

were particularly accessible. Perhaps fifteen minutes were lost in attempting to replace the peritoneal stitches which had been torn out.

The segment of gut measured $11\frac{1}{2}$ inches in length in the fresh state. Four and three-quarters inches of this was above the upper margin of the tumor. The specimen was given to Dr. J. A. Wilder, pathologist to the hospital, who reports as follows.

"The specimen consists of $11\frac{1}{2}$ inches of rectum with surrounding tissue and lymph nodes. The lumen of the rectum is partially occluded by an irregular nodular mass that begins $2\frac{1}{2}$ inches above the anus and extends upward $4\frac{1}{2}$ inches, involving the greater part of the circumference of the gut but being at all points well within the lines of incision. There are numerous lymph nodes in the connective tissue behind the segment of gut above the mass but no enlarged lymphatics are found near the upper end of the intestinal fragment. Microscopic examination shows the mass to be an adenocarcinoma. The lymph nodes show cancerous invasion."

The patient vomited pretty constantly for thirty-six hours after going back to bed. Her pulse at the end of thirty hours was 108, it then dropped to 98. Forty-eight hours after operation her stomach was quiet, she was beginning to take nourishment. During the first thirty hours five pints of salt solution were infused.

The subsequent course was smooth. The median abdominal stitches were taken out on the seventh day and at the same time the silk stitches fixing the gut at the site of the artificial anus were removed. The median wound had been kept clean and both wounds healed primarily. The bowels were freely moved on the fifth day. At no time was there abdominal distention. A part of the perineal packing was taken out on the fourth day, a little more each day thereafter and on the eighth day chloroform was given when the vaginal and perineal stitches were removed and the high gauze packing, that which had held the gut in place, carefully taken out. The sacro-perineal wound closed down gradually and completely. The patient began to be up and about in the usual length of time. It is now six months since the operation. She has gained in weight and strength. The artificial anus behaves well; indeed, the fact that the woman satisfactorily pursues the occupation of cook in a private family would seem good evidence of this. The gridiron incision allows a fair "pinch" to the gut.

Clinical Department.

CESAREAN SECTION FOR PLACENTA PREVIA IN A PRIMIPARA.

BY WILLIAM N. SWIFT, M.D., NEW BEDFORD, MASS.

Mrs. G. Thirty-four years. Married four years. Good family history. She had previous to her marriage been a school teacher and had been well. Menstruation regular. For six or seven years, rather profuse and with a great deal of pain. During pregnancy she had been well but had considerable abdominal soreness. Had no hemorrhages.

On May 11, 1903, had some abdominal pain and felt generally ill. Slept well that night, but the next morning had more cramps. Some of them quite severe. While sitting in a chair about one o'clock had a severe hemorrhage. It came on without warning and without pain. She said it felt as if something gave way. The hemorrhages continued and patient became faint. Dr.

John D. Hilton of South Swansea had charge of the case and called Dr. A. S. MacKnight of Fall River in consultation. Dr. MacKnight made a diagnosis of placenta previa and advised Cesarean section.

I saw the case about ten o'clock. The patient showed the effects of a loss of a large quantity of blood. Her pulse was rapid but regular and of fair quality. The vagina was full of blood-clots with constant flow of fresh blood. The cervix was not entirely taken up and only admitted one finger. A soft mass could be felt through the cervix. The child was a vertex presentation with the back to the right. Immediate section was advised as the only hope of saving the mother and the only possible chance of a living child.

I operated at eleven o'clock, assisted by Dr. A. Martin Pierce of New Bedford and Dr. John D. Hilton. Dr. MacKnight gave the ether.

An incision was made in the median line and the uterus delivered. The uterus was opened on its anterior surface and the child delivered.

The placenta was found to cover the whole of the os, possibly a little more of it being on the right side. The membranes and placenta were at once separated and delivered. The placental site was wiped off with gauze. A gauze pad was packed over the placental site with the end brought down into the vagina. The uterus contracted well. There was almost no loss of blood either from the incision of the uterine wall or the placental site. A continuous catgut suture was put through the uterine mucous membrane and including a little of the uterine muscle. The rest of the incision in the uterus was closed by interrupted catgut sutures through the peritoneal coat down to the continuous suture. The abdominal wall was closed with interrupted silk sutures through all the layers in order to gain time, as the patient's condition was not good. The gauze was taken out without hemorrhage following.

Patient was put to bed in fair condition, having had a hypodermic of strychn. sulph. gr. 1-30.

After stimulation and artificial respiration the baby (a girl weighing seven pounds) did well. The mother had very little lochial discharge. Her bowels were moved on the third day. She had very little rise in temperature and did well in every respect. Stitches taken out on the tenth day — one small stitch-hole abscess. Uterus freely movable, not adherent to abdominal wall.

On May 28 the patient had quite a severe hemorrhage. The nurse thought about a quart of blood. Patient was faint and nauseated. The hemorrhage did not recur. Patient is in good condition at present. Has menstruated regularly. The first few times rather profuse with some pain; now, less flow and very little pain. The mother had very little milk and the baby was fed. The baby has done well and is a strong, healthy girl.

My reason for reporting this case is its rarity. The conditions existing in this case, in my opinion, always demand Cesarean section if the patient's condition will permit, that is a primipara, with undilated cervix and central placenta previa. The operation was performed at the patient's house in the country by lamp light.

THE oil painting of Dr. Thomas G. Morton presented to the Pennsylvania Hospital by a number of contributors was unveiled on Jan. 11. The portrait was presented to the hospital by Dr. J. C. Wilson, on behalf of the Board of Trustees, and was accepted for the hospital by Dr. Arthur V. Meigs. Dr. Morton was connected with the institution for a period of forty years, many improvements and new buildings being added during this time as a result of his untiring efforts in its behalf. — *Medical News*.