LABOUR IN A PRIMIPARA COMPLICATED BY A LARGE URETHRAL CYST AND BY PROLAPSUS UTERI :

DELIVERY BY CEPHALOTRIPSY: SUBSEQUENT OPERATION AND
RECOVERY.

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ON November 12th, 1880, in consultation with Dr. Young of Erdington, I saw Mrs. S., aged 21, who was daily expecting her first confinement. An examination revealed a huge mass protruding from the vulva, which consisted of a greatly hypertrophied cervix; and in front of it a large soft tumour, which I took for a cystocele. Behind the prolapsed mass, and lying in a flaccid condition against the posterior vaginal wall, was a perfect hymen of the typical sickle shape. The pelvis seemed of average size, and there was nothing in the general state of the patient to cause anxiety. The os uteri easily admitted a finger; and with some trouble (from the extreme length of the cervix) I was able to recognise the head presenting. The membranes were entire. After consideration, it was determined to wait and watch until labour should come on, in the hope that gradual dilatation would occur, and the delivery end naturally. Labour began on the evening of the 21st, and, although the pains were strong and regular, no advance was made; therefore Dr. Young asked me to see her again at 11 a.m. the next day.

At this time the os was but little larger than above described, and presented a very peculiar appearance, being perfectly annular, and surrounded by a ring of white, shining, gristly-looking fibres. Immediately above this, the cervix was encircled by large veins, with dilations almost hæmorrhoidal in their character. The membranes had ruptured some hours previously, and the head could be felt at the brim, but was not affected by the pains, which were of moderate length and force.

As the patient showed signs of exhaustion, it was decided to attempt delivery without further delay; she was, therefore, chloroformed, the bladder emptied, and with great caution I endeavoured to overcome the rigidly contracted os. After considerable effort, I was able to get in three fingers, when a smart gush of blood warned us that the vascularity of the cervix had not been over-estimated.

Two courses were now open to us: the first and easiest was to make two or three small incisions, and then deliver by forceps; the second was to treat the constriction as being insusceptible of dilatation, and to deliver by lessening the volume of the foetal head. After earnest consideration, we decided upon the latter alternative; because, although in ordinary cases the incisions through the os contract so much as to be unimportant, and the risk from hæmorrhage is, therefore, small, yet in the present instance, from the altered condition of the tissues, and especially on account of the great vascular turgescence, we felt that the danger would be very considerable. The cranium was, therefore, perforated and crushed by a small cephalotribe, after which there was no difficulty. She went on well; but the tumour anterior to the cervix began to increase, and there was some pain. On the tenth day it ruptured, and there was a free discharge of puriform fluid, after which convalescence was uninterrupted. Neither during pregnancy nor after labour was there any incontinence of urine, or other trouble connected with the bladder.

The prolapse of the uterus had occurred quite gradually, so gradually, indeed, as to push aside the hymen without rupturing it, and so entirely without inconvenience that the poor woman did not know until her marriage that "she was different from other women." Her menstruation was always regular, and her health had always been robust. The cause of the procidentia was, no doubt, lifting and carrying heavy weights whilst very young. Six weeks after her confinement she called upon me, at Dr. Young's request. I found the womb still prolapsed, but the condition of the os and cervix was nearly natural. The tumour which I have described lay in a flaccid state upon the anterior vaginal wall, or rather hung from it, and a large hole, admitting my finger, still remained. A sound passed into the bladder showed nothing abnormal, and she could hold her urine from morning to night.

When the cyst was itself examined, by the finger or sound, I could merely make out a large empty cavity between the bladder and uterus, and apparently communicating with nothing.

She was afterwards admitted into the Women's Hospital, under my colleague, Mr. Lawson Tait, who has kindly given me the following report of her then condition, and the treatment adopted.

"On examining the patient, there appeared, protruding from the vulva, what looked exactly like a cystocele, but which had the singularity of having a hole, about the size of a shilling, punched (as it were) into its most prominent part. The finger was admitted into a large pear-shaped cavity, having its apex directed up towards the urethra; and it was ascertained that it opened into this canal by a small aperture, not larger than a hemp-seed. When the bladder was injected full of milk, and the external meatus forcibly closed, some of the milk found its way into the sac. The cyst ran backwards as far as the cervix uteri, and seemed to double up on each side of this structure into small pockets. I laid the whole cavity open from the urethra to the cervix, dissected out the mucous membrane over the whole surface, and shortened the remaining flaps of the vaginal surface, so that they met correctly in the middle line, when united by suture.

"The removal of the cyst-wall from the cervix was difficult, and the hæmorrhage was profuse and troublesome. The patient made a perfectly uninterrupted recovery, and all traces of the abnormal cyst have disappeared, and the protrusion is cured.

"I have no doubt this case is an illustration of the rare form of congenital malformation, which, I believe, I was the first to describe in the *Lancet* of January 9th, 1875. I have seen three such cases, and in two of them the distress of the patients was very great, on account of the decomposition of the urine escaping into the sac, and there becoming ammoniacal and purulent. In the present instance, this was obviated by the hole in the depending part of the cyst; but it is perfectly certain that urine in considerable quantity must have passed through the cyst.

"The size of the sac in this case was probably as great as that of the bladder, and it was probably five times as large as in either of the other cases upon which I have operated. In all three cases I dissected the cyst out, and found the aperture into the urethra to be very small, being, as I have said, about the size of a hemp-seed.

"I think the relations of the cyst, in Dr. Hickinbotham's case, prove its origin to have been congenital, as it is perfectly impossible to imagine that a cyst could develop itself from any structure lying between the urethra and the cervix uteri, so as to have relations so intimate with both, as existed in this case. In all three cases the cure by operation has been complete."

I may just remark, upon this note of Mr. Lawson Tait, that his hypothesis that the absence of symptoms was due to the hole in the cyst, could only be correct after the labour, since before that there was no hole. I think a more likely explanation is, that the opening into the urethra was protected in some way by a valvular fold of the mucous membrane, which was sufficient, until there was obstruction in front, and more pressure than usual from the bladder. These conditions no doubt obtained during the labour, and then for the first time urine found its way into the cyst, whose contents had previously been unirritating and harmless.

Since the above was written, the patient presented herself at the hospital, complaining of a "lump in her stomach which gave her great pain." Her temperature was 102°, and pulse quick. She was therefore admitted, and examination showed a tender tumour above and to the right of the umbilicus, which I believed to be a movable kidney. A day or two of entire rest in bed seemed to set matters right; the tenderness and fever disappeared, and she was again sent home.

A CASE OF LABIO-GLOSSO-LARYNGEAL PARALYSIS.

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IN the JOURNAL for December 3rd, 1881, a case of "Brain-Disease simulating Bulbar Paralysis" is reported as brought before the Manchester Medical Society by Dr. Ross of that city. The primary disease does not appear to have been in the medulla oblongata, but in the central ganglia, and on the left side, "a streak of secondary degeneration" was traced from the diseased corpus striatum (the right was also affected), "through the crus, pons, and anterior pyramid of the medulla oblongata." Moreover, "these degenerated fibres occupied the internal margin of the anterior pyramid of the medulla, and appeared to bend back in the median raphe to reach the bulbar nuclei of the opposite side." It is to be noted that this man had an attack of hemiplegia and aphasia eighteen months previously.

This striking and, as far as I know, unique case, set me thinking whether one which came under my observation in the early part of last year, and which till now I have associated in my mind with those cases described by Dr. Wilks (*Diseases of the Nervous System*), some of which had hæmorrhage into the medulla oblongata, ought, perhaps, after all,