

OBSTETRICS.

UNDER THE CHARGE OF

EDWARD P. DAVIS, A.M., M.D.,

PROFESSOR OF OBSTETRICS AND DISEASES OF INFANCY IN THE PHILADELPHIA POLYCLINIC;
 CLINICAL PROFESSOR OF OBSTETRICS IN THE JEFFERSON MEDICAL COLLEGE; CLINICAL
 PROFESSOR OF DISEASES OF CHILDREN IN THE WOMAN'S MEDICAL COLLEGE;
 VISITING OBSTETRICIAN TO THE PHILADELPHIA HOSPITAL, ETC.

Cæsarean Section for Contracted Pelves.—OLSHAUSEN contributed a paper upon this subject to the Moscow Congress (*Centralblatt für Gynäkologie*, 1897, No. 38), in which he reported twenty-nine Cæsarean sections performed upon twenty-four mothers for contracted pelves. The greater portion of these were for rhachitis. Twenty-nine children were born living and twenty-six left the hospital living. The children were all much above the average size. Two mothers died, one of sepsis, the other from a towel left in the abdomen by an assistant. Most of these patients had a pulse above 120 for some days, while the temperature ranged from normal to 102°.

His method of performing the operation is as follows: The uterus is turned out of the abdomen and the abdominal wall temporarily closed behind it. The operator palpates the uterus to ascertain the site of the placenta. If he cannot do this he makes an incision at the fundus to avoid the placenta. After extracting the child the placenta is loosened and removed. The inner lining of the uterus is disturbed as little as possible. No elastic tube is placed about the cervix, as Olshausen thinks it exposes the child to danger of asphyxiation. After the uterus is emptied the cervix is compressed by an assistant. To guard against bleeding the patient is given ergotine before the operation. Catgut is the entire material employed.

In view of the success of the modern operation Olshausen thinks it absolutely indicated in many cases, and that its relative indication has a much wider scope. It remains the best method for speedy delivery, as in eclampsia. It is simpler than symphysiotomy and its results are more assured.

In discussion, LEOPOLD had to deal in Saxony with many contracted pelves, and in the last fourteen years had done ninety-three Cæsarean operations, in sixty-seven of which the uterus was retained, while in twenty-six hysterectomy was done. He uses the elastic ligature about the cervix for a few moments only. Ten of his patients had the operation more than once. He diagnoses the position of the placenta by the distance between the round ligaments. To save the child's life he has operated successfully upon a woman who had a violent gonorrhœa. Although the operation is so successful, the induction of labor is most available for the average practitioner. His mortality rate in ninety-three operations was 8, or 8 $\frac{1}{2}$ per cent.

Symphysiotomy.—In the *Monatsschrift für Geburtshilfe und Gynäkologie*, 1897, Band 6, Heft 3, ZWEIFEL contributed a paper written for the recent International Congress at Moscow. He finds sufficient reason for this paper in the criticisms which have been made upon the operation and in his own success in its employment.

He has had at the clinic at Leipzig thirty-one symphysiotomies; all of the mothers recovered without inconvenience or injury; twenty-seven of the children survived and left the hospital in good condition. Referring to cases reported in which patients could not walk without difficulty, he considers this to be due to excessive stretching of the pelvis and specially to injury of the sacro-iliac joint. He would limit the operation to cases in which the conjugata vera is not less than $6\frac{7}{8}$ cms., and he believes that the best results are obtained when the limit is placed as high as 8 or $8\frac{1}{2}$ cms. He believes that no more danger of hemorrhage exists with symphysiotomy than with Cæsarean section, and he has found it quite sufficient to bring the hips of the patient strongly together, to use a tampon of iodoform or sterile gauze in front and behind the symphysis, and to make counter-pressure by tamponing the vagina. To avoid a laceration, he allows the child, whenever possible, to be expelled by the mother's efforts.

He believes that bad results following this operation are caused chiefly by septic infection, and that such occur because the symphysiotomy wound is improperly handled. He insists upon draining this wound and making pressure upon the tissues about the symphysis with gauze and an abdominal bandage. He prefers the open treatment of the symphysiotomy wound, draining it with gauze for eight or ten days until it is filled with granulations. He sews together the symphysis, using two or three sutures which can be absorbed, and usually adding two sutures which are to remain. His exact method of operating consists first in limiting the operation to those cases in which the fetus is not only living, but, by reason of its uninjured condition, is likely to survive. The patient's thighs are allowed to hang down, and a transverse incision is made through the skin about a finger's breadth above the symphysis. Superficial vessels are tied. The fascia over the symphysis and linea alba are separated from their attachments to the bone, and the tissues are loosened from the lower edge of the subpubic ligament. A silver catheter is then placed in the urethra, the finger of the left hand passed behind the symphysis, pushing aside the bladder, and the joint is opened with a probe-pointed knife from above and forward until all fascia and ligaments are separated. He uses a strong knife whose back is not too thick to go readily between the bones. The hanging posture of the legs helps to draw asunder the bones when the cut is made. The symphysiotomy wound is packed with sterile gauze, moderate pressure is made upon the iliac bones, and the patient is delivered, if possible, spontaneously. If slight delay occurs, a broad band of flannel or rubber is placed across the pelvis, and the head made to descend by pressure. He finds oftentimes that bleeding occurs when the head emerges, while not infrequently the head lodges obliquely upon the pelvic floor and must be delivered by forceps. The pubic bones are then brought together by two stitches of catgut and two of non-absorbable material, a catheter is placed in the bladder, and the symphysiotomy wound packed with gauze. The stitches are brought together through the greater part of its extent. The gauze remains eight or ten days, is gradually shortened, and, if silver sutures have been used, they are removed when the granulations approach the surface. An ample antiseptic dressing and occlusion-bandage are kept over the wound.

In three of his cases injury occurred to the urethra or bladder; once by a

catheter, once when the urethra was caught between the pubic bones by the removal of the gouze, and once when a pair of teneculum forceps injured the urethra. In none of these cases was the complication a serious one. Zweifel has found the pelvis appreciably enlarged after symphysiotomy. He believes that such a pelvis will permit spontaneous birth more readily than before symphysiotomy.

In the *Centralblatt für Gynäkologie*, No. 38, 1897, VARNIER also contributed a paper upon this subject, in which he arrived at the following conclusions: An enlargement in the pelvic diameters gained by symphysiotomy reduces infant mortality so greatly that the death-rate of children born after symphysiotomy in contracted pelvis is the same as the death-rate of children born by instrumental labor of mothers who have normal pelvises. Hemorrhage and injury play a very unimportant part. If infection does not occur symphysiotomy is no more dangerous from these causes than is any other instrumental delivery. Wounds to the bladder and urethra after symphysiotomy are generally caused by the use of forceps, and fatal cases result from septic infection which has its origin from the uterus or bladder or urethra. Complete recovery follows symphysiotomy. The operation may be repeated without injury to the patient. It does not, however, permanently enlarge the pelvis, as some assert. The operation should be made only in those cases in which the child is vigorous, the os and cervix completely open, and the membranes ruptured. It should never be made in a pelvis whose true conjugate is less than 7 cms. It is also indicated where the child is abnormally large and the pelvis normal. It should take the place of induced labor, violent efforts with forceps, and version and embryotomy on the living child. Varnier denies the value of Walcher's position in enlarging the pelvis. Symphysiotomy is indicated in symmetrical pelvises where pelvic tumors are not present. It is not indicated in cases where the child is dying from neglect or pressure. In cases already infected, symphysiotomy need not be declined if care is taken that the symphysiotomy wound in no way connects with the infected genital canal.

The Injuries of Parturition, the Old and the New.—At the recent meeting of the British Medical Association at Montreal, the President's Address to the Section on Obstetrics and Gynecology was given by SINCLAIR, of Manchester (*British Medical Journal*, 1897, No. 1914). The text of his paper was the case of a young primipara, whom he saw in consultation, suffering from septic infection, with lacerations of the vagina caused by the use of forceps. The trend of his paper is to show that the use of antiseptics and anesthetics has made physicians careless, leading them to resort to the use of forceps hastily and in cases which would terminate naturally if left alone.

He supports this statement by statistics from English physicians, which virtually amount to a statement that nearly 75 per cent. of the labor cases in manufacturing towns are terminated by forceps. He also alludes to the remarkable statement from the Rotunda Hospital that after forceps application women die from fretting. Sinclair then proceeds to show that at the Manchester Maternity about 9 per cent. of cases in the house are terminated by forceps without maternal mortality. In out-patient practice in the same clinic the forceps was applied in 1.4 per cent. He adds a list of statistics

from the maternities of the Continent, showing that the use of forceps varies from 1.4 to 22.6 per cent. of cases, the highest averages being found at Munich in Winckel's clinic. He urges very strongly a strict limitation in the use of forceps. He thinks it improper to trust simply to mercurial solutions to secure antiseptics. He recognizes the value of closing lacerations, but in his observations such closure has not been very successful.

[We are not deeply impressed with the excellence of obstetric practice in the hands of the average English physician, if these statements are correct. It is unfortunately true, as experience has shown in the case of some, that a large obstetric practice can be built up by giving anodynes freely until the os is nearly dilated, and then by delivering the patient with forceps. Ensuing lacerations were closed when severe, and otherwise were left to heal by granulation. Such practice, however, is not that of the best obstetricians at the present day. Among neurotic and ill-developed women, whether those enfeebled by luxury or by hard work and little food, the forceps must often be used. Many of these cases are delivered by the use of Barnes's elastic dilators, assisting uterine contractions by stimulants and by manipulating the uterus without the use of instruments. In others, the timely use of forceps prevents uterine relaxation and hemorrhage, prevents exhaustion, and brings much speedier convalescence than delay in labor. It is, however, the practice of the best obstetricians in the United States to immediately close serious tears of the cervix, pelvic floor, and perineum, and under antiseptic precautions satisfactory union occurs in a great majority of cases. Septic infection is rare among patients in our best hospitals and equally rare in the practice of our best men in private houses. Dr. Sinclair's comments upon the use of forceps remind us that, if we mistake not, a member of the royal family of England was once allowed to die in childbirth because of an inexplicable reluctance to apply forceps.]

Dr. Sinclair urges, however, an improvement in obstetric instruction so that the student shall receive the same teaching that is now given in surgery and medicine. The need of improvement in this direction in America is quite as great as in England.]

GYNECOLOGY.

UNDER THE CHARGE OF

HENRY C. COE, M.D., M.R.C.S.,
OF NEW YORK.

Intermittent Cysts of the Ovary and Kidney.—WILSON (*Birmingham Medical Review*, August, 1897) points out the fact that the disappearance of an abdominal cyst following the passage of large quantities of urine, usually regarded as pathognomonic of intermittent hydronephrosis, may also occur in connection with ovarian cysts. The following interesting case is cited: A multipara entered the hospital with a tumor of six years' standing, diagnos-