finement was without incident. Labor, still in the first stage, was well underway when I first saw her. Before making an examination, the toilet, if I may use the word, of the vagina and pudenda, as well as my own hands, was carefully attended to.

Presentation O. L. A. The labor was perfectly natural, and terminated within four hours. No examinations were made after the first, except to protect the perineum during the passage of the head. There was no tearing of the soft parts. The patient was not in the least exhausted. The baby was a girl and weighed seven pounds. The placenta, apparently intact, followed in about ten minutes. Sterilized napkins were used.

For five days the temperature and pulse, taken by myself, were absolutely normal. At my visit on the sixth day patient complained of having passed a sleepless night, with pain in the head and back of the neck. Temperature and pulse 100. Very slight odor to the lochia, and slight tenderness to pressure upon the uterus, which seemed about as large as it was twenty-four hours after labor. There was nothing else, so far as I could learn after careful examination, to account for the elevation of temperature.

On the following day, the seventh, the temperature was a little higher. Pulse about as the day before. Bowels had been moved freely. Condition of the uterus about the same, with no more odor to the lochia. Headache not relieved. On the morning of the eighth day the temperature was 102° and pulse 110. Headache and insomnia. Flow of milk very much diminished. Lochia about the same in character as the day before. Vaginal douche had been used.

Bimanual examination showed the uterus larger, with flabby walls, os patulous. Specular examinations revealed no lesions of vaginal walls or of the cervix. With the usual aseptic precautions the cervix was seized with double hook and the interior of the uterus was carefully and thoroughly curetted with large sharp curette, resulting in the removal of a piece of tissue, presumably placental, from two to three inches square. No microscopic examination was made and no cultures were taken; it was slightly offensive. The uterine cavity was left packed with iodoform gauze, which was removed on the following day. The temperature fell at once, as may be seen by the chart, and recovery was rapid, the uterus promptly returning to a normal condition. The internal medication was two grains of quinine three times daily and Dover's powder as necessary.

I have selected this case for no special reason except that it is the last one in a limited obstetrical practice that required any interference. I have purposely given a detailed account of it because it seemed so very simple. So simple, indeed, that, had not the indications been met as they were, it might have eventuated in a very decided and possibly fatal case of puerperal septicemia. I regret that no cultural test was made.

It is from this Society, and such as this, that the science of obstetrics in general practice must be advanced; and I cannot too strongly emphasize the indications for and the method of curetting the puerperal uterus laid down by Dr. Edward Reynolds in his excellent paper read before the Massachusetts Medical Society at its last annual meeting.

The point I wish to bring out in this case is the timely use of the curette, to ascertain if there is within the uterus a possible source of sepsis. The interior of the uterus was *carefully* gone over with a sharp curette, as we believe, without any injury to the endometrium. As the tissue removed, be it placental or otherwise, was not in an advanced stage of necrosis, we were content, without deeper curetting, to leave the uterus packed with iodoform gauze. Of course, had it been evident that the deeper structures were involved, I should have removed everything down to firm uterine tissue, as Dr. Reynolds insists upon.

I have never used the cervical speculum in these cases. The canal is so large and patulous there can be but little danger of retained douche; besides where gauze is used for packing, the cavity of the uterus is readily drained. Moreover, in severe cases, the interior of the uterus, down to and about the os, should be thoroughly curetted.

The country obstetrician, especially in the past, has labored under the great disadvantage of being either without a nurse at all, or what is quite as bad, having a nurse with a limited personal experience and absolutely without training, always ready to account for any symptom that may arise and to apply a remedy therefor.

Thanks to our many and excellent training schools, this condition of things will soon pass away.

With a nurse faithful to her training and a physician who has the courage of his convictions, sepsis in midwifery will be rare indeed.

CASE OF SEPTUM OF VAGINA.

BY S. W. TORREY, M.D., BEVERLY, MASS.

PATIENT, single, about twenty years old, applied to me in March, 1892, for relief from suffering from dysmenorrhea and general pelvic discomfort. Examination showed intense hyperesthesia of entire vagina up to within three-quarters of an inch of the cervix, where the finger struck against a tight transverse septum, cord-like in its tenseness, and so sensitive that the slightest rubbing of the finger over it caused the patient to cry out with pain. The surface of the cervix, as far as it could be examined visually beyond the septum, was red and rough from friction upon the band.

After two or three weeks of treatment by ichthyol on cotton between the cervix and the septum, with improvement in the inflammatory condition but none in the neuralgic, the patient entered my hospital; and her subsequent history, from my case-book, is as follows:

April 21st, patient fully etherized, as slightest touch to septum caused pain under partial anesthesia. Even when under deep anesthesia stretching the septum evidently gave pain, as patient writhed with discomfort. When vagina was distended by Sims's speculum it was seen that the probable cause of the local pain and general neurasthenia was the chafing of the cervix upon the tightly-drawn, cord-like septum. The septum was divided in two places, close to wall of the vagina; no ligatures required. Iodoform gauze to cervix, and large glass vaginal plug inserted.

April 23d. Result of operation entirely successful; pain relieved, and Sims's speculum applied without giving discomfort. Boric-acid to cervix; tampon to upper part of vagina.

Patient discharged from hospital April 25th. My

notes show that local treatment for the cervicitis extended over two months after dividing the septum, and that persistence in the use of ichthyol was followed by cure. There was no stenosis of vagina as a result of the division of the septum. Careful questioning of the patient revealed no traumatic cause for the abnormal condition of the vagina, and I believe the septum to have been congenital.

Medical Progress.

RECENT PROGRESS IN SURGERY.

BY H. L. BURRELL, M.D., AND H. W. CUSHING, M.D.

(Continued from No. 20, p. 490.)

RESECTIONS OF THE ILEO-CECAL COIL FOR STRICTURE AND FISTULA.

W. S. MAGILL, of Chicago, has contributed a paper on the above subject to the *Annals of Surgery*, December, 1894, with a review of 104 cases. He says that excision of the cecum should be attempted in every case of primary neoplastic tumor where extensive infiltration of the vicinity or ganglia is not present to forbid the intervention.

Tuberculosis or inflammation localized at the ileo-cecal coil should determine its resection in every case in which the immediate operation is possible without surpassing the patient's power of resistance, provided that other tubercular localizations be not so extensive as to render the advantage of this radical operation only temporary.

Examination of reports of tubercular cases leads to the hypothesis that operated appendicitis with unsatisfactory results — persisting fistula, repetition of accidents, induration, etc. — is amenable to resection, and that primary excision of the ileo-cecal coil would be less dangerous than and preferable to excision for fistula. A careful diagnosis should therefore be made to determine this point before operating.

Invagination in the region of the cecum is frequently complicated with cancerous disease; and in any case of resection the excision should be extensive to assure the result.

The longer the time that separates the actual condition of the parts from a state of acute inflammation, the better are the results of the operation assured.

Fistula of the ileo-cecal coil can safely be treated by resection, if no extensive suppuration has invaded, nor been allowed to enter, the iliac fossa.

An irreducible cecum may be excised with safety.

After resection, in all cases, the continuity of the digestive tract must be immediately established and secured against leakage. The only exception might be made for acute obstruction.

The continuity has been sought by uniting the intestine, with sutures, with a lateral anastomosis with absorbable plates, with a terminal or lateral implantation of the ileon into colon, best effected with the anastomotic button.

The greater part of the mortality of resection of the ileo-cecal coil is directly imputable to the insufficiency of the sutured intestine. Many of the recoveries show the leakage of intestinal contents through the line of sutures, by the formation and persistence of stercoral fistulæ.

The length of time required for operation is maximum for sutures.

With the exception of a fault of too little excision, not a reproach is found for resection followed by ileo-colostomy with absorbable plates or with the anastomotic button.

These last two methods have time-saving advantages.

These statements correspond with the results of the plates and buttons which Magill has demonstrated in his article.

The conclusion is, therefore, justifiable that sutures are not to be used for establishing the continuity of the digestive tract after resection of the ileo-cecal coil.

He then follows with an account of the preparation of the patient and the operation in detail — the closure of the abdomen and the post-operatory care. Bibliography is appended. The article is of value for reference.

INCISION FOR APPENDICITIS.

Charles McBurney,[12] has found that following appendicitis, in a certain number of cases, ventral herniæ occur. He has advised an operation which is of value. It is as follows: The skin incision should be made. The section of the external oblique muscle and aponeurosis should correspond, great care being taken to separate these tissues in the same line, not cutting any fibres across. This is easily accomplished. When the edges of the wound in the external oblique are now strongly pulled apart with retractors, a considerable expanse of the internal oblique muscle is seen, the fibres of which cross somewhat obliquely the opening formed by these retractors. With a blunt instrument, such as the handle of a knife or closed scissors, the fibres of the internal oblique and transversalis muscles can now be separated, without cutting more than an occasional fibre, in a line parallel with their course, that is, nearly at right angles to the incision in the external oblique aponeurosis. Blunt retractors should now be introduced into this in turn and the edges separated. The transversalis fascia is thus well exposed, and is then divided in the same line. Last of all the section of the peritoneum is made.

Two sets of retractors must be in use, one holding open the superficial wound from side to side, the other separating the edges of the deeper wound from above downward. A considerable opening is thus formed, through which, in suitable cases, the caput coli can be easily handled, and the appendix removed. The appendix having been taken away, the wound in the peritoneum, which is transverse, is then closed by suture. The similar wound in the fascia transversalis is also sutured. The fibres of the internal oblique and transversalis muscles fall together as soon as the retractors are withdrawn, and with a couple of fine catgut stitches the closure can be made more complete. The wound in the external oblique aponeurosis is sewed with catgut from end to end. When the operation is completed it will be seen that the gridiron-like arrangement of the muscular and tendinous fibres, to which the abdominal wall largely owes its strength, is restored almost as completely as if no operation had been done. In performing this operation he has noticed several advantages.

In the first place, muscular and tendinous fibres are

[12] Annals of Surgery, July, 1894, p. 38.