A CASE OF PLACENTA PRÆVIA AND RUPTURE OF THE UTERUS: RECOVERY.*

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THE following case is instructive from several points of view:

Mrs. F., aged 45 years, had had twelve previous full-time pregnancies and one miscarriage. Her previous confinements have been normal, except that she has always lost a considerable quantity of blood. I was summoned on the evening of December 6th, 1898, and found that the patient had been losing blood continuously during the afternoon, though not to any great extent. There had been no true labour pains. On examination the os was found very high up, the finger could just be introduced within it and could detect placental tissue, the head lying above. On realising the state of matters I sent for Dr. Wise, who kindly administered chloroform for me. I then digitally dilated the os till the hand could be passed through, occupying about a quarter of an hour in so doing, brought down a foot, and delivered a living child. On introducing the hand to remove the placenta I found the uterus ruptured, my hand passing readily into the peritoneal cavity. The rent was evidently on the posterior aspect of the uterus, and low down, as I had to withdraw my hand and pass it again forwards and upwards into the body of the uterus to remove the placenta, which was now lying free there. The loss of blood had not been excessive, and none occurred, at least externally, after delivery was effected, but the patient was by this time extremely collapsed and apparently moribund. She was very pallid, with sighing respiration, and no pulse could be felt at the wrist. However, she was surrounded with hot bottles, ether was freely injected and reaction shortly set in, so that after the lapse of an hour the patient was quite conscious, with good regular pulse. When seen four hours later the rally was fully maintained. On the following morning I found that the patient had slept slightly; she had no abdominal pain or tenderness; there was no elevation of temperature. The pulse was 80, regular, and of fair tension.

I need not go into details of the subsequent history of the case. The highest point reached by the temperature was 100.8° F., the pulse never exceeded 102. The patient complained slightly for some time of pain in the left iliac region, and there was slight tenderness here on pressure. The case progressed steadily, and the patient was allowed up on December 25th. My last note was taken eleven weeks after the labour. "The patient makes no complaint except that her strength has not fully returned, and she is not fit for her household duties, but is about all day and able to go out." I have not seen the patient professionally since this date, but frequently meet her in the street apparently in good health.

There was practically no treatment followed. The patient was fed regularly and carefully, and her appetite throughout was good. With the object of doing nothing to disturb the union which had taken place the bowels were kept locked for week. During the same time douching was avoided for the same reason. Douches of biniodide of mercury were then employed as the lochia were very slightly offensive.

This case is worthy of comment in that the patient recovered so uneventfully from the double complication of placenta prævia and rupture of the uterus. I find, however, on hastily looking up the literature of the subject, that recovery after uterine rupture is not so rare as one might imagine. The opinion has indeed been expressed that cases may not infrequently pass unnoticed and be labelled as peritonitis or cellulitis where this is the real lesion. I have been able to find records of 13 other cases in British literature, and in some of these the recovery was even more uneventful than in my case; thus I find "return to occupation in six weeks;" "quite well in thirty-seven days;" "recovery in a month." Norris gives the percentage of cases of recovery thus: Complete rupture of uterus without treatment, 20 per cent.; with drainage, 36 per cent.; with laparotomy, 44.7 per cent.

Undoubtedly laparotomy is the ideal treatment of this complication, but the circumstances and surroundings of the patient may render this impossible, and such cases as I have recorded serve to show that even then the outlook is not altogether hopeless.

With regard to placenta prævia, this case illustrates the danger of too rapid delivery. My impression at the time was that the rupture was caused by the passage of the head, and that the accident was assisted by an atonic condition of the uterine wall induced by the frequent pregnancies. In another case I should, after bringing down a leg, leave the case to be completed naturally. This involves the sacrifice of the child, but in such a complication as placenta prævia this is a secondary consideration.

* Read before the Bath and Bristol Branch of the British Medical Association.

A CASE IN WHICH A PULMONARY ABSCESS WAS SUCCESSFULLY DRAINED.*

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I FIRST saw this patient on April 14th, 1898, in consultation with Dr. Carter, with a view to operation. Four days before I saw him he began to expectorate very foetid pus, and had coughed up about half a pint each day. There was dulness at the right base behind up to a little above the angle of the scapula, with faint and slightly tubular breath sounds over the dull area. I introduced the needle of an exploring syringe into the dull area, and at once withdrew offensive pus. His illness started with an attack of hæmoptysis seventeen days before I saw him, and he had suffered from severe pain with inspiration on the right side of his chest. His temperature at the time of our consultation was 104°. The diagnosis lay between an abscess in the lung and a localised empyema which had opened into a bronchial tube. The discovery of pus at the first puncture seemed almost too fortunate an occurrence for a case of abscess in the lung, and I was, therefore, rather inclined to think we probably had to deal with a localised empyema which had ruptured into a bronchial tube.

On the following day (April 15th) I operated. Chloroform was very carefully administered by Dr. Freeman, and the patient was never very deeply under. I again passed an exploring syringe needle into the dull area and withdrew pus, and then proceeded to resect a portion of one of the ribs a little way below the angle of the scapula, and lying between the two needle punctures. On removal of this portion of rib air was heard rushing in and out of the pleural cavity through a small opening made during the removal of the piece of rib. I therefore freely divided the parietal pleura, and on passing in my finger failed to detect any pleural adhesions. It was clear that the lung would have to be very carefully stitched to the parietal pleura before the pus could be safely evacuated, but this was not by any means easy to accomplish. With every inspiration the chest wall moved away from the collapsed lung, and I was obliged to hold the lung up against the opening in the parietal pleura with forceps which grasped the pulmonary pleura before I could get it sufficiently fixed to suture. The portion of rib which had been excised was very broad, and therefore without removal of part of another rib the opening allowed sufficient room to suture. When the pleural cavity had been shut off around an area of lung the size of a shilling, by suturing the two layers of pleura together, I put the exploring syringe needle into this area of lung and again withdrew pus. Up to this time the patient had been lying on his left side, but he was now turned on to his back, and then by passing a pair of sinus forceps for an inch or two along the needle track and expanding the blades, I liberated about half an ounce of very thick pus. A rubber drainage tube was inserted into the abscess cavity, and around it, and against the circle of pleural stitches, a mass of cyanide gauze was packed. He was none the worse for the operation.

The amount of pus expectorated at once greatly diminished, and a free discharge took place through the drainage tube. On the day after the operation there was no sign of air in the pleura, no friction sound had developed, and there was less pain in the chest than before the operation. In a few days the expectoration lost its foetid odour, and a little later the discharge from the drainage tube, though still profuse, became sweet. The temperature went up to 101° or 102° at night for a fortnight after the operation, and the dulness at the base behind extended round into the axilla, and a probe entered the abscess cavity for several inches. It was evident that after the abscess was opened extensive breaking down of the lung continued, until quite a large cavity had formed. If a long drainage tube was left in this cavity it greatly increased his cough; care had to be taken that it should only just reach the cavity.

The expectoration ceased a month after the operation, but the discharge from the drainage tube was then considerable;

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