

THE DUBLIN JOURNAL

OF

MEDICAL SCIENCE.

JULY 1, 1887.

PART I.

ORIGINAL COMMUNICATIONS.

ART. I.—*The Treatment of Abortion.*^a By JOHN W. BYERS, M.A., M.D.; Physician to the Hospital for Sick Children, and Physician for Diseases of Women to the Royal Hospital, Belfast; Fellow of the Obstetrical Society of London, and of the British Gynæcological Society.

I THINK I need make no apology for bringing forward the question of the treatment of abortion. The great frequency with which abortions are met with—there being probably 1 to 8 or 10 full-term deliveries—the disastrous effect they frequently have on the health of those in whom they occur, as well as their direct action in the causation of pelvic disease—all these circumstances demand that we should have clear and definite ideas as to the treatment of such complications.

As is well known, the term abortion is applied by some, rather in a restricted sense, to expulsion of the ovum in the first two or three months of pregnancy, before the placenta is formed, while if such a condition occurs at any time between this period and the seventh month it is called a miscarriage; but on the present occasion I must be understood as using the terms abortion and miscarriage as synonymous, and as including all those cases in which pregnancy is brought to a termination before the child is viable—that is, about the end of the seventh month.

^a Being an Introduction to a Discussion at the Ulster Medical Society on March 9, 1887.

In the present paper I propose to bring before your notice the following points:—

1st. The treatment of threatened abortion.

2nd. The treatment to be followed when all hope of the pregnancy being continued is gone.

3rd. The method of dealing with neglected or incomplete abortion.

4th, and finally. The question of the after-treatment and prophylaxis of abortion.

I wish, however, *in limine*, to direct your attention to some features in the development of the placenta, of which the greater number of midwifery text-books, with the exception of that of Dr. Galabin, take little or no notice, but which seem to have a very direct and practical bearing on the question we are to discuss. If we suppose a section to be made of the uterus with the placenta *in situ* after the twentieth week of pregnancy, there will be observed a number of spaces in the *decidua serotina* beneath the placenta, and it is through these openings that detachment occurs at the end of pregnancy. In the first two months, as Dr. Galabin tells us, the ovum is most frequently got rid of without rupture of the envelopes, and the whole of the chorion and rudimentary placenta comes away together. “In the middle months of pregnancy,” he states, “after the placenta has been formed, but before the formation of that open meshwork which facilitates its separation from the uterine wall, the separation of the placenta is much more difficult.” In abortions at this period the amniotic sac, owing to the pressure of the uterine contractions, yields near the cervix, the waters escape, and the fœtus is expelled and the small funis is easily snapped. Then the uterus, having got rid of a portion of its contents, retracts, the neck closes up, and the whole or a part of the placenta is likely to be retained unless it is removed by artificial means. The close connection between the placenta and the uterus is met with between the tenth or twelfth to the twentieth week, and this is just the period during which the practical obstetrician finds his greatest difficulties in dealing with abortion. After the fifth month the placenta comes away as at full term.

1st. *Threatened Abortion.*—If the hæmorrhage is not severe, if the os is not dilated, and there has been no escape of liquor amnii, we are bound to make an effort to save the ovum. What I rely on myself is absolute rest and some preparation of opium.

(a) The patient should keep on her back, avoid all movement, use the bed-pan (if possible), have a milk diet, and avoid every form of stimulant. By this means the circulation is kept thoroughly quiet.

(b) Twenty minims of Battley's solution given twice, at intervals of three hours, and then half this dose every five hours; or half a grain morphin suppository, is the form of opium I like best. In a word, the treatment is very much in threatened abortion like that which the physician employs in hæmoptysis. I have not tried the drug recommended in this condition by our American *confrères*—the liquid extract of *viburnum prunefolium*. They give it in drachm doses every three hours. I have little faith in cold, acetate of lead, or sulphuric acid in the treatment of threatened abortion.

2nd. When, however, from the continuance of the pains, the presence of great hæmorrhage, coupled with the dilatation of the os, we feel that there is no chance of saving the ovum, how are we to act? If the abortion occurs within the first couple of months, we should endeavour to do nothing by a too active interference, which would tend to rupture the ovum, so that if possible it may be got rid of unbroken. If the ovum is already in the vagina, or if it has so dilated the cervix that we can work the finger round it, we should take it away. Any part of the decidua attached to the interior of the uterus may be left alone, as it will come away in the discharges. Again, after the fifth month we act precisely as in an ordinary delivery. It is when an abortion occurs between the tenth or twelfth and the twentieth week that one has to deal with the greatest difficulties, for reasons which I have already stated. While I said in the early part of this paper that many pelvic ailments take their origin from an abortion, it must be clearly known to all that there are two immediate dangers to which every woman who is the subject of abortion is liable—hæmorrhage and septicæmia—and she is only secure against these risks when the uterus has been completely evacuated. Now, in certain cases, if seen early, the cervical canal is so patulous that we can introduce the forefinger, and bring away the whole or part of the placenta remaining, while in others, from the undilated condition of the cervix, this is impossible. In the latter class of cases we give ergot to intensify the uterine contractions, while we place a plug in the cervical canal. By these methods we hope to restrain hæmorrhage, to cause separation of the placenta, and to facilitate the introduction of the finger. I usually give two drachms of the

liquid extract of ergot at once, and a second drachm in three hours, although others (especially in the Edinburgh school) prefer to administer ergotin subcutaneously. I remember when a student the usual plan was to plug the vagina in such cases with cotton wadding soaked in glycerine, but now I plug the cervix as a more rational and scientific procedure. This is best done with a sponge or tupelo tent, but in the introduction of a tent, as well as in any other operative interference with the uterus, I am a thorough believer in antiseptic precautions. I have already expressed my views on antiseptic midwifery in another place during the present session.* In introducing a tent we first give a hot vaginal antiseptic douche, the hands having been previously washed and then placed for a time in a 1 in 2,000 perchloride of mercury solution. An antiseptic sponge-tent or one made of tupelo wood (covered with salicylic cream, 1 to 8 of glycerine) is then passed into the cervix, and retained in position with a piece of iodoform gauze. In six to eight hours the gauze and tent are removed, another antiseptic douche is given, and we proceed, if the cervical canal is dilated, to the complete evacuation of the uterine cavity. It is well to have the bladder and rectum empty. For exploring the interior and evacuating the contents of the aborting uterus there is no instrument equal to the finger, but undoubtedly in certain cases it is difficult to carry it up to the fundus of the uterus. If the patient happens to be a multipara with lax abdominal walls, by placing her on her left side, the pelvis being brought somewhat beyond the edge of the bed, while with one hand we press the uterus downwards from above, we can introduce one or two fingers of the other, so as to separate and bring away any portion of adhering placenta. In primiparæ I have met with considerable difficulties in certain cases from two causes:—

(a) Rigid abdominal walls.

(b) Small, undilated vagina.

In such cases the use of an anæsthetic gives great assistance, but latterly I have found the volsella a most useful instrument. By it we can draw the uterus down from below with one hand, while with the fingers of the other we explore its interior. In the following case the volsella gave great help:—

CASE I.—Mrs. A., when three and a half months pregnant, slipped and fell, on alighting from a tramcar, and on reaching home found she was

* Introductory Address to the Students attending the Belfast Royal Hospital, at the opening of the Winter Session, 1886-87. *Brit. Med. Journal.* Nov. 13, 1886.

bleeding. She went to bed, and as pains set in and something came away, I was sent for in the night. On arrival I found a small fœtus had been expelled and a piece of placenta. On vaginal examination I could feel with the apex of my right index a piece of placenta in utero. I tried to press down the uterus from above with the other hand, but as the patient was very fat this was not successful. I then seized the anterior lip of the cervix with the volsella, and drew down the uterus with the left hand, while with the right index I was then easily able to reach, detach, and bring away the piece of placenta I had previously felt. She had no further trouble.

In one case after removing the placenta the uterus did not seem to contract well, and some bleeding still occurring I swabbed the interior of the womb with perchloride of iron. This promptly arrested all hæmorrhage.

3rd. *Incomplete or Neglected Abortion.*—In hospital practice one sees a great many cases of this character. A woman comes to the extern ward complaining that she is losing blood, and, as she puts it, “she is never well.” From her history one gathers that after having passed two or three periods she had a sharp flooding, and that ever since she has had an almost constant red discharge. Such forms of menorrhagia are common among married women, and in them a flooding that has set in after one or two periods have been missed should always be regarded as the result of an abortion. In such cases the usual practice is to dilate the cervix, and then to evacuate the interior of the uterus; but I would strongly recommend as a better line of practice the careful use of the curette. It can be done at once, and, if antiseptic precautions are used, this plan is attended with less risk than the use of the tent. In curetting cases with a history such as I have given, one sometimes meets with a bit of placenta or brings away a piece of vascular tissue, which has developed at the place where the placenta had been attached. I give the following cases from my note-book:—

CASE II.—M. A., aged thirty-five, four children, no abortions, was admitted to Royal Hospital, November, 1885. In September had suddenly “a good deal of loss” after having passed two periods, and ever since has had a red discharge, which is increased on making any exertion.

On examination, uterus enlarged bimanually, sound goes half an inch beyond normal, os slightly patulous. Uterus was curetted, and a piece of placenta, size of a bean, removed. Liniment. iodi applied to uterine cavity. All hæmorrhage ceased, and patient, after having been in hospital fourteen days, was discharged cured.

CASE III.—Mrs. F., aged twenty-seven, sent from the country, Christmas, 1886. After having seen nothing for twelve weeks, she had a severe loss, and “it has come and gone ever since.”

Uterus, on examination bimanually and with sound, found enlarged. The curette was used twice, and on each occasion a vascular portion of tissue removed. Uterus swabbed each time with perchloride of iron. Complete recovery.

In certain cases the retained placenta decomposes, and there is a foetid discharge, and the patient is seized with a rigor, followed by fever; while in other cases the patient when first seen is suffering from septicæmia, and the history alone gives us a clue as to the source of the local poisoning.

In such cases the uterus should at once be cleared out. I think tents should be avoided, but the curette may be used, or if dilatation is practised it should be done by Hegar's bougies. It is in cases like these that antiseptic irrigation of the uterus, especially with a 1 in 2,000 solution of perchloride of mercury, is of such service. In using this solution great care should be taken, by pressure with one hand above the uterus, and by holding the perinæum back with the other, to avoid leaving any of the fluid behind. In these cases a repetition of the sublimate solution is not necessary, but the plan recommended by Dr. Champneys of leaving a bougie of iodoform in the uterus is most useful. As it gradually melts it keeps the parts under the influence of iodoform.

In conclusion, let me say a word or two as to the after-treatment and the prophylaxis of abortion. The reason why chronic uterine disease so often follows abortion is that women think such a condition of slight moment, and do not give the womb an opportunity of returning to its normal condition. The uterus which contains a piece of placenta continues enlarged, as it also does if the patient moves about a few days after an abortion; it remains in a condition of passive congestion, the connective tissue gets increased, and finally we have a form of chronic metritis or “areolar hyperplasia.” It is in the case of a patient with a uterus large, hyperæmic, and heavy after an abortion, that displacements are liable to occur. Again, owing to its incomplete involution, various other pathological conditions may arise. All this teaches us, I think, the lesson that a patient after an abortion should be kept as long in bed, and as carefully attended to, as after a full-time delivery. In order to aid the involution of the uterus, I have found a combination of ergot and quinine or ergot and strychnin useful.

Prophylaxis.—Our treatment of abortion by no means ends when we have cleared out the uterus (by natural or artificial means) and have got our patient up and well again. The careful and scientific obstetrician will endeavour to find out what has been the cause, in order that an abortion may be obviated should conception again occur. The most careful inquiry should be made as to any specific taint on the father's side, and treatment directed accordingly. Indeed, in such circumstances, it is well to put both parents under a course of anti-syphilitic remedies.

Is there any morbid condition of the uterus? Endometritis should be treated and displacements corrected.

Have there been any degenerative changes in the chorion or placenta? In such circumstances Sir James Simpson gave chlorate of potassium, and others have found benefit by recommending this line of treatment.

Is the mother at fault? Extreme care should be taken that she is kept free from any causes such as grief, shock, fright, which might, acting through her nervous system, cause an abortion. Fehling has recently directed attention to renal disease in the mother as a great cause of producing a cessation of pregnancy. If a patient aborts frequently, instead of contenting ourselves by saying she has acquired this habit, we should rather endeavour to find what is the acting cause. It may be a posterior displacement, syphilis, or some morbid condition of the uterine mucous membrane.

In the case of a patient who has become pregnant again after having aborted, the greatest care should be exercised during the first four months, and especially at those times when the periods ordinarily would occur, when she should be kept in bed or on the couch. She should not indulge in travelling or carriage exercise at these times, and all strong purgatives should be avoided. Dr. Jenks (an American) recommends half to one drachm of the liquid extract of viburnum prunefolium, to be taken four times daily at the time the periods should occur, and also for two days before and after. It is not to be taken after the fourth month. In his most admirable annotations in "Smellie's Midwifery," the late Dr. McClintock recommends chlorate of potassium and the tincture of iron in cases where the death of the foetus is not traceable to a syphilitic taint in either parent. He says it should be commenced some weeks before the time at which the death of the foetus is likely to occur (as shown by the history of the woman's previous pregnancies), and be continued up to the time of labour.

In this communication I have, as a rule, brought under your notice only those methods which I have myself tested and found useful in hospital and private practice.

ART. II.—*A Case of Pityriasis Rubra*.^a By WALLACE BEATTY, M.D. Univ. Dubl.; F.K.Q.C.P.; Senior Assistant Physician, Adelaide Hospital.

As pityriasis rubra is rare, I think an account of a case of this disease which came under my observation may not be without some interest. Two cases only of this disease have been published before in Dublin—one by Drs. Benson and Walter Smith, the other by Dr. Finny. My patient's history is as follows:—

Mrs. B., aged seventy-one, was admitted into the Adelaide Hospital on April 15th last. Except for an eruption on her head which she had when a baby, and for an attack of measles, she was quite strong and healthy up to the age of twenty-six, when about six weeks before the birth of the only child she ever had, she received an injury to her abdomen when travelling by train from Belfast to Portadown. Two men were fighting in the railway carriage and fell on her. She was much hurt and had to be helped out of the carriage. After that day, however, she was able to be up and about (feeling at times abdominal pains), until the birth of her child, which took place at full time. The child lived only two days. She says the flesh of the baby was wrinkled on its face and body, as if it had been a fine child up to the time of the hurt; it had not any eruption on its body.

A few hours after the baby was born inflammation of the bowels, she said, set in, and some time after her left leg and arm became swollen, the leg being most affected; it was leeches several times. For several months after her confinement she was unable to leave her bed, as, in addition to the affection of her leg and arm, her womb, she says, gathered, and a very great discharge came from it.

Turpentine stupes were used for the abdominal trouble after birth. The turpentine brought out a rash on her abdomen, which spread to the chest and extended down the arms. The rash finally settled upon the backs of the hands, leaving the other parts. The

^a Read before the Medical Section of the Academy of Medicine in Ireland, on Friday, May 27, 1887.