

PROCEEDINGS OF THE DUBLIN OBSTETRICAL SOCIETY.

FORTY-FOURTH ANNUAL SESSION.

JOHN A. BYRNE, M.B., President.

WILLIAM ROE, M.D., Honorary Secretary.

Saturday, March 4, 1882.

DR. J. A. BYRNE, President, in the Chair.

Uterine Polypus.

DR. ATTHILL exhibited a tumour removed from a patient in the Rotunda Hospital a week previously. She had been sent to him by Dr. Wallace, of Parsonstown, as a case of uterine polypus which had passed into the vagina. On examining her, he found that diagnosis correct. She never had been pregnant, and the vagina, which was narrow, was completely filled up by the tumour, so that the os uteri could not be reached. The tumour was drawn down by means of a vulsellum, and the wire of an ecraseur passed round the pedicle, which was of moderate thickness. This was severed without difficulty, but a forceps had to be employed to extract the tumour from the vagina. Profuse hæmorrhage now occurred—indeed he had seldom seen a case of *post partum* hæmorrhage in which it was so profuse. This was most unusual, for it was in accordance with experience that hæmorrhage seldom followed the removal of pedunculated tumours when they had passed into the vagina. On making a careful examination after the removal of the tumour, he found that the cervix uteri, which was exceedingly thin, had been stretched over the tumour, which had not passed completely out of the uterus; and he could see distinctly that the bleeding proceeded from several small vessels which had been severed by the ecraseur. Syringing with hot water failing to check the bleeding, he filled the whole uterus with pledgets of cotton saturated with a solution of the perchloride of iron. After this there was no further hæmorrhage. The patient was now convalescent. On examining the tumour, it proved to be a fibroid which had been partly enucleated. The whole tumour had been removed, the capsule not having been divided. The tumour had been attached to the uterus by the muscular tissue of the uterus which formed the pedicle, and in which had been situated the vessels from which the hæmorrhage proceeded.

THE PRESIDENT said the case was interesting as indicating the great power of expelling tumours spontaneously which was possessed by the uterus.

Uterine Tumour.

DR. HORNE exhibited another form of uterine tumour. On March 3rd a woman, aged thirty-four, of fair complexion, was admitted into the Rotunda Hospital on account of profuse hæmorrhage. She gave the following history :—She had seven children, and one abortion. Her last child was born three years ago. She nursed it for fourteen months. The catamenia then appeared. Menstruation continued regular, but the amount scanty, until the 23rd of last August, when it ceased. She believed she was about six months pregnant, but never felt any foetal movements. Three days previous to admission, while washing, she felt a slight discharge of blood. She remained at rest during the day and it ceased, but returned two days subsequently. On admission she was very pale and anæmic. The vagina was filled with large blood clots. The os uteri was about the size of a shilling, but no membranes were found protruding. The uterus reached a little above the pubis. When a few hours in hospital, severe pains came on. The os was now dilated to the size of a half-crown, and through it could be felt a mass, which felt very like a placenta. The hæmorrhage becoming profuse, he injected hot water (temp. 105° F.) into the uterus, the immediate result of which was the expulsion of the mass which he now exhibited to the Society. Not yet having carefully examined it, the only idea it gave, to his mind, was that it was a case where the ovum had been blighted, and the decidua had undergone fatty degeneration.

DR. MACAN said there seemed to be regular organised tissue in the specimen, and some degeneration of the placenta. The curious feature was the small size of the ovum, assuming that there had been a six months' pregnancy.

THE PRESIDENT remarked that the specimen was one rather calling for pathological investigation. It had, to a great extent, the appearance of a degenerated placenta, but presented no appearance of vesicles. It was curious that it should have remained in the uterus so long.

DR. NEVILLE said, from looking at the specimen, he believed that if it were placed in a bowl of water chorionic villi would be easily seen traversing its substance. He could even now see some vesicles very distinctly. He thought the case was one of the vesicular myxomatous degeneration of the chorion. If dissected carefully the vesicular enlargements of the villi would be better seen. It must have been retained in the uterus for a considerable time, its size being quite inconsistent with a six months' pregnancy. He had made it a practice to examine aborted ova, and he had frequently seen commencing nodular enlargement in

very young villi. He, therefore, thought the present was a case of commencing myxomatous degeneration, specially interesting because of the completeness with which the ovum had been expelled.

The PRESIDENT.—In that case you think the degeneration commenced in the interior. As far as I can understand from you the villi in the interior are degenerated. I think the specimen one worth examining very closely.

DR. KIDD said it would be well to refer the specimen to a sub-committee. His impression was exactly that expressed by Dr. Neville—namely, that the case was one of commencing hydatiform disease. He had examined a portion of the specimen, and thought he could detect vesicular formations in it. It would be well to have a report on the microscopic structure of the formation.

DR. ATTHILL.—If Dr. Neville will make an appointment with Dr. Horne to come to the Rotunda any day for the purpose of having an examination of the specimen, we shall be very happy to give them assistance.

Dr. Horne and Dr. Neville were appointed a committee to examine the specimen and report to the next meeting of the Society.

Accidental Concealed Hæmorrhage. By ANDREW J. HORNE, M.K.Q.C.P., L.R.C.S.I.; Assistant Physician, Rotunda Hospital, Dublin.

HÆMORRHAGE occurring in the latter months of pregnancy, whether it be accidental or unavoidable, is not of very infrequent occurrence, as numerous examples are to be found in the records of every maternity, but that form which is described under the name of Accidental Concealed Hæmorrhage is fortunately very rarely met with. The difficulty of diagnosis, and the often fatal result which ensues, caused me to think that the following case which I am about to describe may prove of interest to the members of this Society, and, at the same time, may elicit opinions as to the mode of treatment to be pursued in such cases.

CASE.—Mrs. B., aged thirty-four, always healthy, pregnant with her seventh child. All her previous labours had been natural and easy. Between the fourth and fifth she had an abortion at third month of pregnancy.

On November 11th she became a patient of the extern maternity of the Rotunda Lying-in Hospital. She was visited at 9 a.m. by Mr. Chapple, one of our intern pupils (to whom I am greatly indebted for the notes of this case). She was then very pale and weak, with a quick, small pulse, and moist skin, disinclined to speak or move, and complained of pain in the back extending down both groins. At this time it was impossible to learn anything definite from her, further than that she had been in excellent health, far better than in her former pregnancies. She had been out of the house the previous evening following her usual occupation, buying furniture, some heavy piece of which she lifted. During the night she awoke, feeling weak, and with pain in her back.

She quickened at four and a half months, and felt the child quite strong the previous day.

On examination the os was felt high up; the cervix soft. The external os was patulous, admitting the point of index finger, but the internal os was closed. No presentation could be felt. At 4 p.m. there was a slight oozing of bloody serum, soon after which I saw her. On making a vaginal examination I could detect no presentation, but the anterior *cul-de-sac* was filled with a soft tumour. The internal os was slightly open, but no membranes could be felt. I decided, if possible, to rupture the membranes as a preventive of hæmorrhage. I accordingly passed a stillete of an ordinary gum elastic catheter into the uterus, but did not succeed in evacuating any liquor amnii. I then passed a sound, and found that it penetrated to the depth of nine inches. Although moving it about freely I could neither rupture any membranes nor feel any part of a fœtus. I then made a careful external examination with the woman lying flat on her back. I was first greatly struck by the rotund shape of the uterus, which was lying almost entirely on the right side of the abdomen, the left flank within two inches of the umbilicus being quite resonant. The tumour was very tense, as if in tonic contraction, but in no part was bulging to be observed. The woman complained of pain when the left superior margin of the uterus was touched. By palpation no fœtal parts could be felt; nor with the stethoscope was any sound audible. Being greatly perplexed I returned to the hospital, and related the case to the Master, Dr. Atthill, and he kindly came and saw the case with me. The treatment we decided on adopting was first to plug the vagina with cotton wool rendered antiseptic with carbolised vaselin; liquid extract of ergot internally; beef tea and milk diet.

Nov. 12, at 11 a.m.—Patient felt much better; the pulse was 110; could turn in the bed. I removed the plug—a small quantity of bloody serum followed. The os was quite closed.

Nov. 13, at 8 p.m.—A messenger came to the hospital saying the patient felt pain. Found her in much the same state as on first visit; pulse very rapid, but in less pain. She vomited occasionally, and complained of having suffered from “dry retching” throughout the day. On examination the fœtal head was detected; the membranes unruptured, and no further hæmorrhage. After an interval of forty-five minutes the membranes ruptured, and five or six ounces of liquor amnii escaped. Her pains were so slight that patient remained almost motionless, and scarcely uttered a sound. In less than twenty minutes from the time of rupture of the membranes, she suddenly remarked that she thought “she had a pain,” and a dead female child of full size was born with the placenta attached. The uterus still felt large and above the umbilicus. Slight pressure in the fundus expelled a large blood clot measuring from 5 to 6 inches in diameter and from $1\frac{1}{2}$ to 2 inches thick.

Such, then, are the principal features of the case, and it is quite unnecessary for me to enter into the subsequent treatment. Suffice it to say that she made a slow but good recovery. I visited the patient to-day and found her in excellent health.

Being greatly perplexed over the case, I first naturally turned to our ordinary English textbooks for information, but was disappointed to find hardly any mention of the subject in them. On referring to *The Obstetrical Journal* I find that to Dr. Braxton Hicks is due the credit of having first brought the subject forward, in a paper he read before the London Obstetrical Society in the year 1860. He collected 23 cases from various sources, only one having occurred in his own practice. In 1875 Dr. Burton again brought the subject before the Medical Society of London—five cases he met with himself, and he reported five others occurring in the practice of different practitioners. Since 1875 I find there have been four more cases recorded—one by Dr. Weatherby, which was read at the meeting of the British Medical Association held at Bath in 1878; one by Dr. Maberly, reported in *The Obstetrical Journal of Great Britain*, 1877; and two cases by Dr. Edgar Barnes in *The Lancet* of last December. So altogether, including the case I have just read, we have a total of 37. Of these, 23 mothers died, while only 14 recovered. In every case the child was stillborn. In the last German edition of Spiegelberg's work, of 110 cases collected by Goodell and Hennig, 56 died, and only 7 children were saved.

The symptoms of all the cases are very similar. They may be conveniently classified under two heads—general and local. To the former belong the sudden fainting or feeling of weakness attended with anæmia—in fact, all the symptoms of hæmorrhage without any external discharge of blood; the complete absence of true labour pain. To the latter, the continuous stretching pain felt over the abdomen; the pain on pressure over any portion of the tense uterus, and the continuous tense feeling of the membranes.

The diagnosis has generally to be made between rupture of the uterus or rupture of any of the abdominal viscera in a pregnant woman, or possibly from simple fainting in an anæmic patient. In the case I have just read, the first difficulty we had to meet was to find out whether the woman was really pregnant or not, as neither by internal nor by external manipulation could any foetal parts be detected. This was undoubtedly due to the large amount of blood effused, together with the extreme tension of the uterine fibres. The bulging in the anterior *cul-de-sac* may have been due to the placenta being attached low down in the uterus.

The most important question that arises is as regards the treatment of these cases. Are we to treat them as we would an ordinary case of accidental hæmorrhage—to rupture the membranes as soon as possible, and should this fail to check the hæmorrhage, to proceed to delivery by

turning, or forceps, or otherwise as circumstances may advise? or are we to procrastinate and endeavour to husband the strength of the woman by stimulants and nutriment in the hopes that the coagulated blood in utero may prevent any further hæmorrhage, as we should remember the uterus in these cases is in a state generally of tonic contraction, owing to the great distension. Again, we must not overlook the fact that nearly in the whole of the cases that died the membranes had been ruptured.

The PRESIDENT.—Everything on the subject of hæmorrhage is of importance. I have never myself seen a case similar to this; and the small number that have been recorded prove that the accident is not frequent. I remember seeing the late Dr. Sawyer exhibit in this room a case in which utero-placental hæmorrhage occurred, and a cyst was formed between the uterus and the placenta. I think the case ended fatally. Dr. McClintock, in his work on Midwifery, records a case which occurred in the practice of the late Dr. C. Johnson, in which rapid and urgent symptoms set in and the woman died, and afterwards this condition was discovered. In both cases the symptoms were very rapid and urgent, and there was great collapse; and in both it was only the result of the *post mortem* examination that revealed the source of the hæmorrhage.

DR. KIDD.—This case is one of extreme importance. Some years ago I was sent for by Dr. Hadden and Dr. Harley to see a lady in Rathmines, in whom they had very correctly diagnosed concealed hæmorrhage. The lady was between eight and nine months pregnant. She had fallen a few steps down stairs the evening before, and experienced great pain afterwards. In a short time symptoms of collapse set in, and Dr. Hadden, whose relative she was, saw her. The nature of the case was not at first very evident. The symptoms were those of collapse, but what the collapse resulted from was not apparent. She was placed in a recumbent posture, her head was lowered, and stimulants and nourishment were given, and under the influence of that treatment the symptoms of collapse passed off, and for some two or three hours she appeared as if about to recover. Then, however, the reaction that had set in gave place to further prostration; and now the uterus was found to be larger than before, and doughy in its feel, and the collapse was very profound. It was then that I saw her. She had got stimulants freely, which was followed by a partial reaction. The question arose—what treatment should we adopt? On examination of the os it was found to be quite closed, and there was not the least appearance of hæmorrhage, but the enlarged and doughy uterus and general condition indicated that hæmorrhage was going on internally. After some consideration we determined to try to induce labour; and we succeeded in introducing Barnes's bags into the os, and delivered the woman in that way. The dilatation of the uterus occupied from half to three quarters of an hour,

and it was accomplished so far as to enable us to reach the presenting part, which proved to be the breech. With a considerable amount of trouble and difficulty we delivered the woman, and immediately afterwards a large mass of coagulated blood was expelled. So far the case seemed promising enough, but, unfortunately, hæmorrhage continued, and we were quite unable to stop it. We injected the uterus, and I passed my hand into it in order to try to stimulate it to contract. We injected perchloride of iron, but in vain. I then introduced a piece of solid perchloride of iron, but it proved of no avail; the hæmorrhage still continued, and the lady died while we were in the house. My reflections on the case lead me to say that the more promptly the woman is delivered in such a case the better. Of course when the collapse and prostration are extreme one can hardly venture to deliver; but if there be any attempt at reaction at all in the pulse the safest and best practice is to dilate the os uteri as quickly as possible. I prefer that mode of treatment to rupturing the membranes, which is a very slow way of inducing labour. You would have as the result of that procedure a certain amount of contraction produced by the escape of the waters, but not enough to check the bleeding, and I certainly think that if I were to meet a case of the same kind again I would pursue the same practice—namely, rupture the membranes in the first instance and then dilate the uterus as rapidly as possible, and complete delivery. A few days ago Dr. Denham told me of a case which Dr. Johnson was in the habit of relating, and as Dr. Denham is present I hope he will give us the details of it, as illustrating the diagnosis of such cases, which is the real difficulty. In Dr. Horne's case the symptoms were not very marked and the hæmorrhage was not great, and very active treatment was not demanded, but in grave cases of concealed hæmorrhage delivery should be accomplished as quickly as possible.

DR. DENHAM.—The subject is one of deep interest. First, as to diagnosis. I remember Dr. Johnson relating the case of a lady between eight and nine months gone in pregnancy who was suddenly seized with weakness and fainting. In her previous labours she had been subject to hæmorrhage, and she was familiar with the symptoms accompanying loss of blood. When Dr. Johnson saw her he could see no appearance of bleeding, but she exclaimed that she was flooding to death, and continued to express herself in that way until she actually died, although apparently she had not lost a single drop of blood. On examination after death it was discovered that the circumference of the placenta had adhered to the uterus, but that the central part of it had separated, and there was a large coagulum of blood which had welled out, and the amount of hæmorrhage was so great as to have caused death. I believe these cases of concealed hæmorrhage are more frequent than we are aware of. If we diagnose hæmorrhage we should follow Dr. Kidd's plan of inducing labour as

speedily as possible. I would not hesitate in such a case to rupture the membranes, and then induce labour. I think our own fingers are more efficient than Barnes's bags. A careful and practised hand can dilate the os more safely and rapidly than by any mechanical manipulation. Not more than a week ago I saw, in consultation with Dr. Kidd, a very interesting case—viz., that of a lady eight months gone in pregnancy. When I saw her she was in collapse. I got her into bed, and succeeded in rupturing the membranes; a great quantity of blood in the meantime had escaped. The amount of liquor amnii was very considerable, and I hoped that by getting that away I should be able to command the hæmorrhage. She rallied a good deal, but still there was a good deal of collapse, and I did not think it safe to leave her in that condition any longer, and accordingly sent for Dr. Kidd. At that time the head had not come down. After his arrival we found that the head had come down, and we applied the forceps and delivered her of a stillborn child, and I am happy to say that she has been going on most favourably since. She has entirely rallied, and has no bad symptoms, and we have every hope of her recovery.

DR. ATTHILL.—Cases of concealed hæmorrhage are either so rare or so little understood that they are actually not mentioned in the text-books; yet Dr. Horne has shown us that fully 60 per cent. of these cases prove fatal. The case he has laid before us to-night is to me both interesting and instructive. Since I became Master of the Rotunda Hospital we must have had some 14,000 deliveries, either in the hospital or in the extern maternity, and as this is the first of the kind I am aware of having occurred, they must, therefore, be comparatively rare. Dr. Horne feeling himself perplexed as to the exact nature of the case, I visited the patient with him, and I felt much difficulty in arriving at a correct diagnosis. The first question was—Is it a case of pregnancy at all? We had only the woman's word that it was so, but you cannot always rely on what is said by women in her class of life, and I had some doubts on the subject, for, on passing my hand over her abdomen, nothing like a fœtus could be felt, while the abdomen was so wonderfully tense that I could hardly conceive that the uterus could be distended to such an extent from hæmorrhage without its endangering life. I never felt an ovarian tumour which caused more tenseness. The pulse was small and shabby, and the patient complained of great distress, but she was not sinking, and her condition evidently rather improved within the last few hours. Under the circumstances I considered it best to temporise, and therefore advised Dr. Horne to plug the vagina and put the patient on ergot. By and by the pains came on, and afterwards a safe delivery of the woman took place. We find that out of 23 cases of this sort there had been 14 deaths, and that in all the cases in which the membranes were ruptured the patients died. That looks very like cause

and effect. If the placenta has been separated from the uterus by a sudden shock, and if the uterus is stretched by effusion of blood and we empty it very rapidly, are we not putting the patient into a condition much more likely to be followed by further hæmorrhage than if we wait till uterine action sets in? Nothing is more likely to induce *post partum* hæmorrhage than the too rapid emptying of an over-distended uterus. We know that twin births are more likely than single ones to be followed by hæmorrhage, partly owing to the large placental site, but more specially because the uterus is over-distended. Therefore, in such cases, I advocate, before attempting to accelerate the birth of the second child, that we endeavour to excite uterine action. I am also against the too rapid expulsion of the placenta—the principle is the same under all these circumstances. Even Dr. Kidd's case, though treated so skilfully so far as the dilatation of the os uteri and the effecting delivery is concerned, can hardly be called successful, for the patient died. I think it possible that the discussion may rather tend against the treatment of these cases by rapid delivery. In the present instance, before I saw the patient, Dr. Horne attempted to rupture the membranes. I think this should not be attempted till you first set up uterine action; and the statistics accumulated by Dr. Horne are against the practice. Dr. Denham's case is not exactly an analogous one. In his case rupture of the membranes was followed by very satisfactory results, but it was a case of ordinary accidental, not concealed, hæmorrhage; and therefore his treatment in that case does not bear on the subject under consideration.

DR. MACAN.—The case before us is practically one of accidental hæmorrhage. On the Continent it has been long held to be bad treatment to rupture the membranes in cases of accidental hæmorrhage before uterine action has set in. The mechanical reason for this is obvious. If the hæmorrhage takes place when the uterus is not acting, the only effect of rupturing the membranes is to lessen the amount of intra-uterine tension; but if the hæmorrhage be external, we at once increase the amount of intra-uterine tension by plugging the vagina, or, perhaps better, the cervix uteri, and the increase in the intra-uterine tension tends of course to lessen or arrest the hæmorrhage. As regards diagnosis, I did not hear pain mentioned as one of the symptoms. The only case of concealed accidental hæmorrhage that I have had an opportunity of observing was in the first case to which I was called out in consultation from the Rotunda Hospital. The woman had been for some time in labour, and when I arrived I found her in a state of collapse, labour pains having quite ceased. There was hardly a trace of blood externally, but when I lifted up the head of the child from the brim of the pelvis I could feel the blood coming down through my fingers, and it was obvious that the case was one of internal hæmorrhage, the bleeding having been concealed by the close way in which the head fitted the cervix. I think that in

cases of concealed hæmorrhage the amount of collapse is much greater than would be produced merely by the amount of blood lost, and is partly due to shock. With regard to the treatment of the case submitted to us, I think that rupture of the membranes should be practised only if the uterus be contracting. The only way we have of increasing intra-uterine tension is by plugging the cervix. This also brings on labour, which is the one thing necessary; while the forcible emptying of the uterus when there is no uterine action is very likely to be followed by *post partum* hæmorrhage. It is not always possible at once to introduce Barnes's bags in such cases. In fact, Dr. Barnes, when he wants to bring on premature labour, generally introduces some sea-tangle tent the day before, and the following day applies the bags. I should recommend Hegar's dilators for the purpose of enlarging the os to a sufficient size to enable us at once to introduce the bags. I do not think that in any of these cases of concealed hæmorrhage you have proper uterine action, and when it occurs there must be something radically wrong with the muscular tissue of the uterus itself.

DR. DOYLE.—As to the practice of rupturing the membranes in accidental hæmorrhage, I was never called to see a case requiring it, but I have been taught that it is a proper practice. From the observations I have heard to-night, however, I should think that a great deal would depend on whether you were dealing with a primipara, or a woman who had borne some children. In the latter case the effect of hæmorrhage, which went on increasing, would be to produce something like what occurs when an over-distended heart, which is at the same time in a condition of muscular degeneration, collapses. I do not see why the same result should not ensue if the walls of the uterus are thin and degenerated, and if there be over-distension. The effect of the over-distension would be not to increase the pains, but to paralyse the muscular fibres; and in such a case rupturing the membranes would be proper treatment. But in the case of a primipara, where you have a good strong uterus, it would be better to wait and let the uterine pains set in. Another advisable form of treatment, I think, is the injection of some saline infusion, but I am not in favour of transfusion.

DR. DILL.—I have long entertained the idea that this subject of accidental hæmorrhage is one of a very peculiar character. I have an impression that the collapse, or death that occurs, is not exactly owing to the amount of hæmorrhage. I cannot imagine in the case under discussion, in which the hæmorrhage existed between the placenta and the uterus, that the circumference of the former, attached to so small a space, should contain such a quantity of blood as would carry the patient off. We know that in almost all cases of labour we meet with more hæmorrhage than could possibly be retained in a space of that kind, and yet we have neither fainting, nor collapse, nor any other fatal symptom.

The collapse, or death, results more from the shock to the system than from the loss of blood. I believe that in a patient who is nervous, or already anæmic, the tearing, or other injury, of the parts is quite enough to induce collapse apart from any hæmorrhage. My experience has been limited to two cases; but in these there were local pain and collapse, quite sufficient to enable me to diagnose hæmorrhage. I treated these cases more according to an expectant plan—if you will allow me to use the word—than by any forcing measures, for I hold that it is better to sustain and encourage the patient so as, if possible, to allow nature to bring about labour, than to resort to any tampering or interference. I believe that expanding the os, or introducing any instrument for the purpose of performing even the mildest operation of that sort, is only adding to the shock. I believe it is in those cases that are tampered with that death occurs. My two cases terminated favourably.

DR. CRANNY.—It is very important in such cases to get up uterine action. I fully agree with the gentlemen who have said that it is better not to rupture the membranes. It stands to reason that, when the uterus is not acting, if you relieve the tension you will create more space for blood to accumulate in.

DR. MACAN.—I have been misunderstood again. I was speaking of the ordinary treatment of accidental hæmorrhage when I referred to plugging the vagina. I did not mean to say that it is the best treatment of concealed hæmorrhage. I recommended the use of Hegar's dilators in such a case. I was glad to hear to-night, for the first time, that rupturing the membranes in ordinary accidental hæmorrhage is bad treatment, and that it is much better to plug.

DR. KIDD.—Before the discussion closes I beg to be allowed to make some further remarks, as those who have spoken have dealt with the case I related and the treatment of it, as well as with the original paper. Two methods of treatment have been discussed—the expectant, as in Dr. Horne's and Dr. Dill's cases, and the active, as in mine. The expectant plan may, no doubt, answer very well where the hæmorrhage is not great, the symptoms are not very marked, and the diagnosis is not very clear; but where hæmorrhage is going on freely, and the patient becoming more and more prostrate, he would be a brave man, indeed, who could stand by with folded hands waiting for the current to stop. One of the speakers has very aptly compared such conduct to that of the clown who sat by the river's edge waiting till the water had all flowed past that he might cross over. I am sure the most earnest advocate of expectant or do-nothing treatment would adopt the active plan when he saw the patient sinking—sinking—sinking from the continued loss of blood—and would without hesitation try to check the bleeding. The question is as to how this can best be done. Some have spoken of rupturing the membranes, and some of plugging the vagina, either after rupturing the membranes or without

doing so; but rupturing the membranes is a very slow way of inducing labour. We all know that labour may not come on for several days after the membranes have been ruptured, and the immediate contraction induced may be quite insufficient to check the bleeding, in which case, as Dr. Macan has pointed out, it may even increase it by lessening the uterine tension. Rupturing the membranes then is certainly not to be relied on. As to plugging the vagina, unless it is done with a view to inducing uterine contraction, seeing that no blood is escaping from the uterus, it is difficult to understand why it should be thought of. As to inducing labour or hastening it, who ever knew of its doing so? Even in a case of placenta prævia, where the flow of blood from the uterus may be checked by plugging, it is, in my mind, a most dangerous mode of treatment. I maintain that the only mode of treatment that affords a chance of saving the patient in a serious case of concealed hæmorrhage is the prompt evacuation of the uterine contents. Dr. Macan, I am glad to find, agrees with me in this. He, however, would begin the process with Hegar's dilators; I prefer Barnes's bags—I believe them to be safer, more prompt and efficient. If the os be so small that the small-sized bag cannot be introduced, let Hegar's dilators be used in the first instance, if they are at hand, or, better still, let the finger be pushed into the os, and then the bag if necessary; but if dilatation can be effected by pushing in the fingers one after another, as Dr. Denham has suggested, it is the best method of all, and where much hæmorrhage has been going on, and the woman has previously had children, it may be done without difficulty. It has this advantage—there is no time spent in looking for the instruments. Whatever plan be adopted, as soon as the hand can be got into the uterus, the child should be turned, if necessary, and extracted; and I believe it is better to introduce the hand than to attempt bipolar version as being the quicker and more efficient method. But it has been objected to this practice that my patient died, and that a large proportion of the cases collected by Dr. Goodell died. In Dr. Goodell's cases, the treatment was the rupturing of the membranes—a method too slow and uncertain to save the patient. In my case, the patient died from hæmorrhage after delivery, and some of the speakers have attributed this to paralysis of the uterine fibres caused by over distension. I very much doubt the correctness of the explanation; but if it be correct it affords another reason for prompt delivery, and not allowing the distension to proceed. As Dr. Doyle has said, no one would treat an over-distended right heart by means calculated to increase the distension, nor would anyone, I presume, treat a paralysed bladder by allowing the urine to go on accumulating in it. I believe the true explanation of the *post partum* hæmorrhage was, that some large uterine sinus had been injured, and that the patient had been greatly exhausted before the operation.

DR. ATTHILL.—Allow me to explain. I spoke of a particular case, and

not of accidental hæmorrhage in the general acceptation of the term; I decided to wait in that case, because there was no urgent symptom, the woman's condition was improving, and chiefly because there was no attempt at uterine action, and I have no hesitation in saying that I treated her rightly. I further said that, reasoning from the statistics quoted by Dr. Horne, I thought the question of treatment was an open one—that it would, perhaps, be unwise to make it a rule always to rupture the membranes. In every case recorded of rupturing the membranes the woman died. Where you have no uterine action whatever rupturing the membranes, under any circumstances, is bad practice. Dr. Kidd has said that plugging the vagina in unavoidable hæmorrhage is, to use Simpson's expression, fool's practice. I quite agree with him.

DR. DILL.—As I said something which elicited a strong statement from my friend Dr. Kidd, he will allow me to say that, from his standpoint, his line of action is perfectly correct and logical, while from my standpoint my statement is equally correct and logical. My position is that I did not assume the truth of the illustration that the river was flowing past at all. I said that in these cases death arises rather from the shock than the hæmorrhage, and that if the practitioner adopts a treatment which will add to the shock he does what will tend to produce further collapse and possibly death. From that point of view I think Dr. Kidd will admit that my “expectant” line of sustaining the patient, and taking advantage of every circumstance that presents itself, is consistent with my views.

DR. HORNE, in reply.—I have to thank the Society for their kind hearing of my paper and their full discussion of it. The members are, I think, unanimous that in these cases of so-called concealed accidental hæmorrhage the membranes should not be ruptured. I think, also, that it seems to be their opinion that as regards the “expectant” line of treatment we should recognise various possible stages of hæmorrhage. Undoubtedly where there is complete collapse the treatment must be active, and the uterus must be emptied. On the other hand, where there is only a small amount of hæmorrhage the treatment may be of a more expectant character. I am also glad that we have had attention drawn to several different forms of concealed hæmorrhage.

The Society then adjourned.

ENLARGED CERVICAL LYMPHATIC GLANDS.

PROF. S. W. GROSS has found the daily local application of the following ointment of striking benefit in a case of the above:—R. Iodoformi, 3 iss; Ext. Belladonnæ, Balsami Peru., āā 3 ij; Ung. Petrolei, q. s. ad 3 ij. M. Fiat unguent.—*Med. and Surg. Reporter.*