Special instruments are needed; for example, Galbiati knife and metal catheter. Care has to be exercised to prevent too great separation of pubic bone for fear of injury to sacro-iliac joint.

It has been urged that symphyseotomy is the operation to choose when labor has been protracted and many fruitless efforts made to deliver the child, but now we find the same precautions urged as for Cæsarean section. It should be an elective operation, done before there has been any manipulation of uterus or child. Only thus can the best results be obtained.

Much of the prejudice against the Cæsarean operation is owing to the statistics of the operation in former years. At the present day, with modern methods of abdominal operation, the risks are very small. The mortality percentage is five per cent. or less.

It is not necessary to have perfect surroundings in order to get good results, although, of course, the chances are better where the elective operation is done with proper facilities.

During the past summer I was called upon to do two Cæsarean operations in country tenements (reported at Boston Obstetrical Society). One of these cases was done at night by the light of one kerosene lamp and a candle, in a small crowded room, on a board stretched between two trunks and covered with a boiled sheet. Both cases had been in labor more than twenty-four hours, both had had more or less manipulation; both mothers recovered and both children lived.

The result was due to several things. The mothers were in fair condition. The scrubbing of abdomen was carefully done with soap and water and nail-brush, followed by permanganate and oxalic solutions, and these again by alcohol, ether and corrosive-sublimate solution. Instruments and hands prepared with the same scrupulous care. The sheets and towels used were boiled half an hour in the wash-boiler. The uterus was lifted out of the peritoneal cavity and carefully packed around with hot, sterile towels before opening. Placenta and membranes carefully stripped off and the inside of the uterus freely washed down through the vagina with very hot lysol solution. The uterus thoroughly sutured in two layers: a deep one through the muscular portion, the stitches about an inch apart; in superficial layer, a continuous suture through the serous portion, making an absolutely tight closure. The uterus fully cleansed before being put back into the abdominal cavity. Immediate contraction assured by a dose of ergot hypodermically.

I may say here that this can be done without fear if the proper preparation of ergot is used. I have for some years used Tanret's solution of ergotinin, about five minims the dose. Recently I have been using a less expensive and more conveniently arranged preparation, ergot aseptic, put up by Parke, Davis & Co. in hermetically sealed half-drachm vials. The strength being double that of the ordinary fluid extract, each vial represents a dose. I have had no ergot abscesses from the use of this preparation, and it has worked very well.

The long abdominal scar is certainly a drawback; but both these women returned to hard work without any inconvenience from it. The convalescence was comfortable, and it was hard work to make them stay in bed long enough.

To my mind there is no more risk from sepsis in a Cæsarean section done with these precautions, than in a symphyseotomy.

To sum up:

(1) The operation of Cæsarean section is easier to perform.

(2) It is safer as far as hemorrhage goes or injury of adjacent parts, for example, tearing of urethra, vagina, etc.; *just as safe*, as far as sepsis is concerned (I refer of course to skilled operators); it has a less tedious convalescence, with no fear of a loose pelvis, but there is slight fear of ventral hernia.

Clinical Department.

OMENTAL HERNIA OF THE LEFT LABIUM MAJUS; OPERATION, RECOVERY.

SERVICE OF DR. F. W. JOHNSON.
REPORTED BY DR. J. M. CROWLEY,
First Assistant, St. Elizabeth's Hospital.

"THE labia majora of the female are analogous to the scrotum of the male; and the round ligaments, which are analogous to the spermatic cords, do not end in the mons veneris, but, passing downwards, enter the labia majora and distribute their filaments within the dartoid sacs, which extend like glove-fingers, downwards towards the fourchette."

Hernia of the labium major is sometimes described as inguinal labial hernia and consists of the passage of intestine, omentum, ovary, Fallopian tube, or uterus by the side of the round ligament into the labium major. Inguinal hernia, though less common in women than femoral, is not rare.

There is another form which is exceedingly rare. "It may occur in two ways: Firstly, the hernia may descend in front of the ligamentum latum, distending the vesico-uterine fold of peritoneum, and passing down between the bladder and uterus along the vagina into the labium (vagino-labial hernia); or it may descend behind the ligamentum latum between the rectum and vagina, either into the labium or perineum.

"The diagnosis is of great importance, posterior labial hernia being especially liable to be mistaken for cysts of Bartholini's glands."

Winckle found six cases of labial hernia in 5,600 patients examined by him.

Strangulation of the intestine or omentum with the characteristic signs may occur.

Diagnosis.—If the patient bear down, the size of the tumor will often be increased. Often the hernia can be readily reduced by placing the patient in the knee-chest position, returning as soon as she assumes the upright position.

The detection of impulse upon coughing, and resonance on percussion, and the possibility of diminishing the volume of the tumor by taxis and position, aid very much in making a diagnosis.

Hydrocele of the round ligament which has extended into the labium is called a hydrocele of the labium, and presents a fluctuating tumor without redness or tenderness or other indications of inflammatory trouble and is dull on percussion and of translucent appearance.

The contents of a hydrocele cannot be returned into the abdominal cavity.

Treatment.—After reducing the hernia, a truss may be worn, or, as in this case, an operation can be

done to prevent any return of the hernia. When the hernia is strangulated, an incision should be made down to the inguinal canal, and, if necessary, this incision can be continued down into the labium until the hernia is freed.

K. McG., twenty-five, single, entered the St. Elizabeth's Hospital, February, 1898. Always well and strong.

Present illness. About three years ago, while reaching up high to dust a shelf, felt and heard something give way, and felt a sharp pain in the left inguinal region. Four or five weeks later she noticed a small bunch about the size of a filbert in the left labium majus. It was soft, and could easily be "pushed back" so as not to be felt. It would, however, soon return. It slowly increased in size, until three weeks ago when it was as large as an English walnut.

During these three years she has had bearing down pains in her back and over her right side. These pains were increased by standing. Her chief complaints were pain in the back and side. The bowels were constipated.

Examination disclosed a chronic endometritis and retroflexion. No tumor was found in the labium.

February 8th the uterus was curetted, and an Alexander-Adams operation was done. On reaching the external abdominal ring, the inguinal canal was found much dilated, and in it was a portion of the adherent omentum. The little finger could easily be run down into the labium in the canal made by the omentum. The adhesions were broken up, and after slitting up the aponeurosis, the omentum was tied off at the internal abdominal ring and dropped back into the abdominal cavity. The round ligament was then stripped of peritoneum, the sac ligated and the ligament drawn out. The ligament was fastened to the internal ring, cut off and the fascia sewed over the ring and stump. The inguinal canal was then obliterated with interrupted sutures. The round ligament on the right side was also shortened.

Convalescence was uninterrupted.

A CASE OF EXTRA-UTERINE PREGNANCY.¹

BY F. W. JOHNSON, M.D., BOSTON.

THE patient was sent into the St. Elizabeth's Hospital, Saturday night, February 26th, by Dr. C. M. Whitney, as an emergency case.

After hearing the history of the case through the telephone from my first assistant, I told him I thought it was a case of extra-uterine pregnancy, with rupture. After getting to the hospital and learning more of the history of the case, it seemed to me that tumor with twisted pedicle ought also to be considered.

The pulse was 120 and the temperature 100.5° F. Constant nausea with occasional vomiting was present. The bowels were constipated. The face was pale and suggested hemorrhage. The abdomen was enormously distended. On palpation, a tumor was found extending above the pubes and towards the right half-way to the umbilicus; this was found at the operation to be blood-clot. On the left was another tumor, *very* sensitive to palpation and the seat of constant pain. Above these two masses were the intestines, very much distended. The abdomen was larger than if she had been pregnant at term.

The vagina felt soft and velvety, just as it usually does during pregnancy. By vagina the two masses could be made out; and what was thought to be the uterus, pushed back and to the right, was found at the operation to be blood-clot filling the Douglas cul-de-

sac. Stimulants were given and turpentine stupes applied. A saturated solution of mag. sulph. was given in small doses.

Sunday (next day) the pulse and temperature had dropped, and she was feeling more comfortable. Still she looked like a very sick woman. During this day there was free catharsis, with some diminution in the size of the abdomen.

Monday morning Drs. W. L. Burrage and Sarah E. Palmer saw the patient with me. The temperature and pulse were about the same as on the previous day, but the nausea and vomiting had ceased. We could come to no definite conclusion, but thought the difficulty lay between extra-uterine pregnancy with rupture and commencing peritonitis, a tumor or tumors which were giving rise in some way to peritonitis, and systemic disturbance or a ruptured pus-tube. Whatever the cause, we agreed that her condition demanded immediate operation.

The pregnancy was found to have taken place in or near the fimbriated end of the left Fallopian tube. Running along the border of this tube, up into the left uterine horn, was this tumor which I show. About one quart and a pint of clotted and half-clotted blood was found in front of and behind the uterus, which was enlarged to about the size of a two months' pregnancy.

A mass as large as the fist was separated from slight adhesions behind the left broad ligament and from the Douglas cul-de-sac. This contained the fetus and placenta which I show.

Part of the left broad ligament, which formed part of the pedicle of this solid tumor, was clamped, cut, and sewed over and over with catgut. The abdominal cavity was washed out as thoroughly as the patient's condition would admit with normal salt solution. The right tube and ovary were not removed. They were normal, except for recent adhesions, which were separated. One twenty-fifth of a grain of strychnia was given subcutaneously three times; a quart of salt solution was put under the left breast; and a pint of salt solution was put in the abdominal cavity while the patient was on the table. No drainage was used. The foot of the bed was elevated eighteen inches.

The following is a brief history of the case as far as it relates to the ruptured extra-uterine pregnancy:

She is married, thirty-eight years of age. She was married when nineteen years of age and had a child a year later. Never pregnant again until this time. Her first husband died three years ago. One year ago she married her present husband.

Menstruation began at twelve. Always regular until December, 1897. Unwell at the regular time in December, but flowed less than usual. In January, at the time she should have been unwell, there was quite a severe hemorrhage from the rectum.

Tuesday, February 22d, she first had pain in the left ovarian region. This increased until Thursday night, the 24th, when it became excruciating and was followed by collapse.

Dr. Whitney found her Friday morning in a state of collapse, and as soon as practicable sent her into the hospital. Two weeks previous to her present illness, Dr. Whitney had found the solid tumor in the left side.

The pulse kept at about 140 during the whole operation.

She made a good recovery and has gone home.

¹ Reported at the meeting of the Obstetrical Section of the Suffolk District Medical Society, March 23, 1898.