

Midwifery.

THE INVESTIGATION OF THE INTERIOR OF THE UTERUS BY THE CARBOLISED HAND AT LONG INTERVALS AFTER DELIVERY.

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Mrs. A. B. was confined at her home in the south of Scotland on June 5th, 1876. The child born was her second. She was attended by her physician, who lived in the neighbourhood, and to him I owe most of the details now to be given of her case. The labour was easy, natural, and lasted four hours. The placenta was removed without difficulty about fifteen minutes after the birth of the child. The membranes were twisted to ensure their complete withdrawal, and then a dose of ergot was administered. At 9 a.m., all was completed and well. In the evening of the 6th, Mrs. A. B. had a feeling of cold in the back and severe lumbar pain. On the morning of the 7th, her pulse was 120, and at night it was 140, at which rate it continued till after my visit on the 8th. The temperature rose correspondingly, but no note of its height is preserved.

In response to a telegraphic message, I saw the patient on the afternoon of the 8th, eighty hours, or nearly three days and a-half, after her confinement. I found her with every appearance of having an attack of pyæmia or puerperal fever *post partum*. The abdomen was slightly tympanitic, the uterus somewhat tender.

The circumstances of the case, both intrinsic and extrinsic, rendered the crisis extremely alarming and important. The lochial discharge was natural, and reported as having no fœtor. Nevertheless, I made a vaginal examination, pushing the finger into the cervix uteri, and hooking away shreds of clot, which were unexpectedly found to be distinctly putrid. A second attempt brought away a small bit of membrane, putrid. Being at a great distance from proper instruments to complete what I regarded as the desirable treatment—namely, the

removal by forceps of any other pieces of membrane or decidua—and time being very valuable, I had chloroform administered, with a view to the introduction of my hand into the vagina and of my fingers into the uterus, to effect the exploration and removal of what might be found that should be taken away. During this, I gradually penetrated farther and farther into the uterus without finding anything. At last my whole hand was inside the organ, which felt not unlike an uterus only recently evacuated. In the fundus of the uterus, it was now my extreme good fortune to find adherent an irregular lacerated patch of chorionic membrane, about four inches long and an inch broad. It was found to be fetid. After this, I left the patient.

Both pulse and temperature fell in a marked manner after this operation. The alarming appearance and symptoms disappeared. The pulse remained high for several days; but the extreme anxiety of the physician and friends was subdued for good.

The fœtor of the discharge was recognised by the nurse after my visit, but only at first, or for less than a day.

While, as is well known, there is often insuperable difficulty in classifying cases of so-called puerperal fever under the heads pyæmia, septicæmia, ichoræmia, there can in this instance be no hesitation in designating the disease as simple septicæmia. Such cases are familiar to the gynecologist. A decomposing uterine fibroid, a decomposing blood-clot in a hæmatocele, produce shiverings, sweatings, vomiting, delirium, high pulse, high temperature: a most alarming combination of symptoms, which, on the removal of their cause, is dissipated with extraordinary rapidity, in a few hours, as if by a charm. Such was the fortunate course of events in the case just narrated; but, had the putrefying membrane continued much longer in a puerperal uterus, a fatal result was probable.

In the case which I have narrated, the greatest care and attention did not secure the complete withdrawal of the membranes. The position of the persistently remaining shred renders it unlikely that any forceps would have reached it and removed it entirely; nor is it