FIRST DAY—AFTERNOON SESSION.

Dr. Llewellyn Eliot, of Washington, D.C., read a paper,

IS A CHILD VIABLE AT SIX AND A HALF MONTHS?

He referred to the French law, which excludes the possibility of the viability of a child born before the sixth month (one hundred and eighty days), as unjust, since cases have occurred where children born before that time have been reared and lived for many years. He denied the plea of superfetation, in these cases, as untenable. A table comprising cases in which the period of utero-gestation extended from the fourth month (one hundred and twenty days) to the termination of the seventh month supplements the paper. Dr. Eliot related the histories of three cases of early viability, one at six months and eleven days, one at seven months and one day, and one at seven and a half months, and drew the following conclusions: 1. A child under peculiar circumstances of development is viable at four months. 2. A child is viable at six and a half months. 3. The moral character of the parents has nothing to do with the birth of a premature child, when considered from a standpoint of constitutional development. 4. Obstetricians should strive to convince jurists of these facts.

Dr. J. H. Carstens, of Detroit.—The paper of Dr. Eliot is one of great importance from a medico-legal standpoint. I would hesitate to say that a child was five and a half or six months, or six and a half months. I do not see how it is possible for us to say how long a child has been in utero. A woman may have a discharge of blood similar to menstruation when she is already pregnant for a month. In the present state of our knowledge it is clearly impossible to say how old that child is, unless you have two absolute factors: that you have the woman menstruate at a certain date, and that coition was had only at one certain date. You cannot even judge from the time the woman feels life, because that varies.

Dr. Eliot, of Washington, D.C., closing the discussion, said that in using the incubator it was necessary to regulate the amount of moisture as well as heat. If we have it too dry, we kill the child; if we have it too hot, we kill the child.

Dr. E. E. Montgomery, of Philadelphia, read a paper on

THE APPLICATION OF SACRAL RESECTION TO GYNECOLOGICAL WORK,

in which he advocated the procedure in all cases in which uterus and rectum were both involved with malignant disease, and in cases of uterine cancer where the uterus was enlarged or where the vagina was small and the case complicated by disease of tubes and ovaries, causing extensive adhesions.

He places the patient upon the left side or semi-prone position, and makes a bow-shaped incision from the right sacro-iliac synchrondrosis across the median line to a little beyond the apex of the coccyx, enucleates the latter bone, separates ligaments and muscles from the right side of the sacrum, and, beginning just below the third posterior sacral foramen, cuts off with chain saw or bone pliers the right ala of the sacrum.

In operations for removal of the uterus and its appendages, the rectum is pushed to the left and the peritoneum opened. This brings the operator upon the posterior surface of the uterus, when the broad ligaments may be seized by hemostats, raised up, the broad ligaments ligated, and the uterus removed. After removal of the organ the peritoneal surfaces may be stitched over the vagina and the posterior peritoneal opening also closed. He does not prefer it to vaginal hysterectomy where conditions are favorable for the latter. He reported two cases in which he had done the operation. One for cancer of the rectum and uterus, in which three inches of the rectum and uterus and appendages were removed, and the calibre of the gut restored. A large collection of feces pushed up the lower segment of the rectum, requiring the wound to be reopened and a secondary operation four weeks later. The second operation was done for cancer of the uterus complicated by tubal and ovarian disease with adhesions. Both patients recovered, and no inconvenience in locomotion was experienced.

Dr. C. A. L. Reed, of Cincinnati.—This operation attracted my attention when the first publication of it appeared. Like many of the other operations, particularly those that involve the invasion of structures that we have not been in the habit of treating surgically, it appears to be more formidable than perhaps it really is. In an effort to treat malignant disease involving the middle segment of the rectum, this operation would be demanded and would be justifiable, for we are justified, perhaps, in doing almost anything for the relief of malignant cases, particularly those involving important tissues, such as the rectum and uterus; but if we can bring the maximum of relief with the minimum of risk, that is the line we ought to follow. There is one question which cannot be answered as yet from any ascertained results, and that is with reference to the remote influence of this operation. The removal of the coccyx and the removal of the lower segments of the sacrum must of necessity deprive the lower portion of the pelvis of an important basis of support; and what is the condition of our patients with regard to the support of the superimposed viscera following the operation, after a considerable length of time? Dr. Montgomery's cases are yet too recent to afford an answer to this question. While the primary results have been very good, it would have been vastly better to have relieved his patient by primary colotomy; but if this operation will bring the same amount of relief with as little risk of primary mortality, and at the same time insure the patient voluntary control of her fecal discharge, by all manner of means let us encourage it.

Dr. H. O. Marcy, of Boston.—We ought to lay emphasis upon primary colotomy. I mention it simply because I lost two patients where the result might have been entirely different if I had done colotomy first. This was in cancer of the rectum. When we recollect that the intestine is very fully distended with gases and feces, the pressure upon our sutures is something enormous. Primary colotomy gives us that all-important factor of surgical rest of the tissues with a far better promise of success.

Dr. H. T. Hanks, of New York, thought that this operation could be recommended in most cases of chronic pelvic abscess where a rupture has taken place into either the vagina or rectum, and where the tissue underneath the broad ligament is honey-