TWO CASES OF ABORTION,

WITH PERMANENT RETENTION OF THE PLACENTA IN THE ONE, AND GRADUAL DISCHARGE OF THE OVUM IN THE OTHER CASE.

By J. ASHBURTON THOMPSON, L.M., etc.

THE following cases of abortion fall under that embarrassing class of incomplete discharge of the uterine contents, unaccompanied by present urgent symptoms. There appears to be much difference of opinion as to the treatment of these cases; the notices of them in obstetric works are but cursory, and these conflicting in their *dicta*. Regarding the subject from one point of view, it is the *absence* of complication which embarrasses. Were we in attendance upon a case of this sort, accompanied by hæmorrhage, by long continued pain in the exhausted patient, or by putrescency, our course, that of emptying the uterus, would be sufficiently clear. But when, after the expulsion of a fetus of three or four months, we find the secundines retained beyond the reach of the finger; the uterus contracting, indeed, but so contracting as to further withdraw and envelope them; hæmorrhage ceased; and the condition of the patient all that could be wished, if the abortion were complete—then, indeed, there is an absence of indication whether to interfere with the contracted organ and withdraw its contents, or to wait for the supervention of active symptoms. Each of these courses is open to serious objection; and perhaps this question resolves itself into one of the relative harm attendant upon action or expectancy. In weighing their respective merits, it must be remembered that our means of interference, though ample, are not unattended by danger. The introduction of an instrument is universally condemned; its point must, of course, pass beyond the guard of the finger. The introduction of the hand, or even of one finger, is regarded by Dewees and F. H. Ramsbotham as impossible; by Denman and D. Davis, it is not mentioned in the course recommended; by Churchill, though acknowledged practicable, it is considered admissible in exceptional cases only. Finally, Tyler Smith has never seen any ill result arise from the introduction of the hand into the vagina and a finger into the uterus; and recommends such an operation, but with the all-important qualification, “when the hæmorrhage is alarming, the case urgent, and the os uteri sufficiently dilated to admit the finger.” On this side also are Priestley and Hall Davis. It may also assist us to know that the early placenta does not undergo putrefaction with the same rapidity as that retained at the full time; it may be retained for days or even weeks, and then, by some new uterine action, expelled almost unchanged. (F. H. Ramsbotham, 1867, p. 693.) In the extremely favourable cases of this description—*i. e.*, in those unattended by exhaustion, and, above all, by hæmorrhage—we may perhaps, therefore, be justified in trusting, for a time at least, to the powers of nature, and in waiting for symptoms. Such would be a return of hæmorrhage, of exhausting pain, or the appearance of putrid discharge with constitutional irritation, betokening dangerous absorption.

The above are some of the reasons which led to the adoption of the line of treatment followed in the adjoined cases. The expected symptoms never arose, and nature appears to have conducted the cases to a conclusion at least as satisfactory as could have been expected from more active interference.

CASE I.—E. S., aged 36, married, had had eight labours at full term. She had never miscarried. She last menstruated on January 7th, 1868. Having had a slight sanguineous discharge from May 21st to May 25th, she was delivered, after two hours of slight pain, of a fetus of about four months, healthy, recently dead. The fetus remained attached by the funis to the placenta, which examination showed to be just within the os externum. Pain continued from this time (10 A.M.) to 4 P.M., without in the least altering the position of the placenta. At the latter examination, the umbilical cord was separated. She continued to lose a small amount of blood up till 10 P.M.; when, the hæmorrhage decreasing, and uterine pain having ceased, notwithstanding the administration of ergot, it was determined not to attempt the extraction of the placenta, for the present at least. All that had passed since the morning had been carefully examined by me. A final digital examination at 10 P.M. showed the placenta to be still in that position to which it had been traced by following the umbilical cord—*viz.*, just within the os externum; and the patient, having been told that the after-birth was retained, was warned to save all that passed for inspection. She was ordered small doses of liquor ergotæ, with dilute sulphuric acid, with a view of controlling hæmorrhage.

From the date of delivery, the lochial discharge continued up to June 10th, in quantity and quality perfectly normal, without ever becoming offensive, or containing any solid matter. Leucorrhœa then

appeared, as is habitual with this patient. On June 25th, she menstruated. The quantity was normal, and almost ceased on the third day, but returned again, and continued up to July 2nd. By the 6th, all discharge ceased. She had then recovered her usual health, and has since then menstruated in the ordinary manner. The quality of the discharge negatives, in this instance, the supposition of a discharge of the placenta disintegrated; and, from the precautions taken, it is certain that no solid thing passed *per vaginam* after the examination on the night of the 25th of May.

CASE II.—M. F., aged 22, married three years, had one labour at full term at the end of the first year, followed by prolapsus uteri. She had never miscarried. The catamenia appeared as usual on May 14th, 1868. There was a slight sanguineous discharge on June 4th. Considerable hæmorrhage set in on July 29th, and continued up to August 1st, when she came under observation. Examination showed the os to be flaccid and dilatable, admitting the top of one finger to feel the ovum just beyond. She was ordered liquid extract of ergot and dilute sulphuric acid. The hæmorrhage abated considerably; and on August 5th the os externum was found dilated to the size of a florin, the ovum almost projecting into the vagina. It was not found practicable to encircle the whole ovum by the finger; and its attachments were so firm, while its own structure was so weak, that any attempt at traction must have resulted in its rupture. The hæmorrhage had now almost ceased. The dose of ergot was increased to forty minims every three hours, with a view of causing expulsion of the ovum; but, although pains followed each dose, its position remained unaltered. On August 8th, the os was contracted, and the ovum withdrawn altogether into the uterus, and only just perceptible to the finger. On August 9th, the discharge was only just tinged with blood, and was offensive. The uterus was injected with lotion of carbolic acid. The discharge continued up to the 14th; it was much as on the 9th. It then became less offensive, and quite ceased by the 22nd. On the 24th, leucorrhœa returned, as is usual to this patient. On August 28th, she was discharged well, and has since gone into the country.

Sept. 20th. The patient has returned, and has menstruated once while away. She is in perfectly good health.

Throughout the whole of this time, the general health was good. Only a little pyrexia was observed at the onset of the offensive discharge, which, however, quite ceased in twenty-four hours.

The circumstances of this case seem to justify the supposition that this was a case of retention of the ovum, terminated by its gradual discharge in a state of disorganisation.

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CASE OF SPASMODIC CLOSURE OF THE OESOPHAGUS.

By JOHN F. BOYES, M.B. Trin. Col. Dublin.

HAVING seen some remarks in the JOURNAL “On Stammering with other organs than those of speech,” by Mr. Paget, I am induced to give a short account of a case of spasmodic closure of the oesophagus, in a female aged 74.

The patient, who was in good robust health up to last December, suddenly and quite unaccountably experienced a difficulty in swallowing on some occasions. The place where she felt the sensation of closure was more on the left side, at the root of the neck. These symptoms gradually increased, and when I saw her, three months from their first appearance, she was becoming gradually emaciated from actual starvation. The oesophagus would remain closed for hours, and if she attempted to swallow anything, even liquids, during this time, all was ejected in a few minutes. Suddenly she would find her throat opening and then called for food, both solid and fluid, which she eagerly took and retained. The oesophagus on these occasions would only remain open about half an hour, and this two or three times a day. Sometimes it would not open for an entire day, after which she became much exhausted, but would again regain strength after partaking of food. When the throat was closed she would sometimes spit up large quantities of saliva, often a pint; and, during any severe attack, the respiration would sometimes have a croaking sound in the throat. The symptoms gradually became more severe, the spasm continuing longer and the throat only remaining open a few minutes. Now, if she did not get something to swallow quickly, the throat would again close, and she would have to wait till it reopened. She died in one of these attacks, which kept the throat closed two days, during which time she had no nourishment. At no time did she complain of any pain in the throat. There was no swelling or hardness. She never ejected anything but what appeared to be saliva, perfectly clear and without any taste. There was no appear-

ance of any malignant disease. No medicine seemed to give any relief, not even the valerianates. I strongly recommended beef-tea enemata, but she would not have them. I did not see her for three weeks before her death, but up to that time she seemed in good spirits, especially if the spasm had not lasted too long. She could feel when the throat was opening and then immediately called for food. Always at night she had something ready to take as soon as the opportunity offered.

OBSTETRIC MEMORANDA.

[UNDER this head, we shall, from time to time, as materials come to hand from correspondents, publish records of cases remarkable in themselves, or illustrating points of interest in obstetric practice, therapeutic or manipulative. We shall probably in this way preserve from oblivion the notes of very many useful and instructive occurrences in private practice; for the great obstetric experience is that—for the most part hitherto unwritten—of the great body of general practitioners throughout Great Britain. We will only ask those who may forward cases for record, to relate them with the utmost brevity, and equally to condense any appended remarks.]

PELVIC HÆMATOCELE APPEARING AFTER DELIVERY.

By A. B. STEELE, Esq., Lecturer on Midwifery, Liverpool Royal Infirmary School of Medicine.

A MIDWIFE of much experience requested me to visit a patient, whom she had recently delivered, to relieve her from retention of urine. The woman was of middle age, and mother of several children. Her labour, although a breech-presentation, was neither difficult nor protracted; the child was born alive, and she had no unfavourable symptom, except the inability to pass urine. She was relieved daily by the catheter by my pupil for three or four days; but, the retention continuing, I visited her for the purpose of a more minute investigation. I found a large fluctuating tumour springing from the left wall of the vagina, filling the canal completely. An exploratory puncture with a tenotomy knife gave vent to a sprouting stream of thin fluid, resembling venous blood, of a highly offensive smell. A probe passed into the opening failed to reach the bottom of the cavity. The next day I enlarged the opening and evacuated a large quantity of the same kind of fluid as before. The swelling was much decreased in size, and she was able to pass urine. In a few days I found the tumour had entirely disappeared, the patient informing me that the swelling had burst suddenly and "two quarts" of fluid had been escaped. I presume this to have been a case of pelvic hæmatocele, originating probably from a varicose condition of the veins of the Fallopian tube or broad ligament. Although numerous cases of this affection are recorded, I am not aware that it has ever been noticed by authors as occurring in connection with parturition.

RUPTURE OF FALLOPIAN TUBE(?): PERITONITIS: RECOVERY.

By G. G. STANGER, M.R.C.S.E, Consulting Surgeon to Nottingham Dispensary.

MRS. B., aged 34, married eleven years, had one child ten years ago. She enjoyed moderately good health until the present attack, which occurred suddenly on the 27th of August, 1868, whilst she was in the water-closet. She had felt a slight pain in the abdomen which induced her to go to the closet for relief, and whilst she was there the pain suddenly became most violent, accompanied with alarming syncope. I saw her in a few minutes and learned that she was about ten weeks advanced in pregnancy, and that she felt, during the act of defecation, "as if something had given way in her inside," and immediately the pain became most agonising. When I saw her she was bathed in a cold clammy perspiration, with a rapid thready pulse and all the symptoms of extreme collapse. I had her removed to bed. The abdomen seemed rather distended and acutely sensitive to the touch. There was no discharge from the vagina, and an examination *per vaginam* and rectum afforded no explanation of the symptoms. I ordered hot fomentations with turpentine, and administered repeated doses of brandy and opium to relieve the pain and syncope.

Dr. Ransom and Dr. Robertson saw her with me in the course of the morning, and we all agreed that the symptoms were those of perforation or rupture of some internal organ, and that a fatal result seemed inevitable. I saw her repeatedly during the day, and towards midnight was pleased to observe some indications of reaction. The pain was still very severe and the sickness most distressing, but the pulse had become more distinct and the cold sweat had given place to a comfortable warmth. For several days her condition remained very precarious. The catheter had to be passed repeatedly. The skin became deeply jaundiced, ap-

parently from the extension of the inflammation to the liver. On the third day there was a discharge from the vagina of a brownish colour and very offensive odour. On the fifth day the bowels were relieved by an injection—the opium having been continued up to that time. She declared that she could feel something loose in her belly and afterwards could put her finger on the spot where she believed it to have become fastened. The uterine discharge continued for two or three weeks, and for a long time she felt so much soreness and pain in the abdomen that she could not bear the slightest movement, but she gradually recovered and on the 9th of October was able to leave home.

I have not been able to meet with a similar case to the above where recovery has taken place. Dr. Davis, in his excellent work on Obstetrics, has collected a considerable number of cases of tubal and ovarian gestation; and, in some cases where they have grown to the full period, the child has become encysted and the patient has survived for many years and even borne children. A remarkable case of this was related in a recent number of the BRITISH MEDICAL JOURNAL by my esteemed friend Mr. H. Ewen; and, I myself saw one some years ago where the foetus was extracted seven or eight years after pregnancy—through the bladder. But in all the cases referred to by Dr. Davis, where rupture took place at an early period, death was the result. I attribute the favourable issue of this case, in some degree, to a strong constitution, and partly to the persistent use of small doses of opium and perfect rest of the bowels for several days.

REVIEWS AND NOTICES.

A SYSTEM OF MEDICINE. Edited by J. RUSSELL REYNOLDS, M.D., F.R.C.P.Lond., Physician to University College Hospital, etc. Vol. II, containing Local Diseases. 8vo. Pp. 990. London: 1868, Macmillan and Co. (Second Notice.)

IN our first notice of this large volume, we endeavoured to give an idea of the animus pervading it, by drawing a sketch of the treatment advised by each writer in the disease committed to his pen, and pointing out how far this was sanctioned by the pathology he had adopted, in respect of the General Diseases of the Nervous System. We propose to do the same now for the rest of its diseases—Partial Diseases, or those where the function injured can be assigned to a given part of the system.

In Simple Meningitis, Dr. RAMSKILL advises the adoption of the traditional practice of venesection to syncope, repeated as often as the symptoms return, and followed by the application of leeches behind the ears and to the temples, compression of the carotids, hard purging, mercurialisation, icing the head, and blistering the calves, until collapse and coma supervene; when stimulants and ammonia may take their place, and when a cap of blistering ointment applied over the whole skull has been known to rouse the patient. The termination of the disease is usually in death.

Tubercular Meningitis is described by Dr. GEE as an inflammation of the cerebral membranes, when excited by the acute deposit of tubercle, which is almost certainly fatal. Under that circumstance, he has "no doubt that leeches, active purging, blistering, ulcerating, and such-like measures, hasten the advance of death"; and, in hopes of having made a wrong diagnosis, he would support the patient with food.

The difference between the two physicians is evidently one more of natural disposition than of pathology. Both are excited by the same view of an impregnable fortress; the one to make violent exertions, the other to halt.

The articles on Hæmorrhage, and on Adventitious Products in the Meninges, afford little opportunity for comments on therapeutics.

Congestion of the Brain is a highly important complaint, because very amenable to treatment, and Dr. REYNOLDS evidently feels the responsibility of discussing it. His sentences have that epigrammatic style which is the result of thoughtful polish. He points out that there are two practically opposite states of body under which congestion may occur, general plethora, and vascular obstruction through weakness. As a specimen of the first, we may suppose a man of middle age, who has overstrained himself, or placed his head in some dependent position, attacked by violent convulsions, with turgescence of skin, bloodshot eyes, and full labouring pulse. In such a case, Dr. Reynolds would recommend venesection to eight or ten ounces. Even when, with general weakness, there is a hot head and flushed face, he would not object to cupping the nape. But when these two symptoms are absent, and the pulse feeble, small, or irregular, even a small abstraction of blood might be followed by the worst results. He advises icing the forehead and putting the extremities in hot water. After the temporary congestion of old people, he finds stimulants useful. This is in complete accordance with the