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

By JAMES PEARSE, M.D.,
Trowbridge.

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 29th. 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.*

By CHARLES A. MORTON, F.R.C.S.,

Professor of Surgery in University College, Bristol; and Surgeon to the
Bristol General Hospital, and the Hospital for Children
and Women.

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;

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

but when discharged from the hospital at the end of June—that is, two months and a-half after the operation—although a sinus persisted, there was hardly any discharge from it. At this time he was free from cough, and had gained flesh, the dulness at the base of the lung had diminished. The sinus closed five weeks later, but when seen on August 16th there was still some dulness at that base, but much more air entry. He had gained flesh, and had no cough. I did not see him again until January, 1900. He is now very well, actively engaged in work, and has no cough. The air entry at the right base is not quite as good as on the left, but the resonance is remarkably good.

As I did not see him until he had been ill for more than a fortnight, I cannot say much about the cause of the abscess; but it seemed to me most probable that he had had an attack of acute pneumonia, with rapid breaking down of the lung. There may have been actual gangrene of the lung, and by that I mean necrosis of a large mass of pulmonary tissue, but although the pus he at first expectorated and later discharged through the drainage tube was very offensive, I do not think it was quite as bad as we generally get in extensive gangrene of the lung.

The safe evacuation of the pus from a pulmonary abscess through the unobliterated pleural cavity is well illustrated by this case. There is no evidence that any infection of the pleura occurred; indeed such infection would have been almost impossible, after the two layers of pleura had been securely sutured together around the area of lung punctured.

A few years ago Dr. Clark and I published another case of pulmonary basic abscess on which I had operated, and had the patient not died from an epileptic fit his lung would probably have recovered, for at the *post-mortem* examination we found that a small abscess had been satisfactorily drained, and the patient's condition had improved up to the onset of the fit. In that case there were dense adhesions between the lung and pleura, and after excising portions of the ribs I was able to cut into the adherent lung and freely open up the abscess.

In some cases in which the patient is discharging large quantities of pus from the lung the abscess is in the liver, and has eroded the diaphragm and lung and discharged into a bronchial tube, or formed another abscess in the lung which has opened into a bronchus; and in such a case, if no bulging of the liver is present, it may be very difficult to locate and open the abscess. In 1896 I published a case of this nature.² It was only after repeated explorations that at last the abscess was found and drained. But even in an abscess limited to the lung it is not often that one is fortunate enough to hit off a small cavity at the first insertion of the needle of the exploring syringe, as happened in the case which I record this evening.

REFERENCES.

BRITISH MEDICAL JOURNAL, 1897, vol. ii, p. 800. ² *Ibid.*, 1896, vol. ii, p. 1097

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

DOUBLE MONSTER: THORACOPAGUS: SINGLE HEART.

A DOUBLE monster with two complete male bodies joined laterally from axilla to hip was brought to me recently. On dissection it proved to consist of two complete sets of bones and organs, with these exceptions: (1) A single sternum; the outer ribs were very long, and joined the sternum in front; the inner ribs were short, about $\frac{1}{2}$ inch long, and touched mesially; (2) one pair of nipples; (3) one umbilicus placed centrally; (4) one heart.

CIRCULATORY SYSTEM.

The Umbilical Cord is single and normal, with two arteries and one vein, the maternal blood flowing straight into portal vein.

Vena Cava.—Each foetus is provided with a vena cava superior, the right vessel pouring its blood into the right auricle, the left vessel into the left auricle. The two inferior venae cavae unite to form a common mesial inferior vena cava. This vessel is very short (half an inch long), is attached to the middle line of the liver, and pours its blood into the right auricle.

The Heart. which is common to both foetuses, is mesially placed, and consists of two auricles and two ventricles, situated normally in relation to each other. The left ventricle is larger than the right. The two

ventricles together are much broader in proportion to their length than in a normal heart.

The Right Auricle.—The walls are normal. The right superior and common inferior venae cavae, the right pulmonary veins and large thymus veins pour their blood into the right auricle. The foramen ovale is large, and communicates freely with the left auricle. The right auriculo-ventricular opening is tricuspid.

The Right Ventricle.—The walls, etc., are normal; contraction causes the blood to be expelled from its cavity through an opening guarded by three cusps. The blood is thence driven at once into two large arteries; the smaller of these supplies the five pulmonary lobes of the right foetus, while the larger forms an aorta.

The Right Aorta.—The vessel is short ($\frac{3}{4}$ inch) and wide, giving off an innominate artery, and a second branch which divides to form the right carotid and right subclavian of the right foetus. The innominate artery bifurcates and forms the left carotid and left subclavian of the right foetus. The aorta arches to the right.

Ductus Arteriosus.—Absent.

The Lungs of both foetuses alike; the five lobes massed together, the set of two lobes lying above the set of three.

The Left Auricle receives the left superior vena cava and large thymus and pulmonary veins from left foetus; the foramen ovale is large and patent, larger than right auricle. The left auriculo-ventricular valve (mitral) is tricuspid, as also is the aortic. Thus all the valves of the heart are tricuspid.

The Left Ventricle. with very thick and strong walls, drives the blood into the left aorta, a vessel about $\frac{1}{2}$ inch in length, before it gives off at right angles, a large pulmonary branch. It then ascends for $\frac{1}{2}$ inch and gives rise to the innominate; it then arches to the left, giving off a large artery which divides into left carotid and left subclavian of the left foetus. The arch gives place to the descending aorta. The innominate divides at once to form right carotid and right subclavian of left foetus.

Other Viscera.—The two livers are joined mesially by what would be normally their "posterior surfaces"; otherwise normal. The spleens are normal except in position, that of the left foetus being on the left and that of the right on the right. Other organs normal. The thymus glands are large.

An interesting point about the case is that the right child is extremely thin and emaciated, while the left child is plump and well clothed with fat. The left child is said to have lived for half an hour after birth, while the right child was said to have been born dead. When they came into my hands they were both dead, but the colour of the skin differed remarkably in the two children, the left being a rosy red, and the right a venous purple. This is readily explained by the patency of the foramen ovale, all the maternal blood going direct into the left heart, and hence to the left child. This double monster caused dystocia.

Deoli, Rajputana.

DE VERE CONDON, I.M.S.,
Agency Surgeon.

TWIN PREGNANCY WITH CENTRAL PLACENTA
PRÆVIA.

THE case of central placenta prævia recorded by Dr. Collingwood Fenwick in the BRITISH MEDICAL JOURNAL of January 20th, p. 140, induces me to describe a somewhat similar one which occurred in my practice at Kirkcaldy in November, 1899.

The patient, a hard-working multipara, about 38 years old, a sufferer from chronic bronchitis and in poor general health, was probably well into the ninth month of pregnancy. Several days before I saw her she had had slight pains and some hæmorrhage accompanying them, but one morning a sudden and very profuse gush of blood rendered medical assistance necessary. The patient presented a distressing appearance; the pulse could not be counted; the skin was cold and clammy, and she had frequent syncope. A stimulant was given, and the patient gently placed in the usual obstetric position. There was slight uterine action, always attended by fresh discharge. The left hand was introduced into the vagina, and, after removing a large amount of blood clot, the os uteri was reached, situated very high, and dilated to about four-fifths of its size. The placenta was presenting, and engaged the whole diameter of the os, but, on pushing the hand upwards, one edge was found to have become partially separated by the previous contractions of the uterus, and it was possible, by detaching still further, to convert what was probably never an absolutely central implantation into a partial one. This manual separation almost entirely controlled the hæmorrhage, and the membranes were ruptured, the head presenting. The patient having rallied considerably, and being under chloroform to a very slight degree, I decided to use the forceps in preference to turning, as the os was so well dilated. The invaluable axis-traction instrument of Milne-Murray was easily applied, and the child delivered without undue haste, the placenta remaining in the uterus, which was still of large size. The hand being reintroduced, a second set