evidence of an old syphilis. In one clinic in a distant city a Wassermann test was taken in every case of ununited fracture for a year. Every case gave a positive reaction.

Bone disease caused by syphilis, apart from the ordinary osteoperiostitis, may cause a rarefaction or thinning of the bone, making the individual more liable to fracture. Repeated fractures, especially if the trauma is slight, make us think of the possibility of syphilis. The French workers of some years ago understood these facts, which are as yet not fully appreciated in America.

Gummatous infiltration of the testicle is not infrequently operated upon for sarcoma, teratoma, or tuberculosis. In such cases it must be remembered that outside of a Neisser infection, gumma is the common, ordinary cause of

enlargement and it should be ruled out by tests, history, and, if necessary, therapeutic test, before operation is done.

The tabetic arthropathies, with or without ulceration, are not infrequently incorrectly diagnosed, and the underlying cause of the trouble unrecognized. A painless ulcer on the sole of the foot, with a hole leading to dead bone, usually means tabes, though syringomyelia and leprosy must be thought of. All the so-called "stomach cases" that the surgeon sees must be closely scrutinized with a view to syphilis as a cause. Five or six per cent. of ulcers of the stomach are now said to be syphilitic. I believe that 10 per cent. would be nearer the truth. Gummatous ulceration of the stomach may simulate gastric cancer so closely both in symptoms and in radiographic picture, as to make the diagnosis very uncertain. There is an old French proverb which reads, "In a case where a malignant tumor is suspected, happy is he whose father has had syphilis." Fournier modified this saying to read, "In a case where a malignant tumor is suspected, happy is he whose grandfather has had syphilis."

The wide field of the relation of syphilis to trauma and especially industrial injury has been little explored. In industrial accident cases it has been demonstrated that many times a complicating previous syphilis may be overlooked, and the patient's convalescence retarded from lack of specific treatment.

Many times cases have been operated upon for supposed acute appendicitis or gall bladder disease, only to find that the patient was suffering from the gastric crises of tabes.

In this paper it is possible only to outline some of the many important points connected with surgical syphilis. In hospital practice it is often the surgeon who is the first to see the unusual and obscure manifestations of syphilis, as such cases are often sent first to his department, it being supposed they are of a purely surgical nature. Careful thought and examination with reference to lues, will richly repay the surgeon. Many times he will save himself or save others the humiliation of operating for a condition in which active surgical intervention is not indicated. With this in mind, it is fitting to remember the last words of Stolper, in his classic article on "Syphilis and Trauma," "If we are keen observers we

shall shorten many cases of long convalescence, and avoid many bad results, and for some will produce a cure, for in the words of her greatest master, Virchow, 'Shockingly great is the havoc wrought by syphilis.'"

Society Report.

PROCEEDINGS OF THE NEW ENGLAND BRANCH OF THE AMERICAN UROLOGICAL ASSOCIATION.

(Concluded from page 562.)

DR. SMITH: I should like to report briefly two cases of bilateral ligation of the ureter that occurred about two years ago within five days of each other.

A woman of forty had a supravaginal hysterectomy on December 27, 1917. After the operation she passed seven ounces of urine, then one ounce, and no more. I saw her on December 30th, seventy-two hours after operation; she had vomited on that day and had pain in her back. Cystoscopy; normal bladder; both ureters catheterized for about 8 cm. Catheters would not pass above that point. I believed that both ureters had been ligated and advised bilateral nephrostomy. She was given ether; both kidneys were exposed; the pelves were distended but not dilated. I opened the pelvis on each side and urine gushed out. Tubes were inserted by the following method: A curved hemostat length was passed through the pelvic incision, out through cortex; the tube was grasped and drawn in through cortex to pelvis. The incisions into pelves were not sutured. Patient made a good recovery after that. There was a good flow of urine from the tubes. On January 18 I cystoscoped her and found the ureters obstructed as before. On January 21st, attempted to catheterize ureters but could not get by the point of obstruction, so it seemed proper to attempt to relieve the ureteral obstruction. This was done through Gibson incisions, first on one side and then on the other. The ureters were indentified above the point of ligation. At that point there was a mass of adhesions. Both ureters were thinned down to mere threads; on the left side just a fibrous cord between the two ends of the ureter existed. Figure 1 shows this condition.

In the right ureter a very narrow lumen persisted. I made a longitudinal incision into this and sewed it up transversely as shown in Figure 2a. The incision was carried farther in both directions than is shown in the illustration. On the left side, the ureter was practically pinched off. I resected both ends obliquely, then sutured the cut ends together with interrupted stitches of 00 catgut. By