III.

# Rupture of an Incarcerated Retroverted Gravid Uterus. Recovery.

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A young woman of 22 years of age, recently married, menstruated for the last time in the end of April and the beginning of May, 1908. All went well until she was about four and a half months pregnant, when she consulted Dr. Smiley, of Belfast, on account of retention of urine. He drew off the urine and found the uterus to be completely retroverted and not replaceable. With the patient in the knee-chest position he was unable to push the uterus up, and found that the fundus was adherent in the pouch of Douglas. The retention of urine recurred in about a fortnight, and the uterus was found to be still retroverted and fixed. The patient subsequently went on a visit to another district, and Dr. Smiley had not the opportunity of seeing her again until after labour had commenced. On November 1st the patient felt labour pains at 2 a.m. These continued until 3 p.m., when some external hæmorrhage appeared. Dr. Smiley was then summoned, and arrived about 5 p.m. He found the patient complaining of pain in the lower part of the abdomen. She was also tender in this region, and some blood was coming from the vagina. The pulse was 100. On examination no presenting part could be felt and the outline of the os could not be satisfactorily made out. On my arrival at about 7 p.m. I found matters to be in the same condition as when Dr. Smiley had examined. He put her under chloroform in the cross-bed position, and I then washed the vulva and douched the vagina with 1 in 2000 sublimate solution. On inserting the hand into the vagina it was found that a large opening led into the abdominal cavity, the hand passing between the posterior lip of the cervix behind and the bladder in front. No remains of the anterior lip of the cervix could be felt. The finger could be passed over the posterior lip and downwards into the contracted uterus, which lay completely retroverted in the pouch of Douglas On passing the hand upwards above the pelvic brim the fœtus, with the membranes enclosing it entire, was encountered lying free in the abdominal cavity. The membranes were ruptured and the fœtus easily extracted. The placenta and membranes were then removed by hand without difficulty. The coils of small intestine, which had been pushed up by the ovum, now tended to come down into the vagina. A number of strips of sterilized gauze were then

packed into the opening so as to protrude well into the peritoneal cavity on the one hand, and to fill the vagina on the other hand. The application of an external pad of sterilized gauze and cotton wool completed the operation. In four days Dr. Smiley removed the gauze drain and thereafter kept the vagina packed with iodoform gauze. She was nursed in the Fowler position.

The patient progressed favourably, though she had a good deal of tenderness and pain in the lower abdomen for the first week. Her temperature in the forenoon never exceeded 100°. It was not taken in the evening. The pulse rate did not rise above 80. She felt well, ate well, and slept well.

This case is noteworthy from the fact that rupture of the uterus from retroversion is an exceedingly rare occurrence. It is also peculiar in that the rupture took place with the membranes still intact. Fortunately for the patient there was practically no hæmorrhage from the laceration, and it was thus possible simply to remove the ovum and stuff the rent with gauze. The exact direction of the laceration could not be determined, but the body of the uterus was intact, empty and well contracted.

I am indebted to Dr. Smiley for these notes and for permission to publish them.