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POST-MORTEM CÆSAREAN SECTION, WITH DELIVERY OF A LIVING CHILD.

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SUDDEN death of the mother during labor, if the child is living, makes it obligatory upon the attending physician to endeavor to rescue the infant. The success of such an attempt will depend, first, upon the nature of the cause which destroys the life of the mother; second, upon the time chosen for the delivery; and, third, upon the method employed.

Two causes of maternal death are especially fatal to the fœtus. One is traumatism, resulting in severe hemorrhage to the mother, and the other is an infection, producing high fever and profound intoxication. Sudden death in labor from heart-lesions or from mechanical injury, without great hemorrhage, gives conditions most favorable for the survival of the child.

The time for accomplishing delivery in these cases is necessarily brief. A recent case is reported by Hoffman[1] in which in an eclamptic patient he describes the delivery of a living child by abdominal

[1] Centralblatt für Gynäkologie, 1895, No. 50.

and uterine incision ten minutes after the mother had ceased to breathe. It may scarcely be supposed that a longer delay than this could be borne by the fœtus. Where high temperature is present, the time must be necessarily briefer in which successful delivery may be accomplished.

The method of performing rapid delivery in these cases has been variously chosen by different operators; while abdominal and uterine incision is undoubtedly quickest, some prefer forcible dilatation of the uterus, and forceps or version. The practical choice of a method must depend upon the condition of the birth-canal, and also the circumstances and situation of the patient. Where abundant assistance is at hand, the patient can quickly be put in suitable posture for the forceps or version. Where, however, but little help can be obtained, and the patient cannot be placed in proper position readily, it is often more easy to perform abdominal incision.

The survival of children so delivered will depend upon the vigor of the child, and also upon the nature of the cause which destroyed the mother's life. The acute infections are especially fatal to infants, not only from the action of poisonous germs conveyed from mother to child, but also by reason of the high temperature which is often present in these cases.

A recent case may serve to illustrate the foregoing remarks:

The patient, Mrs. L., aged twenty-six years, a primipara, had been in good health during her pregnancy. She was of good constitution, and had

always enjoyed excellent health. A few days before her death she had summoned her physician with the complaint of headache, restlessness, and nervous discomfort. He prescribed a sedative for her which somewhat relieved her symptoms. Shortly afterward, while sitting with her family, she was suddenly seized with convulsions, and soon became unconscious. Her physician was at once summoned, and applied the usual methods of treatment for subduing the eclamptic seizures. These were, however, unsuccessful, and the patient rapidly passed into a comatose condition with extensive œdema of the lungs. I saw her in consultation about six hours after the first attack. She was then in deep coma, with a high temperature and labored breathing. Vaginal examination disclosed the membranes unruptured, the cervix obliterated, and the os about three-fourths dilated. It seemed to me possible to rupture the membranes, complete dilatation with the hand, and apply forceps, as the vertex was presenting. While hastily preparing the forceps, the patient was seized with a convulsion, at the close of which she expired. I hurriedly asked whether the family desired that an effort be made to save the child, and was informed that such was their wish. As the patient was a large, stout woman, and her bed so placed that she could not be put into position for the use of forceps without considerable difficulty, the quickest method of delivery seemed abdominal incision. Accordingly, while one of the physicians held a light, the abdomen and uterus were rapidly opened, and a male child, weighing 7 pounds and 12 ounces, was extracted. In the hurry

of the moment, the patient's temperature had not been taken, but her body felt so hot to the hand that her temperature must have been above 104°. The child was asphyxiated, but speedily revived and breathed naturally. As the child would be without skilled care if left at home, he was immediately warmly wrapped, placed between warmed pillows, and taken to the Jefferson Maternity, where he was placed in an incubator. He was nursed by a healthy young woman whose child was but a few days old, and was given the faithful care of trained nurses. It was observed that the child perspired very freely upon entrance to the Maternity, and that the secretion of urine at first was excessive. The child nursed naturally, its bowels were soon emptied, and its appetite was excellent. It gradually developed, however, symptoms of toxæmia, similar to those of an eclamptic patient. Its urine contained a great excess of uric acid, its skin became dry, and its bowel-movements were dark in color. The child was treated as would be a woman suffering from toxæmia. It derived the greatest comfort from a warm pack. Its intestines were irrigated, and simple diuretics were administered freely. The toxæmic condition considerably improved, and the child continued to nurse regularly. It never had convulsions, and slept when its excretory organs were freely stimulated. At the end of two weeks, however, it developed a purpuric condition of the skin and mucous membrane of the intestine, and died two weeks after delivery from inanition.

This case illustrates very perfectly the pathology of eclampsia, and the toxæmic condition transmitted

to the child which proved so fatal to the mother. It was most interesting to observe that all of the child's nervous symptoms, restlessness, and suffering were directly relieved by that form of treatment which increased its excretions. In view of the fact that the child survived two weeks, that it nursed, and was relieved for a considerable time of threatening symptoms, the attempt to save its life seems to have been justifiable. As a post-mortem examination could not be obtained upon mother or child, the exact pathology of both cases could not be ascertained. Every symptom, however, pointed in mother and child to a profound toxæmia as the cause of the fatal issue.

This case illustrates most pointedly the imperative necessity of watching carefully the excretory processes of the pregnant patient. It is not sufficient to ascertain simply the presence or absence of albumin in the urine, but the physician must know that the skin, kidneys, liver, intestines, and lungs of the mother are performing the double duty which the presence of the fœtus entails. When this is carefully watched, sudden and profound intoxications like that described will rarely happen. An experienced observer will detect the effects of toxæmia upon the nervous system, and by suitable diet and prompt stimulation of the organs of excretion will, in the great majority of cases, succeed in averting the danger to mother and child. In the presence of profound toxæmia with eclampsia there is but a short time in which any form of treatment is of the slightest avail. The fatal line is passed so rapidly that, unless the physician is forearmed and forewarned, he may find himself in the presence of an unpreventable catastrophe.