

of the opening. But it was impossible to extract it in that manner; a forceps and the percuter were both tried, but with no better result. The cork could not be compressed nor crushed; therefore the opening was enlarged with the long knife of Vacca Berlinghieri, the incision being made towards the neck of the bladder, when, with a forceps, the other piece came away quite easily. Both pieces were thickly incrustated. No doubt, by his efforts to get the cork out the musician, in using the wire, had cut the soft cork in two. The operation was not followed by any untoward symptom, after the bladder had been well irrigated and washed out. The patient was not even confined to bed for a single day. Who was happier than our fiddler, when once more he held his dear and unlucky cork in his hands? A proposition of doing away with the tempting opening in restoring a normal channel, he nevertheless refused. I never saw him again.

BRIEF NOTES OF THREE CASES IN WHICH PREMATURE LABOR WAS INDUCED.

BY AUGUSTUS P. CLARKE, M.D., CAMBRIDGE, MASS.

Read before the Cambridge Society for Medical Improvement, Dec. 22, 1884.

In one case where the woman was seven months pregnant, and where premature labor was urgently demanded, I used a carbolyzed sponge tent. This was left in for twenty-four hours, when it was removed and a second one for the same length of time was introduced. I also used a third tent, well carbolyzed. After the removal of each tent I disinfected the parts with a 2 per cent. solution of carbolic acid. After the use of the third tent, labor pains began at irregular intervals, and were assisted by digital dilatation of the os uteri. On the fourth day the foetus (male) weighing six pounds, was expelled alive, and it survived, and the mother, though suffering from some symptoms of septicæmia, recovered, but was unable to nurse her child, owing to the want of a sufficient quantity of milk. This lady had been married some ten years previously. The first time I met her was when I was called to assist Dr. Chas. H. Allen, formerly of this city, in her delivery. The doctor had been with her for the most part during thirty-six hours, and although the os uteri was well dilated, and the long forceps could be applied, yet we found it quite impossible to extract the child without resorting to the operation of perforating the head, and even after this was done, we had great difficulty in bringing down the shoulders. After the placenta was removed, we found that the conjugate diameter of the pelvis was hardly $2\frac{1}{2}$ inches. There was a marked distortion of the right ramus, thus lessening the iliac diameter; besides, the tuberosities of the ischia more closely approached each other than in a normal case. At that time, 1869, we were both satisfied that our patient was unable to bear a living child at full term, and the matter of the induction of premature labor

in a subsequent pregnancy was considered. Some three years later I was again called to this patient, who was again in labor for the second time. The os was dilating and the pains were frequent and strong, but no descent into the pelvic cavity took place. I succeeded at last in accomplishing her delivery, but the child had to be sacrificed as before. In June, 1874, I was again consulted by this lady, who was about five months pregnant. The patient was otherwise in good health. Ballottement could be distinctly felt. I then advised my patient not to allow her pregnancy to continue to full term, but to submit to the chances of a premature labor induced at seven months. Accordingly, on August 15 (1874) following, she submitted to an operation resulting as above detailed. Soon after this her husband died, and my patient escaped further dangers of a married life.

The next case to which I was called was that of Mrs. E., a Scottish lady aged twenty-eight years. She was delivered at the age of twenty-four years of a stillborn child, before she emigrated to this country. She said her labor was a tedious one, and was terminated with instruments and by the inhalation of chloroform. After coming to this country, while in New York city, she miscarried twice. Her uterus was sharply ante-flexed, and she suffered more or less from dysuria. This was in October, 1877. September 1, 1878, I was called to attend her in labor at term. The presentation was normal and of the first position. The labor was unusually prolonged, owing to the narrowness of the pelvis. The conjugate diameter was scarcely $2\frac{3}{4}$ inches, and the iliac diameter seemed insufficient for the exit of a living child at full term. There was a contraction at the outlet of the pelvis. Forceps were applied, but the child was stillborn. The patient made a rapid recovery. Eight months afterwards she became pregnant, May 1, 1879. I advised her as in the case of the other patient, not to allow the pregnancy to continue longer than seven months. Dec. 1, 1879, I inserted a sponge tent into the os uteri; this was followed by a chill and afterwards a good deal of constitutional disturbance. The tent was removed after the lapse of twenty-four hours, and I waited until the third day, when I applied another carbolyzed sponge tent. This brought on the same constitutional disturbance, but on the fourth day some fugitive pains occurred, and I resorted at intervals to digital dilatation. The foetus was born on the evening of the fifth day, but it was feeble, and it died on the third day after its birth. The mother suffered a good deal from what appeared to be septicæmia, evidently superinduced by the application of the sponge tents. The patient finally recovered.

In another case of narrow or contracted pelvis, where the conjugate diameter did not exceed $2\frac{3}{4}$ inches, and in which I determined to induce premature labor, at about seven and a half months, I used a medium-sized (No. 14, French scale) olive tip bougie, introduced carefully while the patient was in Sims's position. The bougie was introduced without rupturing the membranes, and passed across the fundus of the uterus in a spiral or curved direction, and then left for twelve hours, when labor supervened. The labor was completed in six hours, and the infant

was alive and did well. The mother made a good recovery. This case occurred in October, 1880. The mother was aged twenty-seven years, and had been married six years. She was delivered of a child (female) stillborn, at Boston Highlands, Oct. 27, 1876, and another, stillborn, at Worcester, Mass., some two years afterwards. It was from her husband and from her physician, the late Dr. Henry Clarke, of Worcester, that I learned the circumstances of her delivery.

The plan of inducing premature labor by the introduction of a flexible gum elastic bougie, reported in the *Retrospect*, No. 71, p. 190 (by John C. Lucas, Esq.), is evidently a safe and easy method. My experience in the use of sponge tents, even when thoroughly carbolized, for dilating the cervix for any purpose whatever, is unsafe and often leads to irreparable mischief. For a long time I have abandoned their use altogether. The use of a flexible gum elastic bougie is more scientific. The bougie is cleanly, its presence in the uterine cavity, across the fundus, after a few hours, will often excite healthy and normal uterine contractions. And in any case where any unpleasant or any constitutional disturbances arise from its presence, it can be readily removed by the attendant, or the patient herself, before alarming or serious symptoms supervene. The bougie is also applicable in cases in which it is desirable to induce abortion for the relief of obstinate vomiting of pregnancy, that sometimes threatens the life of the patient. I have used it for such a purpose, and have found it a most valuable means of emptying the uterus of its contents. Digital dilatation, when carefully and judiciously practiced, is also a most valuable means in any case where the emptying of the uterus is urgently and speedily demanded.

An important consideration in a case where the induction of premature labor is required, is to ascertain when the time has arrived beyond which pregnancy should not continue. This can only be decided by a careful consideration of the whole history of the case. From my experience in the above cases, as well as from my general obstetric practice, I would state that in no case should the induction of premature labor be undertaken until after a most thorough study or knowledge has been gained of a previous pregnancy, or pregnancies, for it is absolutely impossible to obtain any definite and reliable knowledge relative to the dimensions of the pelvis until after labor is well advanced or immediately after it has been completed.

MEDICAL PROGRESS.

ANATOMY AND PHYSIOLOGY.

CONGENITAL ABSENCE OF THE LEFT LUNG.—Dr. E. Theremin (*Rev. Mensuelle des Maladies de L'Enfance*) gives two cases of this occurrence, which is so rare that it has never been determined in the liv-

ing subject, and out of thirty thousand autopsies made in the past twenty-five years at the *Maison des Enfants-Trouvés*, at St. Petersburg, only these two cases were noted. The first case lived for eleven days, and died after symptoms of fever, accelerated respiration, dullness on percussion, bronchial souffle, and disseminated sub-crepitant râles. The body appeared normal in structure and conformation, except a rudimentary development of the eyeballs. The autopsy showed intense hyperæmia of the brain, hyperæmia and nearly complete hepatization of the right lung, hyperæmia of the liver and spleen. The second case lived from February 9 to May 17, over three months. Cyanosis was present from the first, but became in time very little marked and not constant. The heart was considered as normal; a slight cough called for an examination of the chest, when mucous râles were heard over the right and *left lungs*—nearly complete dullness on percussion over the left lung—later on in life fever set in, with signs of pneumonia of the right lung, marked cyanosis and death. Nothing abnormal was found in the autopsy as regards the other organs and tissues of the body, in structure or conformation, except what will be referred to.

In comparing these two cases great similarity is seen in the anatomical disposition of the lung, of the heart, and of the circulation of the blood. In both cases there was a little cartilaginous enlargement in the position of the left bronchus, one single pulmonary artery, and one single pulmonary vein, which communicated with the vena azygos, and thence with the vena cava superioris. In neither case did the left auricle receive any pulmonary vein; the foramen ovale and the canal of Botal were narrowed or obliterated. The unique right lung, greatly developed and incompletely divided into lobes in the second case, gave an arterial blood, which, mixed with the venous blood, produced a constant cyanosis. The large caliber of the venæ cavæ and pulmonary artery, and the hypertrophy of the right auricle and ventricle, contributed to the increase of the intensity of the general cyanosis. Both children were small, and badly nourished from their birth.

The notes taken during the life of these children, by two different physicians, show that the vesicular respiration also extended to the left in the posterior portion of the thorax, and prove that respiratory murmurs of one side may extend to the opposite side, in cases where the propagation is favorable.

MATERIA MEDICA AND THERAPEUTICS.

ON THE RARER ACCIDENTAL EFFECTS OF SALICYLATE OF SODIUM.—Under this title Dr. J. Dreschfeld gives, in the *Medical Chronicle*, the details of a case of a female patient, æt. 18, suffering from nephritis, after an attack of diphtheria. For five days of her treatment for this affection, she was given salicylate of sodium, ten grains three times daily. On the third day the temperature suddenly rose from 97.9° (axilla) to 103°, pulse from 75 to 120; there was severe headache, drowsiness, dry and brown