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CRANIOTOMY.

Craniotomy is one of the oldest of surgical operations, and while it is, under any circumstances, exceedingly unpleasant, it becomes repulsive and horrible in the extreme when performed on the living child. At one time it was so common in Great Britain as to become a serious reproach to British midwifery. At the same period in France, chiefly through the influence of the Church, it was bitterly denounced, and scarcely ever performed.

At the recent meeting of the British Medical Association, Dr. Meadows, in his opening address before the section of obstetric medicine, expressed the hope that a new law would be promulgated which would put a stop to this method of slaying innocent life. Among the interesting papers presented was one by Robert Barnes on "The Alternatives to Craniotomy." In the discussion that followed the general feeling was in favor of some of the alternatives. It was shown that deformities of the pelvis which require craniotomy might be prevented to a great extent by hygienic and anti-syphilitic precautions. After hygiene we have the induction of labor which, in some cases, is very satisfactory after the viability of the child, being frequently facilitated by turning. When the child has reached full term in a pelvis so much contracted as to prevent delivery, the alternative to craniotomy is some form of abdominal section.

It is generally, though not universally, conceded in this country that the interests of the mother should be considered rather than those of the unborn child. With a case before us, it becomes a serious question to decide whether Cæsarean section or any of its sister operations is as safe as embryotomy. It is said that for one hundred years no successful Cæsarean section was performed in the Vienna or Paris hospitals. With such a discouraging record it is hardly surprising that British obstetricians looked on it with disfavor. The Cæsarean operation was, however, too often deferred until the cases had become hopeless, and it has been shown by Harris that the rate of mortality under favorable circumstances is comparatively low—*i.e.*, about 25 per cent.

The methods of operating have lately been so much improved by Sanger and others that it has become far less formidable. Sanger operates early to avoid the effects of shock; prevents hæmorrhage, chiefly by the elastic ligature enclosing the cervix, and avoids other dangers by his method of closing the uterine wound. His plan is to dissect the peritoneum free from the muscular edges; cut away a slice of this tissue on each side (although this is said by some to be unnecessary); turn in the free edges of the peritoneum; unite the surfaces by deep and superficial sutures in such a way as to close effectually the wound and, at the same time, bring two layers of peritoneum in contact.

In Porro's modification the uterus, after being emptied, is amputated at the cervix. In Thomas' modification, called gastro elytrotomy, the os is fully dilated; an incision is made above and parallel to Poupart's ligament; the peritoneum is pushed up, an opening is made into the vagina, the cervix is drawn up through this opening, and the child is extracted by the hand.

In considering the risks attending these operations it must be remembered that craniotomy itself is attended with grave danger to the mother. Lawson Tait strongly favors Porro's operation. Other surgeons have their choice among the three, and it is somewhat difficult to settle their rival claims to superiority. Lusk, however, points out that they are not rival methods, but clearly fulfil different indications. He chooses the Cæsarean section for favorable cases taken early; Porro's for cases in which the uterus is exhausted, and laparo-elytrotomy where the head is at the brim, with the uterus retracted above it.