

PLACENTA PREVIA CENTRALIS: REPORT OF A CASE.¹

BY JOHN W. DEWIS, M.D., BOSTON.

I WAS called about 5 A. M., October 26, 1900, to see Mrs. C., who was "flowing." The husband, who was the messenger, said his wife was bleeding "very much, very much," and pleaded that I come quickly. As he expressed it, the blood came "as though poured from a bucket." The place was only a little way from my office, and I was soon there. I found the woman almost *in extremis*, and immediately sent for Dr. Dearing and Dr. Kepler. Assistance from the family or friends could not be considered.

The patient was a well-developed, well-nourished Jewish woman — a regular Amazon in build — thirty-six years old. She had three children, all normal births, the youngest child being three years old. There had been no miscarriages, no irregularities of menstruation. She was supposed to be within a week or two of full term. There had been no hemorrhage throughout pregnancy, no untoward symptoms. This morning about 4 A. M., she awoke and found herself bleeding, but had no pain. The hemorrhage increased rapidly, but had ceased when I arrived, though there was evidence that she had lost a great deal of blood. The face was dusky, cold sweat stood on her brow, and the skin of limbs felt clammy. Pulse was 124, and very poor in quality. I listened for fetal heart, and thought I could hear it just below umbilicus. The patient had no heart lesions.

As soon as I could prepare, I made digital examination, and found os dilated to about the size of a fifty-cent piece, and filled with a bulging mass that felt like placental tissue. It was an extreme case, and, Cesarean section being considered impracticable, I concluded to dilate cervix and deliver as quickly as possible. While waiting for medical assistance, I prepared 2 quarts of normal salt solution, and gave about 6 ounces per rectum, then a hypodermic of strychnine sulphate, gr. $\frac{1}{15}$, combined with atropia sulphate, gr. $\frac{1}{30}$, followed by another of digitalis, gr. $\frac{1}{15}$, combined with cocaine muriate, gr. $\frac{1}{3}$. A few minutes later ether was administered by Dr. Kepler, and I turned and delivered a living child. The whole time occupied was about three-quarters of an hour from arrival at house. As hemorrhage had recommenced, I began to dilate cervix without waiting for anesthesia. The placenta seemed to cover the whole lower uterine segment. I went up with my right hand to left, between placenta and uterine wall, the border of placenta being about a finger's length up. I found feet near fundus — an O. D. A. or O. D. P. — and brought down right foot and a hand. During dilatation there was moderate hemorrhage, checked by advent of child's buttocks. In a few moments the head was delivered, and with it about two-thirds of placenta. A hemostat was placed on the cord, and the child, though much blanched, soon responded to external stimulation and artificial respiration. After remaining portion of placental tissue, which was on right side, and some membranes were removed from uterine cavity, I gave a hot douche of permanganate of potash, 1-3,000. The uterus contracted well, and there was no further hemorrhage.

The mother's condition now seemed better than before delivery; pulse about 130, but much improved in

quality, due probably to administration of ether. I again gave, per rectum, salt solution combined with whiskey, which was retained. There had been only primary anesthesia, and no vomiting followed. About half an hour after delivery, the patient was given, by mouth, a teaspoonful and a half of fluid extract of ergot, and a little later, a hypodermic of strychnine, gr. $\frac{1}{10}$. Salt solution by hypodermoclysis was not thought advisable, as patient was comfortable, and seemed to be doing well. I remained with patient about two and one-half hours, watching pulse, uterus, and general appearance. During this time, pulse increased to about 135, and at times grew very weak, though never intermittent. She was given frequent sips of whiskey with water and a pinch of salt added. There was some thirst. At 9 A. M. the salt solution was repeated, per rectum, and a solution of strychnine, gr. $\frac{1}{10}$, given by mouth. Patient felt comfortable. I decided, however, to try salt solution subcutaneously, and went to my office for tablets, leaving patient in care of two intelligent women. I had only reached the house when the husband was after me, saying wife was "taken bad." I hastened back and found her pulseless and gasping, and in a few moments she was dead.

I was told that I had only gone from house when patient began to complain of pain in chest and stomach, and "bad feeling"; then suddenly catching at her breast, with a cry, she sat up in bed, and fell back senseless. There was no post-partum hemorrhage. The uterus contracted and remained so, as in any favorable case. The napkin, examined after death, was only moderately soiled, and there were no clots in uterus. Autopsy was not permitted, but I believe the sudden death due to embolism. The child died on the fourth day, but with proper care might have lived.

The point that stands out most clearly in the history of this case is, that there had been no hemorrhage, no warning of danger throughout pregnancy, and yet this proved a complete "placenta previa." Cesarean section might be advocated in such cases, but I believe nothing could have been gained by the operation in this instance, where the pelvis was large, and the demand for immediate interference was so urgent that scarcely any of the ordinary preparations for laparotomy could have been made. In the majority of such emergencies, however, Cesarean section would seem the choice, and the time cannot be far distant when it will be considered necessary for the general practitioner, who does obstetrical work, to be competent to do this operation.

A CASE OF COMPLETE PLACENTA PREVIA.¹

BY FREDERICK COGGESHALL, M.D., BOSTON.

ON the night of November 18th, I was called some distance into the suburbs to see Mrs. S. The message simply said that she was in labor and having a hard time. I went expecting at the worst a forceps case, but took the precaution to take a nurse with me, as I knew nothing of the one I was told was on the case. I found a well-developed, well-nourished woman of thirty-three, who had been in labor with her sixth child for six hours, and had been flowing very freely from the beginning of the pains. At the onset of the labor

¹ Read before the Suffolk District Medical Society, Section for Obstetrics and Diseases of Women, December 26, 1900.

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she had sent for an irregular practitioner who was engaged for the case. He had, after watching her for a time, given a very unfavorable prognosis, packed the vagina tightly with gauze and administered hypodermically something, as I was told, to stop the pains. As the family had been alarmed he had been dismissed, and they called me in. On my arrival the patient was blanched, with a feeble, rippling pulse which could not be easily counted or even felt. The bedding and mattress were soaked with blood, which was continuing to trickle out through the gauze. No contraction of the uterus had occurred for the last half hour which was severe enough to cause pain. The patient was only partially conscious, having just recovered, I was told, from a fainting fit. Pupils widely dilated. She seemed to me to be in *extremis* from loss of blood and if I waited to send for assistance it would evidently be too late. I therefore went ahead as best I could with the help of the two nurses. Before stopping to examine her I started the subcutaneous injection of decinormal salt solution. In preparing this I did not stop to sterilize the water. The delay was out of the question, and I took my chances. I used Dr. C. G. Cumston's solution for preparing salt solution, which was administered under both breasts and underneath the loose skin of the back at the same time by means of a three-way tube of a pattern contrived for me by Dr. Wm. H. Grant for the rapid administration of salt solution. The foot of the bed was raised. At the same time a tenth of a grain of strychnine nitrate administered subcutaneously.

While the salt solution was being given I removed the packing and examined the patient. The os was dilated to something more than the size of a half dollar. The finger on being passed into the os did not encounter the membranes or the head, which could be felt externally well down to the pubis on the left, but came in contact with a soft, spongy, irregular surface completely covering the opening and through which the head could not be distinctly felt. This confirmed my first impression from the hemorrhage, that I had to deal with a case of placenta previa. By the time I had washed up and examined, the greater part of the salt solution had got in and I decided to empty the uterus as quickly as possible. The pulse had now considerably improved, though it was yet extremely feeble, about 150. The patient was still but half conscious. The side of the bed was now raised and she was placed across it. As the only chance of stopping the hemorrhage seemed to be to get the child out at once, I did a rapid manual dilatation, tearing the cervix deeply in three directions; I then swept the hand rapidly around, detaching the placenta, and tried to push it to one side; as it would not be gotten out of the way, I seized it on the inner side near the cord and dragged it out, grasped the child by the feet and did as rapid a podalic version as possible, and extracted the child without much regard to anything but the saving of time. The perineum was a complete wreck from previous labors, which facilitated my operation considerably. Much to my surprise, the child was not quite dead on delivery, but it was as much blanched as the mother. I felt compelled to leave it to the care of the untrained nurse, while with the other I devoted myself to the mother, who had again become pulseless and was entirely unconscious. The salt solution was repeated with some more injections of strychnine, and an

enema of two ounces each of brandy and fluid extract of ergot with salt solution to make a quart was given.

As the patient had stopped breathing, although her heart could still be faintly heard, though not counted, artificial respiration, including the Laborde method, was applied. After a half hour's work her pulse began to be perceptible and she was evidently reviving. The uterus, which had received a very hot douche of 1-1,000 bichloride the instant it was empty and had then been packed with gauze on which I had emptied a two-ounce bottle of liquor ferri chloridi, had contracted down to extreme hardness almost at once, and the hemorrhage was all over within, I should say, two minutes after the child was out. The child, which had breathed well at first, had lived about half an hour, and was dead before I dared to turn to it. If I had had sufficient skilled assistance I believe it also might have been saved.

The mother remained in an extremely precarious condition for the next two days, but slowly recovered. Strange to say, there was no sepsis. The points at which the salt solution was injected were no sorer than is often the case after proper sterilization, which may be thought by some to be due to thorough local inunctions of Credé's ointment which were begun at once.

Medical Progress.

PROGRESS IN ORTHOPEDIC SURGERY.

BY E. H. BRADFORD, M.D., AND F. J. COTTON, M.D., BOSTON.

(Concluded from No. 6, p. 142.)

ARDOMEN OBSTIPUM.

HABS²⁹ reports a case of a six-months-old child with extreme contraction of the right rectus abdominis, resulting in extreme kyphosis. The muscle was extirpated and a complete cure ensued. The pathology was unknown; perhaps an intra-uterine myositis.

THE ANTERIOR SUPPORT OF THE FOOT.

Seitz,³⁰ after a thorough investigation, convinces himself of the existence of convex transverse metatarsal arch in 50% of all cases, the highest point being the head of the third metatarsal. The head of the first metatarsal bears more weight than that of the fifth. The tuberosity of the fifth metatarsal does not furnish a support for the weight of the body. The heads of the second and third metatarsal, contrary to a common opinion, do not furnish, as a rule, points of support for great weight, though they form segments in the arch. In 20% of the cases the head of the third metatarsal is found to have dropped, and in some cases the head of the second metatarsal also.

OBLIQUE OR UPRIGHT WRITING.

Schubert³¹ has investigated a number of children in the schools in Nuremberg, to determine the effect on the position of the children of the different styles of writing. He finds that the inclination of the head to the side, rather than the upright and proper position

²⁹ Zeitschr. f. klin. Chir., 1899, S. 304.

³⁰ Zeitschr. f. orth. Chir., 1900, Bd. viii, S. 37.

³¹ Ref. in the Zeitschr. f. orth. Chir., 1900, S. 152.