

murmur has existed during this period. Probably the mitral lesion had existed for years before she came under my observation.

In another case the patient, a young girl, came under my observation fifteen years ago. She had then, and has always had since, a loud mitral presystolic murmur. The heart is but slightly enlarged, and the mitral lesion occasions inconvenience only on very active exercise. She has not had anasarca nor œdema, and there have not been any symptoms pertaining to the heart which have called for treatment.

In another case the patient was under my observation for more than ten years. The previous history showed that there had existed a cardiac affection for several years. There was a loud presystolic murmur. The affection was well tolerated up to a few months before her death. In this case, shortly after the occurrence of œdema of the lower limbs and dyspnoea, the presystolic murmur at times was not discoverable. This is probably to be explained by the weakness of the auricular contractions, and, under such circumstances, so far from its disappearance being of good omen, the reverse is true.

To these cases I could add others illustrative of the long tolerance of a mitral obstructive lesion. The existence of mitral obstruction with but little or no mitral regurgitation, and the absence of aortic lesions, conduce to the toleration.

ARTICLE XIX.

A CASE OF CÆSAREAN SECTION. BY GEORGE McCLELLAN, M.D.,
Surgeon to the Philadelphia Hospital, etc.

DURING the summer of 1881, I was unexpectedly called upon to perform Cesarean section at Bar Harbour, Maine, on an Indian woman, in a poor little canvas tent, by lamplight. It was on the evening of August 20th, at half past ten o'clock, in the presence of Dr. Keating, Dr. Amory, Dr. Rogers, and Dr. Chilcothe. The woman, whose name was Susan Antoine, aged 38, was the mother of seven other children. She had always had difficult labours, but was only attended by a midwife, who was a member of the tribe to which she belonged. She was one of the Canadian Indian basket-makers, who encamp on the island of Mt. Desert during the summer season. She had been in labour forty-eight hours. The physician who first saw her said he had "applied the forceps and attempted version;" but not succeeding in delivering the child he called in Dr. Robert Amory, of Boston, who found a foot presenting in the vagina, but could not determine satisfactorily the position of the child. After several hours of traction on the foot, without changing the condition, I was sent for, and wishing to have the advice and experience of Dr. William V. Keating, who happened to be in the neighbourhood, I asked him to see the case also. As his opinion of the woman's condition, from a gynecological point of view, is very valuable, I will add, after giving my own

account of the operation, a note which he has sent me expressing his views of the case.

When we first saw the patient together, the cervix uteri was completely dilated, and the contractions were very strong. The *right* foot was found at the upper portion of the vagina with its heel directed backwards and to the right side. It was conjectured that the head, with an arm and leg, was engaged in the superior strait. The patient was put completely under the influence of chloroform, and traction was made upon the protruding foot, but without avail, although a fillet was applied, and great force used. No change could be made in the position of the child, either by efforts from within, or applied from without over the abdominal walls. Dr. Keating pronounced that the fetal heart had stopped, and that the presentation was a complicated one, resembling the fourth position of the vertex described by Hodge. After repeated and ineffectual attempts to dislodge the head of the child and to bring down both feet, it was decided that Cæsarean section was the only means of saving the woman's life, as craniotomy was not thought practicable under the circumstances. It was, however, agreed to give a hypodermic injection of $\frac{1}{2}$ grain of sulphate of morphia, and to wait a couple of hours to see if nature's efforts would bring about any change. Upon returning, we found the presentation just as before, and it was decided that it was useless to delay the operation.

The patient was etherized by Dr. Chilcothe. On a rude table covered with an old mattress and deer hides, and with only the light of two oil lamps, I began the operation. I first cut through the integuments and fat in the linea alba, from the umbilicus to the symphysis pubis, making one free incision; I then carefully laid open layer upon layer of fascia upon a grooved director, and after dividing the abdominal muscles, which were greatly wasted, opened the peritoneum (cutting sideways, as in opening the sac of a hernia), pushed aside the omentum and intestines, and immediately opened the uterus, coming at once upon the child.

The appearance of the distended uterus was very different from what I expected. It was glistening, and looked like elastic fibrous tissue, and the venous sinuses were not at all marked. The situation of the placenta was conjectured to be on the left side and back, and a bold incision was made into the uterus at a point corresponding to about two inches above the pubic symphysis. At first I was startled by a flow of what looked like fecal matter from the bowel, and for the instant was vexed that I had discarded the grooved director, but feeling assured that the uterus must be before me, I enlarged the incision, and at once discovered that I was in contact with the child, and that it was the meconium which had embarrassed me. Perhaps the bad light which I had to see by (for the lamp was held by an assistant whose eagerness to witness the procedure more than once cast a shadow over the wound) caused the momentary doubt; but I believe it was shared by all who were with me.

The walls of the uterus were very thin, and readily yielded to my finger. The child was immediately seized, and with Dr. Keating's assistance carefully, although with great difficulty, extracted. It was found to be very large, with an enormous head, which, with an arm and the left leg, was firmly wedged at the right sacro-iliac symphysis. The placenta offered no resistance, and was speedily detached. Carbolized sponges were used during the operation, and to mop out the effusion into the pelvis. As the womb contracted promptly, I did not put in any stitches, and without delay proceeded to unite the edges of the abdominal wound, taking deep

stitches with strong silver wire through the several layers, including the peritoneum. A carbolized flannel bandage was applied. I did not have to apply a single ligature. The operation took about half an hour. The patient had had a subcutaneous injection of $\frac{1}{2}$ grain of morphia two hours before the operation, and this was repeated immediately afterwards. Pulse remained good during the operation, and for some time into the night the patient slept peacefully. At eight o'clock next morning, she was restless, and complained to me of being hungry; wanted "beefsteak," and to "sit up;" no vomiting. Temperature normal; pulse 90. Ordered her kept quiet, and a little milk and lime-water to be given occasionally. No after-pains; womb firmly contracted; very little tympanites; wound looked very well, and discharges were natural. Flannel bandage (carbolized) reapplied. At 11 $\frac{1}{2}$ A. M., the doctors met me in consultation. The pulse was found to be 120; temp. 102°. Patient very restless. Wound looked well, and as before. It was afterwards ascertained that some one of her companions had given her during the interval of my visits over a pint of gin, believing that she would starve upon milk and lime-water, and *gin* being to the Indian a panacea for all ills. She asked Dr. Keating to give her some more "gin," and said she was hungry. Morphia was repeated, and a trained nurse obtained to watch her. During the day she complained of hunger more than thirst, and continued to be restless. Took eagerly all that was given her. She had no vomiting. Pulse ran up higher and higher, and the temperature kept pace with it. She was enormously fat, and was oppressed in the position on her back, and wished to turn over on the side. This was, of course, denied; but, being strong, as well as strong-willed, she got the better of the nurse, and turned over on the right side. The oozing was slightly increased, but the wound showed no tendency to gap, and there was no indication of hemorrhage. Pulse 130, and temp. 103°. At 5 P. M., she took milk greedily; voice strong. She said she had no pain, and the wound looked very well; countenance was bad. The morphia was continued to quiet restlessness. The heart was weak from the first, and there was every indication of fatty degeneration. At 9 P. M., after asking for water in a strong voice, and without any symptom of immediate dissolution, she died. No post-mortem could be obtained.

The child weighed over 15 lbs. The biparietal diameter was 4 $\frac{1}{4}$ inches. The circumference of the head measured 12 $\frac{1}{2}$ inches. It had the appearance of a four months' old baby.

I have received the following statement from Dr. Keating in reference to the case:—

In reply to your favour of 11th ult., I would state that when called in consultation upon the case of Susan Antoine, who had then, as I was informed, been in active labour for nearly forty-eight hours, I found the head engaged in the superior strait presenting vertex to the right sacro-iliac symphysis, fourth position of vertex, according to Hodge, an arm, and I thought the left foot engaged with the head; the right leg was protruding. The forceps and version by the feet had been repeatedly tried previous to my visit. The patient's pulse was rapid, and the heart, a fatty one, very weak. I requested that the patient should be thoroughly anaesthetized, and whilst in that condition I then endeavoured by traction

on the right leg, combined with external manipulation over the abdomen, to bring down the breech. After repeated attempts, finding nothing could be accomplished, we decided to administer $\frac{1}{2}$ grain sulph. morphia hypodermically, and wait for two hours for the efforts of nature. Returning at 9 P. M., we found the patient in the active throes of labour, with no change in the presentation. After renewed useless efforts to effect version, and finding nothing could be accomplished, we held a consultation as to our next proceeding. The condition of the uterus and surrounding pelvic tissues was the most unfavourable I have ever met with. The protracted active throes of labour, the continued applications of the forceps, and the repeated attempts to effect version, had produced such a tumefaction of the tissues, that it was with much difficulty, at my last visit, that I could identify a cephalic presentation. Moreover, the anterior lip of the uterus projected in a slinglike condition under the symphysis pubis, so suggillated and tumefied that it might have been mistaken for the placenta, almost occluding the os uteri. Upon my first visit, I had diagnosed from the condition of the fetal cord, which was jammed in the presentation, the death of the fœtus, which was confirmed by all of us in a subsequent auscultation of the heart; no pulsation being audible. Our consultation then did not include the question of preserving the fœtus; it simply resolved itself, as to the selection of the means which, under the circumstances, would afford the most speedy delivery with the least risk to the mother. Viewing the conditions of the presentation, occipito-posterior, with an arm and foot jammed in, the intense tumefaction of the tissues in the pelvis, the enormous suggillation of the anterior lip of the uterus, almost occluding the os uteri, the character of the instruments at hand to perform craniotomy, and our adverse surroundings, Cæsarean section was immediately decided upon, as affording the poor sufferer the safest and speediest means of recovery. The more recent successful results from this operation, with the advantages for a speedy recovery to be expected from the remarkably pure and genial climate of Bar Harbour, compelled us to the above conclusion. The subsequent delivery convinced us of the correctness of our decision, as the head was found presenting in the fourth vertex position, with an arm and foot included, and the condition of the soft parts such as to have positively impeded the proper introduction of the instruments required for the successful performance of craniotomy, with the subsequent delivery of the fetal head. You will readily recall to mind the length of time and the powerful efforts required to remove the head from the pelvis after the operation. I think I but echo the sentiments of my respected colleagues, in stating that the operation was entirely successful, even under the inauspicious circumstances under which it was performed. On the following morning the poor sufferer's condition was as favourable as possible, as to pulse, temperature, and condition of the wound. I am convinced that the fatal issue was mainly due to the excessive amount of stimuli given in our absence, her fatal symptoms all pointing to an exhausted heart.