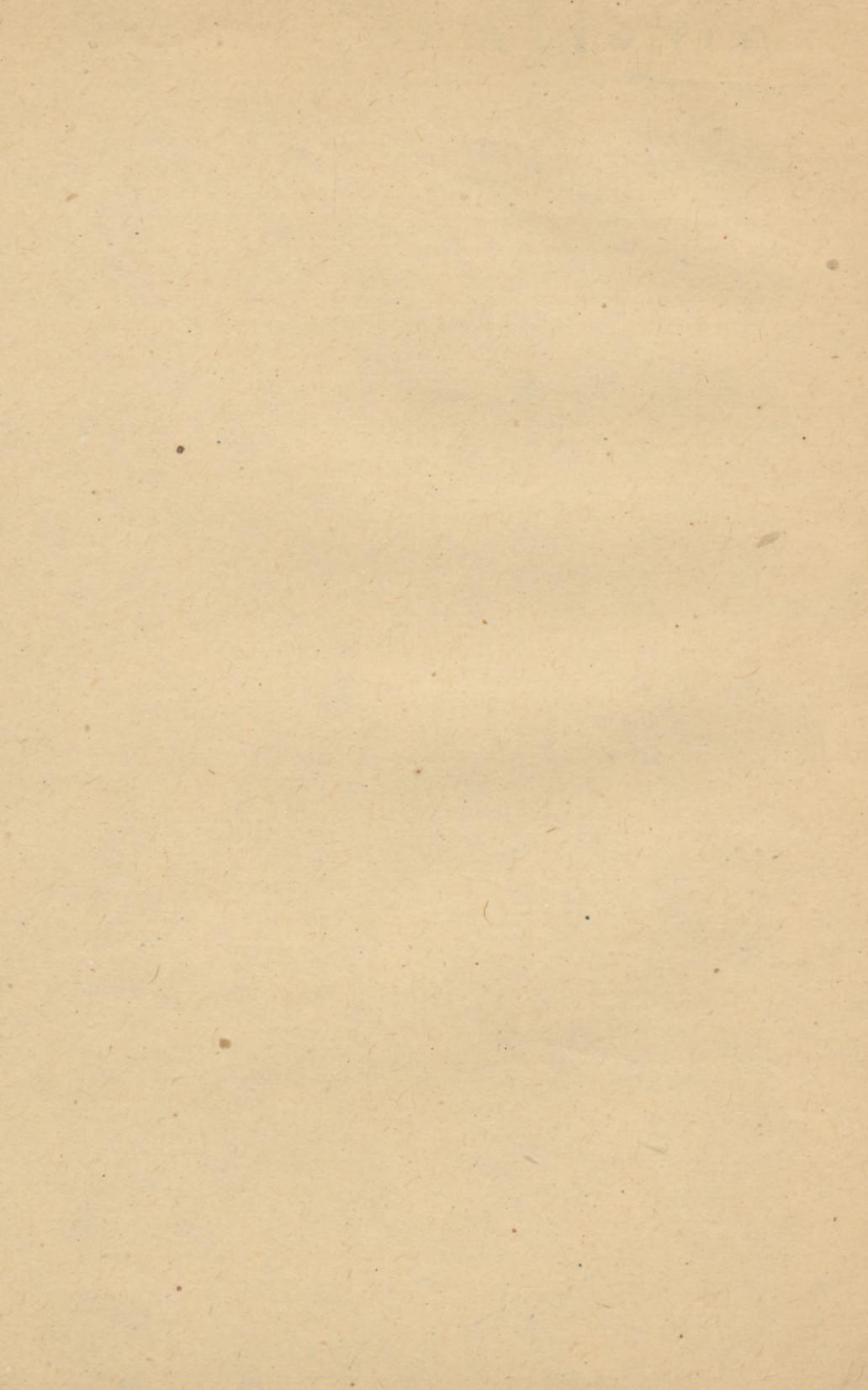


HIRST (B.C.)

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**THE LOWEST LIMIT OF PELVIC CONTRACTION  
ADMITTING OF SYMPHYSIOTOMY.**

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AN impression prevails that symphysiotomy is the proper operative treatment for labor obstructed by a moderate degree of contraction in the pelvis, in which the other alternatives are the induction of premature labor and craniotomy. This view was expressed without contradiction at a recent meeting of a prominent medical society at which the operation was the sole topic of discussion. Increasing experience, however, demonstrates that symphysiotomy is to be depended upon in the case of a pelvis symmetrically contracted, that a few months ago would have been thought quite impassable for a living child, even though the symphysis were cut. Leopold has recently delivered in this way a woman with a pelvic conjugate of only 6 cm., and more than a month ago in the Philadelphia Hospital I delivered without difficulty a rachitic dwarf, a primipara,  $4\frac{1}{2}$  feet high, whose conjugate was, I think, very little if at all over 65 mm. The diagonal was a scant 9 cm., but the conjugato-symphyseal angle was so increased that  $2\frac{1}{4}$  cm. was, in my judgment, a sum scarcely sufficient for the subtraction. To be on the safe side I induced labor two weeks before term; then dilated the cervix, performed version after opening the symphysis, and extracted the child in a few minutes. It weighed 6 pounds, 4 ounces. The head-measurements were: Bi-temporal, 8 cm.;



bi-parietal, 9 cm.; occipito-frontal,  $11\frac{1}{2}$  cm.; occipito-frontal circumference,  $33\frac{1}{2}$  cm. The woman had an absolutely afebrile convalescence and the child is thriving.

The combination of delivery before term and symphysiotomy will give us entire control over any grade of symmetrically contracted pelvis that we are likely to see in this country, and whenever possible the two should be combined. In a very large experience with the induction of labor from two to four weeks before term I have found the mortality for the children no greater than in delivery at full maturity, whereas the slight diminution in head-diameters and the compressibility make a vast difference in the ease of delivery. Another, and a very great advantage in the induction of labor when symphysiotomy is contemplated is the fact that a convenient hour can be selected by the operator for the delivery, and all preparations can be made for the appointed time, as in an abdominal section. The plan adopted in the case here reported, and always followed by me if practicable, was as follows: Early in the morning a bougie is inserted and an ounce of glycerin injected alongside of it. Twenty-four hours later the lower abdomen is cleaned and shaved. By this time, if the pelvis is so contracted that the head cannot enter the inlet, the cervix will be softened but scarcely at all dilated. The cervical canal is then dilated with three sizes of water-bags, the largest twice the size of the largest Barnes's bag, each left in for about an hour. This is most conveniently done by an assistant. At about the time that the artificial dilatation is completed the operator arrives prepared to operate and deliver as soon as the patient is anesthetized, the vagina is disinfected, and the instruments are sterilized.

