

of a long-handled strong pair of blunt-pointed scissors and the usual decapitation hook or sling. The operator then pulls firmly upon the prolapsed arm until the thorax has been drawn down as far as possible into the vagina. He then opens the chest of the foetus at the point which is lowest, making a free opening. He then eviscerates the thorax as thoroughly as possible and gives a copious douche of 2 per cent. lysol; introducing the fingers of the left hand into the thorax, he carries the fingers through the muscles upon the posterior aspect of the chest, and, introducing the hook with the right hand, guides it with the fingers of the left until the hook is carried around the vertebral column of the foetus. By strong traction the vertebral column is then severed and the hook is removed. The fetal body collapses, and the tension upon the lower uterine segment is at once relieved. In some cases the fetal head, unless strongly attached to the child, is gradually expelled by the effort of the mother. In other cases version is performed, followed by extraction.

He reports two cases illustrating this method. The first was that of a multipara with normal pelvis, who had a shoulder presentation, with prolapse of the left arm and pulseless umbilical cord. The uterus was firmly contracted. It was impossible to dislodge the foetus without great danger of uterine rupture. Under anaesthesia, embryotomy was practised by the method described, the breech of the child was brought down and the head brought through the pelvis by suprapubic pressure. The mother made a good recovery.

A second case was that of a primipara with flat rachitic pelvis, the true conjugate being 8.5 cm. The foetus was in transverse position, the back to the right, the left arm prolapsed, and the umbilical cord pulseless and prolapsed. The lower uterine segment was greatly distended. After the spinal column had been severed the left arm was amputated at the shoulder and the remainder of the foetus delivered by version and extraction. The mother recovered.

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**Cæsarean Section.**—OLSHAUSEN (*Zentralblatt für Gynäkologie*, 1905, No. 4) reports two Cæsarean sections, one for symmetrically contracted pelvis, the other in a primipara after nine severe eclamptic convulsions. Both patients recovered. Olshausen has performed between 80 and 90 Cæsarean operations, of which 7 have been done for eclampsia; 6 of these recovered, 1 died. He has used catgut only for suture in these operations.

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**Repeated Cæsarean Section, with Fatal Result.**—TREUB (*Zentralblatt für Gynäkologie*, 1905, No. 3) reports the case of a patient with a highly contracted rachitic pelvis, who was delivered by Cæsarean section in her first pregnancy ten years previously. From this she made a good recovery.

The second section was performed five years later, and recovery followed, with slight rise of temperature. In the third pregnancy the patient was admitted to the hospital for operation, and no vaginal examination was made. The temperature before operation was between 99° and 100°. Upon section wide adhesions were found between the colon and the uterus. The operation proceeded smoothly, and because of the adhesions both Fallopian tubes were resected to