

CASE OF

CENTRAL RUPTURE OF THE PERINEUM,
SCARLET FEVER, AND SEPTICÆMIA.

By J. H. ASHTON, M.R.C.S.

At about 1.30 P.M. on April 26th I was sent for to attend Mrs. W—, age twenty-three, in her confinement. I found her a well-developed woman, with regular but not very strong pains. On examining her, the os uteri was about the size of a shilling, the head presenting, and in the first position. At 2.30 P.M. the os uteri was fully dilated, and the membranes ruptured. At 4.15 P.M. the perineum began to distend; the pains were not very strong; the parts were moist, the pulse was quiet, and the head continued to advance gradually. A few minutes before the birth of the child, which occurred at 5.30 P.M., I observed the skin just in front of the anus cracking, evidently in consequence of its inability to dilate to a further extent; the crack extended with the next pain in a transverse direction, the skin in this situation being hardly thicker than a sheet of paper; at the same time the posterior commissure of the vulva began to tear. I immediately applied the forceps, but in spite of all precautions (in the way of support and direction of traction) the perineum was lacerated from the fourchette to the spot where it originally gave way. During the progress of the labour and afterwards the patient complained of sore-throat and thirst; the skin was cool and the pulse quiet. The following day (April 27th) the same symptoms were complained of. The perineal wound looked healthy; it had been left unstitched. Early on the 28th, fever with diarrhoea and constant sickness came on, the pulse was very rapid, and the throat was red, swollen, and painful. Superficial sloughing began on the right side of the wound, and extended over its whole surface; on the left side the same appearance presented itself, but to a less degree. On April 29th a copious red rash (scarlatinal) appeared, which spread over the whole body. At this time the external parts were swollen and inflamed with a profuse purulent discharge. Sickness, diarrhoea, and delirium had been present. On the following day (April 30th) the lochial discharge ceased. On May 5th the rash had entirely gone, and the wound assumed a healthy appearance. The treatment during the first part of the attack consisted in the administration of salines, with small quantities of stimulants; and during the latter part quinine in ten-grain doses was given, on the nights of the 5th, 6th, and 7th days, with tincture of digitalis and moderate quantities of stimulants; antiseptics were also applied locally. On the morning of May 14th the patient was seized with rigors, sickness, and diarrhoea, with rapid pulse and tenderness over the hypogastric region, the cause being evidently septicæmia, due probably to the discharge from the wound not having been washed away during the night. The tenderness over the hypogastric region passed away on the 17th, and the patient commenced to be convalescent on the 18th. No albumen was found in the urine drawn off by catheter.

Remarks.—Central rupture of the perineum has been known to occur in cases where the coccyx has been less curved forwards than usual, but the condition here was normal, and the cause of rupture evidently the large size of the child's head. It was apparent that rupture would take place some time before it actually occurred, also that the forceps would not only cause a rent, but probably a severe one—an opinion expressed and verified by the result. The sloughing appearance of the wound was due to the scarlatinal poison, which had manifested its presence prior to the outbreak of the febrile symptoms. The scarlet fever gave rise to neither peritonitis nor metritis, differing in this respect from the septicæmic attack where metritis occurred. In a collection of cases by Dr. B. Hicks¹ several of scarlet fever are recorded, in some of which local lesions were found, in others none. It is certain that scarlet fever in the lying-in state sometimes runs its course without any; and it may be inferred that, when present, they probably result from some local cause introduced from without, or

arising within the patient's body, or from injury during labour. The infant did not take the disease, and this was the mother's first attack.

Richmond.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND
THERAPEUTICAL.A CASE OF SUPPURATING OMENTAL CYST;
ABDOMINAL SECTION; EXCISION OF CYST;
RECOVERY.By JOHN WALDY, F.R.C.S. ENG.,
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B. H—, a girl eight years of age, was first seen in May, 1888, when she was suffering from pain in the lower part of the abdomen. Her mother stated that she had suffered at intervals during the last two years from attacks of abdominal pain, which had increased both in severity and frequency. The pain was not accompanied by vomiting, nor did it appear to be caused by food or induced by violent exercise.

On examination, the lower part of the abdomen was visibly enlarged, and measured twenty-four inches in circumference at the umbilicus. On palpation, a tense globular, hard, movable (in all directions) swelling could be felt. Over its surface a creaking feeling was perceptible during respiratory movements. It fluctuated in all directions, and appeared not to be deeply situated or to be fixed in the pelvis or lumbar regions. Percussion gave a dull note over the swelling, with distinct resonance all round. The hand could be passed below the swelling into the pelvis. A hypodermic needle withdrew pus.

My partner, Mr. J. H. Hutchinson, agreed with me that the tumour was either a suppurating hydatid or dermoid cyst, probably situated in the omentum, and that excision or drainage offered the only chance of cure. Accordingly we agreed to open the abdomen, and having obtained the assistance of Mr. Richard Bowes of Richmond, on June 6th I made an incision two inches and a half long in the middle line between the umbilicus and pubes. On exposing the cyst, it was found firmly adherent to the abdominal wall in front. These adhesions were separated, and after tapping the cyst, withdrawing half its contents, and clamping the opening with pressure forceps, it was found to be adherent to the intestines and liver. The child was now turned on to her right side, and a portion of the cyst having been drawn out of the wound, the cyst wall was freely incised and the pus completely evacuated. The second opening was again clamped, and the adhesions were separated without much difficulty until the descending colon was reached; here they were so dense and firm that in dissecting them off the bowel a small aperture was made, which was immediately closed by Lembert's suture. The cyst was now delivered, and the broad pedicle formed by the adherent omentum was divided between numerous catgut ligatures. The abdominal cavity was washed out with warm spring water that had been previously boiled, a drainage-tube was introduced into the pelvis, and the wound was closed in the usual way and dressed with iodoform wool.

On the following day the wool was saturated with red serous discharge. Pulse 130; temperature 100°; urine loaded with urates, passed without the aid of a catheter. Vomited two or three times. The drainage-tube was removed, and fresh wool applied. On the third day the pulse was 100; temperature 99°. Bowels acted naturally on the second day. On the fourth day the wound was healed, and the child gradually convalesced. The diet was warm water for the first twenty-four hours, milk-and-water for the following two days, then beef-tea and milk until the end of the first week, and afterwards a gradual return to ordinary food.

The clinical features of the case are interesting. The age of the patient suggested a dermoid cyst. The resonance all round the tumour, together with its free mobility and the fact that the hand could be passed between the tumour and the liver and spleen, and also below the tumour into the pelvis, as well as into both loins, excluded a tumour com-

¹ Obstet. Trans., 1876.