

mon duct was approached in a new way, namely, from behind the peritoneum; (4) the stone, in the ampulla, had ulcerated through the walls of the ductus choledochus and the duodenum, and would perhaps soon have been extruded; (5) the increase in the weight of the patient seemed phenomenal; it was almost doubled in the year following the operation.

What the result to the patient would have been if this stone had ulcerated its way out of the common duct is quite certain, and yet I have several times found stones imbedded in adhesions outside of the bile passages; they were usually close to the gall-bladder. Once I discovered a stone in the wall of a thick-walled gall-bladder; it was completely buried and was causing no disturbance, and was discovered in the process of sewing in the drainage tube. This is, I believe, the only case in which I have not divided all of the adhesions encountered. If no contraindication exists, such as necessity for abbreviating the operation, we should separate the adhesions if possible. The chance of meeting fistulous openings between bile passages and the intestine I regard as an indication for thorough exploration rather than a contraindication to it. Not infrequently adhesions alone are responsible for the symptoms which persist after the calculi have been removed by the surgeon or have escaped in other ways.

UNLOOKED-FOR DYSTOCIA IN CERTAIN MULTIPARÆ.¹

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If this title is ambiguous or misleading I shall try to explain it as I go along. It is difficult to develop any new fact or plausible theory in obstetrics when the entire field has been gone over so often and so thoroughly by competent writers of large and varied experience. But some accepted facts will bear repeating, and mooted points, if not settled, are better understood by new discussions. I have found difficulties with which I was not familiar, and I shall try to state these difficulties and earnestly solicit your discussion and help.

We are occasionally called to attend in labor women who have already been delivered of from one to several children, and as they got through with these deliveries without special delay or trouble we unhesitatingly accept their cases. Their first deliveries may or may not have been slow, and some later ones may have been precipitate. It is not unusual to be told in such a case that the child had been born before the doctor reached the bedside. Under such circumstances we have no misgivings about the patient's condition nor prospects, and may not even examine or estimate her pelvic measurements; hence, when later we encounter delays and difficulties in delivery, we can certainly regard them as "unlooked for." Why should delivery have been rapid and easy formerly and so impossible now? When called to such a case, if we examine digitally we find the cervix high up and but little dilated, even after some hours of ineffectual pains. We watch the patient awhile, encourage her to be patient, and possibly give an opiate. The pains, though frequent enough and severe, seem to be singularly inefficient, for the head does not engage, much less descend. If after some time we examine again we shall probably find some relaxation of the vagina and a fairly dilated

(or easily dilatable) os, and the head or possibly the breech within reach, quite movable, if the waters are still intact, and no attempt at engagement in the inlet or of the necessary moulding essential thereto.

After many hours or even days so spent we find the patient getting anxious and urgent for relief, and with the pulse and temperature rising, and other evidences of exhaustion, we begin to realize that for safety of the mother, as well as for the baby, something more than masterly inactivity is demanded of us.

When we look for the determining cause in these cases it is very hard to find. The history of former easy and possibly prompt deliveries excludes any great departure from normal in the parturient passages, bulky neoplasms of course, being excluded. It has been suggested that possibly there is persistent at term the globose shape of the gravid uterus which is normal up to six or seven months, instead of the ovoid shape that ought to obtain in the last weeks of pregnancy. If this assumption is correct it would explain the arm or trunk presentations occasionally seen. In most of the cases that I recall the usual polar presentations of head or breech could be easily felt. Sometimes the head seemed to rest on a veritable shelf formed by the os pubes (as a bracket) and the expanded anterior uterine wall.

The most plausible theory of the origin of these cases is based on the fact that in multiparæ we so often find relaxed abdomens and presumably some fault of direction of the uterine ovoid, or failure in contraction in the uterine walls in consequence. We have no doubt this same condition may occur in primiparæ, but in any given case when it is suspected, we must first exclude the more common causes of dystocia, under sacral promontory prominence, narrow superior strait or uterine inertia. If these are excluded we probably have to deal with the same condition primarily which we are assuming is a vicious development in the multipara from some weakening or aberration of originally competent normal forces. However, the occurrence of the difficulty is certainly rare in primiparæ as compared to multiparæ. In two of my cases the development of large mural fibroma seemed to be the cause of breech presentations but neither gave special trouble to the artificial delivery of living children.

Frequency. — In this condition it is not possible to give exact figures as to frequency, clinical varieties as to positions of head or breech, or infant mortality. Excluding doubtful cases occurring in first labors, I doubt if they occur more than once in 150 or 200 cases. This is merely an estimate from my own experience.

Treatment. — Aside from operative interference the treatment is unsatisfactory, and can best be expressed in negatives. Don't hurry; don't give ergot; don't rupture the waters (twins being excluded); don't keep the patient in bed at first, or out of it later; don't fail to empty the bowels and bladder at intervals; don't insist on the patient making expulsive efforts unless the abdomen is manipulated so as to direct the uterine ovoid, especially if the abdomen is pendulous. Usually after many hours have been wasted in these attempts, little will have been secured except possibly greater ease of dilating the soft parts, but your patient will be in poor state to meet the exigencies of artificial delivery. But meet it she must, for we are now face to face with the old problem of high forceps or turning.

That penitent darkey at the camp meeting who, when the fervid though illiterate preacher described

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the only two roads open to him as one leading to sure destruction and the other to perdition, said, "I'll take to de woods," about expresses our feelings in our choice of these two means of relief, only we have no woods for our escape. Sometimes the choice is made for us by circumstances. If breech presents, no one would attempt cephalic version. So, too, if arm or trunk presents, the feet had better be brought down. Turning will not be found difficult in these cases. If the head presents, the tentative use of the forceps promises most if used judiciously and coincidentally with suprapubic help from an assistant to depress and steady the head after first attempting, *per vaginam*, to secure favorable position of the head in relation to the inlet and complete flexion also. The chances for success will be better for thorough preliminary manual dilatation of the vagina and cervix. That complete surgical anesthesia is best none will deny, and much as I believe in chloroform for ordinary obstetric use, in these cases ether is the better choice. While podalic version is relatively easy in these cases, extraction is very difficult; the arms are pretty sure to get extended over the head, and the danger of delays in the after-coming head, always a source of danger, is especially so here. With high forceps even the most careful attempt to secure the head in favorable relations to the blades of the instruments and the diameter of the pelvis, and to drag it through unmoulded by its normal influences is even more severe on the mother than are the manipulations coincident to turning and extraction. Either in turning or high forceps the difficulties and dangers are greater if the patients are fat, and they often are.

The infant mortality is high in either case — too high in these days of trained abdominal surgeons and so commonly accessible hospitals. I believe that a Cæsarean section would be much safer for the child, and practically as much so for the mother, than delivery artificially, *via naturalis*. I have one or two cases in mind in whom, should pregnancy again occur, I shall urge laparotomy. Of course it will be declined, but my conscience will be relieved. The fact that temporizing sometimes leads to unexpected and very happy terminations in these cases, or cases so nearly like these in all clinical respects as to be indistinguishable, makes us all — doctors and parturients alike — willing to wait and take risks.

The risk to the mother in these cases is not great or we could better urge the seemingly greater operation of suprapubic delivery. If we direct our turning or forceps delivery with the aseptic care the gynecologists have taught us, and care for her afterwards with antiseptic precautions, it is surprising what an amount of mechanical abuse the parturient canal will tolerate.

RÉSUMÉ.

(1) Certain multiparæ, after one or more easy deliveries, lose the power of natural parturition.

(2) This is due to failure of the expelling forces in the uterus and abdominal walls.

(3) Artificial delivery is imperative in such cases as promptly as a diagnosis is established.

(4) Infant mortality is high in artificial delivery by the natural passages.

(5) The human female is very tolerant of aseptic mechanical genital injuries.

(6) Is suprapubic delivery justifiable in these cases when a positive diagnosis is established?

A CASE OF EXTRAPERITONEAL NEPHRO-URETERECTOMY FOR TUBERCULAR DISEASE.¹

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THE reason of reporting this case in full is that a considerable length of time has elapsed since the operation was performed. As our knowledge of similar cases is rather meagre, owing to the obscurity in which the diagnosis of them is usually veiled, any contribution to the subject would seem to be of value. The present case had been treated for months as a simple chronic cystitis of an unknown etiology, which had resisted treatment, and there had been no positive sign or symptom sufficiently marked to attract attention to the suppurating kidney which was the principal seat of disease. It also illustrates very well what all observers engaged in this work must have early recognized, namely, that chronic cystitis in a young unmarried girl, who has not been exposed to the usual sources of vesical infection — the catheter, purulent genital affections, etc. — is usually tubercular.

The patient was twenty-two years old, unmarried, and earned her living by dressmaking. She was first seen in September, 1897. Her family history was negative. She herself had always been well. Examination of the various organs of the body, except the urinary organs, was negative. There had never been any purulent affection of the genitalia, such as endometritis or vaginitis, nor had she ever been catheterized in sickness. She dates her trouble from an event which happened in 1896, a year before she came under observation. At that time she lifted a heavy girl, and immediately felt a severe pain in the left lumbar region. Since that time she had been ill. The principal source of discomfort was frequent painful micturition, on some days the frequency reaching so many as forty times in the twelve working hours, and six times at night. The pain during micturition was felt in the urethra, and was at times very severe. There was at all times a constant desire to urinate, which is in these cases the cause of the nervous and physical breakdown rather than the disease itself. Emaciation was rapid, and there was a gradual loss of strength; yet she was able to work at her dressmaking up to within two weeks of the time of her operation. Pain in neither lumbar region since the time of the strain had been complained of, but there was some backache, confined to the spinal region; there was also some pain at times in the left iliac region, and later lying on the left side was painful. She gave no history of previous renal colic.

On October 6, 1897, a cystoscopic examination was made, with the following result: Whole bladder red and inflamed to an intense degree; flakes of fibrin here and there; wall of bladder corrugated, owing to bands of white cicatricial tissue, especially prominent about the site of the left ureteral orifice. The right ureteral orifice was found with difficulty, and a catheter inserted into the ureter. The left one could not be positively identified, although a catheter entered an opening in the vesical membrane for about two centimetres, at which point further entrance was impossible, owing to a stricture of the ureter. Small ulcerated areas were numerous throughout the bladder, but no miliary tubercles were seen. The left kidney was pal-

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