A CASE OF COMPLETE INERTIA UTERI AT FULL TERM: LABOR INDUCED BY ABDOMINAL PRESSURE.¹

BY JOHN M. THOMPSON, M.D.

It becomes my special privilege and pleasure to report a case of complete inertia uteri at full term, and to show how labor was finally induced. Apropos of my case, I am reminded that in a recent issue of the *Boston Medical and Surgical Journal*, Dr. Marshall L. Brown, of Allston, calls attention to "A New, Safe and Sure Method to Expedite Difficult Cases of Labor," in which he recommends abdominal pressure synchronous with the natural labor-pains by means of the obstetrician's hands. The method adopted by the writer was materially the same as referred to by Dr. Brown, yet the circumstances of the case were essentially different and the indications for interference on the part of the physician vastly more urgent.

Mrs. D., aged twenty-seven, a small, fairly well-nourished woman, weighing about 120 pounds, was taken in her third labor on the evening of Thursday, February the 4th. Inasmuch as her previous labors had been of very short duration, — in point of fact almost precipitate, it was thought advisable to send for a physician. The writer arrived that evening about eleven o'clock, when he learned she had been uncomfortable for about four hours; but from her own knowledge the pains were not *bona fide* labor pains, yet she felt confident that the "waters had broken." Upon examination per vaginam and by external palpation, I found a head presenting with its occiput towards the left and anterior, while the os was soft and dilated enough to admit the tips of two fingers. Despite some nervousness and slight nausea, the mother promised a natural labor. I remained by my patient for nearly two hours, during which time the uterus did not contract once. From this I decided to return to my office and await developments. At my next morning's visit, I was surprised to find that the patient had spent a sleepless night, entirely free from pain, save a few cramps in the thighs, which compelled her to remain in bed. I left her this time with instructions to summon me when labor pains really began.

I could not lead myself to believe that it was a "case of false alarm," as she assured me that her last catamenia ceased on the previous 11th of April.

My next summons was at seven o'clock on the morning of the 10th. Upon my arrival I learned that since my last visit she had had no pain till that morning, when she experienced, to use her own expression, "a few good ones," though indefinite and irregular. Examination per vaginam this time found the os no larger than at my first visit, yet I was pretty certain that the bag of waters had not ruptured. At 2.30 p. m. of the same day I responded to a call, which implied that my patient was in a very uncomfortable condition. When I arrived, at about three o'clock, she was extremely nervous, vomiting frequently, and very weak, — in short, in such a condition that she was willing to submit to any form of treatment that would hasten or assist in the delivery of her child. Although up to this stage no progress had been made, it occurred to me that the womb was ready and willing to contract, but wanted some help. So, — and more partic-

ularly in view of my patient's condition, — I resolved to try abdominal pressure. With my left index finger in the os, in order to determine the efficiency of my method, and my right hand spread over the fundus, I began to make firm and steady pressure in a downward and forward direction. To my delight I found that the os began to dilate and that the external force produced a natural contraction of the uterus, for I observed that upon removing my hand the pain and contraction continued. This procedure was kept up at intervals of from five to ten minutes according to circumstances, when soon "the waters broke" and I could feel the perineum distend. By this time very little abdominal pressure was required to promote contractions, which, by seven o'clock in the evening, were efficient enough to produce a healthy, well-nourished male child weighing eight and three-quarters pounds.

My patient made a good recovery and was able to be about attending to her household duties on the ninth day. In this connection it is interesting to note that from the moment her child was born to the time when I discharged her as relieved, she had, nor required, nothing in the way of medication, except an antiseptic pad to the vulva.

Since my experience in this case, it has been a question in my mind whether I would be justified in adopting this means in other cases. I am fully convinced, however, that my efforts in this particular one — a weak, nervous woman, who had considered herself in actual labor for six days, and in all probability somewhat overdue and unable to retain anything on the stomach — were crowned with success. Had I left the case to nature, I fear that such an extreme state of exhaustion would have set in as to render her labor extremely painful and considerably hazardous.

AN UNUSUAL CASE OF PUERPERAL SEPTICÆMIA.¹

BY JOHN M. THOMPSON, M.D.

I TRUST it does not seem like presumption on the writer's part to report a case of puerperal septicæmia in these days of antiseptic midwifery. It is now thoroughly agreed that the cause of such cases can be traced to faults of omission or commission on the part of the obstetrician or nurse; still, notwithstanding all this, some consideration should be shown the physician who does not enjoy the advantages of a lying-in-hospital; for there is no doubting of the fact that in many cases, in spite of his best efforts to carry out to the letter the theory of antiseptics, the physician in private practice is handicapped — whether it be from bad hygienic surroundings, indiscretion of the patient, failure or inability of the nurse to conform to the physician's orders, is difficult to state. All these factors, however, contribute their mite in thwarting the efforts of the painstaking, intelligent physician, who, I fear, is oftentimes unjustly blamed for what under the circumstances could not be averted.

The following case is in line with those reported some time ago by Dr. J. G. Blake, and, if for no other reason, I am sure it will contain something of interest.

The subject of this paper — a young married woman, twenty-seven years of age, well-nourished, of florid

¹ Read, by invitation, before the Obstetrical Society, of Boston, April 9, 1892.

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complexion, yet feebly vitalized — was seized on the evening of December 25th with *la grippe*, which manifested itself in the form of nausea, vomiting, restlessness, insomnia and pains in the head and loins. Most of these symptoms — particularly the gastric — persisted until January 8th, when she was taken in her first labor, which lasted about nine hours and produced a healthy female child weighing seven pounds. There was nothing apart from the normal about her confinement, save a slight perineal tear, which was completely closed under antiseptic measures with one silk suture.

The patient continued apparently well, without any increase of temperature or pulse, till the end of the fifth day, when she experienced a chill. The thermometer at this time registered 101.5°, pulse 100, with nothing noticeably offensive about the lochia, while there was no headache nor abdominal pain. Thinking the sudden change in the patient's condition might be due to fecal impaction, and with the advice of Dr. C. M. Green, I administered two five-grain doses of calomel, followed by a saline at an interval of four hours. This medication proving fruitless, an enema of soap and water was then given, and the bowels were unloaded very satisfactorily. In about twelve hours from the time of the first chill, a second one occurred, more severe, and ushered in a dysenteric diarrhoea. The stools were very offensive, bloody and tarry, resembling very closely those seen in malarial dysentery. The lochia now began to be very offensive, purulent and free; the temperature chart showed a morning fall and evening rise, vacillating between 100° and 103.5°, while the pulse ranged between normal and 140. The patient's general condition was one of prostration and sleeplessness, yet there was no gastric nor abdominal symptoms present. I now began to fear that septic poisoning was a certainty, and hastened to consult with Dr. J. G. Blake. Examination per vaginam found a sanguineous, purulent discharge oozing from an os almost completely covered with septic membrane, which involved a considerable portion of the endometrium. The perineum was healthy, as well as the vaginal walls. No time was lost in curetting the uterus, where no portion of the membranes had been retained, and an intra-uterine douche of 1-5000 bichloride given till a clear solution appeared. A freshly made, five-grain pencil of iodoform was passed into the os, and the vagina packed with iodoform gauze, with an aristol tampon against the uterus. These measures were carefully carried out every morning for six days till the uterus cleared up, the lochia became sweet and the temperature and pulse dropped to normal. The patient partook freely of champagne, brandy and nutritious diet, and was given six grains of bisulphate of quinia per diem. The intestinal discharges were controlled by sugar of lead and opium, and other symptoms as they arose met with appropriate treatment. She made a good convalescence, and was soon able to resume her household duties with former vigor and strength.

A somewhat interesting experience was found in my efforts to produce sleep. Until the evening of the second day of the fever she obtained only an occasional "forty winks," when Sulfonal-Bayer followed by hot milk was given. Two fifteen-grain doses, four hours apart, produced no result. The next evening three hourly doses of chloral and bromide (ten grains of the former and fifteen of the latter) met with a similar fate.

The following morning three drachm doses hourly of bromidia, and in the evening paraldehyde, one drachm repeated in four hours, produced no influence on the insomnia. At 9 o'clock on the evening of the fifth day it was thought advisable to administer some ether, but the anæsthetic increased rather than diminished the patient's excitability. It did seem at this time as if the list of reliable hypnotics had been exhausted, so, almost as a last resort, one-quarter of a grain of morphia sulphate was given hypodermically, and a sweet, refreshing sleep of six hours followed.

The interest which this case possesses lies in the cause of the septic process, which in no way betrayed itself till the end of the fifth day, when we find the usual chill with rise of temperature and rapid pulse, but no gastric nor abdominal symptoms. When a strict adherence to the theory of antiseptics is carefully carried out, and there has been no interference on the part of the doctor or nurse, one naturally asks: Can the cause be laid at the door of the attending obstetrician? It does seem as if the susceptibility of a patient suffering during labor from *la grippe*, and thereby considerably devitalized, should cut some figure in the way of preparing a soil fertile enough for the formation of a septic process. However, even though the worry and fret attendant on such cases be made a matter of personal moment, is it not gratifying to think that by timely interference we can cut short the destructive inroads of the deadly germ?

Medical Progress.

REPORT ON DISEASES OF CHILDREN.

BY T. M. ROTCH, M.D.

ETIOLOGY OF DIPHTHERIA.¹

BAGINSKY, in his recent and important investigations on the cause of diphtheria, states that he has accepted the Löffler bacillus as the criterion for the character of the sore throat, and that in every case the method of D'Espine and Marignac was used to determine its presence.

In ninety-three cases of membranous sore throat, the bacillus was found sixty-eight times, with a mortality of forty per cent., and it will be well to translate the conclusions arrived at by the author.

(1) "There are two forms of disease which produce clinically the same changes upon the tonsils and the mucous membrane of the pharynx. The characteristic change in these cases is the appearance of dirty grayish-white or greenish pseudo-membranous infiltrations in the diseased tissues. As both forms are accompanied, in the same way, by fever, prostration, and swelling of the submaxillary lymphatic glands, a clinical separation becomes impossible. And yet these two forms differ *toto celo*: The one produced by the bacillus of diphtheria is very dangerous, producing a mortality of nearly fifty per cent.; the other, caused by staphylococcus and streptococcus (at least these micro-organisms are constantly found, so that it is probable that they are the cause) is harmless, and runs its course without endangering life.

(2) "These two forms can be differentiated by bac-

¹ Baginsky: Archiv. für Kinderheilkunde, Bd. xiii. Forchheimer: International Medical Magazine, No. 1, p. 81.