SOME RECENT CASES PRESENTING POINTS OF SPECIAL OBSTETRICAL INTEREST.

By SPENCER SHEILL, F.R.C.P.I.;

Ex-Assistant Master, Coombe Maternity Hospital, Dublin.

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IN this paper are submitted the short clinical notes of a few of the most interesting cases that have occurred in my practice during the past twelve months or so. If, on account of the nature of the subject, it appears to be somewhat scrappy and discursive, I trust the absence of statistics and lengthy references to the literature will make my remarks more pithy and acceptable.

I.—*Vicarious Menstruation*.—The patient was a young woman of nineteen years, short in build and rather stout; somewhat listless in temperament; a sufferer from constipation, but not anæmic. She is of the type the Scots call “blæ”—inclined to be blue, limbs heavy, skin thick, little energy—suggestive of a tendency to equalization of the blood pressure in the arterial and venous systems; that is, reduced arterial and increased venous pressure.

She menstruated normally, and for the first time, seven months previous to consulting me, but never normally since. Each month since then she had symptoms of menstruation similar to those experienced on the first occasion, but without any vaginal discharge; instead, she experienced for one day a salmon-pink discharge from the left axilla, which changed for one day only to blood-red, then fading again to disappear on the third day.

Bimanual examination revealed no uterine or ovarian abnormality, other than a perhaps somewhat conical cervix with a small os. There was nothing unusual to be made out in the axilla.

II.—*Eclampsia*.—This is always a grave complication of pregnancy, but the course of the following case was unusually severe and atypical in detail.

The patient, a young primigravida, within three weeks of term, was suddenly stricken with a seizure at 6 a.m. I witnessed a second one at 7 o'clock, and a third occurred at 8 30. There was no premonitory signs or symptoms, and twelve days previous to her illness the urine was normal in amount, contained no albumen, and carried from the system almost 20 grammes of urea in twenty-four hours.

The patient was transferred in a semi-conscious condition to a nursing home after the third seizure. She passed plenty of urine, vomited several times, and the left leg only was seen to be somewhat cedematous. Morphia, jalap, and calomel and rectal salines were administered. She had five seizures during the day, and eleven the following night. Her skin was acting freely, and urine was secreted copiously, and passed under her. The temperature did not rise above 101° , whilst for over a week the pulse varied from 120 to 140. The next day she became so violent that three nurses were unable to control her movements, and it was almost impossible to keep her in bed. During this time she did not utter a word. Croton oil by mouth and castor oil enemas produced no result. Her colour was very high, and her pulse bounding and of high tension.

Following a consultation with Sir Wm. Smyly, it was decided to remove 20 ounces of blood from the patient's arm, during which operation her pulse softened markedly, and the patient fell asleep shortly afterwards. Salines were continued per rectum, and a catheter specimen of urine taken was loaded with albumen, but unfortunately contained blood. Judging from the colour, all the albumen was not accounted for by the presence of blood.

At this time the foetal heart was audible, but weak. The same evening labour threatened. I ordered calomel and jalap again, and magnes. sulph. per rectum with excellent result. It is worthy of note that *formed constipated motions* were passed in spite of starvation, previous free motions, and even diarrhoea before she became ill. Her skin acted freely, and she took some nourishment. There were no seizures that day

or night following the bleeding, but on account of her stiffening up once as if having an abortive fit, I opened the arm bandage and allowed her to bleed a further 5 ounces, after which she slept. The next night she was very restless, and had hallucinations of the death of herself and her baby. She had one bad eclamptic seizure, and the membranes ruptured at the same time. Examination revealed a dilating os, which was further dilated manually. The foetal heart was still audible, but rapid and feeble.

Under scopolamine-morphine she had a painless labour, after which she spoke calmly and sanely. The child was born alive, but lived only sixteen hours. The placenta presented several small hæmorrhages between the membranes, and associated with each were numbers of distinctly burst blood-vessels, yet the placenta was not crushed or broken. Were these, I wonder, associated with the eclampsia as cause or effect ?

Two days following delivery, the patient suddenly collapsed during the night. Her temperature fell to 96°, she became cold and clammy with feeble pulse. Hypodermics became necessary. Later her temperature rose to 98° and she fell asleep.

The patient's right kidney was felt to be considerably enlarged and very tender. The conjunctiva were oedematous. She progressed favourably, and became quite sane by the sixth day of the puerperium, but on the seventh day her pulse rose to 120, though her temperature was but 97°, and a little later she became violently maniacal. She looked so like a case of belladonna poisoning that I removed the plasters from the breasts. During two days and nights, drugs seemed to be almost powerless until, before transferring her to an asylum, I tried paraldehyde. This drug was very successful, and she improved in body and mind slowly, until in twelve days she appeared almost her old self again. Yet it was necessary to keep a watch on her for two weeks longer, as she was inclined to be wilful and erratic.

Her family history was negative. During the convalescent stage, she was at one time depressed, at another sulky, and yet another abusive ; but her quick wit and ready answers

were a source of wonderment to everyone who saw her. She attempted many letters, but the specimens showed the state of turmoil in which her poor brain appeared to be.

Her recovery was absolutely complete, and later examination revealed a small fibroid situated at one uterine cornua, which I do not suggest was a contributory causative factor of her ailment.

I think the principal points of interest in this case were—(1) The excellent result following venesection—a treatment I have always strongly advocated in eclampsia. (2) The peculiarly hidden and obstinate constipation. (3) The sudden appearance of acute mania following a day or two of sanity subsequent to the more usual mental disturbance associated with eclampsia.

III.—We have all observed from time to time profound alterations in the constitution of infants following vaccination ; I refer principally to derangements of the alimentary tract and to skin affections undergoing changes—usually for the better. An infant born with a disfiguring capillary nævus, about the size of a shilling, situated upon the forehead, was vaccinated by me at the age of two and a half months. As soon as the pock became established, the nævus began to undergo changes suggestive of a mild vaccination on the forehead. It became paler, and thin crust formed upon it, which, having fallen off about two weeks later, left no sign of the original nævus except a patch of skin somewhat paler than its surroundings and of pig-skin appearance, like an old-standing adult vaccination mark. Since that time—over a year ago—it has become less visible, and is now quite unnoticeable except on the closest scrutiny, much to the delight of the parents.

IV.—This case is, I am sorry to say, not a rarity ; it should be much more so than it is, for there is not a text-book or handbook dealing with obstetrics which does not emphasise the necessity of keeping the bladder empty during labour. I

include the notes of this case merely to illustrate the train of trouble that may follow neglect of this important point.

A primiparæ in the first stage of labour was allowed by the nurse to remain with a full bladder. As labour was unduly prolonged, I was again summoned as meconium was coming away. The presentation was a Vertex, R. Occip. Postr. The full bladder had obstructed the drawing up of the anterior lip of the cervix, which in its turn had operated against anterior rotation of the occiput. A large caput formed, and the perinæum had become œdematous. Instrumental delivery became necessary, with the bad laceration usual in such cases.

In my opinion, the neglect of the bladder was the sole cause of all these complications.

Retrospective of infantile mortality from *epidemic gastro-enteritis* during the dangerous quarter-year (July, August, and September), two summers have passed by since I published a paper^a on this subject regarding the alarming and fatal epidemic of the previous summer.

In drawing a comparison between the summers of 1911, 1912, and 1913 we find a marked difference in the meteorological conditions which prevailed, and with it a rise or fall in the death-rate from the disease under consideration. Thus in 1911, with its high mean temperature, no less than 426 deaths took place in the Dublin Registration Area, during the three summer months, from epidemic gastro-enteritis; these infants were all under two years of age. In 1912, when little summer weather came to our island, only 95 deaths occurred from this cause. This year, although the exact figures for the quarter are not yet published, I find the mortality averaged somewhere between 20 and 30 deaths per week, or roughly some 300 infants.

^a See *The Practitioner*, May, 1912.

These statistics are more than suggestive—they are a definite accusation that we are powerless to combat the epidemic or to prevent it; or, that the means are at our disposal and we are not making use of them. It would be pleasanter for us to think the former, but that would be equivalent to give up hope for the future. I prefer to think the latter—not only because I am optimistic, but because I believe it to be the true facts of the case.

It has been proven up to the hilt that meteorological conditions affect the microbic content of the staple food of infants—the milk; and that in a clean milk supply lies our only hope of stemming the tide of infantile gastro-enteritis amongst milk-fed babies. Yet, what steps have been taken in the past two years to supply uncontaminated milk to the public? The answer is merely the echo of the question.

Can I suggest a remedy? Yes—individual action is futile; but, if every medical body in the kingdom formed its own milk commission and with one voice pressed their conclusions upon the State, something might be done—how else a happy result can be brought about I fail to see. In the meantime, as we cannot change our climate, we must endeavour to convey milk to the consumer and there keep it as nearly as possible under winter conditions, in the summer time. With this end in view, I devised a simple little receptacle into which a jug of milk could be placed, its contents reduced in temperature 12° F. in one hour, without chemical or ice, and automatically maintained in that state indefinitely. It can be made at a cost of about 1s. 6d.

Theoretically and practically this invention is a success, but in order to fulfil its mission it must be brought to the notice of every individual concerned. This means it must

be a commercial success, and therein lies the difficulty. Thus the matter lies shelved *sine die*.

V. *Anæsthetic Poisoning*.—Æther poisoning, resulting from its use as an anæsthetic, is fortunately rare, and fatalities during its administration are almost unheard of. Yet I regret to say a case of each kind fell to my lot within the past year or two. There is little to tell about them, but possibly much to be deduced from the experience.

The fatal case was that of a young woman, apparently in perfect health, except that she was suffering from signs and symptoms indicative of inevitable abortion. Her thyroid gland had been slightly enlarged for many years, but not beyond the extent which one might call a handsome full neck.

During the preliminary disinfection of the parts previous to commencing the necessary operation, and while fully under the anæsthetic, the patient suddenly ceased breathing, and on immediately auscultating the heart after finding no radial pulse, it was found to have stopped. One hour and twenty minutes' effort on the part of doctors and nurses failed to resuscitate her, and in fact she seemed to have died as quickly as if a bullet had been put through her heart.

The other case, which had a more happy termination, was of a similar nature, as regards the indications for operation. The symptoms were more urgent, and the patient was not specially prepared for operation by purging or dieting. Complications arose, and caused the anæsthesia to be prolonged for nearly an hour. The operation was quite successful, but the post-operative vomiting became persistent, and on the fifth day I was recalled in consultation, as the patient was failing, having vomited absolutely everything which passed her lips since the operation.

It was decided that the case was one of æther poisoning, and the usual glucose clyster treatment was adopted, with complete removal of all distressing symptoms the same evening.

This treatment is rational, and based upon the assumption that the trouble is caused by a derangement of function, or even an actual degeneration, of the liver cells, thereby permitting poisonous substances to reach the systemic circulation unhindered. The fatty degeneration is due to the cells consuming the oxygen of their own tissue, instead of taking it from the glycogen stored for that purpose. Hence, we see that a goodly store of glycogen is necessary, in order to carry a patient safely through a prolonged anæsthesia. The way to attain that end is, not by starvation previous to operation, but, on the contrary, when possible, to supply sugar—glucose for preference—literally up to within two or three hours of the operation. In æther poisoning, if acidosis be present as well, it is probably a result of disintegration of tissue-albumens, and makes the case still more grave.

I am happy to know that these liver changes occur to a much lesser degree in æther anæsthesia than in chloroform anæsthesia—a further argument, if necessary, against the use of chloroform when avoidable. I can only account for the poisoning in this last case, by previous poor health and appetite for some time prior to operation; to the effect upon her system as a result of a degenerating ovum; and to the prolonged anæsthesia without previous preparation.

VI. *Injury to Fœtal Skull during Difficult Labour.*—The next case is illustrative of neither a rare complication or a novel procedure, but rather of the successful application of a well-known method, which, as described, seems simplicity itself, but in practice proves not quite so easy as one would expect.

On receiving an urgent call from a country practitioner one

night, after a drive of almost thirty miles, I arrived at the bedside of a patient, advanced in the second stage of labour of her fourth pregnancy. Her pelvis was contracted in the conjugate diameter, but not to a marked extent. (I regret not having exact measurements to give), but in addition to *this*—which, so far as I could ascertain, was due to bulging in of the symphysis pubes towards the sacrum, and an undue prominence of the sacral promontory, not merely a flat pelvis—there was a bony boss about the size of a pigeon's egg situated slightly to the left of the middle line at the back of the symphysis.

The patient and child showed signs of distress, and the former was in urgent need of help in the delivery. Under anæsthesia, after considerable difficulty, the child was delivered alive by forceps. I should have said that three previous infants had been lost.

Examination of the infant, after resuscitation from asphyxia, showed a deep depression of the frontal bone running upwards from the temporal region almost to the suture, a little in front of the anterior fontanelle. Rather than risk permanent disabilities in the child, I determined to attempt to raise the depressed bone at once, and that without the permission of the parents, which I feared would be refused. The blade of a bullet-forceps was used, the point of which was pressed into the bone at right angles to its surface, and in the deepest portion of the depression. The force necessary to do this is difficult to estimate or describe, but I know full well that twice I stopped the pressure before I succeeded, fearful lest I would further depress the bone. Eventually I raised the bone, but cannot say with certainty if the forceps penetrated the whole thickness or only the outer table. There was no untoward after-result other than a slight hæmatoma under the scalp in the region of the puncture. The child did well in all respects.

I recollect a Fellow of the Academy—I think Dr. Holmes—advocating this procedure some years ago. It would be of interest to know if he or others have experienced any difficulty when performing the little operation,

or whether it was due in my case to unusually hard bone or to want of skill.

VII. It is not without some hesitancy that I include notes of my last subject.—“*Some Cases of Maternal Impressions.*” I say this because my inclination has always been to dismiss these things as being largely, if not entirely, the result of a disordered imagination, or as mere coincidences. That I am converted from this point of view, I am at present neither prepared to deny or confess. But, having regard to the fact that much more wonderful things, and things equally difficult to explain in the present state of our knowledge, have occurred in nature, we are logically bound to admit these as facts until the reverse has been proved.

(a) A patient, pregnant about five months, accidentally stabbed her scalp with a hat-pin. The puncture bled freely for a few minutes, but caused no more trouble except mental worry, which drove her to ask me if it could affect the infant in any way. I tried to reassure her. The baby was born in due course with a capillary nævus, about 1 inch in diameter, situate on the scalp as nearly as possible, from memory, at the spot where the mother had pricked her scalp months previously.

(b) A husband playfully struck his pregnant wife with a stout piece of twine over the left eyebrow. A red mark was visible to me the same evening; the mark was about one and a half inches long and nearly vertical. It caused the mother some concern regarding the baby. The child was born with a distinct red mark in the corresponding region. This mark was visible a year later.

(c) The third and last instance was a lady, pregnant about four months, who scalded her left third finger and half of the second and little finger. She showed it to me one day, but it caused her no concern other than the physical pain during healing. She never alluded to the baby in connection with it, nor did I. The baby was born at term with port wine stains

on the corresponding finger and even half-fingers of the same hand. It is now over four years old and the marks remain.

Having related these details, I offer no comment, but if any one is sufficiently versed in psychology to throw some light upon this obscure subject, his words will fall upon attentive if not anxious ears.

DR. TWEEDY said he would like to hear Dr. Sheill's views regarding bleeding as a treatment for eclampsia. He had never been able to see the *rationale* of this. It had been suggested that it removed poisons from the blood, but this he considered hypothetical. It was mentioned that the patient's urine contained blood, and also that she was passing urine copiously at first; putting these two facts together he suggested that the blood resulted from kidney inflammation, the result of concentrated and poisonous urine. He submitted that even theoretically there was no reasonable foundation for bleeding unless an equal amount of fluid was put back.

With respect to the fracture of the skull he thought that the difficulty experienced was due to the bullet-forceps not being sharp enough. He mentioned a case in which he removed a very deep depression in the skull of a child, aged two years, with the assistance of three bullet-forceps, all three being pulled upon at the same time.

SIR WILLIAM SMYLY referred to a series of pictures of bottle dairying which he had recently seen; the system appeared to be perfect, and he wondered something of the sort was not introduced into this country.

He believed in the bleeding treatment for eclampsia. It had always been well spoken of by those who had experience of it. He suggested that in eclampsia it was known that the blood was of high specific gravity and contained less water than usual; that it clots all over the body, and that the arterial tension is very high and patients often die of apoplexy. Bleeding made the blood thinner and less liable to clot. The arterial tension is reduced and apoplexy prevented. He considered the great difficulty in knowing any-

thing about the treatment of eclampsia was that even with an enormous number of cases no very definite conclusions could be formed. He looked upon sweating in these cases as bad, because it removed fluid from the body when the blood was already too thick.

DR. SOLOMONS considered that one of the most interesting points raised in the paper was the treatment of eclampsia in private practice. There was no doubt that a maternity hospital was the best place for these cases in order to ensure a satisfactory result, and unless the practitioner could devote *all* his time to the eclamptic patient she should be sent to one of these institutions. He still used scopolamine-morphine anæsthesia where the case was suitable and there was a reliable nurse.

DR. FITZGIBBON agreed with bleeding in eclampsia if used in suitable cases. A large number of cases occur in full-blooded women, and such react favourably. The system of introducing saline under the breast had the effect of lowering the specific gravity of the blood. He considered that Dr. Sheill took too severe a view of the responsibility of the medical profession as regards contaminated milk. He experienced several cases in which he attributed the infection to the way in which the milk was kept in the household, and suggested that much of the contamination took place after the milk was received into the house. He considered that more could be done by educating the public than by attacking the dairies, although he recognised that the latter were far from perfect, and could be very greatly improved by enforced supervision.

DR. ROWLETTE, referring to the serious outbreaks of gastro-enteritis, said he believed that most of the disease was due to contamination of the milk after it left the dairy. He attributed the disease to two factors—contamination by flies and contamination by dust.

DR. SHEILL mentioned that none of the cases of eclampsia he had seen ever suffered from *post-partum* hæmorrhage. As to the difficulty in getting the blood to flow he thought once the vein was found this disappeared. He recognised that the milk supplied was contaminated before reaching the consumer, but he also thought it got very much more contaminated afterwards; and even supposing the milk to

be supplied sterile to the consumer one fly might introduce sufficient damage to kill any child. He did not agree that the putting of saline in under the breast had the same effect as bleeding, as saline absorbed into the blood might be as rapidly excreted, whereas in the treatment recommended of bleeding, some of the solid matter of the blood was withdrawn and also some of the poisons. He was convinced that the blood in these cases was toxic, and that the removal of some of it would reduce the pressure and also some of the toxins.