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CASES AND NOTES.

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CASE I.—March —, 1857. I was asked to see Mrs. — in consultation. She was near the end of pregnancy, when she was attacked, without precursory symptoms, with hæmorrhage from the womb. Her general previous state had been unfavorable for the continuance of pregnancy, or of healthy parturition. Nausea and vomiting had been for some time so constant, that very little food had been taken, or kept in the stomach. The hæmorrhage had existed several days before I was called, and its quantity could be very imperfectly reached. This single fact makes the management of labor a very embarrassing office, as it can hardly be ascertained what power remains, in the first place; in the second, how much blood remains to supply the waste, and to carry on functions for life, and particularly to complete delivery.

The appearance of Mrs. — was unpromising. She was pale—exhausted—the veins of purplish color, showing how much blood had been wasted, and how changed was what remained. The protracted vomiting and the recent hæmorrhage had produced just that state which characterizes anæmia. The pulse was 120, small and feeble. The temperature had been preserved by heat to the lower extremities. The liquor amnii had passed off. In early examinations the os uteri had been found dilated. The head had made some advance, and between it and the womb was felt a solid mass, which was believed to be an edge of the placenta. The favorable symptoms were, a clear, firm voice, bright countenance, and cheerful manner. There was also sufficient strength remaining to enable the patient to assist herself in such changes of place as were demanded. The animal functions were not disturbed.

During the three or four days or more from the occurrence of the hæmorrhage, not the least uterine contraction had been noticed by

the patient, or by her physician. She had felt no *pain*. The womb had silently contracted sufficiently to draw the dilated os uteri above that portion of the foetal cranium which presented, so as to leave it partially uncovered. Or, by the shortening of the womb, the head had entered the brim of the pelvis, according to the explanation offered by Mr., afterward Sir Charles Bell, in his excellent paper on the Muscularity of the Uterus, which, if my memory serve, is in the seventh volume of the Medico-Chirurgical Transactions of London. The size of the uterine tumor led to the belief that the foetus was large. The head was firmly fixed in its position. Ineffectual means had been used to produce uterine action and to check the hæmorrhage. Thus, ergot had been given, but such was the irritability of the stomach, that the ergot was at once rejected, and before it could have exerted its specific power upon the womb. In short, everything was vomited which was swallowed. Even small bits of ice, which a very irritable organ will sometimes bear, were vomited.

Such was the condition of Mrs. —, as communicated by the attending physicians, and as observed by myself. The question arose, what shall be done? Shall the case be left to the unassisted powers of nature, or shall artificial means be used? Internal remedies could not be employed. What are the resources of operative midwifery, and which promises best? Turning was suggested. Objections to this measure were the firmly-fixed head and the close contractions of the womb, which had followed the escape of the liquor amnii. Were turning accomplished, might not its completion, or the delivery of the head, require a force which the remaining power would fatally sink under before delivery was accomplished? Besides, there was little or no hæmorrhage now. A very large loss which had occurred the night before would seem to have made such a demand on the remaining blood, that with the following diminished power of the circulating system, a temporary stop had been put to farther flowing. Second, the forceps. Third, craniotomy. It was agreed that the forceps should be first tried. The patient being etherized, the instrument was applied by Dr. — with ease, and efforts made to move the head. These were continued as long as it was thought safe; but when increased exhaustion began to show itself, the instrument was removed; very little was gained by it under its fair use. The head was indeed lower than before the operation, but the descent seemed to be rather a lengthening of the cranium than from any change of place of the head itself. Craniotomy was now done. The cranium was perfectly emptied, the bones collapsed, and delivery accomplished with more than ordinary ease. The womb contracted well. The after-birth was separated, and was expelled without the least difficulty. Some re-action followed, as is common in such cases, but exhaustion soon declared itself. Stimulants

were again given, but were not retained, and death gradually took place.

CASE II.—March 6th, 1857. Mrs. —, aged 24; first labor. I was called to this case at about twenty-four hours from its beginning. Mrs. — is young, strong, plethoric. The liquor amnii had been dribbling away for three days. Uterine action was strong at the beginning, and soon became violent. The os uteri was dilated, in part, and was perfectly dilatable. It could be easily swept up and away from the head, all round. The anterior fontanelle presented, the face being toward the pubis. The os uteri could only be carried for a certain distance, and descended as soon as the fingers were removed. The anterior lip was always the lowest, and the thickest. Hours passed, the uterine contractions constantly increasing in force and frequency, without the least change in the place of the foetal head, which was just outside, or below, the brim. Ether was used, and suffering was made less.

The question arising upon this statement, and investigation of the facts of the case, was, what shall be done? A fair trial had been made of uterine power, and there was no progress. The six hours of perfect rest of the foetal head in one place, notwithstanding vehement uterine action, as named by an acknowledged authority, before artificial aid shall be resorted to, had been far more than accomplished. Dr. — referred to a case to which he called me in consultation, which very much resembled this, in which what was thought perfectly safe delay was practised, but in which rupture of the womb occurred. I recollected the case, but at the same time did not forget that in existing circumstances of each case, mainly, in midwifery, the demand for artificial aid must be found. Hence no department in medicine has in it such responsibility as this, and the wider is experience so much deeper is felt to be the responsibility. I became satisfied, after due observation, that the time had come for artificial aid, and the forceps were used. The application was easy, and effort was aided by fair uterine action. There was no progress. All of force which could be safely applied, and all of uterine contraction, accomplished nothing, or so little as to give no prospect of ultimate success. Very careful and continued uterine auscultation was practised, but not the least evidence that the child was living was obtained. The foetal pulsation could not be heard, nor the placental murmur; nor could any muscular movement of the child be felt. Craniotomy was resolved on, and delivery accomplished, though with unusual delay and difficulty. The after-birth soon followed. The womb contracted very well. There was some flowing afterward, and more than usual after-pains, accompanied with expulsion of coagula. Strong re-action, showed by rapid pulse, and rapid respiration, followed. An opiate was given.

Much anxiety was felt about the result of this case. On the

morning of the second day some tympany was noticed, but there was no pain in the abdomen; there had been no chill, and the pulse was but little accelerated. The bladder performed its functions perfectly well. Food was craved, and nights comfortable. On the fourth day, was quite severe diarrhœa, preceded some hours by griping pain. No constitutional disturbance. The diarrhœa was readily controlled, and recovery has since been uninterrupted.

In order to do something to prevent disease after such deliveries, I have long been in the habit of using a more active treatment than other observers have thought necessary. This method was employed in this case. The following was prescribed the morning after delivery. *R.* Opii, gr. viij.; hyd. submur., gr. iv. *M.* ft. pil. no. viij. One of these was directed every four or six hours, unless sleep occurred. In three days these, and four more of a new number, were taken, and with good results. The mouth did not get at all sore, and if the diarrhœa were produced by the pills, most perfect and entire relief followed.

The question of operative midwifery thus arises under various circumstances. Labor may be advancing regularly. Without obvious cause, contractions grow weak, and cease. The pulse fails, temperature diminishes, sinking is apparent. The head is in the pelvis, at the perinæum. There is little or no hæmorrhage. What may be the causes of this sudden change in a healthful labor? There may be rupture of the womb, laceration of the vaginal *cul de sac*, anteriorly or posteriorly; there may be simple laceration of the peritoneal covering of the womb, more frequently noticed in the neighborhood of the Fallopian tubes. What should be the practice here? I answer, use the forceps. But in laceratio uteri the head recedes. Here the forceps cannot be used. But there are exceptions even to this rule. One has occurred to me:

CASE III.—The head was fairly in the pelvis in this case. The labor was slowly proceeding. Suddenly contractions ceased. There was slight hæmorrhage. Sinking rapidly followed. I proposed to deliver by the forceps. Dr. — strongly advised this measure. The patient would not permit it. She said she was perfectly easy, and would sooner die than submit to any operation. She died in a few hours. Examination showed large uterine laceration. The extremities and trunk of the fœtus were in the cavity of the abdomen, the head in the pelvis.

But suppose the head does not recede, and we are uncertain as to the nature or place of the suspected lesion, questionless and rapidly-increasing sinking being present. Apply the forceps. Why not give ergot? Because, if it increase contractions, the womb will be drawn farther up, over the head, and the laceration of the *cul de sac*, if such exist, will be increased, and danger greater; while in the other, or peritoneal form of laceration, it cannot but be best to secure perfect repose to the womb, as excessive action has been the cause of the laceration already existing.

But suppose hæmorrhage along with sinking, not the small flowing which may accompany laceration, but such as may be ascribed to placental separation, the head being within reach. Use the forceps. Why? Because there may not be uterine power to respond to ergot; or the remaining power will be best used in completing the detachment and expulsion of the placenta, and to secure ultimate and permanent contraction, which is the surest prevention of secondary hæmorrhage.

Suppose hæmorrhage not only complicates the labor, but follows delivery. This very rarely follows delivery after *unavoidable* hæmorrhage; that, namely, which belongs to *placenta prævia*. But suppose the flow be *accidental*. Pass the hand into the womb and learn if retention be from *morbid* adhesion, or the result of imperfect contraction—the womb being soft, flabby, uncontracted. By completing the separation only, strong contraction is often induced, and the placenta delivered. But in this case having it in the hand, let it and the hand be delivered together; in other words, let the progress depend mainly on uterine action. Should the womb remain inactive, then resort to other means, so fully directed in the books, to excite contraction. These are usefully employed while attempting separation.

In a late number of the Journal is an article on "Improvement in plugging the vagina in profuse uterine hæmorrhage, especially in abortions of an early period." It consists in firm compression of the external organs, by a towel doubled or folded lengthwise, and which, having been rolled up in another longer towel, and then passed between the limbs in front and behind, is fastened by its ends to a firm bandage surrounding the abdomen. I allude to this method here, because I saw a similar use of it in a case of dangerous hæmorrhage after labor at the full time.

CASE IV.—Mrs. — has had several children, and has always flowed profusely. I never attended her before. Her labor was natural, and its stages easily passed through. Hæmorrhage followed a short time after the delivery of the after-birth, and was persistent, notwithstanding a fair trial of remedies. I now first learned that she had always flowed excessively, and asked what her physician had done. She said he had always found firm compression of the external organs the best method of stopping the flow. I immediately adopted it, and very much after the manner described by Dr. Casey, and with the happiest result. Re-action promptly declared itself.

In early abortions this method seems liable to no objection. After labor at full time *internal hæmorrhage* is certainly possible, and must be kept in mind. The womb may not contract. Hæmorrhage may continue, though unseen. Coagulation may occur within the womb. But we know this does not always check flow, and we also know that when a great loss has already occurred, a slight

addition may be fatal. Suppose sinking increases, and this rapidly; external examination of the womb should be made, and if *internal hæmorrhage* be discovered, attempts should be at once made to empty the womb and produce contraction. Dr. Casey says of the plan he recommends, "It has rarely or never failed in my hands."

Why does it happen that while the placenta is still attached, or when separated, still remains in the womb?—why is it that this organ is so reluctant to take on that action which will complete the detachment, and in this and in the other case supposed, remove the after-birth? Again, why is it, that this having been expelled, contraction does not take place, allowing internal hæmorrhage to occur, and to an extent to produce a uterine tumor closely resembling the state of the organ when filled by the fœtus?

[To be continued.]

DR. EDWARD BROWN-SEQUARD'S EXPERIMENTAL AND CLINICAL RESEARCHES APPLIED TO PHYSIOLOGY AND PATHOLOGY.

[Continued from page 158.]

It will be sufficient, I believe, to remind the reader of the cases of cure of epilepsy that I have given in a preceding section of this paper (see § IX.). They prove peremptorily that the source of fits of epilepsy may be in the peripheric part of sensitive nerves. The fits were certainly due to an external cause of irritation in cases of epilepsy where they have been prevented by the following means:

- 1st. Application of a ligature around a limb or finger.
- 2d. Section of a nerve.
- 3d. Amputation of a limb, a finger, a toe, or the testicle.
- 4th. Extirpation of a tumor, a foreign body, or a tooth.
- 5th. Expulsion of worms, of calculi or other concretions.

Some other facts which I have mentioned in the beginning of § XI. show, in the most direct way, the possibility of the production of a fit by an irritation of the periphery of the sensitive nerves. Together with these facts, I might have spoken of a young man, observed by Zimmerman, and who had a fit of epilepsy every time he practised masturbation (*Esquirol, loco cit.*, p. 301). That an external irritation may cause fits is also proved, without any doubt, by the facts I have almost daily observed in animals for many years; facts described in the first part of these papers. It seems, even from what is observed in these animals, and from various circumstances observed in man, that when there is a cramp preceding a fit, the cramp is nothing but the first effect produced by the irritation of a sensitive nerve. Cramps in some of the muscles of the neck and face are sometimes the only effects of the excitation of the skin of the neck and face in my animals, and when a complete fit takes place, it is almost always preceded by the spasmodic contraction of these muscles. So that if we did not know that