ON PLACENTA PRÆVIA.

(A paper read before the Medical Society of University College, London, on Friday, January 30th, 1846.)

By JOHN ELLIOT WOOD.

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The symptoms of placenta prævia are decided and unequivocal. The most important of these is hæmorrhage; and the time at which this may occur varies very considerably. In the greater number of cases it does not appear before the last month or six weeks of utero-gestation; but instances are on record where flooding has come on at a much earlier period, in the fifth or sixth month, or even sooner. If it take place before this, the case should rather be regarded as one of abortion, as it can scarcely be supposed that any changes in the neighbourhood of the os and cervix uteri could have produced separation of the placenta at that early period.

This hæmorrhage generally arises without any obvious cause; the patient has probably been living much as usual; there has been no excitement either mental or bodily; no violent efforts or accident to which she can attribute its attack. It is usually more or less profuse according as the patient is near to, or far from, the completion of her pregnancy. Its violence is said to be increased at what would have been a catamenial period in the unimpregnated state; and when those changes occur in the cervix uteri which immediately precede labour, it is in general very profuse. As labour ensues, the discharge, which may hitherto have occurred at intervals merely, becomes frequently constant, being increased, however, during every pain; in this particular differing remarkably from accidental hæmorrhage, which is controlled by the contraction of the uterus. On examination per vaginam, an irregular spongy mass, communicating a stringy feel to the finger where it has been torn, is found presenting at the os-uteri, and in complete cases blocking up the orifice; in partial cases the edge of the placenta may be felt projecting over one lip of the os, while the membranes and presenting part of the child may be felt at the other. The practised finger will not confound the presence of clots of blood merely, with placental presentation, as the sense of touch communicated by the latter when once experienced can scarcely be mistaken; it would be useless, therefore, to lay down any express rules in this particular instance. It has been stated by some writers that the abdomen is less distended than usual in these cases, on account of the absence of the placenta in the fundus of the uterus. The observation, however, requires confirmation, and Dr. Rigby states that his experience has not as yet led him to such a conclusion.

From the views generally entertained respecting the cause of the hæmorrhage, it might, *a priori*, be expected that where the placenta was situated centrally over the os uteri, hæmorrhage would inevitably ensue with the gradual obliteration of the cervix, which occurs several weeks before the termination of utero-gestation; while, on the other hand, where one edge of the placenta merely overlaid the os uteri, the patient might go the full term without the occurrence of this symptom. This view of the case is supported by the high authority of Professor Naegelé, but it cannot be denied that we meet with many instances of hæmorrhage

occurring early, where the presentation is only partial; while in complete cases it may be absent till the commencement of actual dilatation. At any rate, as a means of diagnosis as to the exact nature of the presentation, independently of other aid, this symptom is of little value.

This naturally leads us to consider the source of the hæmorrhage in placenta prævia; and it will at once be evident that this question is of the very highest importance as directing or modifying our treatment. The principal object in these cases, is to arrest the bleeding, which is at once exhausting the mother and destroying the fœtus, whether this be attempted by topical applications in the form of the plug, by artificial delivery, or otherwise; and it is of course essential, to render our measures of use, that we should clearly understand from whence this hæmorrhage proceeds.

It is far from certain, however, that we are as yet acquainted with the exact nature of this serious complication. M. Gendrin, whose views as to the mode of increase of the placenta have been before alluded to, says, that the rupture of the vessels which produces the flooding, is caused by ruptures in, or exudations from, the placenta, and not from denudations of the uterine sinus. Hamilton was of M. Gendrin's opinion as to the source of the hæmorrhage. He says, that, "From the earliest period of his professional life, he has been anxious to show that the hæmorrhage in these cases proceeds more from the separated portion of the placenta, than from ruptured uterine vessels." And lastly, Dr. Simpson, of Edinburgh, thinks the hæmorrhage proceeds from the vascular openings which exist on the exposed placental surface. "Bleeding," he says, "could not readily occur from the venous openings exposed on the interior of the uterus, because venous hæmorrhage by retrogression is here prevented by a variety of anatomical and subsidiary means. On the other hand, the placental orifices are not, like the uterine, surrounded by contractile fibres capable of constricting them; they are in free communication with the general vascular system of the mother, through the medium of the maternal vascular or cavernous system of the placenta, and the blood in that cavernous system readily escapes from the exposed venous orifices on the surface of the placenta, which is, in fact, its natural and forward course." He makes the following highly important and interesting observation: that "in common cases of unavoidable hæmorrhage, the amount of the attendant flooding seems to be as much regulated by the quantity of placental surface still remaining attached to the uterus, as by the quantity already separated from it; the degree of flooding depending as much, or more, upon the extent of the means of supply of blood, as upon the extent of its means of escape. And in proportion as we approach nearer and nearer to a total separation of the placenta, the number of its afferent utero-placental vessels is diminished, till at last we find, that when one organ is once completely separated from the other, the flooding is instantly moderated, or entirely arrested, for the placenta ceases to yield any discharge of maternal blood as soon as its own supplies from the maternal system are thus cut off by the dismemberment of all its organic and vascular attachments with the uterus."*

* *Medical Gazette*, Oct., 10th, 1845.

On the other hand, Dr. Ashwell remarks that "it would have been as well if these (placental) orifices and their capacities had been demonstrated. I have never yet seen them, although I have subjected numerous placentæ to examination, both before and after injection; nor have I been more successful when I have carefully peeled off an adherent placenta after death. It is, on the contrary, easy enough to show to the satisfaction of the most incredulous, the great openings existing in the lining membrane of the uterus, exactly opposite the attachment of the placenta; and which are covered by interposed decidua. Surely such an organization affords the clearest proof of the source of the hæmorrhage in placenta prævia. The foetal economy at no time requires such a supply of blood, as must of necessity be furnished, if vessels or orifices existed in the placenta, capable of pouring out the vast quantity of blood which sometimes, after one gush, proves fatal to the mother in placenta prævia. I do not believe that the placenta ever contains anything like the quantity of blood which is often lost in one or two gushes at the commencement of a placental labour. Another proof of the little probability of bleeding from the placenta when this is partially detached, is furnished by the fact that extensive punctures of its substance by the trocar, when in apposition with the uterus at its fundus, or when implanted over the os, are not followed by hæmorrhage"*

Dr. Lee coincides with the writer last quoted, in believing that in uterine hæmorrhage the blood flows from the venous openings on the lining membrane of the uterus, and also from the arteries that are laid open by the separation of the placenta.

Mr. Ingleby gives a case in which a portion of the placenta was cut away by the practitioner, on account of its obstructing the mouth of the womb, and yet no discharge of blood escaped from the cut surface.† And most of the older authors, as far as I know, attributed the source of the blood to the large valvular openings on the surface of the uterus; unless indeed we can except Giffard, who in his 116th case, says, "as the os internum was gradually dilated, the placenta at the same time was separated, from whence proceeded the effusion of blood." If this be the correct interpretation of his meaning, it would be curious as exemplifying the fact, that in ninety-nine cases out of a hundred, so called discoveries are merely revivals.

Unless we can suppose that a gradual effusion of blood takes place from the placenta, and accumulates in the uterus, it seems hard to account, on this view, for the profuse gushes which so frequently attend separation of this organ, whether manual or otherwise; and many more observations are necessary before we can take for granted a theory which has so much of positive evidence, as well as of seeming improbability against it. In cases of extensive lacerations of the placenta, while the extent of its means of supply of blood, (according to Dr. Simpson's view,) is very considerable, the hæmorrhage in the vast majority of cases is trifling, and not to be compared with what occurs in merely partial separation.

* *Medical Gazette*, Nov. 7, 1815.

† *Lancet*, vol. i., 1839, p. 913.

(To be continued.)

CASE OF MEDULLARY SARCOMA OF THE PROSTATE GLAND, IN A CHILD AGED NINE MONTHS.

By C. R. BREE, Esq., Stowmarket.

A. C., aged nine months, a fat and well-grown child, of light complexion and hair, required medical assistance on the 9th of March, 1843. The mother informed me that it had passed no urine for twenty-four hours, in consequence of which it was restless, refused the breast, and was in evident pain. Upon examining the abdomen the bladder was found much distended, reaching merely to the umbilicus. An elastic-gum catheter was introduced, and a pint and a half of pale straw-coloured turbid urine, with a strong ammoniacal odour was drawn off. As the child was teething, and the gums swollen, I at first referred the cause of disease to dental irritation. I lanced the gums freely, used the warm bath daily, and administered internally occasional calomel purges. At the end of ten days the symptoms were not at all improved, the child had not been able to pass a drop of urine, and the catheter was necessarily introduced as fast as it accumulated in the bladder.

My original impression was as I have stated, that the case was one of paralysis of the bladder, from dental irritation in the first place, and over distension in the second. There were, however, two circumstances which convinced me, upon reflection, that this was not the case; 1st, the child made voluntary efforts to expel the urine; and, 2nd, the retention was perfect. An examination per rectum was accordingly instituted, when all obscurity in the case was cleared up, by the discovery of a large tumour, occupying the perineum, evidently attached to the neck of the bladder, and which, by pressure upon the urethra prevented the passage of urine. The tumour was dense and elastic, without conveying to the touch a sense of fluctuation.

From this period it rapidly increased in size; the health of the child gave way, it lost flesh, was restless, and constantly crying. It was found necessary to introduce the catheter twice or three times a day, as the secretion of urine was morbidly increased, and the bladder becoming irritable under frequent useless efforts to expel its contents. The tumour gradually pressed upon the rectum, preventing the passage of fæces, and ultimately presented itself through an ulceration in the sphincter ani of about the size of a shilling. The portion of the tumour which appeared in sight was white in colour and had a smooth glassy appearance.

The child now rapidly sank, and died on the 22nd of April, forty-four days after I was first consulted in the case.

Sectio Cadaveris.—The intestines were considerably distended with fæces and flatus, but the viscera generally were healthy; the bladder was much enlarged and thickened, as seen in the preparation. The tumour was found to be an enormous enlargement of the prostate gland, occupying the perineum between the neck of the bladder and the verge of the anus, and pressing upon the urethra and rectum. Externally, it was white and shining, and irregular on its surface. Upon making an opening into it inferiorly, it was found to consist of a thick cyst or external envelope, filled