Lectures

ON

DISEASES OF WOMEN AND CHILDREN.

DELIVERED AT THE SAMARITAN HOSPITAL.

BY

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LECTURE II.

THE CONSEQUENCES OF ENDOMETRITIS.

GENTLEMEN,—In my last lecture I spoke of endometritis. To-day I pass on to the consequences of this disease upon the generative organs themselves; for time would not allow me to refer to those which affect more generally the system. I shall allude especially to the following—I. Mucous Polypi; II. Dysmenorrhœa; III. Occlusion of the Internal and External Os; IV. Physometra and Hydrometra; V. Displacements of the Uterus—Retroversion and Anteversion; VI. Hypertrophy of the Cervix; and VII. Sterility.

I. MUCOUS POLYPI. You will remember that, when I spoke of endometritis of the *body* of the uterus, I noticed the intensely red colour often observed in the lining membrane, due to villous projections of the mucous coat. That these projections should enlarge and develop in the same way as piles do, can be readily imagined; but I have verified the supposition. In the history of a case which you will find recorded in the *Obstetrical Transactions* (vol. ii, p. 123), the possibility of this change is almost substantiated. Dr. Tyler Smith has gone a step further; and he states that vesicular polypi are nothing more than Nabothian bodies which have become elongated instead of rupturing, and so project from the surface of the os uteri, and bleed as freely as though a small vessel were opened. If this view be correct, or whether, according to Robin, a Nabothian body be only a dilated tubular gland, we can readily understand the origin of mucous polypi within the uterine cavity as a result of local inflammation in a gland. These polypi are of two kinds—1. The *cellulo-vascular*; *i. e.*, those attached flatly to the mucous membrane, sessile, varying in size from a pin's head to a small pea, sometimes assuming an arborescent appearance, which are found generally within the uterine cavity, and chiefly on the posterior surface. They are very vascular, and bleed on the slightest touch, and so far resemble those vascular bodies found in the urethra. 2. The *cellulo-fibrous*. These are generally attached by a pedicle of a harder consistence, and are more frequently found within the cervical cavity, not very easily torn off, and which generally attain a larger size. The nature of these polypi has been very fully investigated by M. Charles Robin (*Archives Générales de Médecine*, 4ième série, No. xvii), and by M. Ferrier (*Thèses de Paris*, No. ci, 1855). According to their inquiries, we find in these same polypi all the elements found in the uterine mucous membrane—(a) Fibres of cellular tissue, generally less abundant on the surface than in the centre; (b) fibro-

plastic elements in sufficient quantity, nuclei and fibres, cellules very rarely; (c) an amorphous homogeneous mass, which abounds more than any other products; (d) capillaries in abundance; (e) follicular and tubular glands, the epithelium linings of which come away very readily; (f) some oil-globules, few in number; (g) epithelium of the cylindrical variety, destitute of cilia. M. Aran believes that, although the elements in these two varieties are the same, the exceeding vascularity of the former proves that their relative proportion varies greatly.

The presence of these bodies almost always gives rise to menorrhagia, either constant or periodical; in the latter case, the catamenia being very copious, and accompanied by clots. In many cases, the hæmorrhage proceeds from their external surface; this is more often observed where the polypi are soft and yielding. The slightest touch makes them bleed. Where cellulo-fibrous polypi exist, the menorrhagia seems rather to proceed from the surrounding mucous membrane of the uterus. Hence the advantage of opening freely the os by the hysterotome. This arrests the hæmorrhage, because the polypus no longer presses against and irritates the uterine mucous membrane. I have observed the same result to follow the use of the hysterotome in cases where there was no polypus, and where the menorrhagia was produced by a simple projecting fold of the inflamed mucous lining—a practical point not to be lost sight of.

Treatment. The same measures adopted in the case of the fourth variety of endometritis—first, dilatation by a sponge-tent, then the use of the uterine gouge with or without injection—are to be used here. Among injections, I prefer the tincture of the sesquichloride of iron, because it at once arrests the hæmorrhage. In a few days, a yellow muco-purulent discharge sets in, which usually disappears with rest and cold-water injections.

II. DYSMENORRHŒA often succeeds endometritis. Dr. F. Churchill (*Diseases of Women*, page 167) has remarked that uterine leucorrhœa persists during the intervals of menstruation in this species of dysmenorrhœa, and rarely in the neuralgic form. This fact proves the connexion between endometritis and this variety of dysmenorrhœa. It is, clear, however, that the disease may arise as well from inflammation or intense congestion of the whole organ. There is often super-added a neuralgic element, kept up by the local endometritis, as in analogous examples of irritable stricture of the urethra. This is proved by the great relief to all symptoms which follows a full anodyne. At first the pain may be extreme, and there are strong forcing efforts; but after a time all the symptoms gradually subside. The duration of these pains may vary from two to twenty-four hours, as if the spasm had only been relieved, and before any copious flow can have occurred to remove the inflammatory complication. With the cessation of all pain, the obstruction disappears. In many cases, however, there is considerable fever; and the ejection of a dysmenorrhœal membrane, either entire or in shreds, compared by some to croupy exudation, which proves that there has been plastic inflammation. The distinction between dysmenorrhœa due to parenchymatous uterine inflammation from that due to endometritis has not, I think, always been

clearly made out. The pain and fever are more marked in the former; in the latter, the leucorrhœa and spasm are always present.

The *treatment* of this affection is that of endometritis. Large doses of anodynes should be given, in addition to the local depletion. In severe cases, the hysterotome may be used with great advantage.

III. OCCLUSION OF THE OS, INTERNAL AND EXTERNAL. There are two varieties—the first or *senile*, in which the external os is closed; the second, or *intermittent*, where the internal os is chiefly closed.

1. The *senile variety* is commonly observed among very old women; and frequently, as all the uterine functions are in abeyance, it gives rise to no discomfort. Aran, however, has described a class of cases in which occlusion occurs in old women, and where painful symptoms are complained of. Sometimes the occlusion is due to unusual development and thickening of the mucous folds. It is more frequent when women have ceased to menstruate. A vague sense of fulness about the hypogastrium, irregularly colicky expulsive pains occurring at long intervals, are observed. On examination, the os is found enlarged, more or less congested, and tender. There is also increased uterine volume inferiorly. After a time, as a result of unusually violent expulsive pains, the closed os is forced open, a large quantity of muco-sanguineous or purulent fluid is liberated, and all the symptoms disappear. A cure generally follows after two or three days. Sometimes, however, the same painful symptoms, alternating with complete relief, keep continually recurring. In some, the pain is exceedingly violent, so as to make life very miserable. This variety differs from the following in the entire absence of any signs of pregnancy. Whether this is due to the fact that the accumulation is confined to the cervical cavity, or to the abeyance of all specific uterine function, I know not.

2. The *intermittent variety*, as it occurs in younger women, is generally due to obstruction at the internal os. At any rate, the accumulation extends to within the uterine cavity. Beside the general symptoms before described, we have superadded pseudo-signs of pregnancy. The cervix yields to the touch the peculiar velvety feel. There may be some dulness above the pubes. The os may be slightly patent; but the passage of the sound is obstructed from a quarter to half an inch up, as if by the ordinary mucous plug of gestation. There is absence of menstruation. The breasts are full, areolæ large, follicles well marked. Such cases are very difficult to make out; indeed, occasionally nothing but the progress of it will clear up the doubt. There are, however, some important points to notice. The position of the woman, if unmarried, and the character good, will make you hesitate. The breasts are not only large, but often much hypertrophied. Now, so far as my experience goes, I do not remember a case of pregnancy where this condition existed—certainly not in the early months. Then the areolæ of the two sides differ; one is darker than the other. The enlarged follicles on both sides are not symmetrically disposed. It is, again, those near the nipple which are large; not those on the outer rim of the areola, so commonly observed in pregnancy. Again, the breasts discharge sometimes a drop or two of serous milky-looking fluid when the nipple is compressed. The blue colour of the vulvar

opening is not present. As the case progresses, from two or four weeks to three or four months, but usually before the three months are accomplished, the patient's condition becomes no longer doubtful. She will tell you—and this usually occurs after some exertion—that she has felt something give way in her, which was followed by a copious leucorrhœal discharge, and which, as in the senile variety, removed all painful sensations. The same series of symptoms may in a few days recur, or a complete cure may follow. Generally speaking, the duration of the symptoms, if they recur, is not so long, and the breasts gradually become smaller. The symptoms of pregnancy are less marked each time, till finally a menstrual epoch is perfected, although generally with much pain. Dysmenorrhœa, in fact, is the disease left behind.

There are two diseases between which and this last affection the diagnosis may be difficult. One is the ulcerative form of fundal endometritis, spoken of in my last lecture. The sound here would clear up the doubt, only that it is not wise to use that instrument where there is suspicion of pregnancy. Time, however, coupled with the periodical discharge of pus and remission of all the symptoms, will develop the case. The other disease is hydrometra; but the differential diagnosis will follow in the sequel.

IV. PHYSOMETRA AND HYDROMETRA. There are two forms of uterine disease which are also due to occlusion of the os—*physometra*, where air is contained in the cavity; and *hydrometra*, where a watery fluid occupies its interior.

Dr. Churchill attributes *physometra* to subacute or chronic inflammation of the lining membrane; and we know that mucous membranes in an unhealthy state secrete gas. Occasionally the closure of the os is only partial. Once a sufficient quantity has been secreted, it escapes suddenly from emotion or a uterine contraction, giving rise to an explosive sound resembling that which follows the escape of flatus from the rectum. This is a very common affection. Where the os is, however, completely closed, the air will accumulate, and *physometra* is established. P. Frank mentions two cases. The *post mortem* examination of one revealed an ulcerated uterine lining, a hardened os, corroded internally. The gas contained was fetid. The orifice in the second case was closed by a polypoid mass.

The symptoms observed in these cases are those of pregnancy. In most instances, milk is secreted. The uterus is also large. That there is no pregnancy is, however, at once made out by the tympanitic state of the abdomen.

Hydrometra, the twin affection to the latter, consists in the retention of fluid matter within the uterine cavity, instead of air. The fluid is secreted idiopathically by the lining membrane, or symptomatically by an ulcer upon it. In the former case, it is usually serous, albuminous, or mucous; in the latter, purulent. The quantity may vary from fifty to a hundred and eighty pints. I do not dwell on this form of disease; I never saw but one case, and that was a doubtful one. The symptoms are very similar to the two classes before noted, at least at first. You will find two examples recorded in Dr. Churchill's work. In Dr. Thompson's case, the patient died after amputation; in her eight quarts of fluid, of a dark brown colour, and coagulating by heat, were found. The mucous lining appeared

healthy, but the os was obliterated. In Dr. Coley's case, the patient died of peritonitis and purpura; and three pints of dark coloured, thin, and offensive fluid were found. The uterus was thinned to the consistence of a bullock's bladder. The os was closed by a large tuberculous mass about the cervix, and a plug of mucus. The entire lining membrane was softened, in many places ulcerated.

The treatment in these last three diseases is the same. The os must be opened to give free exit to the uterine contents. The opening may be made by a cannula; but some preliminary precautions should be taken. In one case I treated, where occlusion of the os was due to a severe instrumental labour, and in which, moreover, the uterus was retroverted, I pulled down the uterus by a vulsellum, so as to get the cervix and fundus in the same axis; and, using a very fine trocar, penetrated to about a line or two every day, keeping open the passage made towards the uterine cavity by a plug of wood covered with cotton wool, and secured in its place by a large plug of cotton behind; but in this case the adhesions extended about half an inch up the cervix. When once the cavity is entered, dilatation by a sponge-tent or the hysterotome is an easy matter. It is wise in these cases to keep the new opening made patent by a plug, changed daily, till the proper menstrual epoch occurs, when all danger of reclosure ceases.

[To be continued.]

Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

ST. MARY'S HOSPITAL.

FATAL CASE OF GROUP IN WHICH TRACHEOTOMY WAS PERFORMED.

By EDWARD PARKER YOUNG, Esq., House Surgeon to the Hospital.

—, aged 4½, was sent to the hospital by Dr. Handfield Jones, on Feb. 16th, 1862, to have tracheotomy performed, as the symptoms were very urgent, and as tracheotomy appeared the only chance of saving the child from death.

It appeared that the child had been unwell for three or four days, and had been gradually getting worse up to the time of its admission; for when it was first admitted the face was livid, the head thrown back by every inspiration, the pulse quick but full, the alæ of the nostrils were expanded; and the child presented all the symptoms of impending suffocation. Tracheotomy was, therefore, performed; and it was with great difficulty that the tube was inserted, on account of the enormous venous hæmorrhage. When the trachea was opened, blood was drawn in, which was sucked out by the mouth of the operator, and nearly an hour and a half elapsed before good breathing was established through the tube. After this time, the breathing became very good, and the child took nourishment, and slept at intervals, till the next day, twenty hours after the operation; when alarming symptoms came on, the breathing became more laborious, the respirations quickened; the child appeared very restless, and vomited frequently; and expired twenty-eight hours after the operation.

A *post mortem* examination showed that the lungs were collapsed and pneumonic, and contained very little air. The trachea was lined by a false membrane, which was loose, and extended into the bronchi and their ramifications. As this state of parts explained the cause of death, the examination was not proceeded with further.

The remedies in this case were emetics, salines, and expectorants; but the *post mortem* examination clearly showed that it was impossible that the child could have survived with the respiratory apparatus in such a disorganised state.

WESTMINSTER HOSPITAL.

MEDIAN LITHOTOMY ON A BOY: RECOVERY.

Under the care of B. HOLT, Esq.

MEDIAN lithotomy has been practised occasionally during the last five years at many of the metropolitan hospitals; but the operation has been confined for the most part to adult patients. Mr. Holt has, however, performed it on several occasions upon children, with the best results. The case here recorded is interesting from the fact that, finding some difficulty in withdrawing the stone (which was of considerable size), Mr. Holt made a small incision in the side of the prostate, which allowed of the immediate withdrawal of the calculus, and was productive of no injury to the patient; and it serves to illustrate the fact that it is tearing rather than cutting which gives rise to inflammation and abscess about the prostate, as was so strongly insisted upon by Mr. H. Thompson in his Lettsomian lectures.

In this case, as in all Mr. Holt's other cases, the urine did not pass involuntarily through the wound, as it usually does after the lateral operation; but the patient was able to hold it for some hours, although in the act of micturating the urine came through the wound for the first few days.

John Stenson, aged 16, but small for his age, and of a pale, flabby appearance, although he has always lived in the country, was admitted into the Westminster Hospital, under Mr. Holt's care, with stone in the bladder, on Jan. 24th, 1862. He had suffered from symptoms of stone since birth; and four years ago a surgeon sounded him, and recognised the presence of a calculus; but no operation was performed, because it was supposed that the boy was labouring under kidney-disease.

Mr. Holt, having detected a stone, proceeded to perform median lithotomy on the 11th February, 1862. After opening the membranous portion of the urethra, Mr. Holt always passes a curved steel probe with a handle along the staff into the bladder, and then introduces the forefinger between the probe and the staff, upon both of which traction is made. Thus dilatation is accomplished with ease and certainty, both instruments being withdrawn when the finger reaches the bladder.

The stone was readily seized with the forceps, and withdrawn for a short distance; but it was found impossible to draw it through the neck of the bladder; nor could the forceps be disentangled, so as to remove it with the scoop. Mr. Holt, therefore, introduced a straight probe-pointed bistoury, and divided the tissues slightly in a lateral direction, when the stone was immediately and readily extracted. The calculus was an inch and three-fourths in length, an inch and one-eighth in width, and seven-eighths of an inch in breadth, and weighed six drachms, two scruples, and six grains. Its composition was phosphatic externally; but upon section there was found a mulberry (oxalate of lime) calculus, of the size of a hazel-nut, imbedded in the centre of a mass of phosphates.

The boy had a good night, and was able to hold his urine; when he passed it, however, it all came through