

# RUPTURE OF THE KIDNEY AND TRAUMATIC ANEURYSM OF THE ABDOMINAL AORTA, THE RESULT OF A FALL FROM A BICYCLE.

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A REPORT of the above case will no doubt interest some of the readers of THE LANCET.

On Sunday morning, July 26th, I was called to see H. B—, aged twenty-one, a reacher in Denby Pottery Works, who on Saturday night got a severe fall off a bicycle. (I may here mention that the machine was not a "safety," but one of the ordinary high bicycles.) The messenger said the patient was suffering from great pain, and was passing blood in his urine. On arriving at the man's house, he was unable to give me any information about the fall or what part of his body came in contact with the ground first. He had been fomented during the night, but the pain was no better. His face was anxious, tongue slightly furred, pulse 100, and temperature 101°; shock was not marked. An examination of the urine showed that the hæmorrhage was from the kidney; the colour was smoky, and the blood had been passed with the urine, and not before or after micturition. Several small clots could be discerned adhering to the bottom of the vessel in which the urine was contained. On examining the patient, there was exquisite pain in the lumbar region, over the right kidney, increased on pressure, shooting forwards and downwards to the right testicle; there was marked retraction of the same testicle. The bowels were constipated. There was some retching after the accident, which had ceased on my arrival. I put the patient on small quantities of milk only, and ice to suck to quench thirst. I also gave him a diaphoretic mixture, and powders containing five grains of Dover's powder and ten grains of gallic acid, one to be taken every four hours. I applied six leeches to the seat of pain in the lumbar region, and continued the hot fomentations and bran poultices, into which the patient bled very freely.—July 27th: Pain no better. The urine contained less clots, but there was no improvement in colour. Pulse 120; temperature 102.2°. The patient did not pass much urine since I had visited him. The skin was acting well. Bowels open; tongue dirty and dry; thirst much worse. The same treatment was continued, everything being taken cold.—28th: Pain still severe, but more anterior than before. Temperature 103.5°; pulse 120. Urine was not voided during the night, but the patient had a frequent desire to do so.—29th: The patient passed a fair quantity of urine about 6 A.M., improved in colour, and containing no clots. The temperature had dropped to 100°, and the pulse to 94. The pain was not severe. The bowels were again opened. Tongue cleaner, and condition generally improved.—30th: Patient sat up in bed yesterday, contrary to all directions, and exerted himself a good deal in many ways. Temperature 101.3°; pulse 76. Tongue about the same as on the previous day. He was suffering from a severe abdominal pain in the umbilical region and vomiting. The urine contained more blood than on the previous day. All pain had left the lumbar region, except on pressure. A mixture, containing bismuth, morphia, hydrocyanic acid, soda, and gentian, was prescribed to stop the vomiting. On examining the abdomen, a large pulsating tumour, which had a distinct thrill on palpation, could be discerned, limited to a space three inches by two, in the region of the abdominal pain before mentioned, and to the left of the median line, immediately over the aorta. The lower end of the tumour was on a level with the umbilicus. On auscultation a systolic bruit could be heard.—31st: Pain better. The vomiting had ceased. The lumbar pain had again returned. The urine was improved in colour. Temperature 99.6°; pulse 62; tongue cleaner; bowels open. Aug. 1st: The patient's condition was improved. Pain less severe. Urine clearer. Tongue clean. Temperature normal; pulse 56. A peculiarity about the pulse might not be out of place here. Taking it by the minute, it was always the same. When taken by the quarter-minute, it was never the same for two consecutive quarters—e.g., 13 first quarter, 16 second, 15 third, and 12 last quarter. I repeatedly took the pulse, with the same result.—2nd: Still improving. Urine clearer. The gallic acid was continued,

but Dover's powder omitted. Milk diet continued. The pulse had dropped to 48. Temperature normal; tongue good; bowels regular.—3rd: Urine clear for the first time; on examination it contained a slight amount of albumen. Pulse 44; temperature normal. No pain either in umbilical or lumbar regions.—5th: Pulse 48; temperature normal. Urine clear; albumen less. No pain. The gallic acid was stopped.—6th: The patient was now allowed some fish and dry toast—the first solid food since the accident. He was put on fifteen-minim doses of the liquor ferri perchl. three times daily after food.—10th: He sat up for about an hour to day. Urine free from albumen. He continued to sit up every day, gradually increasing the length of time, and is now (Sept. 5th) walking about, enjoying fairly good health. The aneurysm does not diminish in size and is still well marked. His pulse has risen to about 60. He passes normal urine in sufficient quantity, and feels no inconvenience from the aneurysm.

I have recorded this case, as, I believe, an exactly similar case has seldom occurred. As to the cause of the aneurysm, the fall itself could scarcely produce it. I believe the patient ruptured one or more coats of the aorta while endeavouring to save himself. A severe wrench seems to have been the most likely cause. Attention may also be drawn to the slow pulse coexisting with the comparatively high temperature.

P.S.—Nov. 10th: The aneurysm seems now to be enlarging. The patient also feels more inconvenience from it than he did before.

Nottingham.

## ON A CASE OF COMPLETE OCCLUSION OF THE OS UTERI.

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NOTICES of anomalies which are apt suddenly to confront the medical practitioner in his daily work have their uses, and may even claim a place, albeit a humble one, in medical literature; and it is in the hope that the following case may prove of service as well as of interest that it is here somewhat minutely recorded; for though its importance is not of an eminently practical kind, it has a certain value of its own, lying largely, like that of many other things, in its rarity, its place being mainly rather among the pathological curiosities, or what may be called the romance of medical practice. Yet there is no denying that it is an occurrence which *does* occur, and *may* occur to any practitioner in an evil and unguarded hour; and if it is true that it is the unexpected which always happens, this case may do practical duty as a beacon of warning and an *aide mémoire* in some such time of unexpectedness, for "thrice is he armed" who is forewarned and remembers.

Mrs. T—, aged thirty-four, a primipara, had enjoyed what is usually regarded as excellent health during the whole period of her pregnancy, excepting only that in the latter months she had experienced some slight abdominal discomfort now and then, scarcely amounting to pain, and of which she had never complained, this fact having been elicited only after the termination of the labour. She was a healthy woman, rather small, and of fair complexion; and she inherited a decidedly rheumatic diathesis, for her mother passed through a long illness under my care, suffering from eczema, sciatica, and rheumatic arthritis, while her brother was at least twice attended by me for rather severe attacks of acute rheumatism. She herself, however, had for years previously been remarkably free from illness, the only occasion being a sharp rheumatic tonsillitis, for which I had treated her several years before. She found labour beginning sensibly to assert itself during the evening of May 13th, and I was sent for at six o'clock next morning. The usual report by both patient and nurse agreed in characterising the pains as having been both severe and frequent; but as the lady was moving about, and exhibiting, meanwhile, no visible or audible signs of special uterine vigour, I exercised a comfortable scepticism as to the correctness of this description. On making a vaginal examination, I expected to find an os at the respectable half-crown, or at the most the crown-piece, stage of dilatation. But I found nothing of the sort; in fact, I had not a clear idea at all what it was that I did find. I was

only conscious that I had not found the familiar spot which my senses could distinctly recognise as an ordinary os. I knew that I was confronted with a novel and strange arrangement which in the course of a fairly extensive obstetric experience I had never before encountered. The uterus was rather high up, but the presenting part, which had the usual more or less globular shape, was within reach of the examining finger. This finger I passed in every direction in search of the missing os, believing that possibly it might be so obliquely placed or so high up as to escape detection; but in vain, except that I thought, or half-persuaded myself at least, that a fold of membrane, crumpled before the point of my exploring finger, must really be the edge of the dilated os, in which case the labour must have advanced with unexpected facility. I tried to verify this suggestion, as I am in the habit of doing, and which I find Spiegelberg recommends, by applying half of the hand to the roof of the vagina to ascertain the continuity or otherwise of the vaginal wall with the membrane covering the presenting part. I fancied that somehow there was enough to satisfy my revolving finger and equally revolving mind that this fold must be the dilating os. As, however, the pains were by no means very forcible or very frequent, I resolved to give nature time and opportunity, if possible, to unravel the mystery; and I left with the promise that I would call in the forenoon unless previously sent for. I returned before midday, by which time the pains were recurring with more steady regularity and strength. The state of parts, however, was very much what it was before, with the exception that the presenting part certainly seemed somewhat fuller, larger, and nearer, and gave to the finger a more distinct feeling of elasticity such as the bag of membranes gives. The fold or ridge of tissue formed by the pressure of the examining finger was not now so markedly suggestive of the edge of the os, and my suspicion that the os had as yet been discovered was strengthened. Still, a definite idea of an occluded os had not even yet dawned upon me; and I was under the impression, besides, that it was a head presentation I had to deal with. After a little more profitless delay, I made up my mind to put the matter to the proof by rupturing the membranes; but they were everywhere so tough that I failed to do so with my finger-nail, which still more reinforced my doubts. I procured a strong steel knitting-needle, punctured the hypothetical membranes during a pain at the softest and likeliest spot I could find, and tried to gently tear them, but to no purpose, for fortunately they would not tear. No amniotic fluid appeared to escape, but on again examining I found my finger stained with meconium. This small puncture threw a flood of light on the case, and I at once perceived that not only had I to deal with a completely occluded os uteri, but also with a breech presentation. There were now no reasons for further delay, the pains being quite strong enough for expulsive purposes. I therefore informed the friends that I would get some assistance, as the case was a rather unusual one, but that there was no danger or any cause whatever for anxiety. I was fortunate in securing at once the help of Dr. Johnston, to whom I communicated the peculiarities of the case. On examination he also found the condition of affairs quite new and puzzling to him, but after some careful and patient digital exploration a faintly depressed spot was discovered, situated pretty far back, high up, and not quite in the median line, which I have found to agree with the description given of most of the cases of this form of occlusion. This was accepted by both of us as a fairly reasonable indication of an os which must at one time have existed; and as the patient had now been in labour over fifteen hours, and as there was not much hope that with the breech presenting uterine action alone would be able to open up a way of escape either for us or the ovum, we agreed to artificially reopen the passage into the uterus. This was satisfactorily accomplished after some difficulty by operating on the spot agreed upon with a uterine sound. The os dilated rapidly and well, assisted by the finger, up to a certain point; but in a short time, when it had attained a diameter of between three and four inches, further stretching became much more difficult and tedious. Notwithstanding, we considered it advisable to hasten delivery; the legs were brought down and the head extracted—not, however, without a vast deal of trouble by Dr. Johnston, who, in the friendliest

manner, undertook the major part of this manual labour. The child was evidently dead, for no sign of life was manifested even after prolonged efforts at resuscitation. As the head was being secured at the outlet, the perineum was unfortunately torn pretty deeply; but I inserted at once a couple of deep stitches, and, as the wound healed by first intention, it never gave any further trouble. The placenta was brought away easily. No chloroform had been granted to the patient, who, however, behaved admirably throughout. She was carefully nursed, and douched regularly with sublimate solution; so that she made an excellent recovery, her temperature never having reached 100° except once.

There are two forms of this occlusive dystocia which are met with and described. The one is a true cicatricial atresia or ulcerative adhesion, which may result from the supervention of pregnancy very soon after a previous confinement, from ineffective attempts to procure abortion, from cauterisation of the os during pregnancy, from syphilitic disease, or, in fact, from any cause productive of ulceration. It is quite clear, however, that our present case cannot belong to this category, for there was no trace whatever of any history which could suggest any of these causes, or, indeed, any others; and, besides, it is always easy, according to Spiegelberg, to diagnose this condition by the rough and hard cicatrix which is present, except when the labour has so advanced that the pressure of the ovum has thinned out the uterine wall, and smoothed out even the cicatrix. The other form is that of simple epithelial atresia or agglutination, caused probably by the agglomeration of excessively proliferated epithelium, fibrinous exudation, and inspissated mucous secretion. It may, however, in some cases result from a real superficial adhesive endocervicitis, from some irritation, mechanical or other, insufficient to be appreciable, or considered of no importance, by the pregnant woman herself. We know that the maternal blood, during the latter half of pregnancy at least, becomes largely increased in its fibrin, and that the cervix during the progress of the pregnancy gradually softens from the os upwards, by means of an abundant production of plasma, fibres, and cells. And as in primiparæ (in whom this special form of abnormality is mostly found) the external os remains closed till the beginning of labour, it is conceivable that from some slight unknown cause this plasmic exudation and cell proliferation may be in certain cases increased, and a kind of tough, semi-organised false membrane, as Naegelé terms it, may thus be formed. This appears to me to be the form of obstruction and a probable explanation of its existence in our present case, and how far it may be possible that her rheumatic constitution may have contributed to an increased fibrin formation I cannot venture to assert.

Barnes and Parvin both speak of certain very rare cases where the occlusion is caused by the adhesive union of the chorionic and amniotic membranes with the maternal membrane. In these cases the rim of the os is recognisable, and all that has to be done is to separate the membranes, or, failing that, to rupture the amnion. However this obstetric anomaly may be produced, every authority who alludes to it at all regards it as of rare occurrence. Churchill says "there are cases on record"; Barnes speaks of it as "a condition commonly described, but very rare"; Leishman has it that "there are some cases in which it seems that the os is completely occluded"; Parvin remarks that "conglutination of the external orifice is occasionally met with"; and Spiegelberg says of both forms of occlusion that they are "equally rare." Ramsbotham, in his ponderous and learned volume, takes no notice of it whatever, nor does Denman; nor have I found any mention of it in Simpson's collected writings. Mazzoni mentions having observed an instance of it; and Dr. Campbell, cited by Churchill, relates two cases, both first pregnancies, in one of which uterine action continued twelve hours, and in the other two days and a night, before any trace of an os could be discovered; and Churchill himself had a case which took forty hours to divulge an os, which even then was but the size of a small crow-quill. In a number of the *International Journal of Medical Sciences* of last year a brief record is given of a case published by Jentzer in the *Archives de Tocologie*. He was sent for by a midwife who was attending a woman, aged twenty-two, at full term, and he found a tumour between the patient's thighs, which was the child's head covered with an elongated cervix, almost impervious. There was no history of previous disease or injury to account for it. He says several similar instances are found in the literature of the subject.

The references and descriptions furnished by the few authorities whom I have consulted are mostly brief and imperfect; but Rigby, quoted by Churchill, and Spiegelberg supply adequate enough accounts of this condition and its management. Rigby says: "We may suspect that the protraction of labour arises from agglutinated os uteri when at an early period of it we can discover no vestige of the opening in the globular mass formed by the inferior segment of the uterus, which is forced down deeply into the pelvis, or at any rate when we can only detect a small fold or fossa, or merely a concavity, at the bottom of which is a slight indentation, and which is usually a considerable distance from the median line of the pelvis. The pains come on regularly and powerfully, the lower segment of the uterus is pushed deeper into the cavity of the pelvis, even to its outlet, and becomes so tense as to threaten rupture; at the same time it becomes so thin that a practitioner who sees such a case for the first time would be induced to suppose the head was presenting, merely covered by the membranes. After a time, by the increasing severity of the pains, the os uteri at length opens, or it becomes necessary that this should be effected by art. .... Although the obstacle is capable of resisting the most powerful efforts of the uterus, a moderate degree of pressure against it, whilst in a state of strong distension, either by the tip of the finger or a female catheter, is quite sufficient to overcome it." Spiegelberg practically corroborates this description: "Only when the parts are greatly expanded, thinned, and smoothed out, are difficulties likely to arise; similarly, when the seat of the orifice is displaced far backwards and cannot easily be reached by the examining finger. Under such circumstances practitioners have repeatedly failed to recognise the stretched lower uterine segment and vaginal fundus, believing the presenting head to be only covered by the foetal membranes. .... The os may either not be detected at all, or else it merely presents a shallow groove which is very apt to be overlooked. It is generally spontaneously remedied when the ovum is forced down, but if it detains the latter, it must be ruptured by a finger during a pain, or by the uterine sound."

In this case there is no doubt that the breech presenting, instead of the head, produced a modified state of parts differing somewhat from these descriptions, and not only slightly increased the difficulties of diagnosis, but materially affected the progress of the labour. For the uterine contractions do not bear with the same direct force on the lower segment of the uterus when this is occupied by the breech; and when especially the os was situated somewhat obliquely and out of the normal axis, the expanding power of the pains would to a certain extent be lost, demanding therefore a much longer time for their opening up the womb. It seems to me there is no advantage gained, but the reverse, in waiting for the natural efforts to remove the obstruction, once the diagnosis is made and the labour has made fairly distinct progress. The only dubious point of treatment in the case was whether, after an opening had been made, the labour might not have been better left to nature; but the woman was certainly becoming tired, and a hope was entertained that by expediting delivery the chances of saving the child would be thereby increased.

I would only add, in conclusion, that Mattei, who brought together a careful statistical collection of cases, found that thirty-six operations were necessary among forty-two patients, of whom three died. In twenty-eight cases in which the operation was not done till late, seven children were stillborn, and two of the mothers died.

Dundee.

### A CASE OF DOUBLE PYO-SALPINX IN A CHILD ONE YEAR AND NINE MONTHS OLD.

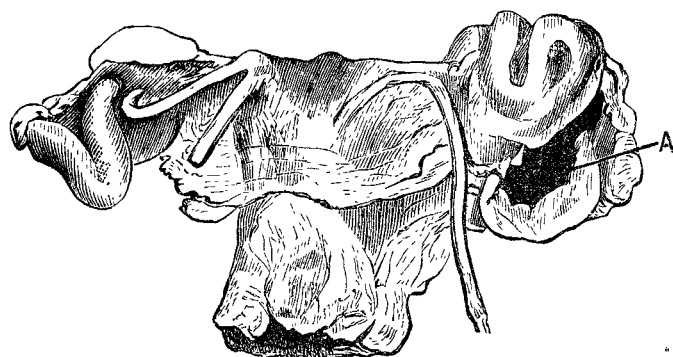
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L. B.—. aged one year and nine months, was admitted in May last into the Evelina Hospital, under Dr. Frederick Taylor (who kindly allows me to publish the case), with tubercular disease of the right lung. Nothing abnormal was detected in the abdomen beyond some tumidity, the walls being lax and admitting of free examination.

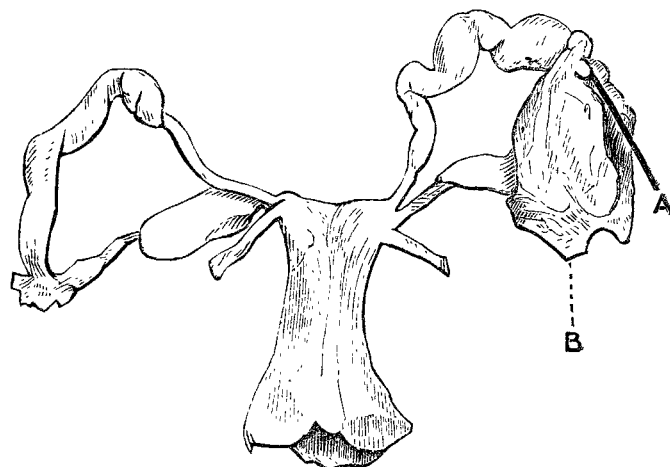
No vulvo-vaginitis present. At the post-mortem examination, a large irregular cavity, containing an ounce and a half of thick pus, was found in the superior lobe of the right lung, surrounded by tubercular consolidation. Tubercular deposits were also found scattered through the middle and inferior lobes, in the liver and right kidney. The peritoneum was studded with yellow tubercles, especially in the pelvic region. No ulceration

FIG. 1.



AS REMOVED.  
A, Abscess cavity.

FIG. 2.



AFTER DISSECTION.  
A, Probe passed into Fallopian tube. B, Abscess wall laid open.

was detected in the small intestine. On removing the sigmoid flexure some thick pus was observed at the left pelvic brim, which was found to be exuding from an abscess in the left broad ligament. The uterus and its appendages were then removed, both Fallopian tubes found to be coiled and distended with pus, the left more so than the right, and apparently in communication with the abscess, the left ovary being completely hidden and the right tube prolapsed when the specimen was looked at from the front, the whole presenting the appearance represented in the first sketch. On dissection, the peritoneum, though somewhat thickened, was fairly easily dissected off. The proximal ends of both tubes were found to be healthy, the right for an inch, the left for a quarter of an inch, the left opening into the abscess and forming its wall, the abscess containing about one drachm of thick pus. The uterus was found to be perfectly healthy. The second sketch represents the specimen after dissection.

FUNERAL REFORM AND CREMATION.—Surgeon-General Sir Joseph Fayrer, presiding last week at a meeting of the Funeral Reform Association in the Church House, Westminster, said that on the battlefield and during a pestilence cremation might be necessary, but if the body were buried in a perishable coffin in suitable soil there was no need of cremation. The Hon. George Waldegrave Leslie and General Lowry, C.B., moved resolutions, which were carried unanimously, advocating a return to the ancient practice of burying simply in the plain earth. It was also resolved to urge the transference from the Home Office to the Local Government Board of the control over burial places. Other meetings were held during the week in the Town Halls of Leeds, Manchester, and Colchester, and at Dewsbury.