OBSTETRICS

UNDER THE CHARGE OF

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Management of Ovarian Tumors Complicating Pregnancy, Labor, and the Puerperal State.—BEACH (*Am. Jour. Obst.*, June, 1916) reports the case of a multipara in labor, the fetal head at the pelvic brim, and a contraction ring developed, but the descent of the head prevented by an ovarian tumor in Douglas's cul-de-sac. An attempt was made under ether anesthesia with the patient in the knee-chest posture to push the tumor up out of the way, but neither tumor nor fetal head could be safely dislodged. Accordingly the abdomen was opened, the lower uterine segment found greatly thinned, and a right-sided ovarian tumor present. An attempt was again made to draw the tumor up out of the pelvis while an assistant pushed the head up from below. This failed and the pedicle of the tumor began to tear. A trochar was then introduced into the tumor and a small amount of mucilaginous material was removed, but not sufficient to lessen the size of the tumor. The head was then pressed upward by the hand in the abdomen while an assistant pushed the tumor up from below. This was successful and the head of the child came into the pelvic brim and was delivered by forceps. The tumor was then removed and the stump covered with peritoneum, and the placenta pressed out by the hand grasping the uterus within the abdomen. The abdomen was then closed. Mother and child made a good recovery. In a second case three and a half months pregnant, there were several tumors in the pelvis and at the pelvic brim. These were bilateral. On opening the abdomen it was found that both had undergone torsion and both were removed. The patient recovered from the operation and aborted. The writer believes that in cases such as his first, one should avoid opening the uterus through fear of infection, especially if the membranes have long been ruptured, and repeated examinations have been made.

Posterior Dislocation of the Lower Humeral Epiphysis as a Pelvic Injury.—TRUESDELL (*Am. Jour. Obst.*, June, 1916) contributes a paper upon this subject well illustrated, giving his experience in 17 cases of this sort. The roentgen-ray pictures make the article very clear. He finds that when the arms become extended in breech cases, forcible efforts to bring them down may fracture the shaft of the humerus, or dislocate the lower humeral epiphysis. Under these circumstances the arm will hang limp at the side. Fracture of the humerus is indicated by false point of motion at the center of the shaft below the insertion of the deltoid muscle where fracture of the shaft of the humerus always occurs in the newborn. There is also dislocation of the lower epiphysis of the humerus where one can eliminate

fracture of the shaft by the absence of a false point of motion at the center; but where there is abnormal motion backward and forward at the elbow when the forearm is held at a right angle to the arm, distinct crepitus may be present with either condition, and this may easily suggest the false diagnosis of fracture. The replacement of the dislocated epiphysis should be attempted as soon as possible. Traction should be made upon the arm and the forearm extended, and at the same time pressure from behind forward is applied over the dislocated epiphysis. When this is reduced the forearm is flexed to an acute angle, and a Velpeau bandage applied for three weeks. As a rule the functions of the arm are not in the least disturbed, and a good result is obtained often without a complete reduction of the dislocation.

Spontaneous Rupture of a Pregnant Uterus Followed by Little Disturbance.—CHERRY (*Am. Jour. Obst.*, June, 1916) reports the case of a multipara, aged thirty-five years, admitted to hospital eight months pregnant. The day before she began to have cramp-like pains in the lower abdomen a spontaneous rupture of the membranes occurred and a diagnosis of false labor was made. Twenty-four hours later the patient came to the hospital. She stated that she had felt no movements of the child for a week. She had moderate dyspnea with slight cyanosis and some increase in pulse and respiration. On examination pregnancy was eight months, the fetus apparently presented by the breech. The head could not be felt in the upper abdomen. No fetal heart could be heard, the cervix was closed, and an irregular soft mass was movable above the pelvic brim. The patient's chief complaint was of dyspnea on lying down. The heart and lungs were normal. It was decided to introduce a dilating bag so as to hasten the development of labor. On the following day labor not having developed, section was performed. On opening the abdomen there was free blood in the peritoneal cavity, with the fetus and the placenta among the intestines. The fetus was dead, and an anencephalic monster. The uterus was well contracted and showed a longitudinal tear on its anterior and lateral walls, extending from the junction of the fundus and lower segment to the right broad ligament. On disturbing the tissues there was considerable hemorrhage from the uterus. Hysterectomy was performed followed by the uninterrupted recovery of the patient. The case is interesting, but unfortunately a minute examination of the uterine tissue was not made.

Induction of Labor Terminating in Death from Infection by the Gas Bacillus.—CHERRY (*Am. Jour. Obst.*, June, 1916) reports the case of a negress, aged thirty years, a multipara. When admitted to hospital she had felt no fetal movement for two weeks. Heart sounds could not be heard. Pregnancy was seven and a half months. The patient was kept under observation for two weeks, and as the uterus showed no signs of expelling the fetus, labor was induced. This was done by introducing a dilating bag, as the cervix was hard and rigid from previous lacerations. To introduce the bag it was necessary first to dilate the cervix by instruments; antiseptic precautions were carefully observed, and twenty-four hours after the bag was introduced, as no