THE TREATMENT OF HEMORRHAGE IN ABORTION.

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The Treatment of Inevitable Abortion.—In the first two months little treatment besides rest in bed for a few days is ordinarily required. In the exceptiona' cases the treatment does not differ from that in the hemorrhages of the non-pregnant uterus.* In the third month we distinguish:

I. Cases in which the ovum is thrown off entire.

II. Cases in which the sac ruptures and the embryo escapes with the discharged fluid.

1. When in the third month the ovum is thrown off without rupture of the fetal membranes, the hemorrhage rarely assumes dangerous proportions. The uterine contractions press the ovum into the cervix, which dilates, and in primiparæ becomes somewhat elongated. As the ovum descends, the body of the partially-emptied uterus retracts. The effused blood coagulates in thin layers between the ovum and the uterine walls. The ovum forms a tampon which fills the cervix and restrains the hemorrhage.

No active treatment is therefore demanded. A vaginal douche, consisting of a pint of tepid water, may be used twice a day as a measure of cleanlinesss All attempts to disengage the ovum with the finger. should be avoided, as endangering its integrity. The vaginal tampon is unnecessary. It should only be used as a safeguard where patients live at a distance from medical assistance, and can only be visited at long intervals. As it is never certain that the rupture of the ovum may not take place during the course of its expulsion, the tampon may in such cases be employed in anticipation of a possible increase of hemorrhage from sudden collapse of the membranes. In multiparæ the ovum seldom remains long in the cervix. In primiparæ, upon the other hand, the tardy dilatation of the os externum may lead to a retention of the ovum in the cervix, lasting for days. As this condition is extremely painful, it is allowable to dilate the os externum with the index finger, or even by incisions through the ring of circular fibers which furnish the cause of delay.

Small portions of the decidua vera sometimes remain after abortion, attached to the uterine walls. They commonly do no harm, but are discharged later with the lochial secretion.

2. When the sac ruptures, and the liquor amnii escapes, the removal of the pressure exerted upon the uterine wall by the intact ovum is followed by profuse hemorrhage from the utero-placental vessels.

The diagnosis of rupture may be made either from finding the embryo in the clots, or, in the case of a dilated cervical canal, by the direct examination of the uterine cavity. Although after rupture portions of the ovum may still be felt, we miss the smooth surface of the fluctuating amniotic sac. When the embryo can not be found, and the cervix is closed, profuse hemorrhage alone would render the occurrence of rupture extremely probable.

The principles of treatment in these cases are very simple. The indications are to check the hemorrhage and to empty the uterus. As to the best methods of attaining these results opinions widely differ.

When cases are treated with rest in bed, the internal administration of ergot, and cold cloths applied to the abdomen and vulva, the loss of blood is usually considerable, but the most of them terminate favorably. In some, however, the hemorrhage may prove so severe as even to threaten life. Now it is in every way desirable for the future welfare of the patients to restrain the hemorrhage within the narrowest limits. The most effectual means of arresting the hemorrhage is to clean out the uterus. If, therefore, the physician finds at the time of his visit the cervix sufficiently dilated to allow him to introduce his finger into the uterus, he should not hesitate at once to remove the retained portions of ovum. The operation does not require any considerable amount of technical skill, while the immediate results are in the highest degree satisfactory. The patient should be placed crosswise in bed, with the hips drawn well over the edge. The legs should be flexed, and the thighs held, where assistants can be obtained, at right angles to the body, to secure the greatest degree of relaxation to the perinæum and abdominal walls. The right index finger should be then passed into the vagina and through the cervical canal, while the left hand placed upon the abdomen gradually presses the uterus down into the pelvic cavity, so as to bring it within reach of the examining finger.* This portion of the act should be performed slowly, while every effort is made to divert the attention of the patient. Hasty manipulations invariably excite, in the most willing of patients, the full resistance of the abdominal walls. When the point of the finger reaches the os internum it is sometimes necessary to pause for a minute or two, to await a sufficient degree of dilation to allow the finger to pass beyond the insertion of the nail. When the right finger is used, it should be made to pass upward with its dorsal surface along the left side of the uterus to the opening of the fallopian tube, thence across the fundus to the right side. As the tip of the finger passes down upon the right side it presses the detached ovum before it toward the os internum. By the time the finger has thus made circuit of the uterus, the ovum is pressed into the cervical canal, and thence passes easily into the vagina. With the left finger the movement is exactly the reverse. The finger passes first with its dorsal surface directed to the right side, from the right fallopian tube across the fundus, and downward along the left side of the

* In the discussion following the reading of this paper Dr. Barker drew my attention to the occasional severity of hemorrhages in the first two months of pregnancy.

* Prof. A. R. Simpson (Trans. Edin. Obst. Soc., Vol. IV, p. 227) recommends drawing down the uterus by means of volsellum forceps attached to the anterior lip of the cervix. I have once seen extreme hemorrhage follow this manœuvre (seventh month of pregnancy), and now feel some hesitation about its employment, at least in the latter months.