Difficult Obstetrical Cases.

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Retroversion of Impregnated Uterus—Great Accumulation of Urine—Successful Reposition and Recovery—Dr. Mola, House Physician.

Isabel Armstrong, aged 25, was admitted into Bellevue Hospital on the 27th of October, 1863. She was a healthy woman, and stated that her health had always been good. Has had two children, both now living and in good health. After the second confinement she suffered from falling of the womb, which came down near the vulva, but was never treated for this trouble. Four months ago her menses stopped. She suffered from morning sickness and the other evidences of pregnancy as in her previous gestations, and now has milk in the right breast. On the 15th of October she went to a funeral, and on getting out of the carriage slipped and struck her abdomen against a gravestone. She was much prostrated by the shock, and had to be assisted home in the carriage of a friend. She has since been confined for most of the time to the recumbent position before entering the hospital. I saw her in the afternoon of the 28th, and recognized a large tumor in the recto vaginal cul-de-sac; the os uteri could be reached with difficulty through the vagina, narrowed by the projection forwards of the posterior vaginal wall, but could be recognized on the level with the upper part of the symphisis pubis. The patient had walked the whole length of the ward to the examining bed; she presented no symptoms calling for immediate relief; she had no evidences of inflammatory action. Pregnancy was evident from her history and symptoms, though neither fœtal heart nor fœtal movements were recognizable. Some cathartic medicine, which had been given on the previous evening by Dr. Mola, had not operated, and I ordered castor-oil to be given, preparatory to a true examination on the morrow.

Oct. 29th.—Bowels have been freely moved. Her condition as before. She again walked across the ward to the examining bed. But now, before proceeding to the thorough examination of the case, I inquired about the bladder, when she declared that she had not passed water for a week, though, she stated, some had dribbled away at times when she walked. This was the first allusion made by her to the state of her bladder. A catheter was then introduced, and one hundred and forty-four ounces of urine were drawn off in the presence of my colleague, Prof. Barker, and other gentlemen. This urine was of natural color, good specific gravity, of healthy odor and reaction, and free from albumen. The abdomen diminished in size, and the diagnosis of a retroverted pregnant uterus could be clearly made out.

She was then brought at once under the influence of chloroform by one of the house physicians, while another, standing on the bed, raised her hips high in the air, so that the abdomen looked downwards towards the bed. I then introduced the fingers of the right hand in the vagina, and pressing the fundus of the uterus through the posterior vaginal wall, succeeded in an instant in passing it along the curve of the sacrum, and leaving it well anteverted. In so doing I distinctly felt the ballottement of the fœtus.

After the effects of the chloroform had passed, she said that she felt perfectly well and comfortable. All traces of the tumor, which had so greatly

distended the posterior of the cul-de-sac, and which had been so readily grasped between the fingers of one hand in the vagina and one in the vulva, had disappeared, while an ample vagina and pelvis could be recognized.

The urine drawn from this patient, and the patient, was shown at my clinical lecture. She never had an unfavorable symptom afterwards. She never once needed the introduction of a catheter, or showed any further tendency to uterine displacement or hæmorrhage; and after ten days of close observation, she left the hospital somewhat wearied with what she had considered to be unnecessary care.

In the *American Medical Times*, May 4th, 1861, p. 289, Case LXII., is the history of a case of a unilocular ovarian cyst under my care, which is interesting in the differential diagnosis of such cases, as the position of the os uteri was exactly similar

CASE CX.—*Retroversion of Impregnated Uterus—Death—No Autopsy.*

Dr. Young asked me to visit Mrs. —— on the 14th of August, 1862, who had come to the city about two days before, suffering from dysuria, from which she had been complaining about two weeks. She had been treated in

a neighboring city, and had once had her urine drawn with a catheter, though no thorough vaginal exploration seemed to have been made. On the morning in which I saw her, Dr. Young had seen her, and found her in an unconscious state, and evidently in an alarming condition. He had drawn off two-thirds of a large chamber-potful of clear urine with a catheter, and had recognized a retroverted uterus. He had been obliged to give chloroform to introduce the catheter. I found her unconscious, with a very bad facies, eyes like those of the dying, and recognizing nothing; slight froth on the lips; pulse very rapid and feeble; skin neither cold nor warm; not perspiring; respiration hurried. She tossed, moaned, threw herself on her elbows and knees; frequently rolled in a rapid manner to the edge of the bed, as though desirous of throwing herself on the floor, and necessitating the constant presence of some one to restrain her. No paralysis; no special tendency to roll in the same direction. Unconscious, evidently, but not raving. On examination I found the uterus entirely retroverted, the os on a level with the upper rim of the symphysis, the fundus down to the sacro-coccygeal articulation. Os sufficiently open to admit the finger. The uterus seemed about three months impregnated. To effect the reduction, we put her on her hands and knees, holding up the hips, as it was necessary to give an anæsthetic (chloroform) to quiet her. Pressure on the posterior vaginal wall caused half a tumblerful of bloody and very offensive urine to come away. Continuing the manœuvre, I was enabled to push up the fundus uteri; and then, by introducing two fingers within the rectum, to continue pushing it up until it cleared the promontory. But the abdominal straining would force it down again. The vagina was short, and the cul-de-sac very deep. Satisfied that the uterus could not then be permanently replaced, I desisted. Not altogether liking the respiration, we gave a prompt trial of Hall's method, and she soon breathed as before. Consciousness as before. Without an anæsthetic no satisfactory uterine manipulations could have been made. Believing that the case must terminate fatally, and as she would scarcely swallow, we agreed that the colpeurynter should be used to cushion and replace the uterus, that the bladder should be kept emptied, and that she should be nourished by enemata.

In five hours we met again. She was quieter and sitting up, but if possible looked worse. Bladder nearly to the umbilicus. Half a chamber-potful of bloody and very offensive urine drawn. Advised recumbent posture. 15th. Continues to sink. Renal secretion copious and drawn with catheter. Some sent to Dr. Draper for examination did not reach him. The uterus has never fallen back as low as it was, and is movable. Sank steadily, and died during the night. No autopsy permitted.