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Original Communications.

CLINICAL LECTURE—PLACENTA PRÆVIA.

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REPORTED BY J. S. WHITE, M. D., CITY HOSPITAL INTERNE.

TO THE EDITOR OF THE SOUTHERN PRACTITIONER:

(MY DEAR DOCTOR: At the commencement of my service as Gynæcologist to the city hospital in Nov. 1886, I determined to make the clinical material at my disposal available for others, by keeping a record of the most important and interesting cases, which should serve as a basis for a report of each case, or for a clinical lecture, in which should be interwoven such practical hints to the class of medical students in attendance, as might naturally suggest themselves, by way of illustrating my own views of the manifold diseases which are found in all well-conducted hospitals. The cases which I shall report and the clinical lectures I shall deliver represent faithfully the difficulties, anxieties, successes and disappointments inseparable from these arduous and responsible duties. The clinical remarks represent succinctly and fully

my views of practice, and are open to criticism. While available, therefore, to the students attending the State University, I desire in grateful recognition of the benefits I have derived from the recorded experience of others, to give especially to the younger class of practitioners the benefit of my own hospital experience as as a debt due to the profession.—W. D. H.)

GENTLEMEN: The patient before you was admitted to the obstetrical ward of the hospital a day or two ago, on account of hæmorrhage. One of the internes, Dr. J. S. White, informed me, that after a careful examination of her condition he finds she has placenta prævia.

We will now endeavor to obtain her clinical history from her own lips: "Will you tell me how many children you have had?" "Six sir." "Did you ever have any hæmorrhage while carrying your other children?" "No sir." "How far are you advanced in pregnancy?" "I expect to be confined about the last of this month." "You have reached about the eighth month of pregnancy then?" "Yes sir." "When did you have the first hæmorrhage?" "About four weeks ago." "How many have you had since?" "Three." "Did you lose much blood?" "A good deal, sir, especially the last."

Now, gentlemen, you have her clinical history, and a sad one it is, because it involves the problem of life or death, not only to the mother, but to the unborn child which she bears.

Fortunately she is now situated where she can obtain assistance at any moment required, which renders her situation much less perilous.

The idea entertained by the ancients was that the placenta was originally attached at the fundus of the womb in all cases, and that in placenta prævia it fell down and occupied the lower segment of the womb, after it had been entirely separated from its site at the fundus.

Portal, who figured about the year 1664, was the first, so far as I know, who distinctly described the placenta as implanted by nature over the os uteri.

Nothwithstanding, Gifford, Rœderer, and Levert, all adopted the same opinion. The profession was slow to accept this new

dogma, and it was not until Smellie's practical and valuable contribution to obstetrics became well known, that the truth was generally received by the profession.

Even after the publication of this work, little consideration seems to have been given the subject, until about the year 1775, when Rigby's admirable essay on this subject, in which he divided hæmorrhages occurring in the last three months of gestation into "unavoidable," and "accidental," was published.

Placenta prævia, by which we mean an abnormal or faulty attachment of the placenta, implies that the placenta, instead of being attached at its usual site, occupies the lower segment of the uterus, and is designated placenta centralis, when it occupies the entire circumferance of the cervix; and placenta lateralis when it is adhered to only a portion of the cervix. When the placenta grows wholly or in part within the cervical zone, its relation to the uterine wall at the point of attachment is liable to be disturbed.

At any time during the last three months of gestation hæmorrhage from this cause is apt to take place. Hæmorrhage may come without warning, by a smart flooding of florid blood. It often occurs at night when the patient is asleep. Sometimes when she is out of doors, or away from home. Sometimes it occurs after manual exertion, or under strange emotions as fright, anger, etc. The bleeding usually subsides and the patient is reprieved for a time. The seventh and eighth months constitute the most critical epochs.

The detachment may take place gradually, as the lower segment of the uterus expands in the latter months of pregnancy, or suddenly, when the mechanism of the first stage of labor tears asunder more and more, at each uterine contraction, which effects dilatation of the os. In either case the term unavoidable, as originally applied by Rigby, is in the strictest sense correct. As it is impossible for the circumference of the os to equal the circumference of the child's head, without tearing assunder the utero-placental vessels to a degree that must bring on a hæmorrhage of the most alarming description.

Nægele says, "That there is no error in nature to be compared to this, for the very action which she uses to bring the child into

the world is that by which she destroys both it and the mother."

The causes of placental presentation are not well established. The hypertrophied and tumid condition in which the mucous membrane is found during menstruation, throwing it into convolutions or folds, is well calculated to arrest the fertilized ovum, which by reason of its fertilization has already attained a high degree of vitality, and is ready to adhere to the mucous membrane whenever the arrest may occur, sufficiently long to establish a connection from which it is to derive its pabulum in future. If, however, the fertilization of the ovum does not occur, as is doubtless exceptionally the case, until the ovum reaches the lower segment or cervical zone of the uterus, it attaches to whatever surface presents, and then goes through the physiological changes necessary to the formation and development of the embryo. The development of the ovum in the fallopian tube, and in the abdominal cavity, tend to show that contact with that portion of the mucous membrane intended for its reception, is by no means essential to its growth. Reasoning then from analogy, we are entitled to assume that a fertilized ovum may attach itself to the mucous surface lining the cervical zone, if its descent occur later than usual, and after the convolutions of the mucous membrane have mainly disappeared.

Again, there is nothing extravagant in the assumption that an ovum may, contrary to the usual course, because fertilized after passing out of the fallopian tube, meeting the spermatozoa low down in the uterine cavity—for example, when no sexual intercourse occurs for some time after menstruation.

You will remember I told you that Rigby divided ante-partum hæmorrhage into "unavoidable" and "accidental." I would fail to do my whole duty if I did not point out the essential differences in the forms of hæmorrhage, since there is a most important clinical distinction between the two. The nearer the full time of utero-gestation, the more feeble the attachment between the uterus and the placenta. In accidental hæmorrhage the placenta is attached at its normal site; but owing to the anatomical relations being more feeble, separation either from some accidental cause, as a knock or a blow on the abdomen, or from a patholog-

ical condition, such as fatty degeneration of the placenta or constitutional depravity may occur.

The separation usually begins it is said, near the center of the placental attachment, and extends toward the periphery. When this is the case, the blood accumulates in large quantities between the uterine wall and the placenta, producing fatal syncope, before the obstetrician is aware of the trouble. This is called concealed, accidental hæmorrhage.

To you then, young gentlemen, this is even more important than the hæmorrhage from placenta prævia. In the one you are fighting an open enemy, in the other your enemy is concealed. In the one the blood flows from the vulva, in the other it is pent up in the uterus. It is always safer to fight an open, than a concealed enemy. Accidental hæmorrhage is, however, generally open, as is placenta prævia. Now listen, and I will tell you how to differentiate between the two, even without a digital examination. Remember that in accidental hæmorrhage the placenta occupies its usual site; therefore, when the uterus contracts the placenta is compressed between its wall and the fœtus, and hence no hæmorrhage occurs during the pain. When the pains cease the bleeding begins.

In placenta prævia the attachment is at or near the cervix; hence, when the uterus contracts, the open mouth, of the utero-placental vessels are open, and thus bleeding occurs during the pain. If you are still in doubt, a digital examination will impart to the sense of touch, a soft, boggy feel, produced by contact of the finger with the placental mass.

In either case, and indeed in all cases of hæmorrhage before delivery, please remember the hæmorrhage proceeds from the open mouths of the utero-placental vessels, as the result of a separation of a portion of the placenta from the uterine wall, and just in proportion to the extent of the separation will the bleeding follow.

It has been the practice from time immemorial, in all cases of hæmorrhages of a serious character, occurring during pregnancy, to empty the uterus of its contents. Prior to the days of Gifford and Portal the practice was purely empirical; but since it was es-

tablished that the placenta, in all cases of unavoidable hæmorrhages, is attached at or near the os internum, the practice has been based on scientific principles.

Levert and Rigby taught that nominal extraction of the fœtus by the feet, was absolutely necessary to save the life of the mother.

Almost all subsequent authorities concurred in accepting the doctrine, and in adopting the practice of Levert and Rigby.

Denman says: "It is a practice established by high and multiplied authority, and sanctioned by Luens, to deliver a woman by art, in all cases of dangerous hæmorrhage, without confiding to the resources of the constitution. This practice is no longer a matter of partial opinion, on the propriety of which we may think ourselves *at liberty* to debate; it has for nearly two centuries met the consent and approbation of every practitioner of judgment and reputation in this and every other country."

Churchill says: "The flooding is the necessary consequence of the dilatation of the os utero, by which the connection between the placenta and uterus is separated, and the more the labor advances the greater the disruption, and the more excessive the hæmorrhage."

Barnes says: "Pain, that is contraction, is the thing wanted, but if it comes it brings danger with it. Expansion of the cervix uteri is a necessary condition of labor, but the cervix can not expand without causing more hæmorrhage! Nature is utterly at fault. She is condemned without appeal. Art must take her place."

[TO BE CONCLUDED IN OUR JANUARY NUMBER.—ED.]

ERYSIPELAS.

BY DEERING J. ROBERTS, M. D., OF NASHVILLE, TENN.

FROM time immemorial this morbid condition has claimed alike the attention of the surgeon and the general practitioner; and from its so frequent occurrence during the progress of a traumatism, either accidental or the result of the most skilled operator's knife, is of no little importance to the devotee of the most select specialty.

In an edition of Dunglison's Medical Dictionary, of forty years ago (sixth edition), we find it defined as "a superficial inflammation of the skin, with general fever, tension and swelling of the part; pain and heat more or less acrid, and redness diffused, but more or less circumscribed; disappearing when pressed upon by the finger, but returning as soon as the pressure is removed. Frequently small vesicles appear upon the inflamed part, which dry up and fall off, under the form of branny scales. * * * * * Generally an acute affection; its medium duration being from ten to fourteen days. * * * * * * * * * * * * When erysipelas is of a highly inflammatory character, and invades the parts beneath, it is termed *erysipelas phlegmonodes;* when accompanied with pheyotenulæ, and the inflammation terminates in gangrene, *erysipelas gangrænosum;* and when associated with infiltration of serum, *erysipelas œdematosum.*"

In the latest and revised edition of Dunglison, we find very little, if any, material difference; merely speaking of the "surface being smooth and shining as if oiled: *Erysipelas Glabrum;* and when superficial and tending to spread" designating it as "*erysipelas erraticum.*"

Thomas' dictionary, edition of 1887, defines it briefly as "Redness or inflammation of the skin, with fever, inflammatory or typhoid, and, generally, vesications on the affected part and symptomatic fever."