

ever to any hospital."<sup>22</sup> The only argument I have ever heard made in favor of doctors giving their services free to hospitals is that the doctors were increasing their knowledge and reputation by being permitted (!) to do this. But this is no argument at all, and it is most unjust to use what is the glory of the medical profession as a means for destroying their livelihood. Every conscientious man in every profession, trade or business is learning his work better and is perfecting himself daily by the accomplishment of each piece of work; yet that is never put forth as a plea for paying him less, rather is such a man worth more. It is the same with the doctor; instead of paying him less because he is learning more, he should be paid more.

A final plea for the parasitism of the hospital has been the teaching facilities which are nowadays an essential part of the scheme of every well-regulated hospital and dispensary. Probably nothing does more to promote the deplorable tendency to look upon sick people as "cases" and "material" than the belief that a poor patient is, because of his poverty, legitimately at the disposal of the teacher and his class of students, while the paying patient, in his private room, is exempt from this annoyance. Modesty and self-respect are as much or more to be cultivated in the poor as in the rich, and the use of his or her body or organs for the purposes of study or demonstration should be a free concession to the good of his fellow-beings on the part of every patient, rich or poor. The value, nay, the necessity, of such methods should be constantly taught every member of the community by every physician, and a public spirit promoted which should encourage every one to make this contribution to the common good. (The same effort should be made to educate people to the general performance of autopsies.) Much has already been done in this line, and it has been found that it is not necessary to offer free treatment as a bribe. In some of the English reports it is especially mentioned that the introduction of the Provident system has caused "no impairment of hospitals as places of medical education." The attendance was even increased at the Royal Albert Hospital, to which a medical school is attached. The experience of Professor Volkmann, at Halle, is in the same direction. One of his rules is that every operation shall be performed in the operating-theatre of the public hospital, so that the students may have the advantage of seeing it, the patient being brought in anesthetized and removed unconscious. He will not undertake the care of a patient who declines to submit to this rule. He has, the report says, six private hospitals, and there is no trouble.<sup>23</sup>

As a final word, it must not be expected that any Provident scheme evolved shall, at any rate in the beginning, be self-supporting. Every community in this great and prosperous country has plenty of money, every community has plenty of people filled with the sincerest desire to help their weaker fellows. It should only be insisted upon that this money and this enterprise shall be directed towards making all independent and self-respecting and self-helping.

This résumé of the subject would not be complete without some reference to a new theory which is forcing its way into the management of medical, as

well as industrial, subjects. It may well be that in matters where mass action of the community is demanded, as in quarantine and the control of contagious diseases, socialistic or communistic measures may find favor. But it must not be forgotten that socialism or communism is, at its best, what one writer calls "compulsory co-operation,"<sup>24</sup> whereas the ideals of a free people, like those of this country, are all in the direction of the development in each individual of that sturdy self-reliance and mutual respect which lead legitimately to that voluntary co-operation which is the outgrowth of the Golden Rule.

## CASES OF DISLOCATION OF THE OS MAGNUM.

BY SAMUEL L. ABBOT, M.D., BOSTON,

*Of the Board of Consultation of the Massachusetts General Hospital.*

CASE I. I was called to a young married lady, and found her with her left forearm in a sling, the back of the wrist being considerably swollen and red and very painful. She told me the following story:

On the evening before, as her husband was sitting at the table in her drawing-room reading, she walked by him with her arms crossed upon her chest, and as she was passing he extended his right arm and drew her to him, his arm completely encircling her waist, outside of her flexed arm. In doing this he bent her left wrist so severely that she cried out with pain. The pain continued through the following night, and I was called to her in the morning. I found her still suffering, and as she held out her wrist for examination I saw there was considerable swelling with redness on the back of it, with a marked prominence towards the outer side. It looked so much like a ganglion that I said at once "That is a weeping sinew," although I had never seen one in that location before. It was quite tender on pressure and felt harder and was less rounded than ganglia usually are. On extending the hand on a plane a little above that of the forearm it subsided entirely, leaving no marked prominence above the level of the wrist. On flexing the wrist again the prominence reappeared, and I at once saw that the injury must be a dislocation of the os magnum. No other bone was displaced. As I had never seen such a dislocation before, I made my diagnosis with some hesitation, reserving my final decision.

The treatment of the condition was obviously simple enough. After extending the hand backwards until the prominence disappeared I applied a Bond splint with a roller bandage up to the elbow, leaving the fingers of the hand free. The arm was supported by a sling. I examined it carefully from time to time and was pleased to find that the bone remained securely in its place, so that my diagnosis became a positive conviction.

After watching the case for a few days I asked permission to show it to an eminent hospital surgeon, the late Dr. R. M. Hodges, as one of much interest. This gentleman examined it most thoroughly — bending the wrist repeatedly so as to raise the bone from its bed, and then replacing it again in its normal position. He said nothing to the patient about the nature of the injury, but most cordially approved of the treatment it was receiving. After leaving the house I waited a few moments for some expression of opinion

<sup>22</sup> Hospitals, Dispensaries and Nursing. International Congress of Charities, Correction and Philanthropy, Chicago, 1893, p. 131.

<sup>23</sup> Henry C. Burdett: Pay Hospitals and Paying Wards throughout the World, p. 48.

<sup>24</sup> Herbert Spencer: Principles of Sociology, II, 2, p. 604.

from my friend as to the nature of the case, but he said nothing, so I asked him what he thought of it. His somewhat brusque reply was, "It is n't what you think it is." "Well, what is it, then?" "I don't know," was his answer, repeating his first confident assertion. Of course I was somewhat disconcerted by his positive manner, but could see no good reason for giving up my diagnosis. The next morning I received a note from him in which he said: "No one can read the article in the *Encyclopædie de Science Chirurgicale*, in the Hospital Library, on Dislocations of the Wrist and have any right to question the accuracy of your diagnosis."

The result proved I was right. By the end of a month the bone had become firmly fixed in its original place, although the wrist was so tender that the hand could not be used with facility in playing on the piano for six months.

CASE II. While I was in medical attendance upon a young lady who had just returned from her summer sojourn in the country, her sister, who happened to be in the room, held up her left wrist for my inspection, flexing and extending it repeatedly without making any remark. At once I saw a dislocation of the *os magnum*. I told her what it was and asked her how she had hurt it. She replied she had n't hurt it at all; that the condition had come on gradually during the summer. I examined it carefully; the bone slipped easily into its place on extending the hand above the plane of the forearm, but became dislocated again on bending the wrist, which was not broken or in the least degree painful or reddened, nor had it been at any time. It could be handled freely without pain. By the most careful questioning I found it impossible to elicit the least information as to the cause of the condition.

I asked her about her daily use of her hand at her summer residence, a few miles out of Boston, but for some time could not get anything from her which could be accepted as a cause. She had not met with any kind of accident. At last she said: "You remember that black horse which I ride almost every day in summer is a most spirited animal, and I have to hold him with a very firm hand."

"That's it!" I exclaimed; "you have gradually stretched the ligaments about that bone until it has been squeezed almost entirely out of its socket."

The wrist was not in the least degree tender, and bore all the handling necessary to make out a positive diagnosis, without exciting complaint. I treated the case as I did case No. 1 and with an equally good result. At the end of a month the bone was fixed firmly in its proper bed. I then advised her during the next summer to hold the bridle rein in her right hand rather than the left, which she promised to do. When I saw her for the first time the following autumn she immediately held up her right hand, without comment, bending her wrist slightly, and there was a dislocation of the *right os magnum*! — painless, — the gradual result of following my advice to hold her bridle rein in her right hand during the previous summer, — thus confirming my opinion as to the cause of the trouble in her left wrist the autumn before.

CASE III. The previous pathological history of this young lady may not be without interest, as bearing upon her special surgical susceptibility, so to speak.

It happened a few years before I treated her for her first dislocation, that during several successive winters

she was under the care of the eminent surgeon of this city, to whom I had shown it, for "water on the knee." The trouble was a painless one, and was under his observation and treatment for several successive winters. While she was in the country in the summer it disappeared. Early in the autumn, one year, soon after her return home, I made a professional call on her older sister, who occupied a chamber adjoining hers. During my visit I noticed a very disagreeable smell in the room, and commented upon it. My patient had noticed it that day for the first time, and together we tried to trace it to its source. Nothing could be found in her chamber, so I accompanied her into the adjoining room, that of her younger sister. We found her engaged in a similar search. On approaching a set basin in the room an overpowering stench was found to be issuing from it, evidently coming up the waste pipe which led into the drain. This occurred before the drainage of Beacon Hill, where the ladies lived, had been completed under the new system, and all the filth was carried directly down into the Charles River. When the tide was out of course there was a strong draught inwards, particularly when the wind was from the west, bringing into the house a horrible effluvium from the river deposit and the deposit in the drain. A very expensive system of drainage had been put into the house the year before, block-tin pipes having been used instead of lead, in order to secure the most complete protection against leakage and the gnawing of rats. A thorough examination of the pipes at this time led to the astonishing discovery that not one of them had been trapped. Of course traps were immediately put in the proper places, and the set basins were taken out of the chambers.

The right knee of the young lady whose case is the second above reported had begun to swell, as it usually did in the fall, and she was looking forward to a repetition of her usual winter surgical treatment. But what was her astonishment and that of all the members of her family, — from the moment the foul air from the drain was excluded from the house her knee began to get better, and was soon well, without any local treatment, and continued well until her death, several years after. It is an interesting question whether her horseback exercise during the summer had any influence in producing a special susceptibility to the painless effusion of water, never into her left knee, but always into the right one, which in riding was over the pommel of the saddle.

CASE IV. Several years after treating case No. 3 I was called to a lady's maid and found her with a swollen, red and very tender right wrist. She had been for some time devotedly attending upon her mistress, who was in her last illness, and very heavy with dropsy. She was obliged to lift her a great deal, frequently changing her position in bed, and her right wrist, from this cause, had got into the condition in which I found it.

Examination showed it to be a dislocation of the *right os magnum*. She was unwilling to give up her work and submit to the application of a splint to her arm, so I was obliged to compromise by applying a figure-of-eight bandage in such a way that the point of crossing of the lines at the middle of the figure came directly across the dislocated bone. It kept the bone fairly in place, but interfered a good deal with her work, so, without consulting me, she took off the band-

age and substituted for it an eel skin, which she herself, with some assistance, applied as I had the cotton bandage, taking it off at times when she was obliged to use her hand in her heavy lifting.

I do not find much notice of this injury in books on surgery, — some of them not mentioning it at all. The most explicit account of it which I have seen is in Chelius's "System of Surgery," translated by South, volume II, page 234, in which he gives as a method of reduction, "pulling at the fore and middle finger while pressure is made over the bone." He advises that the hand "be laid upon a flat board, pressure made upon the projection with a compress, a splint applied, and the whole fixed with a roller." I found a much more simple method, and one likely to be much more comfortable to the patient, to be the use of Bond's splint, by which the bone drops into its place without any painful handling, and remains there as long as the case may require, without disabling the fingers and thumb, or causing the patient the least pain.

### INVERSION OF THE UTERUS.<sup>1</sup>

BY H. E. MARION, M. D., BOSTON.

By complete inversion of the uterus is meant a uterus that is "upside down and inside out," no matter whether it is within the vagina or outside of it. Denue attributes the first recognition of this accident to Hippocrates.

**Frequency.** — Winckel in more than 20,000 labors has not seen a case of complete inversion; nor had Braun one in 250,000. Denham in 100,000 cases of labor in the Rotunda Hospital found one case of inversion. Kehrer states that the accident is thought to occur once in 2,000 labors, while others state that it does not occur oftener than once in 140,000. Cross collected 500 cases, 450 of which followed delivery. Mann states that the puerperal cases comprise between 85 and 90 per cent. of all the cases. I wish to consider simply those cases immediately after delivery, or coincident with the third stage of labor. Although it is stated that inversion may take place hours and possibly days after delivery, I think it would be nearer the truth to say that they were not recognized until hours or days after delivery. In other words, I am extremely sceptical about a puerperal inversion of the uterus taking place at any other time than immediately after delivery.

Furthermore, I am decidedly of the opinion that complete inversion of the uterus is much more common than the books would lead us to believe. By far, as will be seen later, the greater number of deaths from this cause occurs within half an hour after delivery. From my experience, this is not putting it too strongly. In many of the deaths reported as from post-partum hemorrhage, if the truth could be known, the cause would be post-partum hemorrhage due to complete inversion of the uterus.

**Etiology.** — Complete inversion of the uterus presupposes, and must be preceded by, complete uterine relaxation, inertia or paralysis. The factors that contribute to this condition may be briefly summarized: A weakened and debilitated condition of the patient from whatsoever cause prior to labor; a uterine wall thinned and weakened by over-distention, as from

hydramnios or multifecundity; a prolonged, tedious and difficult labor, instrumental or otherwise; complete syncope from hemorrhage or shock; profound anesthesia carried into the third stage of labor. (The causal influence of primiparity is pretty well established. In 146 cases given by Crampton 88 were first deliveries. No satisfactory explanation for this, so far as I know, has yet been given. In most works on obstetrics external violence is mentioned as the chief factor in the production of inversion. W. Bickman, on the other hand, who has carefully studied 100 cases, has obtained the conviction that inversion occurs most frequently in primiparae and young persons, and that violent manipulations rarely play the most important rôle in its etiology.) Rokitsansky speaks of "paralysis of the placental zone." Inversion may occur spontaneously by the simple weight of the placenta, especially if that be implanted at the fundus, — which conditions are further enhanced if the patient be in an erect or semi-erect position. The inversion may be caused by abdominal pressure when the abdominal muscles and diaphragm are fixed, as in the act of straining, or by pressure of the hand upon the uterus. Kaltenbach makes mention of such a case. It is not uncommon to require of the nurse to "make pressure over the uterus" to insure its contraction, while the obstetrician is looking after or resuscitating the child.

Inversion may be caused by undue tension of the cord, either in the delivery of the child, there being absolute or relative shortening of the cord, or when the child is expelled when the mother is in a standing position. Perhaps the most fruitful source of inversion is pulling on the funis in order to remove the placenta, especially so if this is done immediately after the delivery of the child, and in cases where the placenta is more or less adherent.

While the above factors imply a defect or vulnerable condition in the patient, on the one hand, and a faulty technique of the obstetrician, on the other, yet I am convinced that it is only an unfortunate conjunction or combination of two, oftener more, of the above conditions that produces this disaster.

**Symptoms.** — Most prominent among the symptoms is *hemorrhage*, showing itself by excessive flow and amount of blood lost, and by extreme pallor, syncope and collapse of patient. *Shock* is also spoken of as one of the prominent symptoms, and when there is no hemorrhage, as when the placenta is still attached, it might strictly be called shock *per se*, but oftener it is shock from the loss of blood.

**Diagnosis.** — Diagnosis of uterine inversion on the spot at the time of occurrence, to which this paper particularly refers, offers almost no difficulty. The exsanguined condition of the patient, that ghastly pallor which once seen can never be forgotten, together with collapse, large amount of blood in the bed or flowing constantly from the ostium vaginae, the absence of tumor — contracted uterus — above the pubes, and the presence of a globular tumor either without or within the vagina, presents a picture that has but one interpretation. Immediate action looking to its restoration is of far more importance to the patient than a refined diagnosis, such as finding the oviducts, demonstrating the endometrium and the urn-shaped opening of the inverted uterus through the abdominal wall, which latter condition will be most characteristic as restoration progresses. Naturally when the patient is seen some time, possibly days, after the accident, one

<sup>1</sup> Read before the Obstetrical Society of Boston, January 17, 1899.