

period was not more than five or six days. Out of the 6 deaths, 2 showed at postmortem no pathological changes in the intestinal tract. The other form showed anatomically only a relatively mild follicular enteritis, which would indicate that this disease is almost always a dysentery. After convalescence two negative tests of the feces are not sufficient to prove the cases non-infectious, as the bacilli may remain in the bowel for months, and rigid isolation for a long time is often necessary. Relapse occurred in 5 of the 20 cases, and lasted from two to six days. In 2 of these relapsed cases and in 2 other cases, the bacillus was found in the stools two months after the illness.

OBSTETRICS

UNDER THE CHARGE OF

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Thrombosis and Embolism in the Puerperal Period.—JUNGE (*Archiv f. Gynäkologie*, 1912, Band xcvi, Heft 2) contributes an interesting paper upon this subject and has collected an extensive series of statistics. His study of the subject leads him to believe that alterations or injuries to the endothelium of the bloodvessels producing interruption of the circulation is the most important factor in causing thrombosis. Such lesions are present in 26 per cent. of all labors, but do not develop sufficient severity to cause the complications in question. Multiparæ at middle life are most apt to have this lesion, and it occurs in them in 71 per cent. Puerperal thrombosis in some form develops in 74 per cent. of multiparæ, and of these 72 per cent. are cases of varices. In the first days of the puerperal period the saphenous vein is most often affected; in the latter portion of the puerperal period the femoral; and in the midportion of the puerperal period the pelvic veins. The lesion is bilateral very frequently, but when the saphenous vein is affected it is usually upon the right side, the femoral vein upon the left. This accident happens after obstetric operations, hemorrhage, infection, systemic disease, and prolonged labor, and especially in multiparæ who have varicose veins before labor. One attack predisposes to a second. The process begins with very slight elevation of temperature. The highest fever is seen when the femoral vein is involved, but no premonitory symptom can be definitely recognized. Thrombosis of the saphenous vein gives a good prognosis, while the same complication in the deeper veins is much more serious, as it predisposes to pulmonary embolism. He reports 81 cases from Fehling's clinic in Strassburg, and gives condensed histories of 22 of especial severity. Fortunately, embolism is comparatively rare, for in the records of 10,056 labors in the Strassburg clinic there were 51 cases of thrombosis, and but 4 cases of embolism—0.04 per cent.—with but one fatal issue.

When the records of other clinics are compared in 16,000 labors in the Dresden clinic there were 20 cases of embolism, or 0.0125, with 14 fatalities. This is the largest number in his collection of statistics, other clinics giving an average closely resembling the Strassburg clinic.

DUFFEK (*Archiv f. Gynäkologie*, 1912, Band xcvi, Heft 2) contributes a paper upon septic thrombosis, reporting a series of experiments upon animals. He finds that in the human subject septic thrombi show a peculiar formation resembling coral, which readily produces detached masses forming emboli. These are composed of leukocytes and layers of fibrin and contain bacteria, while the permanent masses are not so rich in germs. The formation of a thrombus and the localization of bacteria indicate that the activity of the bacteria has become limited to the local lesion. Under normal conditions the uterine veins at the placental site very rarely form detached masses. In puerperal infection these thrombi become infected and later become separated. Where the uterus is in a tonic condition and is not in active contraction, whether in pregnancy or the puerperal period, the separation of thrombi from their original site rarely occurs. The question as to whether there is a premonitory symptom of thrombosis and embolism has occasioned considerable discussion.

KÜSTER (*Zentralblatt f. Gynäkologie*, 1911, No. 30) has maintained that there is no premonitory alteration of pulse and temperature in cases of thrombosis or embolism.

MICHAELIS (*Zeitschrift f. Geburtshülfe und Gynäkologie*, 1912, Band lxx, Heft 1), maintains his original contention that the pulse and temperature are always altered before thrombosis and embolism occur. In this connection it may be well to recall Maehler's sign, that the pulse rises out of proportion to the temperature, the temperature often falling after a preliminary rise, while the frequency of the pulse steadily increases. The effort to lessen puerperal mortality is a constant one and meets with varying success.

In view of the recent discussion upon midwives in America, Grünbaum's paper (*Zentralblatt f. Gynäkologie*, 1912, No. 35) is of interest. He believes that midwives should conduct cases of labor without internal examinations. In 1000 confinements, 741 were conducted without an internal examination, while 259 were examined. This would indicate that 75 per cent, of cases do not require internal examination. It is usually thought that the omission of examination is dangerous because abnormal presentations and prolapse of the cord will not receive early recognition. In the 1000 labors there were 5 transverse positions which were recognized by external examination only. There were 7 cases of prolapse of the cord, in 3 of which the patient was brought into the clinic with the cord pulseless. In the remaining 4 diagnosis was made easy three times sufficiently early to save the child. In but one case could omission of internal examination be blamed for the loss of the infant. When one comes to study the influence of internal examination upon morbidity, it is found that among those not examined the general morbidity was 2.1 per cent., and of these but 0.6 per cent. were from puerperal causes. Among those examined the morbidity was 6.6 per cent. The general mortality of this entire series of cases was 0.3 per cent., and there was no death from puerperal septic infection. Among these patients 95 were operated

upon, of whom but 5 had a moderate elevation of temperature. This occurred among 37 forceps cases and 14 versions. In 3 transperitoneal Cesarean sections, one had abscess in the abdominal wall.

GYNECOLOGY

UNDER THE CHARGE OF

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New Operation for Rectal Prolapse.—SIPPEL (*Zentralbl. f. Gyn.*, 1914, xxxviii, 297) describes an operative procedure which he devised for the treatment of a rectal prolapse in a patient aged sixty-eight years. The prolapsed portion of the rectum formed a mass outside the anus, about the size of a small fist, and was composed entirely of the pelvic portion of the rectum and lower end of the sigmoid, the anal portion of the rectum for a distance of about 3 cm. above the sphincter remaining in place, the pelvic portion prolapsing through this and through the sphincter. The perineum was somewhat relaxed, but the uterus was forward, in good position, and showed no tendency to come down. The first step in the operation was to make a longitudinal incision through the entire posterior wall of the vagina and cervix, exposing the anterior wall of the rectum from the sphincter to the reflection of the peritoneum at the bottom of Douglas' pouch. The peritoneum was pushed upward somewhat, and the lateral flaps of the posterior vaginal wall, with the underlying tissue, were dissected well back on each side, so as to give a good exposure of the greatly distended and relaxed anterior wall of the rectum. This was then infolded in a longitudinal direction by transversely placed sutures, the process being repeated four or five times, until practically the whole anterior wall was folded into the lumen in the form of a thick, longitudinal ridge, the diameter of the rectum being reduced by this means about to normal size. The upper portion of the rectum was then firmly sutured to the posterior surface of the cervix, these sutures serving at the same time to close the incision in the latter. An anterior colporrhaphy was performed; the redundant portions of the flaps of the posterior vaginal wall were cut away, and the edges brought together with deeply placed sutures, which included in their bite a portion of the rectal wall. The separated levator fibers were then brought together, the rectal wall being included in these sutures also. The operation was concluded by a plication of the sphincter, which was quite markedly relaxed. In this manner, the portion of the rectum which showed a tendency to prolapse was firmly anchored to the cervix, the posterior vaginal wall, and the levator ani. The wounds healed well, and the patient shows after six months every appearance of being permanently cured. Sippel suggests that in similar cases, in which, however, there is some tendency to prolapse of the uterus, a firm ventrofixation of this organ to the anterior abdominal wall might be necessary in addition.