

ECTOPIC GESTATION.* Case Report.

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Mrs. D., age 35, mother of two children, ages 8 and 6, having twin sisters in her family, had a six and one-half month miscarriage five years ago; case of twins, following which she suffered six or seven months with pain and tenderness on right side with the diagnosis of "Rheumatism of the Ovary." Three years ago had a six weeks' abortion, during which she had severe hemorrhage. Following this her health was excellent and her menses were as regular as clock work. Saw her April 26, at 7:10 P. M. Sitting at supper table a few moments previous was stricken with violent pain, which continued persistent. Gave her hypo M. & A. No. 3 and obtained the following history: Pain in pelvis, more intense in right side, radiating to and over the gall bladder. No temperature, pulse 96. Slight nausea twenty minutes after hypo. Extremely nervous. Menstruated last on March 8. Pain persistent and a second hypo given, making a total within the hour of one-half grain. A tentative diagnosis of abortion was made. Patient became easy, and I left at 9 P. M.

Called again at 1 A. M. and found her suffering greatly from pain and also in a state of severe shock. Face pale and waxy. Lips bloodless. No uterine show. Pulse 120, weak and thready. A hypo of morphine one-quarter and atropine 1-150 was given.

Thursday morning patient had recovered from shock. A slight stain was observed. Still in some pain. Little nervous. A slight tumor was noticed on right side. Temperature 99.5, pulse 110. A diagnosis of extra uterine pregnancy with rupture of tube was made. Diagnosis concurred in by Dr. Smythe Friday A. M. and patient was operated on Saturday, with the following findings: An intraperitoneal rupture of right tube, twin tubal pregnancy. Left tube enlarged and swollen. Uterus enlarged and flabby. Appendix showed a diseased condition. The operation performed was a right salpingo-cophorectomy-appendectomy-left tubal resection-ventral suspension. More than five pints of blood, clots, etc., were washed out.

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TREATMENT OF RETRO-DISPLACEMENTS OF THE UTERUS.*

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This is by far the most common of all uterine displacements, and it is a condition that the general practitioner meets with almost daily at the bedside. The etiology and symptoms are well known, the diagnosis easily made, and for this reason will be omitted in this paper. The treatment is general, palliative and operative, depending on the individual case. Gen-

eral treatment is demanded for those cases of retro-displacement that are associated with a general abdominal petosis. Surgery is contraindicated in this class of patients, unless after a careful and prolonged study of the case, it is discovered that the displaced organ is the pathology that produces the symptoms. In the writer's opinion and experience, it is quite

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rare that a retro-displaced uterus, associated with a general abdominal ptosis is the offending member, and for this reason surgery is not advisable. The treatment indicated here is a properly fitting abdominal belt, tonics, fresh air and regulation of the bowels, kidneys and diet. It is unwise in these neurasthenic patients to have their attention fixed on any one organ, and for this reason results will depend on the good judgment and suggestions of the attending physician, assisted by sensible treatment. This latter class having been eliminated, we now come to those that demand operative or palliative treatment. The first step after diagnosis should be an attempt at replacement of the uterus, provided the tubes and ovaries are normal, the perineum is intact, and no laceration of the cervix exists. If any one or more of these conditions are present there is no reason to replace the uterus because a pessary is contra-indicated, and we would have no means to retain the organ in position. The best method of reducing the displacement, in the great majority of cases, is to put the patient in the knee chest posture, retract the posterior vaginal wall with a Sims speculum, seize the cervix with Volsellum forceps, and make traction on it in the direction of the coccyx, at the same time make pressure on the uterus through the posterior fornix with dressing forceps, the ends of which are wrapped with cotton. If this is not successful the posterior fornix should be packed tightly, and this packing is held in place by vaginal tampons. At the end of two days another attempt is made, and if this is unsuccessful, the same procedure as before is followed, and this in turn by another attempt at replacement in two days. If the organ is not bound down by adhesions, and the patient will relax herself, the displacement is usually reduced at the first attempt. Some sensitive patients object to the knee posture, and if this is the case, the bimanual method of Schultze may be tried. If the patient has a thick abdominal wall or rigid muscles, it is a waste of time to attempt the

bimanual method without the assistance of an anæsthetic. The bimanual method is carried out as follows: The patient is placed in a slightly exaggerated dorsal position. Two fingers of one hand make pressure against the uterus through the posterior vaginal wall. As the organ rises out of its bed from the pressure that is brought to bear from below, the other hand is pressed down behind the uterus, through the abdominal wall. With the abdominal hand holding the uterus up, the vaginal fingers are changed from the posterior fornix to the anterior surface of the cervix, and at the same time that the vaginal finger pushes the cervix back toward the sacrum, the abdominal hand should push the fundus forward toward the posterior surface of the bladder. Sounds or other intra uterine instruments for the purpose of replacing the uterus are dangerous, and should not be used except by experts, and only by them in a well appointed hospital, where it is possible to carry out an aseptic technique. If the uterus can not be put back in position, the patient should be given the choice of operation or palliative treatment. The palliative treatment consists of rest in bed during the monthly periods, the avoidance of any prolonged muscular exertion, regulation of bowels, kidneys and the use of hot vaginal douches and tampons. If the uterus can be replaced, a well fitting pessary should be immediately inserted, and the patient kept under observation for two months. At the end of this time the pessary is removed, and if the organ remains in position a cure is effected. If it does not, then the patient has the choice of a continual pessary life, or of an operative procedure. The technique of inserting and the requirements for a well fitting pessary can be found in any text book, and will not be discussed here. It is essential to remember, however, that a pessary should never be inserted until the uterus is in its normal position, and the instrument should keep it in place without causing the slightest annoyance to the patient. Those cases of retro-displacement that are associated with lacerations of

perineum or cervix, even if the organ can be put back in position, are best relieved by operative procedures at the same time that the laceration is repaired. Some authorities advise the repair of the lacerations, and then after the parts have healed, the replacement of the uterus and the insertion of a pessary. This seems unwise to me for the reason that a cure of the displacement can not be promised, and the patient may have to undergo a second operation, which means a loss of time, added anxiety, and last but not least an extra expense to the patient. On the other hand, if the operation for the relief of the displacement is carried out at the same time that the lacerations are repaired, it means, in the great majority of cases, a cure for the patient with but little added danger, and no extra loss of time or money. An operation is not only indicated in this last condition mentioned, but also in all cases that are associated with diseased tubes or ovaries or pelvic inflammation. I should like to state that this comprises a very large class of retro-displacements. It is also indicated in all cases that are bound down by adhesions, and also in those cases where the pa-

tient prefers an operation to a continual pessary life. The operative technique I will not discuss in this paper. Good results are obtained by many different operations, and if an operator has been accustomed to obtain results by any one method, my advice is to continue to use his accustomed procedure, and not "seek after new gods." There is no condition in the domain of surgery that has brought out as many different operations for its relief as retro-displacements. Many of these are bad, some are good, but to my mind the perfect operation for the relief of this condition is yet to come.

TO SUMMARIZE.

(1) General treatment should be carried out in neurasthenic cases whose symptoms are not produced by the displaced uterus, also where there is a general abdominal ptosis.

(2) Pessary treatment should be given a fair trial in all cases in which the uterus can be replaced, provided there is no pathology of the tubes, ovaries and an intact perineum and cervix.

(3) Operation is demanded in all cases that are associated with diseased tubes, ovaries, lacerations of perineum and cervix, also in those cases that are bound down by adhesions, and again where pessary treatment has failed.

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CONVULSIONS IN AN ADULT FROM COPREMIA*.

Report of a Case

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My excuse for reporting this case is the remarkable symptoms the patient exhibited. On Sunday, May 29th, at about 1 o'clock in the afternoon, I was summoned to see the patient, whom I was told, was having very violent fits, requiring four men to hold him in bed. The patient's family physician had seen him at noon, and had then gone to see another case, and they were unable to get him at once, hence I was called. I reached the patient's house at 1:10 P. M. and found a well

developed white man, about 35 years of age. He was in bed, and there were four fair-sized men endeavoring to restrain and keep him in bed. The patient was unconscious and was having a tonic convulsion, his head was drawn well backwards, the eyes were shut and there was marked opisthotonus. The convulsion lasted about two minutes. He did not regain consciousness after the convulsion, his radial pulse was 90, the respirations were 16, his temperature—by the rectum—was

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