A CASE OF RUPTURED UTERUS IN A MULTIPARA.

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THE following case is the first case of the kind I have met with in an experience of over 2,000 midwifery cases.

A charwoman, a widow, aged 33, whose husband had been dead twelve months, was taken in labour with her fourth child at full term on the morning of May 29th, 1901; none of her neighbours knew she was in the family way, not even her mother or sisters, two of whom she saw frequently, and it was only when she had been in labour several hours that she confided in her next-door neighbour that she was about to give birth to a child, and as she felt very bad, asked her to send for a doctor. This must have been after she had cut the arm off the child and after rupture of the uterus, as the arm was found when the neighbours entered her room. I was out when sent for, and on reaching home I proceeded to her at once and found a midwife already there, who showed me the right forearm of the child lying in a clothes-basket. The patient was *in extremis*, unable to speak, almost pulseless, and gasping occasionally; there was little or no external hæmorrhage. The stump of the right arm was protruding from the vulva, the forearm having been separated with a breakfast knife. The right arm had presented, and, I believe, the poor woman knowing the child could not be born without her relatives and neighbours knowing, in her pain and desperation cut the forearm off just at the epiphysis of the olecranon process of the humerus, and this act, in my opinion, was the cause of her undoing. I tried to deliver as she was gasping her last, but I could not find a foot to lay hold of, and as she was pulseless I desisted from any further attempt at extraction.

A *post-mortem* examination was made two days after death. The body was well nourished. On opening the abdomen the child and placenta was found in the peritoneal cavity, with the exception of the stump of the right arm and the head, which were in the cavity of the uterus. The reason so much of the child had escaped into the abdominal cavity was no doubt the movement in putting the body into the coffin and in bringing it to the mortuary, as only the feet and placenta had escaped into the cavity when I examined her just before death; the peritoneal cavity was filled with blood clot and fluid blood. The rupture, about four inches in length, was on the left side, just at the point where the peritoneum is reflected to form the broad ligament. The edges of the tear were uneven, but the tear did not involve the fundus nor the vaginal portion. The uterine tissue appeared healthy to the naked eye, and no trace of organic disease could be discovered. The other organs of the body were healthy.

My theory as to the cause of the rupture is this: The head of the child—a strong male—was lying in the left ilio-hypogastric region with its back to the outlet of the pelvis; this being so and the body being doubled on itself the feet would be in the region of the left sacro-iliac synchondrosis. When the mother amputated the forearm it produced strong reflex action in the child, causing it to plunge with its feet against the uterine walls, which would be in a relaxed and weakened condition, causing rupture at this point. Thus it escaped with its feet first into the peritoneal cavity, and dragged the placenta with it.

The causes of rupture given in textbooks are many and varied. Obstruction to labour either from narrowed pelvis or tumour, pressure of the head against the sacral promontory or the ileo-pectineal lines, fatty degeneration of the uterine fibres, more than normal, softening and thinning of the uterine walls, disease of the walls—for example, cancer—and obliquity of the uterus. Ergot is said to be responsible for many cases when given injudiciously; blame could not be given to ergot in this case. The frequency of rupture according to Jolly is from 1 in 1,300 to 1 in 3,403 deliveries. Guy's Hospital Charity coincides with Jolly's statistics, as according to Galabin when assistance was given sparingly and forceps cases were in the proportion of 1 in 200 deliveries rupture occurred in the ratio of 1 in 3,371 deliveries subsequently where forceps cases were 1 in 93 the cases of rupture were 1 in

5,098, thus proving that the legitimate and timely use of forceps has considerably reduced the chances of this terrible danger to the parturient woman, and so saving life.

INFECTION BY THE URINE IN CONVALESCENCE FROM TYPHOID FEVER.

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IN the *BRITISH MEDICAL JOURNAL* for November 24th, 1900, Dr. Walker, of Peterborough, published a very important article on the dangerous quality of the urine of persons convalescent from typhoid fever. Dr. Walker traced an infection of certain wells to the urine of a convalescent trooper from South Africa. These wells, as subsequent investigation showed, had supplied to the inmates of a particular house water contaminated by sewage; but with no apparent ill consequences, until the trooper came thither, who had been discharged from hospital in South Africa convalescent from enteric fever. On the seventeenth day after his arrival at the house 12 persons were laid up with the fever. Dr. Walker urged on sanitary authorities their responsibility in this matter. Seeing that in urotropine we have a ready means of disinfecting the urine of such convalescents* I also would urge medical practitioners to satisfy themselves of the purification of the urine of convalescents from typhoid before allowing them to go at large. That the bacilli may live in the urine for many weeks at least has been impressed upon us by Dr. Horton-Smith; and since the publication of his Goulstonian Lectures a case has been recorded by Dr. Cushing in which the bacilli are said to have lived in the urine for a period of no less than five years! On account of many engagements I was unable at the time of Dr. Walker's communication to try to enforce his lesson, and to arouse professional opinion to a sense of this new duty; but I write now, as the enforcement is still necessary.

The reason why I should myself enter upon this homily is that I have been in the habit for many years of pressing upon my pupils the danger of letting convalescent "typhoids" go free without thorough disinfection of the stools for many weeks after recovery. It now turns out that I bestowed my labour erroneously; my suspicions were justified, but my advice was ill-directed. Many years ago I published the following history, in what journal I do not remember, and it is no matter now. Briefly it was as follows: I had then been called to a large farm in the neighbourhood of Maryport, where the head of the house lay ill of typhoid fever. The very intelligent medical man who met me told me that the case was a test of Budd's law of the specificity of the infection, then attracting attention. This law had been verified by my reports of two outbreaks of the disease, at Bramham College and at the Flounders Institute at Ackworth, in both of which cases the drinking water had been long fouled with sewage, but without engendering enteric fever until in each case, a typhoid patient had been introduced into the area from a distance. In the Bramham College a boy returned to school sickening with the disease; in the other institution a visitor from Wakefield fell ill with it after being but a day or two at Ackworth. In these cases typhoid stools had found their way into the water sources; but my friend assured me that on the Cumberland farm there had been no such importation. The farm, rather a large community, was isolated and remote. The goings of every inmate were well known; no visitor had entered its precincts. Yet on a certain day enteric fever broke out, and as it seemed, "spontaneously."

I was unable to return home the same night, so having some time on my hands I set to work to unravel the coil. After all chat with the family had proved unavailing, I asked to have all the dependents of the place called together, that I might obtain direct information from each. In this way I lighted upon a charwoman from Carlisle who admitted at once that she had had the disease recently, but had been well for some weeks before accepting an engagement to work at

* It is much to be regretted that recent experience has shown that the use of this remedy is not free from certain risks.

the farm, where she had been occupied for two or three weeks (I have not my original paper at hand). I asked her if when she came to the farm she had any diarrhoea, but this she denied. She assured me that during these intervening weeks she had been in good health.

At this point arose a further remarkable problem. She had fallen ill at another remote farm, where she had been working; so that unless there had been fever there our difficulty was but thrown one step backward. At this farm accordingly I had full inquiries made, and with the parallel result that there, too, typhoid fever had been unknown till this woman fell ill (whether other cases had arisen there I forget, but I think it was so). Thus, as I say, our difficulties were not solved, only pushed back a step. To cut a long story short, it turned out that to this second isolated farm, then and always before free from typhoid, had come a kinsman of the occupier, who was convalescent from the disease contracted in Liverpool. He came to the farm for country air after, as was supposed, a perfect recovery had been made.

On the basis of these observations of mine I begged Dr. Dreschfeld, when engaged upon the article on Enteric Fever for my *System of Medicine*,² to go closely into this matter, urging upon him that the bacilli survived for indefinite terms in the stools—in the stools, there was my error. Dr. Dreschfeld, with unwearied kindness, examined again and again the stools of convalescents from typhoid, but with no success in this respect. With the help of Dr. Richmond the fullest investigation was made into the alleged survival, but in vain. In the stools the bacilli certainly do not survive long into convalescence, even if until convalescence. To suspect the urine never occurred to me. The victims of the arrows of Apollo fell at our feet but we failed to see whence they came.

Dr. Hugh Walsham has been so good as to demonstrate to me that tubercle bacilli are usually excreted by the kidney without the formation of "tubercle" in the organ; and Dr. Horton-Smith and others assure us that typhoid bacilli thus excreted may come through in millions, and for a period long enough to poison a county. I repeat, then, that upon all practitioners, and medical officers of health especially, it is incumbent to see that the disinfection of the urine urged by Dr. Walker is carried out systematically in every case before the patient is allowed to mix again freely with his kind.

REFERENCE.

¹ Richardson, *Journal of Experimental Medicine*, January, 1899. ² *System of Medicine*, vol. 1, 1896, pp. 799 and 800.

ON THE EVOLUTION OF MYELOPATHIC ALBUMOSURIA.

By T. R. BRADSHAW, B.A., M.D., M.R.C.P.,

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It is now more than three years since I first brought the subject of myelopathic albumosuria to the notice of the Royal Medical and Chirurgical Society. The disease was then unknown to the profession in this country, and only 8 clear cases were to be found recorded in the medical literature of Europe.

Since that time 7 more cases have been published, more or less fully, bringing the total up to 16. Of these I have personally examined 2, and in a third case I have been enabled to make a thorough investigation of the urine. There is one point in the clinical history of the disease which has never been determined—namely, the manner in which the albumose appears first in the urine. In all recorded cases it has been present in massive quantities, but it has never been ascertained whether it begins to appear in minimal quantities and gradually increases, or whether the onset is sudden, the maximal amount appearing almost from the first. The possibility of the latter mode of onset is suggested by what we know of the onset of pancreatic diabetes.

I have lately been consulted by a physician of eminence practising on the Continent of Europe, who is the subject of myelopathic albumosuria, and owing to exceptional circumstances it was possible to detect the abnormal condition of the urine at an early stage. As this is the first case of the disease which has been recognised as such in a country with a population of more than 50 millions, it is not surprising that the exact

condition of the urine was at first apparently not understood, the albumose being mistaken for albumen; but at the present time the reactions are highly characteristic, and apart from the symptoms which have recently become prominent, they leave no possibility of doubt as to the nature of the case.

The albumose was first observed in December, 1899, when the patient, who was then 53 years of age, had an attack of mild pneumonia. The quantity was at that time minute, but it has subsequently gone on continually increasing, and has reached a maximum of 10 parts per 1,000. Until the middle of May in the present year the patient felt no inconvenience and was able to follow his profession, but since then he has grown pale and lost flesh and strength. He has also found a soft tumour about the size of a hen's egg, in connection with one of his ribs.

The foregoing account of the case does not claim to be in any way complete, but it illustrates two important points, one of which is new.

1. The presence of the albumose in the urine is the earliest symptom of the disease, and may be observed for many months before there are any other indications of failing health, or any local signs of alterations in the skeleton.

2. If we may be permitted to generalise from the only case in which the point has been investigated, the albumose is first excreted in small amounts; but, owing to the fact that at this stage the subject of the disease does not suffer any inconvenience from it, he is not likely to consult a medical practitioner, and so the urine is generally not examined until the albumose has risen to a large amount. Its early discovery in the present instance was doubtless due to the fact that its onset closely coincided in time with an acute illness, and that the subject of it a member of our own profession.

ON SOME CASES OF HÆMORRHAGE INTO THE SKIN AND SUPRARENAL CAPSULES.

BY

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THE following four cases are apparently of sufficient rarity to justify us in putting them on record; at all events they are the first cases that have ever been noted in this hospital.

CASE I.

G. F., a male child, aged 11 months, was admitted to the East London Hospital for Children, Shadwell, on February 4th, 1901.

History.—On the day previous to admission the child was running about and playing, apparently quite well. At 9 P.M. he went to sleep, but a quarter of an hour later he woke up and vomited slightly. He was very restless all night, and on waking in the morning he did not seem at all well, and the mother noticed one or two dark spots on the back. At 7 A.M. violent diarrhoea began, the stools being very frequent, watery, and yellow-green. He did not again vomit. From this time he got rapidly worse, and at 9 A.M. was brought to the hospital. The child was a breast-fed baby, but on the day before admission he had had in addition some potato, some bread and butter, and a little toast. He had had no previous illness of any kind, and had never been vaccinated. The family history was good, but there was a slight history of rheumatism.

Condition on Admission.—The patient, who was extremely well nourished, was moribund; his eyes were half open, respirations were slow and shallow, and the pulse rapid, but scarcely perceptible. The face and lips were cyanosed and the extremities cold, though the body felt hot. All over the surface of the body there were numerous subcutaneous hæmorrhages, irregular in shape and of various sizes from a pin's head to a threepenny piece. These were most numerous on the back, where they were of a larger size than elsewhere. On the face they were small and not very numerous, and were distributed for the most part on the forehead and behind the ears. There were a few on the scalp, and they were very numerous on the upper and lower extremities. All over the chest coarse rhonchi were heard; the heart sounds were feeble; the abdomen was natural to palpation.

Death.—The patient died at 11.15 A.M., having been ill fourteen hours altogether.

Post-mortem Examination.—The body was extremely well nourished. Subcutaneous hæmorrhages were present as above described. The lungs showed some areas of emphysema and collapse, but there were no subpleural hæmorrhages. The heart was natural. The thymus was very large and natural. The stomach was natural. The Peyer's patches throughout the whole length of the small intestines were very much swollen and prominent, as in the early stage of typhoid fever, but there was no ulceration. There were a few minute petechial spots on the peritoneal surface of the bowel. The mucous membrane of the large intestine