Medical Memoranda

Uterine Sepsis from Unabsorbable Sutures

The following case report may be of interest to those obstetricians who still advocate the use of unabsorbable ligatures for sewing up the uterine wound after caesarean section.

CASE REPORT

A woman aged 44 was admitted to the Royal Masonic Hospital on August 8, 1949, complaining of irregular uterine bleeding and a purulent vaginal discharge. The average duration of her menstrual period was 7 to 14 days, and the cycle was irregular. The loss was variable, but enough to cause

a moderate anaemia. In 1938 an artificial menopause had been induced with radium, but her periods had returned after three months' amenorrhoea and had continued since. She had had two children, aged 19 and 13 years, both delivered by caesarean section. The Fallopian tubes had been tied at the second operation.

As this was a case of persistent irregular haemorrhage after radium it was considered advisable to perform a total hysterectomy, and this was undertaken on September 5. The uterus was found to be densely adherent to the

Uterus with abscess, showing old caesarean suture.

anterior abdominal wall by a broad adhesion about 1 in. (2.5 cm.) in diameter. This was dissected away from the anterior abdominal wall and a small abscess, containing frank pus and several long strands of silk ligature, was opened in the middle of the adhesion. The abscess connected with the cavity of the uterus and there was a nest of silk sutures in the abscess.

On section, the myometrium showed considerable fibrosis, possibly the result of the radium menopause. The wound was closed, with drainage to the extraperitoneal space, and the patient had a smooth convalescence. The accompanying illustration shows the uterus with adhesions cut away and a probe passing down the abscess cavity into the uterine cavity. The thick plaited strands of silk are clearly visible, and one or two strands have been removed to show that they are no more absorbed than on the day when they were inserted. The cause of the bleeding and discharge was a stitch abscess in the endometrium.

Most gynaecologists condemn the use of unabsorbable ligatures in the uterus, but a few still advocate the practice. This case is perhaps instructive in showing that such sutures are never absorbed and may give rise to serious mischief—in this case over 13 years after their insertion. I would further submit that nylon used for suturing the uterine incision after caesarean section may well give similar trouble in the future. Though not ideal, catgut is the best suture material to use in the uterus.

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Volvulus of Transverse Colon Complicating Labour

The following case is reported because of its rarity and also because it brought to mind that host of differential diagnoses of collapse occurring during labour and in the immediate period post-partum.

CASE REPORT

A woman aged 22, in her third pregnancy, was admitted at term with abdominal pain and nausea on the evening of May 12, 1949. Her past general and obstetric history was normal. She was believed to be in labour. Her blood pressure was 160/110, pulse rate 130, and temperature 97.8° F. (36.55° C.); the urine contained a heavy cloud of albumin. The foetus was presenting by the vertex, and the head was engaged. The foetal heart rate was 84, and the rhythm was irregular.

As she was thought to be in the pre-eclamptic state, treatment was carried out in the routine manner. Six hours after admission an asphyxiated female infant, weighing 7 lb. 9 oz. (3.4 kg.), was delivered spontaneously and survived after resuscitative treatment. The mother collapsed and was treated for obstetric shock. Moderate abdominal distension and generalized tenderness was then discovered. She vomited during the night, and eight hours after the birth her blood pressure was 70/50 and her pulse rate 156.

Gastric suction was begun and intravenous fluids were administered. She had received an enema shortly before admission, but since then had passed neither faeces nor flatus. Her condition did not deteriorate further. Two days after the child was born a lump could be felt in the abdomen above and to the right of the umbilicus. The abdomen was tender, and the fundus of the uterus was felt 3 in. (7.5 cm.) above the symphysis pubis, 1½ in. (3.75 cm.) from the lower border of the tumour.

Four and a half days after the onset of abdominal symptoms laparotomy was performed by Mr. Keith Vartan under general anaesthesia. The lump was found to be distended transverse colon: the mesocolon was longer than normal, and the ascending colon was freely movable. A volvulus had occurred, involving the upper half of the ascending colon and the proximal two-thirds of the transverse colon. It was thought that the mesentery had become untwisted to some extent spontaneously, and nothing was done by the surgeon, apart from completing the untwisting. The other abdominal viscera were examined and found to be normal. The patient was discharged with her baby on June 8, 28 days after admission.

COMMENT

Involvement of the ascending and transverse colon is rare in volvulus occurring during pregnancy. All authors consider the condition from the point of view of intestinal obstruction and discuss the maturity of pregnancy at which such obstruction is most common. Lambert (1931) found the greatest number of cases of volvulus at term or during labour. Kohn *et al.* (1944) also found the last trimester to be the most common time, but remark the strangeness of its occurrence at a time when the abdomen is so distended by the pregnant uterus that torsion of abdominal contents would seem most difficult. On the other hand, it is easy to see the strength of the theoretical argument of Spence (1937) that immediately after delivery there is such a great alteration in the position of the alimentary tract that it is a wonder volvulus is not more common at that time.

The case reported was characterized by three features: (1) the extreme degree of peripheral vascular failure complicating labour and the immediate period post-partum; (2) the dominance of this feature over all other signs and symptoms, and (3) the spontaneous partial resolution of the pathological condition. For, indeed, vomiting as a symptom