

particular cases. The variation in the findings of different periods in a normal individual is often marked. The abnormal condition from which the patient suffers may not be present upon the day of examination, or it may be prominent only in the afternoon, while the contents are obtained in the morning. A finding of a normal acidity upon the day of the examination does not, therefore, necessarily prove that the patient has not a hyperacidity present at the time when symptoms are marked. The knowledge of such facts makes us very slow to argue from negative findings in particular cases. But it does not prevent us from accepting the indications in cases of positive abnormal findings. And, what is of special importance, these facts in no way invalidate the conclusions which we have drawn from the special study outlined in this paper.

The facts upon which we have built our conclusions and hypotheses are, first, that certain common symptoms are present as a groundwork or part of the symptomatology of practically all cases of gastric disorder of various causes, and, second, that the same group of symptoms forms the symptomatology of many cases of opposite chemical findings. Neither of these facts or conclusions is invalidated by the assumption that in several of our cases the chemical finding recorded was not that present at the time or as a cause of the symptoms complained of. For it is not reasonable to assume that all our cases examined belonged to one type only, or that all our cases of hyperacidity and hypoacidity with similar symptoms were in reality all cases of hyperacidity. And unless we adopt some such conclusion we must accept the facts as valid for the deduction of general conclusions, such as we have deduced.

It may be suggested that in this work I have assumed that where I found an abnormal chemical condition as the sole discoverable abnormal condition in a case, this was the cause of the symptoms or the disturbance in that case. I have not intended to make any such absolute assumption, and such an assumption is not necessary to support our conclusions. Such a finding is suggestive in this regard and gives us definite ground to go upon in our treatment. It is doubtless the cause of symptoms in some cases in which it occurs, but not necessarily in all. Some of the cases with hyperacidity and some of those with hypoacidity which had similar symptoms may in both sets have been suffering from a similar cause not connected with the secretions. Whether the apparent abnormality was the real cause of the disturbance in each case or not, one cause for symptoms was present in and common to all cases, a disturbance of function, and one symptom or set of symptoms was common to all cases, and these we have connected as cause and effect.

A CASE OF PERNICIOUS VOMITING OF PREGNANCY.¹

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THE patient was a young married woman of thirty, residing in one of our pleasant suburban towns. She was quite tall, with a stout figure, and had always been healthy and well. No disturbance at the monthly

periods, which had been regular; no kidney trouble. First pregnancy began about September 15, 1897, and vomiting commenced about the end of October (after skipping one period) and continued until her death. She had been confined to her bed from November 1st, and had not been able to retain any food.

I was sent for on December 30, 1897. She was then three and one-half months along, and had been vomiting eight weeks. During this time she had been treated by two other physicians without relief, and the last attendant "did not seem to be alarmed at her condition until, perhaps, two or three days at the last, during which time she was partially unconscious," when he had told the family that there was no hope for her. Realizing that it was a desperate case, and that immediate action might be necessary, I asked Dr. Kingman to go out in consultation with me. On arrival at 9 A. M., we found the patient nearly moribund, without power of speech, and she simply turned and looked at us without any sign that we were as strangers to her. Rectal temperature was 96°, pulse 150. Subcutaneous injections of strychnia, applications of heat, and solutions by the rectum revived her a little, and then a vaginal examination was made showing the pregnant uterus crowded down in the pelvis with sharp antelexion of the cervix. The cervix was dilated and the pressure somewhat relieved by packing. Within one hour she began to swallow small quantities of liquids without vomiting, and the temperature rose to 98° and pulse came down to 100. After hard work over her all the morning she seemed more comfortable at 2 P. M., but did not become fully conscious, and at 10 P. M. collapsed again, and in spite of prompt treatment applied by Dr. Dennett, whom I had asked to help me, died in about one hour. I find in my note-book this comment: "Treatment too late to be effective."

On reviewing this sad case, it seemed to both Dr. Kingman and myself that the doctor who had taken care of her had trusted too much that the vomiting would some time stop of itself, and, from our point of view, he had neglected to take even the ordinary helpful measures. We felt that if there had been given us a week, or possibly even three or four days, the result might have been different, for we had a healthy woman with a good physique to work upon, although she was much emaciated.

The two points which I wish to bring to your notice by this case, and which I hope may be thoroughly and widely discussed, are these:

(1) That displacements and faulty positions of the pregnant uterus which delay its rising out of the pelvic cavity and press upon the neck of the cervix are more often the causes of excessive vomiting than has been generally supposed. This takes for granted that the irritant is the local one, and that we exclude vomiting originating from other conditions than those connected with a pregnant uterus (chronic gastritis, cancer of stomach, tubercle of brain, fatty degeneration of liver, icterus, etc.). Many cases might be cited where these displacements were rectified with the immediate betterment of the patient. Sometimes the cervix is so rigid, indurated, thickened, or compressed by the fundus doubled on it, that dilatation is necessary to relieve the tissues of the cervix (especially at the internal os) from compression. Not only must the body of the uterus be brought into a favorable position but it must be kept there. When allowed to return

¹ Read before the Suffolk District Medical Society, Section for Obstetrics and Diseases of Women, January 24, 1900.

to its faulty position, the vomiting recurs. Physicians often examine and find the uterus in the anterior position, either anteverted or anteflexed, and they consider that position practically normal, and let it alone. Graily Hewitt calls particular attention to this condition, where the fundus is behind the pubic arch and can be so held by it that it is delayed in rising from the pelvis and prevents symmetrical growth, and is also causing a constant pressure on the nerves of the cervix, compressing it in anteflexion. He says: "The cause of the sickness is, in the majority of cases, practically the same, namely, compression of nerves in the cervical tissue, associated with a bent, indurated condition of this part of the uterus, and the consequent loss of the natural pliability and expansibility of the tissues." Elevating the fundus and keeping it so produced a cure in 10 cases out of 12. In the two unfavorable cases, one died—uterus was allowed to return to faulty position, and patient lived at a distance and was very ill before she could be treated; in the second one abortion occurred. The retrodisplacements are more commonly recognized, and replacement or partial replacement by packing is followed by immediate improvement. Hewitt quotes 19 cases, with success in 13, where reduction was effected and maintained. If replacement alone is not effective then dilatation of the cervix should also be tried, which incidentally draws the cervix forward and down, and lessens its cramped condition.

(2) That if all these measures fail in the early months of pregnancy, we should not trust to nature and time to effect a cure, but should proceed to empty the uterus by surgical means, as soon as a consultation has been carefully held, provided the religious beliefs of all concerned are not against such a step. When the patient cannot retain sufficient food to nourish her, either by mouth or rectum, when rest in the horizontal position, when rectifying the displacements of the uterus so far as possible, and the dilatation of the cervix, have been faithfully tried without relief, these measures should not be persisted in while the patient is rapidly losing flesh and strength and getting into the condition where nothing will avail. If we put off the evil day, knowing that there is a risk even in operating early, hoping that, after the third month when the uterus rises out of the pelvis, vomiting will cease, we increase the chances of a fatal result.

Our text-books teach delay. Klein says: "In hyperemesis of the third degree the artificial induction of labor is *occasionally* required." Bacon² says: "Induction of abortion is *never* indicated." Leclerc states: "Good results . . . by simple cauterization of cervix; this measure is *far superior* to artificial abortion." Lush says that uncontrollable vomiting is a *rare event*, but when it occurs "there remains as an *ultimate* resource the artificial induction of abortion." A. F. Currier, New York, says in review: "Finally there remains the emptying of the uterus as a last resort, and *only as a last resort*. It should only be done after careful deliberation and with the approval of skilled counsel." Edward Reynolds justly remarks that the solution of the question depends in "a certain degree upon the religious beliefs of the individual family, and upon their estimate of the relative value of maternal and fetal life. Among Protestant physicians in Protestant families it is generally considered the best practice to advocate abortion when all other

treatment has failed, but patients are constantly lost by over-conservatism in the most skilled and experienced hands." Gardner³ says: "As regards the ultimate procedure of emptying the uterus, the general tendency is to delay too long the operation, one which in itself is not without danger." Jewett⁴ states: "Evacuation of the uterus is often too long delayed."

Delay and its dangers are emphasized by these last three men. Delay and its dangers are what I am emphasizing to you, and I enter my plea for earlier interference, before the patient's courage is gone, her vitality exhausted, and her system in the worst condition to withstand the shock.

Indications for emptying the uterus.—(1) Inability of retaining any food taken by the mouth; (2) intolerance of rectal enemata; (3) more or less albuminuria; (4) progressive emaciation; (5) headache constant; (6) frequent and feeble pulse; (7) a certain apathy of the patient.

BICORNATE UTERUS, WITH TWIN PREGNANCY; ABORTION FROM ONE HORN.¹

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IN presenting the following case, it is with no intention of using it as an introduction for a paper upon any of the subjects which it naturally suggests, nor do I care to speak dogmatically concerning even this particular case. It has, however, seemed to me a case of sufficient interest, by reason of the unusual and instructive elements which it presents, to be worth placing upon record.

Mrs. S. E. W., thirty years of age, was a healthy woman of New England birth and parentage, with sufficient intelligence to know better. After having one child at full term nine years previous to the experiences about to be related, she soon became adept in the art of inducing abortions, admitting three prior to 1897, she being each time from two to three months pregnant. On one occasion there was a twin pregnancy, one fetus coming away partially decomposed, the other in normal condition. This incident becomes exceedingly important in the light of subsequent events. She was first seen by me in April, 1897, when she admitted another operative abortion. Intra-uterine douches were used and recovery was complete in two weeks' time.

I next saw her November 8, 1898, when she gave the following history: Her last menstruation was September 17th, and supposing herself pregnant she had inserted a catheter into the uterus one week previous to my visit. Flowing had begun the next day and had continued, with the accompaniment of more or less pain and the occasional expulsion of clots. There had also been moderate gastric disturbance. The os was dilated to size of a quarter dollar. There was moderate flowing and offensive odor. Abdomen tympanitic and slightly tender. Temperature 100°, pulse 92. I removed several vaginal clots and gave a hot intra-uterine douche of lysol. Next day she was quite comfortable, her temperature being normal, pulse 88;

¹ Read before the Suffolk District Medical Society, Section for Obstetrics and Diseases of Women, January 24, 1900.

² British Medical Journal, 1897.

³ Canadian Practitioner, September 18, 1897.

⁴ American Journal of Medical Sciences, 1898.