nancy, and also to the physiological infarction which has been shown by Eden⁷ to occur normally towards the end of pregnancy.

I also hope to show in another communication that the phagocytic action of decidual cells is not exercised under abnormal conditions alone, but that it plays a part in the development of the normal placenta and membranes. For in every placenta those portions of the chorionic villi which become embedded in the decidua undergo the same changes as do the villi of a retained dead ovum. First they lose their foetal blood supply, next large decidual cells of the serotina crowd round them, destroy and remove their epithelium, and form round the remains of the stroma a delicate connective tissue.

Again, those chorionic villi which do not enter into the formation of the placenta leave but few traces on the outer surface of the developed membranes of the ovum. For when the placenta begins to take its shape, changes in the foetal circulation destroy the blood supply of those villi which are not in the placental area. Soon after, the decidua vera unites with the decidua reflexa, and the decidual cells of these structures attack the now non-vascular villi, and help to reduce them to the remnants which represent them upon the developed membranes of the ovum.

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A CASE OF OLD PELVIC ABSCESS AND ACCIDENTAL HÆMORRHAGE IN A PREGNANT WOMAN.

By ROBERT JARDINE, M.D. EDIN., M.R.C.S. ENG.,
F.F.P. & S. GLASG.,

Physician to the Glasgow Maternity Hospital.

CASES of pregnancy complicated by an old pelvic abscess are so rare that I feel justified in publishing the following one, more especially as it was further complicated by accidental hæmorrhage.

Mrs. C., aged 34, 6 para, was admitted to the Glasgow Maternity Hospital on April 20th, 1897. She stated that she had never been a very strong woman, but had never had any serious illness. There had been nothing remarkable about her confinements except that after her third she had had an attack of "inflammation of the womb." After that for six months she had suffered from weakness, pain in the back, and "whites." She gave no history of ever having had any discharge of pus from the vagina, but gave a confused account of having noticed a swelling in the abdomen midway between the umbilicus and pubes about three years ago after her fourth confinement. She stated that for the last month or so she had noticed that this swelling was rapidly increasing in size. Her last menstrual period had been towards the end of March, and it had been scantier than usual. Before that she had been quite regular. Eleven days before admission, after retiring to bed, she was seized with a sudden discharge of blood from the vagina, which lasted about nine hours. It came in a gush without any warning, and was accompanied by a little pain, dull in character, over the lower part of the abdomen, if anything more severe on the right side. She felt feverish and shivered at times, but there was no severe rigor. The blood was dark in colour, with some clots but nothing else. She got up in the morning and did her usual housework. There was no discharge during the day, but on retiring to bed the next night the discharge recurred in smaller amount. Up to the date of admission she had more or less discharge each night, but none during the day.

Condition of Patient on Admission.—She is weak, and very anæmic. There is evident pulsation in the veins of the neck, but no cardiac murmur. There is an abdominal tumour, central in position, measuring about 7½ inches vertically from the pubes, and 9 inches transversely in its widest part. The swelling is freely movable from side to side. It feels soft and elastic. There are no contractions evident; no foetal heart sounds, but a distinct uterine *souffle* is heard. No foetal parts can be felt *per vaginam*; the cervix is thick and soft, and the external os admits the tip of the finger. The internal os is completely closed. The uterus is enlarged, and lying well forward, and feels doughy and soft. In the anterior fornix, at the junction of the body and cervix a distinct groove is felt. This distinct groove was also noticed by Dr. Edgar, the assistant physician, who kindly examined her for me. We thought it was caused by the body of the uterus lying so far forward that it formed an angle with the cervix. At the *post-mortem* examination this was shown to have been the track of the sinus which we had felt. After the examination there was a little dark watery discharge. A douche was given.

The diagnosis presented considerable difficulty. She was evidently

pregnant, but from her menstrual history she had only missed one period¹ and the one before that had been very scanty, so that, going by the history, she could not be more than two months gone. The uterus by its size would indicate at least between six and seven months. I was inclined to think we had to deal with a hydatid mole, but could get no indication of any vesicles having been passed. She was put upon small doses of ergot, strychnine, and iron, and a liberal diet.

Next day there was a slight oozing of serum. The catheter had to be passed. She said she was feeling stronger. Her temperature was practically normal. She did very well until May 3rd, when some dark-coloured blood began to come away. In consultation with my colleague, Dr. Black, I decided to dilate the cervix with Hegar's dilators, and explore the cavity of the uterus. Under chloroform I pulled the cervix down and steadied it with forceps, and dilated until the finger could be introduced. The lower part of the uterine cavity was full of black clot, but no foetus could be reached. As the cervix was still full length I could not reach any distance into the cavity. Some of the clot was washed out, and a small Barnes's bag introduced. A firm binder was put on. The forceps had torn the mucous membrane of the anterior lip of the cervix transversely. The walls of the cervix were intact. The dilatation was done about 1 P.M. At 11.30 P.M. I removed the bag, and found the cervix was shortened considerably. On dilating further with my fingers, I found there was a foetus in its bag of membranes attached to the fundus of the uterus. More than half of the cavity was occupied by blood clot. I ruptured the membranes and drew the foetus down. The amount of liquor amnii was small. Dr. Black then dilated further, and delivered the body of the foetus, breech first. The head came off, but was caught in the fingers and removed. The placenta was detached from the fundus, and removed. It and the membranes seemed healthy, and showed no evidence of hæmorrhage. The uterus was thoroughly washed out, and it contracted firmly. The anterior wall of the cervix was found to have been lacerated. This had evidently happened during the dilatation with the fingers and delivery of the foetus, but we could not understand why it had given way.

A hypodermic of ergotin was given. The patient did not show any signs of collapse. Her temperature was 100° at the time of delivery. It had been 99° and 99.8° the two days previous.

The foetus had been dead a short time, but was not macerated to any great extent. It was fully four months developed.

May 4th. Temperature in the morning was 102°, and in the evening 102.6°. She complained of nothing except feeling feverish. The vagina was washed out, and a good deal of *debris* came away, but the discharge was perfectly sweet. There was no distension. She was frequently fed with milk and beef juice. Her pulse was about 100, and soft. She was given 10 gr. quinine.

May 5th. Patient has not been so well to-day. She has suffered from sickness and retching, which causes pain all over the abdomen. Temperature 101.2° in the morning and 101.4° in the evening. Pulse varying from 100 to 120, and very soft. Large doses of bismuth relieved the stomach symptoms for a few hours, but in the evening she rejected everything. Rectal alimentation was commenced, and a mustard leaf applied over the stomach. Small pieces of ice dipped in brandy were given. A half-grain morphine suppository was inserted. There was no distension of the abdomen. The vomiting ceased during the night, and she was fairly comfortable.

May 6th. She was much weaker to-day, and although she has been freely stimulated the pulse was not improved in strength. The temperature in the morning was 99°, and in the evening 101.4°. The nutrient enemata were continued all day, and she had brandy and egg flip by the mouth. At midnight she had improved a little.

May 7th. She was much weaker, and could not be roused. Temperature 100°. She gradually sank and died at 3.20 P.M.

Post-mortem examination report by Dr. R. M. Buchanan.—The lungs were hyperæmic, and left one slightly adherent. They both showed healed tuberculous lesions at the apex. In the heart there was slight thickening of the aortic cusps, and also along the base of the mitral curtains. Abdomen.—The lower fringe of the omentum lies between the uterus and the bladder. It is hyperæmic and slightly glued to the part, but there is no naked-eye appearance of exudation. In this situation there is a small amount of stringy fibrin associated with a very small amount of an opaque yellow fluid. The liver is very pale, and presents the appearance of fatty degeneration. The spleen is slightly enlarged and dark coloured. The kidneys show the character of cloudy swelling. The stomach and small intestine appear normal. The caput cecum is firmly bound down in the right iliac fossa, and the vermiform appendix lies along its inner aspect in a direction upwards and inwards. When the caput cecum is pulled forward, comparatively empty, is exposed. The cavity extends upwards as far as the crest of the ilium, where it is not limited by a very definite wall, downwards and inwards over the right side of the bladder by means of a series of sinuses. Purulent infiltration of the cellular tissue extends downwards as far as Poupart's ligament and round the right side of the pelvis. The contents of the pelvis are now removed *en masse*; the rectum appears normal; the posterior aspect of cervix and uterus is opened by a median incision. This displays a longitudinal tear in the cervix anteriorly continuous through the whole length and thickness of the wall into an abscess cavity. This cavity appears large enough to admit a hen's egg, and is found to be continuous with the sinuses and cavities above described. The suppurative process has invaded the cervical tissue to some extent, and has passed through it by a short sinus about ½ inch in diameter and ½ inch in length just within the external os anteriorly. It also appears to have perforated the cervix at the upper end of the tear. The internal surface of the uterus is covered with a greyish purulent exudation. No bacteria were found in the blood of the jugular vein on microscopic examination.

The cause of death seems to have been exhaustion, as there was no evidence of septicæmia. The discovery of the abscess was a complete surprise to me, as nothing in the patient's history pointed to its presence. The indefinite history of the swelling in the abdomen did not indicate anything pointing to an abscess in the right iliac fossa, as she distinctly stated that

it was central. The increasing swelling she had observed for the last few weeks had undoubtedly been the uterus. One can hardly suppose the abscess had formed there when she had the so-called attack of inflammation after her third confinement, as her fourth and fifth pregnancies and deliveries had been normal. It is a curious circumstance that so large an abscess could have discharged itself without her having been aware of the pus coming away. The opening was very small, and its being within the external os would tend to make it ooze away slowly. The position of this opening accounts for our not seeing it when the cervix was exposed during the dilatation. The reason why the anterior wall of the cervix tore was made plain at the *post-mortem* examination. The thin partition between the cervical cavity and the sinus had given way.

A careful exploration of this tear would have led to the detection of the sinus, but nothing would have been gained as regards the result of the treatment. No operation would have been of any avail.

The reason why no hæmorrhage occurred during the day was, I think, due to the fact that the sinus so weakened the cervical wall at its upper part that the weight of the uterus while she was up caused an acute bend at the junction of the body and cervix, and thus closed the cervical canal.

Last year I saw a *post-mortem* examination on a somewhat similar case in the hospital. The patient was admitted under Dr. Oliphant's care in a very exhausted condition. She was a primipara, with a slightly contracted pelvis. She had been in labour for a considerable time, and several attempts had been made to deliver her by means of forceps by two medical men before sending her into the hospital. Craniotomy was done, and the child easily extracted, but she died in a couple of days.

At the *post-mortem* examination an abscess cavity was found in the left broad ligament. A tear in the left side of the cervix opened into a channel communicating with the abscess cavity. This sinus opened into the vagina by a small orifice in the posterior lip of the cervix. Her mother could give no history of her ever having had any illness pointing to such a condition of affairs.

Both of these cases illustrate how important it is to have a *post-mortem* examination in all fatal puerperal cases.

I am indebted to my late resident, Dr. Forbes, for the careful notes of the case.

SOME ILLUSTRATIVE CASES IN GYNÆCOLOGICAL SURGERY.

By ROBERT O'CALLAGHAN, F.R.C.S.I., Etc.,

Late Surgeon to the Carlow Infirmary, and to the Chelsea Hospital for Women.

CASE I. Abdominal Hysterectomy for Large Myoma.—Mrs. H., aged 49, was sent to me in May, 1897, by Dr. Clement Godson. She gave the following history: Owing to considerable loss she consulted Dr. Godson in 1893, for which he treated her successfully. For the past three years she had noticed a lump in her abdomen, which gradually increased until the last six months, when she began to have great irritability of the bladder, and frequent desire to micturate. Her periods became very profuse, lasting ten days to two weeks, and between these she had a watery discharge which required the constant use of a diaper. She presented a very bloodless appearance, and was very weak. On examination I found a large oedematous myoma rising as high up as the umbilicus, but uniform in growth, and about the size of a six months' pregnancy. I advised operation, and at once, as it was quite evident that if she were left much longer in her existing condition operative interference would become impossible. I performed hysterectomy on June 11th (kindly assisted by Dr. Clement Godson), Drs. Fagge and Scholtz, Mr. Hurry Fenwick, and others being present. The patient made an uninterrupted recovery, and left the Home in five weeks, already much improved in health. This is, I consider, one of the typical cases which justify mutilation so irreparable as hysterectomy, and the risk which such a serious operation must always involve; it is in striking contrast to the many excuses which are now made for so-called total hysterectomy.

CASE II. Vaginal Hysterectomy for Epithelioma of Cervix.—Mrs. M., aged 36, was brought to me by Dr. James Donelan in February, 1897, with a history of interperiodic losses since February, 1896, but during the previous three months bleeding had become profuse, was seldom absent, and necessitated the constant wearing of a diaper. She had also great irritability of the bladder. I found the uterus fixed on the left side, and a small growth protruding from the cervix, which bled freely; no foetus. Before giving a definite opinion, I curetted the uterus and removed the growth, under ether, next day. Dr. Donelan had it microscopically examined, and it was pronounced to be epithelioma. Dr. Granville Bantock saw her in consultation with Dr. Donelan and myself on March 10th, to decide upon the advisability of further operation. I pointed out the marked infiltration of the left broad ligament with the disease and slight cachexia. Dr. Bantock held, however, that the patient would be much more comfortable after operation, though holding out no hope of prolonged life. She decided upon operation, and I removed the uterus with great difficulty, owing to advanced disease. The left broad ligament gave much trouble, being very friable, and the ligatures cutting through time after time. In addition to this, the bladder wall was fixed and required very careful handling. I had the invaluable assistance of Dr. Bantock in the most difficult case of the kind I have experienced. The bladder gave some trouble for ten days, but otherwise convalescence was uninterrupted, and the patient left for the seaside in a month.

CASE III. Removal of Appendages for Double Pyosalpinx.—Miss M., aged 22, was a patient of Dr. Morgan Richards, who attended her a year previously for an attack of acute peritonitis. She sent for me in September, 1897. I found her suffering from localised peritonitis of left side: the temperature was 102°, and she was in considerable pain. On vaginal examination, which was very painful, I found acute tubal mischief, with cystic disease of left side, and marked tubal disease on the right side; the uterus was completely fixed. Dr. Granville Bantock saw her with me ten days afterwards, when by suitable treatment the temperature was going down, and agreed with me that the only treatment advisable was complete removal of the appendages, which were utterly useless, and a source of great danger to life. The patient drifted away, and after consulting many specialists in London, returned to say that the general consensus was against operation. After examination again, I reiterated my previous views and advice, and said that when she came and told me that she wanted the operation I would do it, as I knew that time would force it upon her. She then consulted Sir John Williams, who agreed with the necessity of operation. This advice, combined with another acute attack of pain, sent her back to me, and I removed the appendages with the greatest difficulty; the cyst in the left ovary was ruptured in trying to extract it. Both tubes and ovaries were embedded in a mass of old adhesions, and were very hard to bring up and tie off. Dr. Bantock gave me his kind and invaluable help in this case also, Drs. Richards and Wood being present. I washed out the abdomen with water at a temperature of 110°, and drained with Bantock's glass tube, which was removed on the third day. The patient made an uninterrupted convalescence, and left the Home in three weeks.

REMARKS.—I have much pleasure in selecting these 3 cases from my year's work to report, because I think they are all interesting to both surgeon and practitioner, and are undoubtedly cases which demand operation. In Case I the myoma was simply a large sponge of blood, which medicinal treatment had failed to squeeze, and the patient was slowly bleeding to death. In Case II the point is that the patient was saved a great deal of distress from profuse discharges, menstrual and fetid, as she was only 36. Case III illustrates a form of tubal disease which had got far beyond the stage of palliative treatment, and the condition would have ended sooner or later with an acute attack of general peritonitis.

PRESENTATION.—Dr. Thomas Easton has, on the occasion of his leaving Stranraer, been presented with a silver salver bearing a suitable inscription, accompanied by a cheque representing nearly £100. The presentation was made at a cake and wine banquet presided over by Provost MacRobert.