toms. If we were to rely simply on the old descriptions, we would, however, overlook four-fifths of the cases. The primary pain may sometimes be very slight, perhaps only a few ounces of blood may be lost, when no material increase in pulse will occur. We must bear these cases in mind as the old classical description will not answer for them.

DR. RUFUS B. HALL, Cincinnati—We occasionally see cases with a history so very different from that of a typical case that there is some excuse for the general practitioner. I quite endorse what the Doctor said about the cases that come for operation, because of repeated attacks of hemorrhage. I have a case in mind that was operated on eight or ten weeks ago, 35 years old, married. She was very anxious to have children. She had a catarrhal endometritis and for eighteen months her family physician had made local applications, given her tonics, massage and everything possible to build up her general health. Her menstruation was very irregular, and was frequently accompanied by a very severe pain. Her physician was obliged to give her a hypodermic of morphin so that she could sleep. After the last menstruation, nearly nine weeks elapsed before the menstrual period again came on. She had very severe pain, and had to have a hypodermic. The flow stopped, but began again nine days afterwards, and the doctor gave her another hypodermic. Three weeks later she went to bed with a third attack. There was no collapse. The doctor examined her very carefully, but found no swelling in or near the uterus. The bleeding continued. Repeated examinations were made, and after eight or ten days he noticed bogginess behind the uterus. He suspected ruptured tubal pregnancy. Thinking that she was aborting, he gave her an anesthetic, and curetted. He could not get the consent of the family to an operation until three weeks later, when infection set in and she had to be operated on for ruptured tubal pregnancy.

DR. L. H. DUNNING, Indianapolis—I agree with the speakers that not every case of ectopic pregnancy can be diagnosed, as the classical symptoms are not always present, especially in the ampullar variety. I have encountered two cases of this sort, where the patients had several hemorrhages, and ectopic pregnancy was not suspected until infection of the clots set in. Some years ago, while visiting a neighboring state, I met one of my friends, who asked me to come to his house to witness an operation for what he believed to be a tubal abscess. Three other physicians had examined the woman and confirmed this diagnosis. He opened the abdomen, and to the great surprise of everybody found an ectopic pregnancy which had ruptured three weeks previously without much hemorrhage. Subsequent infection gave rise to fever, and rapid growth of the tumor, and all the symptoms of pelvic suppuration. We often make a mistake if we attempt to lay down dogmatic statements for every case of ectopic gestation.

DR. C. L. BONIFIELD, Cincinnati—Within the last six months I have seen one case where I confirmed the diagnosis made by a general practitioner, and also confirmed by my colleague, Dr. Zinke, not one of the three knowing what the other thought. The diagnosis was made before rupture occurred. My interne in Christ's Hospital since last Christmas diagnosed two cases of ectopic gestation, one before rupture and the other at the time of rupture, so that I think extra-uterine pregnancy is now frequently diagnosed by men who are not specialists, not gynecologists. A number have said that hemorrhage oftentimes is not fatal in the first rupture. I believe there are many cases of ectopic gestation where we have hemorrhage that is not fatal to the patient, but is fatal to the life of the ovum, and these cases are not only not diagnosed at the time, but go on to complete recovery without ever being recognized.

DR. INGRAHAM, in closing—I did not say that the diagnosis can be made in every case, yet recurrent paroxysmal pains in the pelvis certainly constitute an important symptom. If the woman gets gradually worse, we may not be absolutely sure of ectopic pregnancy, but we are certain that there is something in the pelvis that should be removed. By making a vaginal examination a mass can usually be felt. When a case goes along like that mentioned by Dr. Hall, something should be done. We should not let the woman go on and die without doing anything. The diagnosis can not always be made, but we can make out that the patient needs operative interference.

CESAREAN SECTION MADE NECESSARY BY A VENTROFIXATION.*

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Cesarean sections are not so numerous that any case is uninteresting or should not be reported even if success has not attended the efforts made for relief. Even want of success has its lessons and much may be learned which can be made profitable if heeded.

THE DANGERS OF VENTROFIXATION.

Much of value has been written in later years by such eminent authorities as Edebohls, New York; Burrage, Boston; Kelly, Baltimore; Noble and R. Wood, Philadelphia, and others as to the damages of ventrofixation in the child-bearing period, and yet the lesson does not seem to have been learned that ventrofixation during this period may become a very dangerous complication in pregnancy. The train of symptoms, for which women consult gynecologists, which require the operation of ventrofixation, are so well known that it is not necessary to recall them, and yet, would it not be better to allow a woman suffering from prolapsus uteri, cystocele, rectocele and pain in the back, to continue to suffer at least during the child-bearing period, or at most resort only to other modes of relief such as the Alexander operation or the various vaginal operations—not vaginal fixations however—rather than jeopardize her life by a ventrofixation, done without that very necessary accompaniment, viz.: removing the adnexa, and thus preventing the train of disastrous possibilities which follow. In order to show that this is no fancy sketch of the dangers which follow this operation in the child-bearing period, it is only necessary to recall a few facts as recorded.

Milænder has collected 54 confinements at term after ventrofixation with 11 difficult labors; 4 forceps; 2 Cesarean sections; 2 podalic versions; 2 transverse presentations; 1 foot presentation, making no mention of the fetal loss. Of this whole number of pregnancies after ventrofixation, 74 collected by Milænder, 6 terminated in abortion; 3 by premature delivery; 10 were still pregnant, and no one knows the conditions resulting, and no one knows how many of the operations for ventrofixation were absolutely so complete as to prevent the tearing loose of the uterus which would have removed the danger.

THE CASE IN POINT.

With these preliminary remarks the writer wishes to put on record the following case.

Mrs. A. S., aged 43, American, had three children, aged 19, 17 and 15 respectively. Was taken in labor Dec. 6, 1901, pains increased gradually, and on December 7 the membranes ruptured. She continued to have pains, gradually increasing in number and severity. On December 11 the attending physician took another physician with him and administered chloroform for the purpose of doing version. On attempting this he found that the cervix could only be reached after introducing the hand and forearm up to the elbow. The cervix was not patulous, and no presenting part could be outlined. At this stage it was learned that the patient had had, seven years before, a perineorrhaphy and ventrofixation, and that since that time she had aborted once at three months. A surgeon was called and found the conditions as above stated.

Externally, the patient presented an irregularly enlarged

* Read at the Fifty-third Annual Meeting of the American Medical Association, in the Section on Obstetrics and Diseases of Women, and approved for publication by the Executive Committee: Drs. A. H. Cordier, W. E. B. Davis and Henry P. Newman.

abdomen, broad and with a rounded eminence on the right side, sloping off to the left flank. The patient was in poor condition from being so long in labor, having a weak pulse of 120, nevertheless a Cesarean section was decided upon as the only course open. Preparations were immediately made, and at 3 p. m. the operation was begun. Meanwhile the attending physician, fearing rupture of the uterus, without consulting the surgeon, kept the patient partly under chloroform.

The operation, done under ether anesthesia, was the Porro type, and was completed in 30 minutes, less than 2 oz. of ether being used; but just as it was finished the patient expired, despite all restorative attempts. The death had all the symptoms of chloroform poisoning, the heart stopping suddenly and death evidently due to its long use to prevent rupture.

EXPLANATION OF THE OBSTRUCTION.

The uterus was attached at the posterior surface of the fundus to the abdominal wall just above the bladder by two silkworm-gut sutures, which were still in place—these had been there for seven years. On account of this condition the anterior wall and the fundus could not lengthen, and so the total enlargement necessary for a pregnant uterus had to be provided by the posterior wall, which was greatly attenuated and which had drawn up the cervix and vaginal vault far above the superior strait, directing the cervix upward and backward. The thickened anterior wall acted as an obstruction to the descent of the head, and the position of the cervix directed the head upward and backward, making labor impossible.

CONCLUSIONS.

In these days when so many abdominal operations are being done for the relief of suffering women, it is very necessary for the physician, when called to a new case, as he often is, to inquire carefully as to whether anything of such a character has been done.

Taking the present case as a guide, ventrofixation should not be done on any woman during the child-bearing period without the removal of the ovaries and tubes, or at least their obliteration.

No physician who is suddenly called to such a case should be censured for the unfortunate results.

DISCUSSION.

DR. M. ROSENTHAL, Fort Wayne, Ind.—I want to draw attention to the difference between ventrofixation and ventrosuspension. I do not approve of the former, as it fixes the uterus, and it must necessarily interfere with the excursions of the bladder. I do not believe that ventrofixation will prevent the uterus from prolapsing unless the stitches are passed through the muscle and fascia, so as to hold the uterus rigidly, making an immovable organ of it, which is not justifiable in women likely to become pregnant. Ventrosuspension, however, produces a new ligament, which will hold the uterus in place and allow it to turn on its axis with some freedom of movement. I have performed the operation a number of times, and have had pregnancy follow, with a normal delivery. I do not believe that ventrofixation can be done for prolapse of the uterus without doing damage to the organ or hinder its proper movements. If you have a retroversion with an intact perineum and intact pelvic floor, then I believe that Kelly's operation is the best. I do not believe that we should say that in all cases we will do a Kelly operation or a Goldspohn operation, or that we will do any operation, because retroversion is not a pathologic entity, but simply an indication of something abnormal in the pelvis or in the abdomen. The uterus itself may be absolutely normal, and then we must make a very careful diagnosis. We must find out why there is a retroversion, and our operative procedure must be dependent on the pathology of the case.

DR. H. D. INGRAHAM, Buffalo, N. Y.—A ventrofixation usually interferes with the development of the fetus in the uterus. I have never seen a case that went to full term. I have had two miscarriages in just such cases. In both I had to clean out the uterus. The pains were not sufficiently strong to expel the contents of the uterus, and before it was cleaned out the hemorrhage was very profuse.

DR. J. H. CARSTENS, Detroit—I do not do these operations very often. A woman who is liable to become pregnant after such an operation ought to be operated on only with catgut or kangaroo tendon, a ligature that is absorbable. If you use a silkworm-gut or silk ligature, it fixes and holds the uterus, whereas an absorbable ligature will disappear. The communication will be there just the same, but with a certain amount of mobility, and the uterus, when it develops, will be able to rise above the brim of the pelvis and there will not be that interference with confinement that there is when you put in a permanent, fixed suture. That is where most of the trouble comes from.

VAGINAL SECTION FOR THE RELIEF OF THE UNCOMPLICATED SYMPTOM OF STERILITY.

IS IT JUSTIFIABLE TO ENTER THE PERITONEAL CAVITY UNDER THESE CIRCUMSTANCES?*

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The curse of sterility in women has ever been typified by the unfortunate fate of Sarah, of Biblical history, and in the cry of Rachel, "Give me children or I die," there comes wailing through the ages the expression of the saddest disappointment that can befall a woman's heart. The desire for offspring is one of the most powerful instincts that dominates the human breast, either of man or woman, and in the disappointment that attends the failure to realize one's hopes in this direction we have the pregnant source of unhappiness, not only to womankind, but the cause of frequent rupture of the marriage ties.

An inscrutable mystery has always shrouded the beginnings of life and the unfortunate woman doomed to barrenness has been wont to rely on the use of charms, amulets and other marks of superstition to eradicate the curse. Penetrate as we may into the processes of nature the mystery of life remains a mystery, and the causes of sterility are in many instances beyond our ken.

CAUSES OF STERILITY IN THE MALE.

Certain facts, however, are within our grasp. We know that the prerequisite of procreation is contact of the sperm cell of the male with the germ cell of the female, and that in them both must exist sufficient vitality to light up by their contact and coalescence the spark of a new life. It is apparent that the responsibility for a barren marital life may rest equally on the man and the woman, i. e., each must contribute the healthy requisite conditions. The reproductive power of the man can be more easily determined than that of the woman, and it behooves any gynecologist who undertakes to solve the problem of sterility in a married couple, before resorting to any serious procedure upon the woman, to make sure that the man is competent to perform his part. It is coming to be realized more and more as this subject is investigated, that many men, through the indiscretions of early life, are responsible for the barrenness of their marital relations, either through the disease existing in themselves or communicated by them to their wives. Careful investiga-

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