

SEVERE UTERINE HÆMORRHAGE AFTER VAGINAL OPERATIONS.

BY SIR JOHN PHILLIPS, M.A., M.D. CANTAB.,
F.R.C.P. LOND.,

HON. PHYSICIAN TO H.M. QUEEN MARY; CONSULTING OBSTETRIC
PHYSICIAN TO KING'S COLLEGE HOSPITAL.

IN certain cases profuse hæmorrhage from the uterus has followed shortly after an operation on the vagina; I am not speaking of recurrent hæmorrhage, which often takes place from a vaginal wound itself. Everyone must be aware that it is not uncommon, after a simple perineal suture, to get a few hours of slight metrorrhagia, but in the cases under consideration the hæmorrhage was so profuse as to jeopardise the patient's life.

The first case which called my attention to this complication was that of a young primipara of 24 years of age. She was delivered with forceps, but unfortunately a complete laceration of the perineum took place; sutures were inserted at the time, but union did not follow. Fourteen days after, as the lochia had quite ceased and the uterus had sunk into the pelvis, the medical attendant had the patient placed under an anæsthetic and inserted some silk-worm gut sutures, bringing the granulated edges of the laceration together. Within a few hours the patient was attacked by violent hæmorrhage from the uterus, and this organ was found to be much distended with blood, and reaching up to the level of the umbilicus. Grave symptoms of shock followed, and for some days her life was in considerable danger. The physical condition was confirmed by a well-known obstetric physician, who saw her 24 hours after the complication arose. She ultimately recovered, menstruation becoming regular, but she remained very weak for some time and lost control of fæces and flatus. A few weeks later I saw her for the first time, and after careful preparation operated upon the perineal tear and good union followed, no post-operative hæmorrhage taking place. She subsequently became pregnant, and, as the first child had been rather large, I thought it better to induce her labour 14 days before term. A living child was born, and no recurrence of the laceration took place.

The subsequent history of the patient is somewhat interesting. About six years ago—that is, about 15 years after the original operation—she developed signs of commencing Graves's disease, with rapid pulse, loss of flesh, characteristic changes in the blood, and the usual train of symptoms in that disease. After four years' treatment, which included a prolonged rest-cure, followed by a course of X rays and subcutaneous injections of iron and arsenic, she ultimately made a good recovery, and is well at the present time, her menstruation being quite normal, her weight good, and her general health excellent.

This case is, in my experience, unique, and I have never before met a case of ballooning of the uterus as the result of a vaginal operation. I have, however, among my notes, four cases in which alarming hæmorrhage occurred from the uterus after minor operations on the vagina. These were: the removal of a small vaginal cyst from the anterior wall of the vagina, the excision of a fleshy, tender hymen, and two cases of posterior colporrhaphy. In all these four cases the hæmorrhage came on 12 to 15 hours after the operation, and inspection showed that no blood was issuing from the wounds but that it came from the cervix. In each case the hæmorrhage was so alarming as to require saline injections and ergotin subcutaneously, convalescence being prolonged from the resulting anæmia.

Although the uterine hæmorrhage occurred after vaginal operation, it is well known that a woman may be attacked with violent flooding quite apart from menstruation and from some non-pelvic cause, and on three occasions I have been sent for to arrest uterine hæmorrhage, one case being after a gas removal of a

tooth, the second after an operation on the breast, and the third after a small operation for external piles. It is also a recognised fact that a patient's period may anticipate its date of onset by as much as a week under certain cases of mental stress or anxiety, as that of awaiting the performance of an operation. It is difficult to give any definite reason for this hæmorrhage, but I think the operator is always well advised, where he possibly can, to make the date of the operation after seven days have elapsed from the day of the last period and not to perform any operation on any patient for six days before the period.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF

SEVERE FRACTURE OF FEMUR DUE TO A BULL'S HORN.

BY H. A. LEDIARD, M.D. EDIN., F.R.C.S. ENG.,
SURGEON TO THE CUMBERLAND INFIRMARY.

THE case is that of a ploughman, aged 35, who took a three-year-old bull for its usual morning walk in a lane on April 5th, 1921, when the animal suddenly attacked him, and got him down on the hedge-side. He had known the bull for two years, and was on excellent terms with it. He received the first blow on the chest; when the man was down the bull's horn reached the left femur about the centre, but did

Diagrams showing Conditions observed by Radiography.

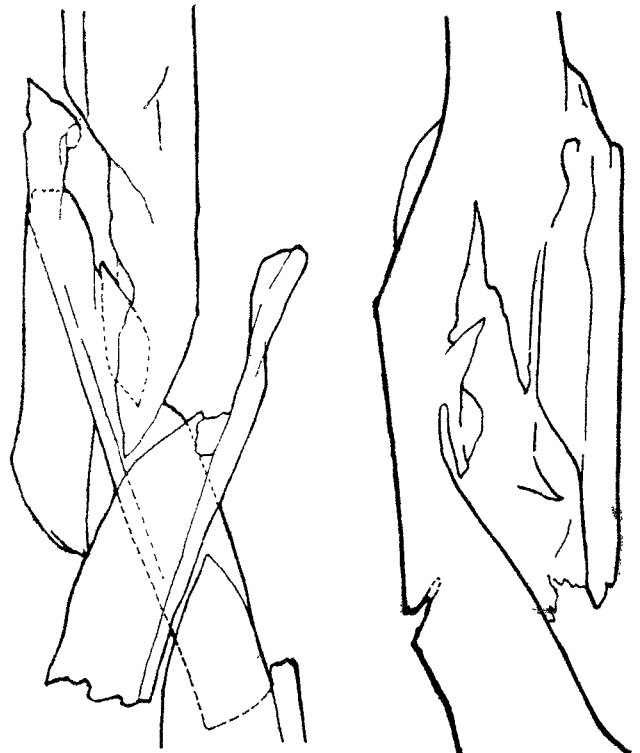


FIG. 1.—Immediately after fracture.

FIG. 2.—About 10 weeks later.

not penetrate the skin beyond an abrasion. The bull was driven off by the courageous action of the ploughman's wife.

The fracture shown by the tracing of the radiograph (Fig. 1) speaks for itself, as also does the final picture (Fig. 2). The thickening at the site of fracture was massive, but the limb was straight, and shortened by not more than $1\frac{1}{2}$ inches. Treatment was by extension, but no plating was ever contemplated.

The patient was discharged from hospital on June 29th, 1921, on crutches.