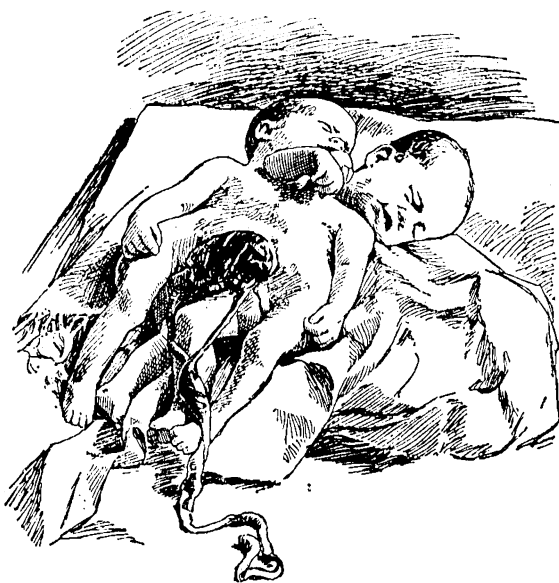


widely from the pubes to the navel from incomplete closure of the lateral halves of the body, otherwise normal. They were dead when born. They were



united from the sternal notch to the navel in front, and from corresponding points on one side only, by a continuance of the skin, best shown by photographs taken on the spot. There was one cord and one placenta, both unusually large.

PLACENTA PRÆVIA AT THE BOSTON LYING-IN HOSPITAL.¹

BY CHARLES W. TOWNSEND, M.D.

AMONG the 6,700 deliveries at the Boston Lying-in Hospital in the past twenty years there were 28 cases of placenta prævia recorded. This proportion, four per cent., is four times larger than that stated by Müller, of not quite one case to a thousand births, but is explained by the fact that difficult and abnormal

cases are particularly apt to be sent to the Boston Lying-in Hospital, so that the proportion of these cases is necessarily increased.

Of the 28 cases, 15 were marginal or lateral, the placenta reaching to the border of the inner cervical ring; eight were partial, the placenta overlapping the os to a greater or less extent; and five were central, the implantation of the placenta being directly over the os.

The proportion of multiparæ to primiparæ, instead of being six to one as is usually stated, was less than two to one—17 to 11—the difference being due partly to the large proportion of primiparæ delivered in the hospital. The proportion of multiparæ was greater in the partial and central cases, there being three primiparæ to five multiparæ in the partial class and only one primipara to four multiparæ in the central class.

Marginal or Lateral Placenta Prævia, fifteen cases.

In four cases there was no hæmorrhage until there were recognized labor pains, while in eleven hæmorrhage was noticed at varying intervals before the advent of labor. Two of these flowed about once a month so as to simulate true menstruation; three began to flow in the seventh month, two at eight months, and three at eight and a half months. In one this point is not stated. Seven went on to full term, six gave birth prematurely at eight months, two of these being delivered artificially, and two gave birth at the seventh month, one of these being delivered artificially. The hæmorrhage was slight in six, considerable in four, profuse in three; while in six the records also spoke especially of the postpartum hæmorrhage.

As regards the treatment of these cases, the majority of the patients came to the hospital in labor with the history of flowing as given above, and proceeded to give birth to their children without artificial help; the diagnosis of lateral placenta prævia being made by examination. Others, labor not being present, were kept in the hospital under close observation, and later gave birth to their children without assistance. This non-interference method was practised in twelve out of the fifteen cases. Of the remaining three, in one case where there was considerable hæmorrhage at the eighth month, a colpeurynter was inserted, and the child was born in eight and a half hours. There was also considerable postpartum hæmorrhage in this case. Two cases were delivered by manual dilatation and version; one at the seventh, the other at the eighth month, both patients having lost considerable blood—one by slow dribbling, the other by a sudden gush of one and a half pints. In the former case manual dilatation took five minutes, in the latter fifteen minutes.

As to the results in these fifteen cases of marginal attachment of placenta: All the mothers recovered. One child, born naturally at the seventh month, died in two days. One born by version died in twenty minutes, probably due to the asphyxia owing to delay with the after-coming head. The child whose delivery at the eighth month was hastened by the colpeurynter was still-born.

Case 19 illustrates this class of cases. C. D., twenty-one years old, primipara, entered the hospital with moderate flowing about two and a half weeks before the completion of her pregnancy. A diagnosis of probable placenta prævia marginalis was made by the feel of the lower uterine segment and by the hæmor-

¹ Read before the Obstetrical Section of the Suffolk District Medical Society, March 22, 1893.

rhage. She was kept in bed a week, during which time there was a moderate leaking of blood. The hæmorrhage then ceased, and ten days later labor came on with moderate bleeding until the head came down and acted as a tampon. There was quite a severe postpartum hæmorrhage following the birth of the placenta. Mother and child were discharged well on the fifteenth day.

It may be said that the diagnosis of this class of cases is somewhat uncertain, and that some of them were simply cases of accidental detachment of a portion of the normally situated placenta. This error has been excluded as carefully as possible. In many of the cases the edge of the placenta was actually felt.

Partial Placenta Prævia, eight cases.

In two cases there was no hæmorrhage until labor began, at full term in one case, a week ahead of time in the other. In another case hæmorrhages or pseudo-menstruation occurred twice a month throughout the entire pregnancy, which went on to full term. The remaining cases had hæmorrhages, first, at the fifth, sixth and eighth months and at eight and a half months and at full term respectively. Five were delivered at full term, only one of these by natural means; two at eight months; one by version; one spontaneously; and one without help at the sixth month. In this latter case there had been profuse hæmorrhages every day for three days, when the dead fœtus was expelled spontaneously, the edge of the placenta overlapping the head one-third of its extent. The hæmorrhage was slight in two, considerable in two, and profuse in three of these cases. In two, postpartum hæmorrhage was well-marked.

In the treatment of these cases of partial placenta prævia, the greater hæmorrhage demanded a greater amount of active interference. In three only the delivery took place spontaneously, the remaining five were delivered by internal podalic version, two having been first tamponed. All of the eight mothers recovered, and four of the infants; but four infants were still-born. Two of these infants were born spontaneously, two were delivered by version. It is fair to add, however, that of the two born spontaneously, one was non-viable, the other was macerated. Of the two still-born infants delivered by version, in one case there was a complicating ovarian tumor which had to be pushed out of the way before version could be done.

Case 24 is an example of the more severe cases of partial placenta prævia. A multipara (x), thirty-eight years old, was seen outside the hospital shortly after she had lost about a pint of blood by a sudden gush. She was at full term, and began at once to have labor pains. The os was two inches in diameter, and the edge of the placenta was easily felt. The vagina was packed with charpie as a temporary expedient while she was being brought to the hospital. Here she was at once etherized and easily delivered of a living child by version, the whole operation taking not much longer than one minute. A gush of blood followed the withdrawal of the arm used in turning, but the child's body acted as a tampon and stopped further bleeding. There was a moderate hæmorrhage immediately following the extraction, but the uterus contracted well and everything seemed all right. Three hours later, however, there was profuse bleeding, which was soon checked by a hot intra-uterine douche; but the patient went into an alarming state of collapse, be-

came pulseless, the extremities cold, face blanched, heart sounds weak and irregular. The foot of the bed was raised, heaters applied, and brandy and other stimulants given subcutaneously. The patient was left in an anæmic condition, but made a good recovery.

Central Placenta Prævia, five cases.

This central form of placenta prævia is the rarest and the most serious form, so that it is worth while speaking of these cases more in detail. All of the five cases were delivered by version, a tampon having been first used in two of them. Three of the mothers died, two recovered. Four of the infants died, only one lived. It must be said, in palliation for these results, that all of the five cases entered blanched from loss of blood, two of the three fatal cases being almost in extremis. Such cases are sent to the hospital as a last resort, and in that way the fatal statistics are increased.

In one of the successful cases as regards the mother, a multipara (viii), thirty-four years old, there was no hæmorrhage until the eighth month when there was a sudden profuse flow. She was brought eleven hours later into the hospital plugged with a sponge and colpeurynter, she was extremely blanched, pulse 120 to 140, respiration 50. The os, which was about half an inch in diameter, was dilated manually in ten minutes, and the child delivered by internal podalic version. The child was dead and slightly macerated. The mother recovered after a moderate attack of septicæmia due, no doubt, to the manipulations outside the hospital and to the sponge introduced there.

Case 2, a primipara, had been flowing copiously at the eighth month for a week before she was sent to the hospital. She was delivered by podalic version without much loss of blood, but a secondary hæmorrhage occurred; she never came out of the collapse and died. The child was very feeble but was kept alive for two and a half hours.

Case 3, multipara (iv), twenty-six years old, had her first hæmorrhage at six months and three weeks, — a sudden gush while sitting on a vessel, the blood filling it one-half full. A week later she had a second severe hæmorrhage, and was brought to the hospital in a blanched condition. Manual dilatation of the cervix occupied fifty minutes, and the child was turned and delivered. During the delivery a large amount of blood was lost. The child gasped, but soon died. The mother went into a collapse, although there was no further hæmorrhage, and died in two hours.

Case 4, multipara (iv), thirty-four years old, had her first hæmorrhage, a small one, at seven and a half months. Two weeks later there was a profuse flow and she was brought into the hospital in a blanched condition. The os was at once dilated manually, in thirteen minutes the child quickly turned and delivered. It is stated that from one to two quarts of blood were lost during this procedure. The uterus contracted firmly and the patient appeared bright for an hour after coming out of the ether, and there was no further hæmorrhage. About five hours later, respiration became rapid, the pulse became small and thready and the patient died in twelve hours. The baby lived ten hours.

Case 5 I can speak of more particularly, as it occurred during my service two years ago. M. G., twenty-one years old, multipara (ii), when eight months advanced in pregnancy had several slight hæmorrhages, followed a week later by a very profuse one for which

she was tamponed by a doctor at 2 A. M. On entering the hospital at 1 P. M. the same day she was in a blanched condition, the pulse 100, weak and compressible, the fetal heart about 210 and irregular. The patient was at once etherized, placed in a position for operation and the packing removed. The os was found to be about one and a half inches in diameter and completely covered by placenta. While satisfying myself of the diagnosis of central placenta prævia, the blood suddenly spurted out copiously by my hand. Without withdrawing my hand I at once peeled off the placenta on the left border, quickly finished the dilatation of the os and passed my hand up around the placenta. The child was easily turned, and the half breech at once checked the hæmorrhage. The child was quickly delivered and the head was followed immediately by the placenta. The uterus contracted well, but in all at least a quart of blood was lost, and there was considerable postpartum hæmorrhage, which was controlled by pressure and friction externally, and by a hot intra-uterine douche. The child was anæmic and did not cry at first, but recovered, and was with the mother discharged well on the fourteenth day.

The following table gives an analysis of these 28 cases of placenta prævia:

TABLE OF TWENTY-EIGHT CASES OF PLACENTA PRÆVIA.

	Lateral or Marginal. (15)	Partial. (8)	Central. (5)
No hæmorrhage until beginning of labor.	4	2	0
Hæmorrhage every month.	2	1	0
Hæmorrhage first at fifth month.	0	1	0
Hæmorrhage first at sixth month.	0	1	1
Hæmorrhage first at seventh month.	3	0	1
Hæmorrhage first at eighth month.	2	1	3
Hæmorrhage first at eight and one-half months.	3	1	0
Hæmorrhage first at ninth month.	4	3	0
Delivery at sixth month.	0	1	1
Delivery at seventh month.	2	0	0
Delivery at eighth month.	6	2	4
Delivery at full term.	7	5	0
Hæmorrhage, slight.	6	2	0
Hæmorrhage, considerable.	4	2	0
Hæmorrhage, profuse.	3	3	5
Hæmorrhage, postpartum.	6	2	2
Delivery natural.	13	3	0
Tampon used.	1	2	2
Delivery by version.	2	5	5
Mothers recovered.	15	8	2
Mothers died.	0	0	3
Infants lived.	12	4	1
Infants died.	2	0	3
Infants still-born.	1	4	1

THE IMPORTANCE OF EARLY ATTENTION TO THE DISABILITY CAUSED BY INFANTILE PARALYSIS.¹

BY A. B. JUDSON, M.D., NEW YORK.

I PROPOSE to consider briefly the question whether a certain class of patients should not be committed more entirely and more early than they are to the care of the orthopedic surgeon, a consideration as interesting to the family physician as to the orthopedist, as they meet in friendly alliance to secure the greatest benefit for their common patient.

I refer to the patients disabled by infantile paralysis. The child has passed through the stage of onset.

¹ Read before the New York Academy of Medicine, November 2, 1893.

Ergot, electricity and massage have produced their legitimate effect, and we will say that the eighteen months, which are believed to be the limit of spontaneous recovery from the paralysis, are passed. The friends and the patient, with many grievous misgivings, have become reconciled, or at least accustomed, to disability and deformity which now seem to change for neither the better nor the worse. What can now be done? The question whether such a patient may not yet receive benefit from the advance of scientific knowledge, or from the daily increasing facilities for the application of knowledge, will surely spring up in the parental heart.

Now it is curious to note that the deformity in these cases is often found, upon analysis, to be a disability more than a deformity. Take a case, for example, in which the knee cannot be completely extended. When the patient is sitting there is no deformity, but when he stands the apparent deformity is due to a disability—an inability to extend the knee. How easy it would have been to prevent contraction of the hamstrings by providing for their repeated elongation by complete extension of the knee, easy, comparatively, for one who has given himself to such details, and is habitually mindful of their importance and free from the manifold cares which beset the average practitioner. And it should be borne in mind that cases sometimes occur in which shortening of the tendons begins, in a manner not well understood, at a very early stage, before simple desuetude can be fairly accused of being the author of the mischief. The prevention of muscular and tendinous shortening, then, should receive attention on the part of the early observer of the case. It is not an obscure and difficult point, but one which has, perhaps, escaped the consideration to which it is entitled.

To recur to the disabled knee, and this part of the anatomy is used simply as a convenient example to illustrate points in pathology and treatment applicable to all the joints, if the knee is kept extended at those times when walking is attempted, not only are the muscles and tendons kept in normal elongation, but the general welfare of the limb is assured. Neglected patients may be seen in the streets walking laboriously with extension of the knee produced by the hand pressed firmly at every step on the lower part of the thigh when the weight of the body is on the limb. It is doubtful whether this in any case prevents the final resort to a crutch, by the use of which the limb is made to dangle, being carried about as a worse than useless burden, twining limp around the crutch, subject to the painful affections which attack the lower extremities in cold weather in the absence of healthy circulation, and more and more impeding locomotion, until, as has happened many times, the adult patient seeks relief and improved locomotor ability in amputation and an artificial limb. If the knee is stiffened mechanically, the pressure of the weight of the body in standing and the repeated concussion of the limb, as the foot strikes the ground in walking and running, will improve the tardy circulation; but beyond this, and better than this, will be the development of unused muscular fibres and special groups of muscles, by whose action important motions will be acquired which would have been impossible if the limb had remained in suspension.

Now, in order to keep the knee firmly extended under the weight of the body in standing and walking,