DROPSY OF PREGNANCY.

DROPSY OF THE FŒTUS IN CONNECTION WITH DROPSY OF THE MOTHER, AND ITS IMPORTANCE IN THE QUESTION OF INDUCTION OF LABOUR IN SUCH CASES.

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THE whole subject of dropsy of pregnancy requires much investigation; writers of general treatises of medicine appear to think it almost out of their province, and few obstetric authors refer to it, except incidentally, as a symptom often present in cases of puerperal eclampsia.

Much has been written discussing possible causes of the kidney disease which underlies it, but apparently, without a sufficient study of the natural history of these cases. Little do we know of the previous history and almost nothing of the subsequent history, and of the connection of the disease with the death of the patient, in cases where the patient survives, and apparently recovers from, the first and perhaps only attack of the disease.

The object of this paper is, however, to direct attention to the great mortality of fœtuses in these cases, especially to one cause of this mortality, and to the bearing of this on the question of the induction of labour, which in the author's opinion is too often postponed in the supposed interest of the fœtus, and not without grave risk to the mother. The following case illustrates the main point.

Mrs. H., aged 29, was admitted into the Great Northern Central Hospital on June 4th, 1888, under the care of Dr. Griffith. Of her family history she knew nothing important. She believed she had had neither scarlet fever, rheumatism, nor any serious illness previously. She had had six children, no miscarriages, the youngest child being fourteen months old. She had had no serious complication in connection with her previous pregnancies. Her general health, though never robust, had been fairly good; she is dull, and perhaps somewhat deficient in intellect. The last menstrual period she stated was at the end of January, 1888, but from the size of the uterus and the development of the fœtus, as well as from the fact that she quickened on May 12th, pregnancy commenced probably a month earlier.

In March (the third month of pregnancy) she first suffered from severe frontal and vertical headache, nausea and vomiting; this had continued more or less since. She first noticed œdema of the face two or three weeks ago, and of the body and legs a few days later. The urine had lately become scanty, not containing blood. There had been diarrhœa for the last few days.

On admission, the face, abdominal walls, the back, vulva, and legs were much swollen; the peritoneum contained a moderate amount of free fluid, but there was none in the pleural cavities, and the lungs were not œdematous. The uterus reached nearly to the umbilicus, and fetal movements were felt. The temperature was normal, the pulse small and compressible; urine 32 ounces in twenty-four hours, acid, specific gravity 1022, albumen about four-fifths. She slept well, was not drowsy during the day, but suffered much from headache and giddiness. The bowels were now costive. Beyond paleness of the fundi, corresponding to her general anæmic state, the ophthalmoscope revealed no abnormality.

Under a milk and light farinaceous diet, with iron and magnesium sulphate, aided later on by the compound jalap powder, the peritoneal fluid disappeared, and the headache was relieved; but at the end of a month the general œdema was still so extensive that it was decided to induce labour. The labia had twice been punctured, the distension being great, and the serum poured out from them in a continuous stream to the extent of 32 ounces.

On July 4th a bougie was introduced into the uterus; labour pains began twenty-four hours afterwards, and the fœtus was born twelve hours later. It made some ineffectual respiratory efforts, but could not be kept alive for more than a few minutes. During the first week after this the dropsy rapidly diminished; the urine was abundant, and of low specific gravity, and contained less albumen.

On the 12th and 13th she had rigors, the temperature rising to 102° and 103°, followed by profuse perspiration, and preceded by headache. There being no evidence that this depended on septic conditions, no change was made in the general treatment, and the ordinary carbolic douche continued. The breasts gave no trouble, having been firmly bandaged after the birth of the child. On the

following day there was aching pain across the loins and abdomen, rather profuse diarrhœa and vomiting, frequent and painful micturition, and the urine contained blood. The left kidney was enlarged and tender. These symptoms continued, with only partial relief.

On the 20th the urine was smoky, specific gravity 1010, contained one-sixth albumen, and a little pus.

On the 24th there was tenderness in the course of the left popliteal vein, and some swelling of the limb, but not phlegmasia.

From this time she steadily lost ground, losing flesh and becoming melancholic; and in the second week of August, being violent and unmanageable, she was moved to the infirmary, where she improved, and was able to leave for a convalescent home in October.

On making a careful examination of the fœtus it was found that, though there was little perceptible œdema of the skin and cellular tissue, the serous cavities contained a considerable amount of fluid, that in the pleural cavities being sufficient to cause death when respiratory movements were needed. The lungs were partially inflated.

In cases of dropsy, such as this one, it frequently happens, as it does also in cases of considerable hæmorrhage during the later months of pregnancy, that great objection is felt by the medical attendant to interfering with the progress of pregnancy, and for what reason? Almost invariably in the supposed interests of the child, under the rule that every additional week *in utero* increases the chances of the ultimate survival of the child. But what is gained if it is stillborn? and what is lost to the mother by the delay? When the induction is put off until in the one case the uterus has to be emptied with great interference and haste owing to severe or protracted hæmorrhage, little thought being then given to the child born dead in the satisfaction that the mother's life is saved, if this is happily the result; and, in the other case, the woman lies for days and weeks hopelessly waterlogged, the dangers of labour and the puerperium increasing; and though, as a rule, she makes a comparatively rapid recovery, she runs grave risk from asthenia, dropsy, eclampsia, hæmorrhage, phlegmasia, and septic infection, and little chance is there of the child surviving even if it is born alive.

The principles which should guide us in the management of cases in which considerable hæmorrhage occurs during pregnancy are absolute: to empty the uterus with as little delay and with as little risk as possible. This rule is clear and definite; the manner of carrying it out varies somewhat in different cases.

What rule should we adopt in the case of considerable dropsy of pregnancy? Treat the patient as a case of acute nephritis with dropsy; if there is no distinct improvement within a reasonable period (from two to four weeks), and with less delay if the dropsy increases, empty the uterus. The best method for doing this is by the introduction of a clean bougie, leaving it until labour is established, a couple of five-grain doses of quinine being given at the end of twenty-four hours if the uterus needs further stimulation.

The rapidity with which the dropsy and the kidney symptoms diminish must not be taken as necessarily indicating a complete recovery, and the patient must be warned of the necessity of taking the greatest care of herself, and especially of the importance of not allowing herself to run the risk of pregnancy until a considerable time has elapsed and she is free from symptoms of renal disease.

FUNCTIONAL (? RICKETY) INFANTILE PALSY, WITH A NOTE ON "LINGUAL IRRITABILITY."

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THESE cases tend to prove the existence of paralysis of the spinal motor centres, not due to obvious lesions but yet destroying faradic irritability of the paralysed muscles. Unfortunately the peripheral nerves have not been examined. Diphtheria appears to be excluded. Whatever the cause may be, the mere existence of such cases in infants of so tender an age makes them of remarkable clinical interest.

E. G., a full-term child, aged eight months, was brought to me on September 1st, 1888, with the history that she was quite