

lowed, and no improvement was observed for more than a year after birth. Under continued electrical treatment a slow return of natural function was observed. In the third case the mother was a small woman, her children being relatively large. On the third day after the birth of her second child, by forceps, paralysis of the right arm was noticed. Gradual improvement under massage and electricity ensued. In these cases the prognosis depends upon the extent and character of the lesion and the early use of the proper treatment. This consists in proper bandaging, in flexing the elbow, and, in addition, the use of friction, massage, douching, or sponging, and passive motion. If possible, the faradic current should be used after a few weeks. A mild galvanic current may also be employed. Gymnastic exercises, when the child is old enough, should be added.

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**Successful Labor at Term in Contracted Pelvis, by Version.**—BUDIN (*Gazette Hebdomadaire*, 1897, No. 35) reported at the Obstetrical Society of France the case of a patient who had a contracted pelvis whose true conjugate was found to be 7 cm. The patient's husband declined symphysiotomy, and hence version was performed before the membranes ruptured, after the patient had been in gradual labor forty-five hours. The circumstances were favorable for the descent of the child, and the head was delivered by introducing the hand to secure flexion, while the external hand made pressure above the pubes, and an assistant made traction with a loop of tape upon the child's leg. The living child was successfully extracted by this manœuvre.

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**Pistol-shot-wound of the Pregnant Uterus and Fœtus.**—In the *Münchener medicinische Wochenschrift*, 1897, No. 19, NEUGEBAUER reports the case of a patient, eight months pregnant, who was shot in the abdomen with a pistol loaded with large shot. The patient was brought to a hospital, and as hemorrhage was present from the wound the abdomen was opened. The shot were found to have penetrated the uterus on the right side, two fingers' breadth below the insertion of the Fallopian tube. The uterus was incised and the child and placenta removed, four No. 1 shot being found in the placenta. The edges of the wound in the uterus were resected and the uterus closed by suture. As the intestine was not injured, a gauze drain was placed in Douglas's pouch and the abdomen closed. The child was killed by the shot, which penetrated the thorax and heart. The patient suffered from peritonitis, and pneumonia and suppuration occurred. On the eleventh day, as the abdominal wound had been closed and the uterus had not healed, the abdomen was reopened and the uterus drawn up and amputated at the neck, the stump being fixed in the lower angle of the wound. The patient made a very tedious recovery.

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**The Treatment of Uterine Rupture.**—In the *Wiener klinische Wochenschrift*, 1897, No. 12, LUDWIG concludes an extended paper upon this topic as follows: these cases demand two sorts of treatment; the first is the delivery of the child; the second the treatment of the tear in the womb. As regards the first, the child should be delivered through the vagina if possible, especially when the greatest portion of its body is high within the pelvis when the physician sees the case, and also when a positive diagnosis

of rupture cannot be made. If, however, the rupture is diagnosticated, and the child is still within the uterus, delivery through the vagina should not be undertaken if it will increase the injury to the uterus, and thus add to that already existing. If the child has entirely escaped into the abdomen, then abdominal section must be performed. This is especially the case when the birth-canal is not dilated, when contracted pelvis is present, and severe hemorrhage occurs. If the child is living after uterine rupture, abdominal section gives it the best chance for life. It is often better to extract a dead child by abdominal section than to increase the injury to the uterus by other modes of delivery.

So far as the treatment of the rupture in the uterus is concerned, the use of the tampon and compression of the wound are demanded only in mild cases. It is occasionally possible to suture the tear by operating through the vagina, although this is not usual. If the conditions are favorable, abdominal section should be performed and the tear in the uterus sutured in that way. Unless, however, the conditions are favorable for securing union, this must not be attempted. It is better to extirpate the uterus through the abdomen, if necessary, as it enables the operator to determine the presence or absence of injury to surrounding organs. In the presence of bleeding and collapse the most rapid method of operating is demanded. This consists in abdominal section, the use of the elastic ligature, with supravaginal amputation of the uterus. So far as results go, in patients who can be treated in hospitals, abdominal section with uterine amputation is best. When patients have not the advantage of such treatment, the use of the tampon in cases of moderate injury is often successful.

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## GYNECOLOGY.

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UNDER THE CHARGE OF

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**The Use of Steam within the Uterine Cavity.**—PITHA (*Centralblatt für Gynäkologie*, 1897, No. 22) reports the results of his observations in Pawlik's clinic, extending over two years and including forty-six patients. The deductions are also based on examinations of six uteri removed from four to fourteen days after the application of steam.

The technique is quite simple. A small kettle, fitted with a thermometer, is connected with a double-current uterine catheter by means of rubber tubing; a wooden handle on the instrument protects the hand of the operator. The temperature is raised to 105°–115° C., and after the steam issues from the bores in the catheter the instrument is cooled to avoid burning the vagina, and is then introduced into the uterine cavity. The steam is then allowed to escape for one minute. It condenses within the uterine cavity, where its action is really due to the heat from the catheter and the hot water. Nar-