

symptoms of strangulation are ascribed to inflammation of the bowels, without a suspicion of the true cause having been excited, and the patient dies, as is supposed, of idiopathic peritonitis."

He also describes the following case: A man was admitted into St. Thomas's Hospital with symptoms of strangulated hernia, which for five days had been treated as a case of simple inflammation of the bowels, without a suspicion of the true cause having been excited. On examination a fullness could be perceived above Poupart's ligament, and when this was compressed, a small tumor like the end of the little finger, appeared at the abdominal ring, which again receded to its former place on withdrawing the pressure; pain was felt at the same time and in coughing much uneasiness was produced at that spot. As five days had elapsed between the first accession of the symptoms and his admission into the hospital, the performance of an operation afforded but little prospect of success, for besides vomiting he had been troubled with a hiccup for forty hours, his belly was sore on pressure, and his pulse so small as scarcely to be distinguished. However, as it was the only possible chance for recovery, the operation was undertaken. On cutting down to the tumor, it was found to be produced by a hernial sack an inch and a half long, and when this was opened about half the circumference of one of the small intestines was found to be contained within it, together with a quantity of sanious serum. The stricture which existed an inch and a half above the abdominal ring was then divided. The intestine was discovered, but the point of the knife having accidentally touched one of its superficial veins, the blood issued from it freely, proving that the bowel was in a fit state to be returned, which was accordingly done as soon as the bleeding ceased. The patient had stools in twelve hours, and although he afterward suffered from a severe purging, he ultimately recovered. Here is a report of a case occurring in the days of Sir Astley Cooper, and under his own observation, and what reason have we to believe that the same errors in diagnosis are not made to-day; Prof. Agnew says in the first volume of his work on surgery, page 468, "that in concealed inguinal hernia, a portion of the intestine may be strangulated at the internal ring so small as to render it impossible for the surgeon to discover its existence either by sight or touch. I have witnessed a number of deaths from this form of hernia which have been treated as cases of colic." I think we may fairly conclude that notwithstanding the many great improvements that have been made in modern surgery, we fail to-day to impress upon the medical student, the liability of its occurrence and the great danger of excluding the possibility of its existence, because *all* the ordinary symptoms of hernia are not present. I am surprised that so many of the authors of the recent works on surgery should dismiss this; to my mind, important form of inguinal hernia, some with barely a reference and others with the briefest sort of an allusion. The question naturally arises, that having taken the ground that this form of disease is frequently overlooked, what is the remedy? I answer that being fully alive to the pos-

sibility of its existence and a knowledge of its obscurity and great difficulty of detection, will have the effect to diminish largely the number of deaths from strangulated hernia, treated as colic or idiopathic peritonitis. The student should be taught where to look for a slight hernial protrusion through the inner ring. He should be told of the changes and liability of mistaking it for an enlarged inguinal gland; of the possibility of the enlarged canal protruding into the abdominal cavity, with but slight or no external swelling; of the necessity of carefully compressing both sides of the abdomen.

These are a few of the essential points to be inculcated that present themselves to my mind. I desire here to speak of another point in connection with the formation of the hernial sack, that seems to be almost forgotten, and that is to call attention to the *importance* of remembering that the portion of peritoneum employed to form it may be represented by a plain membrane about three inches in diameter, more or less, according to the amount of protrusion; and the circumference of this portion of peritoneum would be about ten inches. Now when the sack is formed the fundus is covered with a single layer of peritoneum. The periphery folded and puckered like the mouth of a closed purse would be formed at the inner ring, and the greater the amount of protrusion the more folding and the deeper the folds at the internal ring. This crowding of ten inches of peritoneum into the space of one inch would become an important factor in producing strangulation at the inner ring, and the pressure of these folds of peritoneum against each other, under such circumstances, would rapidly result in adhesion, and render the strangulation of the intestine dependent, to a partial extent at least, upon the peritoneal ring so formed. Is it safe, then, to simply divide the outer band of stricture and return the sack and its contents into the abdominal cavity? My own opinion is that in these days of antiseptic surgery when wounds of the peritoneum are not considered dangerous, that the plan advocated and followed by Bangs, of England, Marcy, of Boston, and others, viz: The ablation of the sack should be followed; the fissure in the peritoneum so produced closed with carbolized animal ligatures; the pillars of the inner ring approximated and held in position by the same material, and the external wound closed with antiseptic precautions.

POST-PARTUM POLYPOID TUMORS.

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[Read to Section on Obstetrics and Diseases of Women, June, 1883.]

The title of this paper is intended to indicate that its subject-matter is concerned with tumors, 1st, which resemble polypi, more or less; and 2d, are found only after delivery. I will further restrict it to labor at full term, since the conditions after abortion differ clinically in some respects, and open too wide a field.

The subject is one of great practical interest. Not infrequently the physician is accused of having left a piece of the after-birth behind—of not completing the delivery. A patient has secondary hæmorrhage or

septicæmia, in the course of which are discharged or removed masses of fleshy or membranous consistence, which the old women or an unfriendly colleague pronounce to be "a bit of after-birth," greatly to the detriment of the attending physician.

I believe that, as a matter of fact, the detention of a fragment of placenta after labor at full term is a rare occurrence, though perhaps the same could not be affirmed of the membranes. I once witnessed a case in which the perinæum had suffered a complete laceration. The accoucheur, apparently excited by the accident, immediately introduced his hand into the womb, and, with a clutch, brought away about one-half of the placenta, leaving the remainder for me to extract, not without difficulty. Such ignorant brutality is certainly uncommon, and without it, the placenta is generally, sooner or later, expelled entire. The conditions which, no doubt, are often mistaken for this accident are as follows:

1. Attached fibrinous coagula; the free polypous hæmatoma of Virchow. Slight oozing of blood may take place from a sinus imperfectly closed by a thrombus. The blood clots form gradually, and in somewhat concentric layers, until we have a tumor which feels very like a polypus, and hard enough to bear considerable handling. According to Schroeder, "a peculiar roughness or too great projection of the placental insertion into the uterine cavity appears chiefly to predispose to their formation." He mentions, however, having seen two cases in which there was no question of excessive roughness. The firm structure and laminated appearance of these slowly formed clots are no doubt occasionally misinterpreted by those who examine them hastily. Inasmuch as these blood-polyps have been found under many and varying circumstances, we are at present unable to determine exactly even the principal predisposing causes. A remarkable feature in their clinical history is that for quite a long period, comparatively, their presence is unattended with harm. Our attention is first called to their existence by a sharp attack of secondary hæmorrhage. This may occur in the first week, but has been postponed to the third week after delivery. The hæmorrhage may be immediately fatal, or, if timidly treated, may recur to a dangerous extent. Septicæmia is also apt to follow the hæmorrhage.

Unless the patient succumbs to the first flow of blood there is little to fear from these tumors. Their removal is not difficult, and is usually followed by prompt recovery—which will be expedited by the free use of iodinized intra-uterine injections.

2. A priori, fibrinous clots might be expected to form more frequently when a fragment of placenta adheres to the uterine wall.

The authors who mention the subject seldom detail cases, and I am not sure whether direct observation or inductive reasoning has guided them in their remarks. There is at least a possibility that some cases have been confounded with, or rather wrongly taken from, the next two classes of which we will speak. Courty¹ figures a blood polyp attached in this manner, but if the cut is approximately correct there is room for doubt whether the attached mass is

placenta or hypertrophied decidua. Admitting the occurrence as probable, but much more rare than its comparative prominence in books would warrant, we have a second form of polypoid tumor consisting of a mass made up of placental tissue and clotted blood. This form causes the same symptoms as in the mere blood polyp, but is both more difficult to remove and more dangerous to life.

3. The decidua vera or scrotina may become in part detached during the labor. Small strips of mucous membrane are thus left dangling from the uterine walls. This condition directly favors the stalactitic growth of blood-clots, and is probably the most frequent cause of their formation. Winckel¹ gives full details of a case of this character. Dr. Munde's case reported in March, 1883, (*Am. J. Obst.*, and elsewhere), appears to have been similar. When these tumors are removed, the laminated structure of the clot, interspersed with shreds of decidua membrane, are very liable to be taken by a careless observer for placental tissue. Such mistakes are not likely to be made by experts, but I speak of things as I find them. Thus we see that we may have polypoid tumors composed of blood, either formed in a normal uterine cavity or connected with placental or with decidua fragments.

4. A fourth form is thus briefly noted in Barnes²: "C. Braun (1851) describes the *placental polypus*. This results from the remains of the placenta, consisting of hypertrophied decidua, which, projecting into the uterine cavity, forms a polypoid mass." This, it will be noted, is a very different thing from either retained placenta or prematurely detached, but otherwise normal decidua. It results from the hypertrophy of the decidua scrotina, or vera, due to inflammation or intense localized hyperæmia. I have not had access to the original paper of Braun, nor have I been able to meet with the record of any other cases. A detailed report, therefore, of two cases observed by myself may be of interest:

CASE I.—Mrs. F., æt. 27, third pregnancy. Labor continued for eight hours, nothing noteworthy occurring until after the birth of the child, a male weighing ten pounds. The method of Credé was then instituted, but a half hour elapsed before the placenta was finally shot out of the vulva. The membranes resisted considerable traction, and required to be much twisted before they could be withdrawn. The afterbirth was then carefully examined. It was of irregularly oblong shape, and "battledore." One or two small patches on the maternal surface presented the appearance of recent adhesion. On the membranes, about an inch from the placental edge, was a patch one and one-half inch in diameter, of roughened and flaky surface, and stained in spots by hæmatin. There was no history of inflammation during pregnancy, notwithstanding the presence of plain evidence of adhesion of both placenta and membranes. The womb was well contracted, and the patient comfortable in all respects.

Convalescence was uninterrupted, the patient being allowed to sit up on the eleventh day. On the even-

¹ Dis. of Uterus and Am. Ed., p. 675.

¹ On Child-bed, p. 157.

² Diseases of Women, second American edition, p. 689.

ing of the twelfth day (post partum) she suddenly, while nursing the baby, suffered a copious hæmorrhage, and when I arrived an hour later, was still leaking, with a rapid pulse and exsanguined appearance. An examination showed the rectum to be so loaded with fæces as to prevent access to the os uteri. Knowing this to be a not uncommon cause of secondary hæmorrhage, I at once administered an enema with prompt effect. On then introducing the finger into the womb I found that it contained a mass of firm tissue with polypoid knobs—but no blood clots. At the lowest end of the mass I found a slightly detached edge, and with a prying and sawing movement of the finger, succeeded in detaching the greater portion of it, until I could no longer reach to a sufficient distance. By this time, the condition of the patient demanded a cessation of hostilities, and having injected into the womb a strong solution of iodine, she was allowed to rest until the morning. No hæmorrhage nor pain during the night. In the morning, assisted by Dr. Loving, I proceeded to remove the mass, which had shrunk in size, since its partial detachment, and was attached like a veritable polypus at the fundus. The placental forceps brought away the greater part at one seizure, but a small fragment was unavoidably left for spontaneous detachment. Intra-uterine and hot water vaginal injections were used from this time, and the patient entirely recovered with the following remarkable diversions, viz.: A chill occurring exactly one week after the hæmorrhage, another one week after that, and a third slighter chill just one week later. The free use of arsenic finally controlled them. It may be added that she had been a frequent sufferer from ague from her youth up.

To return to the tumor. While dissecting up the mass from the uterine wall, the conclusion that it must be a retained cotyledon of placenta was forcibly present. This was negatived by the careful inspection previously made of the placenta, and also by the density and comparative thinness of the mass. This also militated against the supposition of a "*placenta succenturiata*." Doubts were resolved when the mass was removed. Macroscopically it was unmistakable uterine mucous membrane, although over a half inch in thickness.

Being referred to Dr. A. M. Bleile for microscopical investigation, he reports:

A hardened and stained section exhibits:

1. And principally, connective tissue with large number of cells.
2. A few tubules.
3. Blood vessels of respectable magnitude.
4. Free surface, covered by columnar epithelium. The whole giving the impression of uterine mucous membrane, in which the tubules are widely separated by embryonic connective tissue.

We have, then, here a case in which a relatively enormous hypertrophy of the decidua took place, resulting in a mass too large to be disposed of in the usual and physiological manner during the process of involution. That the cause was inflammatory may be inferred from the adherence of the foetal envelopes, notwithstanding the apparent health of the mother during gestation. That the predisposing

cause was malaria is suggested by the subsequent history.

CASE II.—Mrs. D., æt. 23, primipara, delivered Feb. 12, by a midwife. By a curious coincidence nothing retarded convalescence in this case until the twelfth day after labor, when a sharp hæmorrhage occurred. Unfortunately the midwife did not appreciate the possibilities of the case, and it was not until after three days and repeated hæmorrhages that I was called. I then found in the uterus several fibrinous polypi, which, when removed, were found to contain small shreds or flakes of membrane. After their removal the posterior wall of the uterus was noticed to be roughened or rather nodulated, and, a fragment being removed, proved to be mucous membrane. The midwife insisted that the placenta had been removed entirely, without difficulty, and by the method of Credé. As in the former case the condition of the woman was so low that I was compelled to defer further proceedings for the time, using hot water copiously in the interval. At a second sitting I succeeded in removing further bits of decidua, after which the uterus gave no further trouble, as the woman advanced to complete but slow recovery. For several weeks the extreme bloodlessness of the patient had to be combatted, and this was followed by œdema of the lower extremities with phlebitis. During the course of this she had many chills, alternating with fever. To make a diagnosis of malarial poisoning under such circumstances is somewhat hazardous, yet I am inclined to think that a malarial element of causation existed also in this case.

MAN ACCORDING TO NATURE.

[Address before the District Medical Society of the Eleventh Congressional District of Ind., and published by request of the Society.]

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The laws governing our physical origin and development are so numerous and so imperfectly understood, and still less perfectly obeyed that we exclaim how fearful and wonderful the result.

With all the recorded facts of the past, scientific men of this age ought to occupy a higher plane of action, in defense of nature's laws. Man's spiritual nature has been so clearly taught, and the laws for its progressive growth till its final consummation in perfection at death in Christ so well obeyed, that the believer in and obeyer of the Bible furnishes the world with the highest and most perfect psychical type of man.

For elucidation and verification of this statement we refer you to those individuals, communities, states and nations that receive the Bible as the word of God, and who accept and obey its legitimate teachings, in contrast with those individuals, communities, states and nations that reject the Bible as the word of God, and deny and disobey its teachings.

We desire to direct your attention, to-day, to a brief consideration of nature's laws, so far as they pertain to our origin and development from elemental life to its final consummation. In so doing, we shall avoid whatever might lead us into a dissertation upon the inherent force of cell life or the physical