to its faulty position, the vomiting recurs. Physicians often examine and find the uterus in the anterior position, either anteverted or anteflexed, and they consider that position practically normal, and let it alone. Graily Hewitt calls particular attention to this condition, where the fundus is behind the pubic arch and can be so held by it that it is delayed in rising from the pelvis and prevents symmetrical growth, and is also causing a constant pressure on the nerves of the cervix, compressing it in anteflexion. He says: "The cause of the sickness is, in the majority of cases, practically the same, namely, compression of nerves in the cervical tissue, associated with a bent, indurated condition of this part of the uterus, and the consequent loss of the natural pliability and expansibility of the tissues." Elevating the fundus and keeping it so produced a cure in 10 cases out of 12. In the two unfavorable cases, one died—uterus was allowed to return to faulty position, and patient lived at a distance and was very ill before she could be treated; in the second one abortion occurred. The retrodisplacements are more commonly recognized, and replacement or partial replacement by packing is followed by immediate improvement. Hewitt quotes 19 cases, with success in 13, where reduction was effected and maintained. If replacement alone is not effective then dilatation of the cervix should also be tried, which incidentally draws the cervix forward and down, and lessens its cramped condition.

(2) That if all these measures fail in the early months of pregnancy, we should not trust to nature and time to effect a cure, but should proceed to empty the uterus by surgical means, as soon as a consultation has been carefully held, provided the religious beliefs of all concerned are not against such a step. When the patient cannot retain sufficient food to nourish her, either by mouth or rectum, when rest in the horizontal position, when rectifying the displacements of the uterus so far as possible, and the dilatation of the cervix, have been faithfully tried without relief, these measures should not be persisted in while the patient is rapidly losing flesh and strength and getting into the condition where nothing will avail. If we put off the evil day, knowing that there is a risk even in operating early, hoping that, after the third month when the uterus rises out of the pelvis, vomiting will cease, we increase the chances of a fatal result.

Our text-books teach delay. Klein says: "In hyperemesis of the third degree the artificial induction of labor is *occasionally* required." Bacon² says: "Induction of abortion is *never* indicated." Leclerc states: "Good results . . . by simple cauterization of cervix; this measure is *far superior* to artificial abortion." Lush says that uncontrollable vomiting is a *rare event*, but when it occurs "there remains as an *ultimate* resource the artificial induction of abortion." A. F. Currier, New York, says in review: "Finally there remains the emptying of the uterus as a last resort, and *only as a last resort*. It should only be done after careful deliberation and with the approval of skilled counsel." Edward Reynolds justly remarks that the solution of the question depends in "a certain degree upon the religious beliefs of the individual family, and upon their estimate of the relative value of maternal and fetal life. Among Protestant physicians in Protestant families it is generally considered the best practice to advocate abortion when all other

treatment has failed, but patients are constantly lost by over-conservatism in the most skilled and experienced hands." Gardner³ says: "As regards the ultimate procedure of emptying the uterus, the general tendency is to delay too long the operation, one which in itself is not without danger." Jewett⁴ states: "Evacuation of the uterus is often too long delayed."

Delay and its dangers are emphasized by these last three men. Delay and its dangers are what I am emphasizing to you, and I enter my plea for earlier interference, before the patient's courage is gone, her vitality exhausted, and her system in the worst condition to withstand the shock.

Indications for emptying the uterus.—(1) Inability of retaining any food taken by the mouth; (2) intolerance of rectal enemata; (3) more or less albuminuria; (4) progressive emaciation; (5) headache constant; (6) frequent and feeble pulse; (7) a certain apathy of the patient.

BICORNATE UTERUS, WITH TWIN PREGNANCY; ABORTION FROM ONE HORN.¹

BY CHARLES H. WINN, M.D., BOSTON.

IN presenting the following case, it is with no intention of using it as an introduction for a paper upon any of the subjects which it naturally suggests, nor do I care to speak dogmatically concerning even this particular case. It has, however, seemed to me a case of sufficient interest, by reason of the unusual and instructive elements which it presents, to be worth placing upon record.

Mrs. S. E. W., thirty years of age, was a healthy woman of New England birth and parentage, with sufficient intelligence to know better. After having one child at full term nine years previous to the experiences about to be related, she soon became adept in the art of inducing abortions, admitting three prior to 1897, she being each time from two to three months pregnant. On one occasion there was a twin pregnancy, one fetus coming away partially decomposed, the other in normal condition. This incident becomes exceedingly important in the light of subsequent events. She was first seen by me in April, 1897, when she admitted another operative abortion. Intra-uterine douches were used and recovery was complete in two weeks' time.

I next saw her November 8, 1898, when she gave the following history: Her last menstruation was September 17th, and supposing herself pregnant she had inserted a catheter into the uterus one week previous to my visit. Flowing had begun the next day and had continued, with the accompaniment of more or less pain and the occasional expulsion of clots. There had also been moderate gastric disturbance. The os was dilated to size of a quarter dollar. There was moderate flowing and offensive odor. Abdomen tympanitic and slightly tender. Temperature 100°, pulse 92. I removed several vaginal clots and gave a hot intra-uterine douche of lysol. Next day she was quite comfortable, her temperature being normal, pulse 88;

¹ Read before the Suffolk District Medical Society, Section for Obstetrics and Diseases of Women, January 24, 1900.

² British Medical Journal, 1897.

⁴ Canadian Practitioner, September 18, 1897.

² American Journal of Medical Sciences, 1898.

flowing slight and no odor; intra-uterine douche morning and night; stimulants and quinine.

November 10th, next day, several clots passed; odor offensive. Temperature 100°, pulse 96. Headache and slight gastric disturbance. Intra-uterine douches continued.

November 11th, general condition being the same, she was etherized and, assisted by Dr. W. F. Temple, I dilated the cervix and thoroughly curetted the uterus, removing much debris which was rankly offensive; one piece of tissue was nearly as large as a walnut. After douching with lysol, the uterus was packed with iodoform gauze. After this, all pelvic symptoms quieted down and the temperature remained normal, but severe and persistent vomiting proved intractable. There were occasional remissions, when light nourishment would be retained, but these were brief.

One month after curetting, I find by my notes that nothing whatever could be retained, and even the smell of food would cause vomiting. For two weeks it had been noticed that the stomach disturbance was more marked in the morning. Rectal feeding was now begun, and used exclusively for four days. Gastric symptoms gradually abated, and by January 1, 1899, was able to take some solid food. General condition is improving. She still vomits occasionally, at least one meal being lost every day. Temperature continues normal. Menstruation has not appeared and patient is growing anxious.

January 12th. Called Dr. Kingman in consultation and he kindly supplies me with the following notes of his examination: "The cervix is softened almost one-half its length. The uterus is much enlarged and softened, and presents an irregular contour. At the right there is a softly elastic, globular mass, being apparently a pregnancy of about four months' development. Continuous with this at the left and slightly behind is a smaller and firmer mass, about the size of a small fist."

In view of the history, Dr. Kingman stated as his belief that there had been a twin pregnancy in a bicornate uterus, abortion having occurred from the left horn, while the fetus in the right horn had remained undisturbed.

From this time on, gastric symptoms gradually subsided and ceased entirely about April 1st. On July 12th, after eight hours of labor, she was delivered of a healthy nine-pound female child, forceps being required. The placenta was normal. She made an uninterrupted recovery, and mother and child are to-day in good health.

The salient points of the case to which I would call attention are as follows:

(1) The abortion with twins some years ago, in which one fetus was macerated and the other not. In the light of our present knowledge it seems very likely that each horn of the bicornate uterus contained an embryo. Violence being done to one, it underwent changes due to its death and maceration and then both were expelled together.

(2) A second twin pregnancy, both horns being occupied. The abortion in November was complete, as shown by the foul, decomposing tissue removed by a vigorous curetting, and the immediate relief of the septic conditions which resulted.

(3) The demonstration of the bicornate condition, by the facts just mentioned, and by the finding of the contracted horn on the left side of the pregnant

uterus in the course of Dr. Kingman's examination in January. Dr. Kingman assures me that the mass described did not suggest the presence of a fibroid tumor, and the preceding and subsequent history contains no indication of such disease.

(4) The probability of superfetation. The last menstruation occurring September 17th, and the child being born July 12th, nearly ten months later, impregnation must have occurred nearly a month later than the menstruation. But abortion in the first week of November must have been of more than a month's development, as proved by the large piece of tissue removed by the curette. It seems, therefore, highly probable that pregnancy occurred in the left horn of the uterus shortly after the cessation of menstruation in September, that a few weeks later, about October 12th, pregnancy occurred in the right horn; that when abortion was attempted, the catheter passed more readily into that horn which contained the larger and more advanced ovum; that this horn emptied itself or was emptied by the curette without any disturbance to the contents of the right horn.

(5) The tolerance of the pregnant uterus to adverse influences is markedly shown by the persistence of pregnancy in spite of catheters, abortion, sepsis, curetting, intra-uterine douches and iodoform-gauze intra-uterine packing.

Incidentally it may be edifying to contemplate the predicament of the physician who attends a woman during an abortion, curettes her uterus, assures her that her uterus is empty and is prepared to take his oath that he has left nothing in it, and who is then brought suddenly face to face with the fact, not only that she is still pregnant, but that the very vomiting which followed the ether of his operation was actually the so-called vomiting of pregnancy.

A CASE OF PERNICIOUS VOMITING OF PREGNANCY.¹

BY H. S. KNIGHT, M.D., WORCESTER, MASS.

THERE are two elements about this case which are very personal to me: (1) the confession of my failure, and (2) the obligation I feel under to Dr. Kingman for correcting the difficulty which existed and restoring my patient from a condition of extreme emaciation, where it seemed as if death was near, to a condition which promises the very best result.

This patient was a primipara, twenty-seven years old, who menstruated the last time September 20th. On October 27th or 28th I was consulted at my office in reference to the vomiting she complained of. The patient was carried along without very great complaint until November 13th, when the vomiting was so excessive and her rejection of almost all forms of food was so constant, that rather more urgency was expressed on the part of the patient and the friends that something be done, and of course I reported to the house at very short intervals. The usual treatment by the stomach which you all are familiar with, and probably have tried with more or less success in various cases, was that which was adopted by me. Suffice it to say that while it gave a certain amount of relief the result was not permanent, and on December 7th I was asked to renew my visits because of the ex-

¹ Read before the Suffolk District Medical Society, Section for Obstetrics and Diseases of Women, January 24, 1900.