HÆMATOMETRA IN RIGHT HORN OF AN UNDEVELOPED DOUBLE UTERUS,

SUCCESSFULLY TREATED BY ABDOMINAL SECTION.

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CASES of absence of fusion of the Müllerian ducts to a greater or less extent are of comparative frequency, and as might be expected give rise to almost endless varieties of anomalous conditions. These are of great interest, not only on account of their anatomical peculiarities but more particularly from a clinical standpoint, as the pathological effects of arrested development tend frequently to extremely grave consequences, and at the same time are often surrounded with difficulties of diagnosis by no means easy to elucidate.

In many instances duplicity of the genital tract in whole or in part may give rise to no symptoms whatever, and the owner may go through the functions of maternity unembarrassed, but frequently other developmental complications are coincident, and give rise to occlusion of the canal. Atresia may occur at any part of the tract, and may be either bilateral or unilateral, and thus when menstruation occurs we have a series of retention cysts which vary according to the seat of obstruction, and form an almost indefinite number of types of hæmatometra and hæmatokolpos. The following case forms an interesting example of the condition:

B. M., aged 24, consulted me in February last, and complained of having for the last seven years suffered from irregular but very severe pain in the right side. On one occasion two years ago she had a severe attack of general peritonitis which was thought to be due to appendicitis. Menstruation had never appeared. On bimanual examination of the pelvis, the cervix was felt to be small and conical, and through the right fornix an ill-defined boggy mass about the size of an orange was distinctly palpable. The sound passed 1 inch into the uterine cavity. Through the left fornix an extremely tender matted condition of the pelvic organs appeared to be present. From the experience of a similar condition the case was diagnosed as one of enlarged and inflamed appendages with an atrophic uterus, and their removal by abdominal section was undertaken.

The abdomen, when opened, showed evidence of previous general peritonitis from the adhesion of the omentum and intestines to the surrounding structures. The pelvic swelling proved to be the horn of an undeveloped uterus distended with tarry material, which had ruptured the original sac and extravasated between the layers of the right broad ligament. From the external aspect of the thinned and ruptured uterine horn there arose the round ligament and impervious Fallopian tube. The ovaries on both sides were much enlarged and showed signs, from the large number of blood cysts and extravasations in their substance, of intense congestion. They were embedded in the pelvis by strong inflammatory adhesions. By careful dissection they were enucleated and removed along with the distended uterine horn. The extravasated blood between the layers of the broad ligament was washed out, and the edges of the ligament stitched together. The operation was prolonged and tedious, but the patient, a strong, healthy woman, recovered without an untoward symptom.

The case is of much interest from several aspects, particularly in so far as there has been a total absence of external menstruation, the patent horn being atrophic, while the occluded horn was to a certain extent functionally active. Several cases have been cited by Hegar, Emmet, Leroy, and others, of unilateral retention in a rudimentary horn, but in all the patient menstruated regularly from the functionally active horn. In the case described, from the extremely irregular paroxysms of pain there can be little doubt that the uterus as a whole was poorly developed. The rupture of the distended horn, at first evidently intra-peritoneally, giving rise to general peritonitis as in tubal extraterine gestation, is also of much interest, as it would appear that the adhesions thus formed prevented future extravasations of blood into the peritoneal cavity.

As regards treatment I should strongly recommend that all such cases should be treated by laparotomy and removal of the uterine sac. Vaginal incision and evacuation of the contents is prone to be followed by septic infection and subsequent pyometra and peritonitis. Of 11 deaths recorded by Wells¹ in a series of 32 collected cases, 9 followed puncture of the sac and were due to septic peritonitis. The diagnosis must at all times be difficult, but is usually to be suspected if a boggy, somewhat cystic pelvic tumour can be felt, with a history of periodic paroxysms of pain at the menstrual periods should menstruation be present, or at regular periodic intervals should the menses be in abeyance. In the case mentioned, however, the irregularity of the paroxysms and the

absence of menstruation rendered the diagnosis practically impossible. Exploratory abdominal incision alone remained, therefore, for its elucidation.

REFERENCE.

¹ *Amer. Journ. of Obstet.*, 1900, p. 364.

THE TREATMENT OF PUERPERAL ECLAMPSIA BY DIURETIC INFUSIONS,

WITH A TABLE OF TWENTY-TWO CASES.

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PUERPERAL eclampsia is a subject of absorbing interest to obstetricians. Although many theories have been advanced we are still in the dark regarding the cause or causes of this exceedingly fatal disease. At present all that one can say is that the convulsions seem to be caused by a toxic substance which the organs of excretion have failed to remove from the system. The nature of this toxin is unknown. The marked diminution in the amount of urine, the presence of blood in many and of albumen in nearly every case point to the kidneys being out of gear. The liver also seems involved.

Taking it for granted that we have a poisonous substance circulating through the system, how are we to counteract its effect or get rid of it? If we knew what it was we could use an antidote, but as we are ignorant of its composition we can only hope to turn it out of the system through the natural channels of excretion. The channels through which a poison can be best got rid of are the kidneys, the bowels, and the skin. In the treatment of eclampsia the importance of free action of the bowels and skin has always been recognised; but it seems to me that sufficient attention has not been paid to the importance of securing prompt action of the kidneys during the actual attacks. In cases of threatened convulsions proper dieting and the prompt administration of diuretics and saline cathartics will, in the vast majority of cases, prevent the fits. In the actual seizure diuretics by the mouth are too slow in action. For the last three years I have been giving saline infusions consisting of sodium chloride and potassium bicarbonate or sodium acetate. As I have now had experience in 22 cases, I desire to place the results before the profession.

The principle of the treatment is to try to control the fits by one or other of the drugs in use, and to secure free action of the bowels, skin, and kidneys. In controlling the fits, chloroform, tr. veratrum viride, chloral and bromide, and morphine have all been used. If the pulse is quick and tense, tr. veratrum viride (℥x or ℥xv hypodermically) acts well. Morphine I have given up, as it seems to have the effect of lessening the excretion of urine. Chloral and bromide in large doses are certainly very useful. In plethoric patients bleeding may be resorted to. For clearing the bowels enemata are only useful to unload the rectum. Croton oil is very uncertain. I have given ℥v without the least effect. If there is oedema of the tongue and pharynx, it may increase this and cause oedema glottidis. I have seen this in 2 cases, one of which proved fatal. Magnesium sulphate I am now using entirely, giving from 4 to 6 tablespoonfuls in warm water. If the patient cannot swallow, it should be given through a tube. Chloral and bromide may be given along with it. To keep the skin acting a hot pack or steam bath is most useful. Great care must be taken to prevent the patient being blistered. It is surprising how easily this may happen when the patient is comatose. A hot bottle must never be allowed to touch the bare skin. Pilocarpin is a drug I have never tried. Oedema of the lungs is present in most of the cases, and the risk of increasing this is too great.

What I consider the most important part of the treatment now comes to be considered—namely, that directed towards getting the kidneys to act. When the patient is having convulsions diuretics by the mouth are too slow in acting. As soon as the patient can swallow they should be given to keep up the action. All our cases were given large amounts of Imperial drink and milk for several days. To insure prompt action of the kidneys I have given saline infusions under