Cases of Placenta Prævia. By W. DENNY, M. D., of Ellicott's Mills, Howard County, Maryland.

CASE I.—*February* 22, 1823. I was sent for to see Mrs. ——, the mother of two children. I found this lady sitting at the fire-place warming her feet. She stated that on rising from bed she had had an active pain, which ruptured the membranes and discharged the amniotic waters with a gush. For an hour or two since, she had experienced neither pain nor discharge; no mention was made of blood being lost, either anticipatory or concurrent with the setting in of labour. Placing herself in a convenient posture on the bed to undergo an examination, she said: "I am flooding furiously." I found the vagina relaxed, and the os uteri dilated. The placenta was centrally implanted over the orifice, its anterior half detached from the pubic lip of the womb, lying loosely, and, from the interspace, blood flowed freely. I insinuated my hand easily into the vagina and through the os uteri into the cavity of the latter organ, which was flaccid enough to allow me to make search for and grasp the feet with perfect ease. I promptly turned the fœtus, and brought down its buttocks to the pubic aspect of the maternal pelvis. The external hemorrhage instantly ceased. Dizziness, tinnitus aurium, pallor, and failure of the pulse, announced the approach of syncope. In a few seconds she rallied, and an active contraction of the womb took place.

A somewhat tedious parturition ensued with the case rendered footling, and, after two or three hours, a stillborn child was delivered. The secundines soon followed with permanent contraction of the uterus, and the patient's getting up was without drawback, being much better than in her two former confinements, as she represented, and better also than in her recoveries from three or four of her deliveries, on which I afterwards attended.

CASE II.—*June* 11, 1831. I was sent for to see Mrs. ——, who had had seven or eight children. I found her flooding at the onset of her labour, having had no anticipatory hemorrhage. The os tincæ was dilatable, the placenta over it half detached. The pains of labour were not suspended. My fingers entering the womb discovered a footling presentation. I brought down the feet, and the delivery was accomplished without disaster; the infant, to the best of my recollection, being born alive.

CASE III.—*January* 31, 1847. I was called to a servant girl who was at the end of the sixth month of pregnancy, and threatened with premature labour with considerable hemorrhage. I think she had borne a child before. She was lying on a pallet which was transuded with blood, and that fluid was running along the planks of the floor and settling in a puddle at the far end of the room. Her circulation did not sympathize with the loss. Her pains were active. On examination, I found the vagina too narrow and unrelaxed to venture upon the violence of introducing my hand. The os uteri was fully dilated, and one edge of the placenta was protruded largely through it. Believing that I could not safely pass the hand, and, if I did, that I should be completely foiled in attempts at version; and finding nature was making efforts to empty the womb with fair prospects of success, I determined upon a negative course, the propriety of which became more and more manifest in the progress of the case, with a diminution, or, at least, absence of increase in the hemorrhage, and especially as the pulse maintained its force. A reversed

delivery of a stillborn fœtus took place, viz: placenta first, and fœtus afterwards, when the womb contracted permanently, and shrunk so as to insure a favourable recovery.

Case IV.—*March*, 1854. Mrs. ——, the wife of a very intelligent physician, one of my most intimate and highly esteemed friends, in her fifth pregnancy, expected her confinement early in April. She was taken in her carriage, proceeding homeward, with some anomalous feelings, along with anticipatory hemorrhage, on the 25th of February. I visited her on the 28th of that month, and advised quietness. A second hemorrhage occurred on the 15th, and a third on the 26th of March. On the 19th, I made a cautious examination, and came to nothing more than negative conclusions. The cervix uteri was not yet obliterated, but not being able to ascertain the presentation of the fœtus, either through the anterior lip of the womb or within the circle of the os tincæ, I became suspicious of placental intrusion, which, however, was not positively ascertained. On the night of the 26th, the flow had been arrested by the use of the tampon, and I was induced at first to postpone an examination. At length the tampon being cautiously removed, and no hemorrhage occurring, I found the os uteri crossed from behind forwards by the edge of the placenta, the os itself not at all impressed by any parturient effort, although the abdominal tumour felt tight to the touch externally, and I thought I could recognize some rhythmical contraction.

Leaving her on Monday morning, March 27, I remarked to her husband "that our case was one of partial implantation of the placenta on the circle of the os uteri on the left side, and, therefore, whenever the labour shall come on, which was close at hand, we may look for unavoidable hemorrhage with the earliest throes. Should the passage admit, can you so far command yourself as to enter your hand into the womb, seize the feet, and turn?" He replied, "I cannot." "Then if hemorrhage again returns, whether anticipatory or concurrent with labour, plug the vagina completely, and send for me at once."

About 10 o'clock P. M., his carriage came for me and landed me at his door, four miles distant, about an hour from the date of the message. Some active throes had commenced the labour with profuse sanguineous discharge, the pains subsiding upon the loss, and the hemorrhage restrained or concealed by two well-applied plugs, one shutting the os uteri and the other blocking up the os externum. I found her pallid, her pulse accelerated and somewhat feeble, but without any marked exhaustion. Her pallor might be occasioned partly by alarm, besides which she always had presented it in all her previous confinements in which there had been no hemorrhage. She complained of uneasiness in the bladder, for which I attempted, ineffectually, to pass the catheter without disturbing the plug. The lower one was accordingly removed, and I proceeded to make an early examination by passing a finger by the side of the upper tampon to ascertain the state of the os uteri, as well as to judge of the flow, which might ensue upon its removal.

Some slight drainage was all that now proceeded from the womb, whose orifice was about the size of a half dollar. I insinuated my left hand through the vagina to determine, as I proceeded, whether I could safely enter the womb or not. The hand found considerable resistance in passing the os externum, and gave a good deal of pain, but the fingers, concentrated into a cone, entered the os uteri without either difficulty or distress. My fingers passed on the free side of the uterine orifice, and I recognized a presentation of the head; occiput to left acetabulum; my hand was somewhat upon the abdominal aspect

of the fœtus, and on the fœtal side of the ovum. Advancing gently, I traversed the thoracic extremities which moved as with life.

I now reached a foot, doubled downwards towards the umbilicus, of which I immediately obtained command. Finding it enveloped by the membranes unbroken, I tried to rupture them to evacuate the water in order to diminish the bulk of the ovum. But they were so tough, as well as flaccid, that I could not succeed. I accordingly brought down the foot, and ruptured the membranes afterwards; a very small portion of water was discharged, the larger amount being still in utero beyond the fœtus, whose body or breech closed the os uteri completely.[1] All external hemorrhage had entirely ceased, and I looked anxiously, and confidently, too, for contraction of the womb, responsive to the stimulation of the version performed.

I remembered with what lively satisfaction I contemplated the womb contracting from its inertness upon the turning of the fœtus in Case I. That organ, in the present case, showed no disposition to act; accordingly, I gently and perseveringly proceeded to assist the passive exit of the fœtus from the cavity, and gave the patient ʒss of ergot in powder.

I have had more experience with this agent than it is, perhaps, creditable for me to acknowledge. D. D. Davis, of the London University, pronounced it inert, and that the effects attributed to it by others were concurrent with, and not consequent to, its administration. But all who, like myself, have used it more freely in the early years of practice, than we have deemed prudent under advancing experience, refrain from using it, not because it has proved inert, but because we have sometimes found it too powerful, without that power being afterwards within control. Normal rhythmical labour consists of full contractions of uterine muscle, with complete relaxations intervening. This last allows to the placenta its easy performance of duty for the fœtus in lieu of its pulmonary apparatus. The placento-pulmonary office of this appendage can no more be dispensed with by the fœtus in utero than can the lungs of the child with the atmosphere after its birth. Administer ergot, and you induce *spasmodic contraction*, which consists not only of increased effort in uterine muscle, but also in a protracted duration of the contraction, intruding on the period of relaxation or annulling it altogether. The fœtus, therefore, may be born asphyxiated. In cases of atony and consequent hemorrhage, where an infant has been duly delivered, and, therefore, safe when ergot acts efficiently and promptly, the spasmodic action induced merges into that permanent shrinking of uterine tissue which does away with the atony of the organ, and will arrest *post partum* hemorrhage by the *modus operandi* exerted by the surgeon's tourniquet or ligature. But, unfortunately, ergot may fail, certain European accoucheurs say, especially in atonic conditions induced by losses of blood; ergot having a general depressive influence along with its special agency upon the womb in labour. Thus it fails us sometimes at the point of our utmost need.

[1] It would have given me more satisfaction, in my cross-examination and criticism of myself, if the ovum had been lessened by evacuating the womb of its water. My finger failing to rupture the membranes after gaining command of the foot, this might have been effected by a female catheter, or its wire, or a probe, all which I carried in my pocket. But finding the version easily performed, a sense of triumph over our danger came over me, and I did not anticipate that, when ruptured externally, so large a portion of water would have been retained in the womb. Still less did I expect that the organ would have remained atonic; calculating that the stimulation of the manœuvre would have excited that contraction by which the latter part of the delivery should have been accomplished, and in the mean time have arrested the hemorrhage by which she sunk.

Awaiting its action, I continued mild and gentle manipulation, to terminate the labour. I passed a finger over the groin, and brought down the right lower extremity, along with which a loop of cord descended, which I noticed was now pulseless. At length I passed a finger over the right shoulder, and subsequently over the left, sweeping down, in succession, the upper extremities over the facial aspect of the fœtus.

The womb now only contained the head and the placenta, and the fluids of the ovum. I laid my other hand upon the abdominal tumour, and kept it there persistently. At length the ergot acted, inducing a powerful and sudden expulsion of the head, with a copious splash of fluid, believed at the moment to be liquor amnii only, but probably the result of internal hemorrhage added thereto. Recognizing the uterus shrunken in volume, and firm in the resistance offered to the hand, without intermediate relaxation, I proceeded to seek the placenta. I found it wedging up the dilated os uteri, entirely detached, and only awaiting a slight movement to become expelled. Dividing the cord, and laying aside the secundines for further examination, I turned my attention to the patient's general condition. Her pulse was prostrate, head dizzy, ears ringing, and there were threats of syncope.

Syncope presents two very opposite prognoses. If a woman in parturition sheds blood to the amount of one or two pints suddenly, she may probably faint. But syncope renders the current of the circulation more slack; if it does not contribute to, it is not incompatible with, contraction of the bleeding orifices, and it more or less increases the coagulation of their blood. That which impresses the bystander with alarm, assures the accoucheur of his patient's safety. But if losses of blood occurring slowly, but in the end profusely, be followed by syncope, perhaps a condition is arrived at when the circulating organs have met with great and irreparable waste. It is clear that the capital stock of the circulating fluid may be so far exhausted as to render a rally to health a slow and distant process, and, in some instances, to prevent the success of reaction altogether. Under such circumstances syncope becomes exhaustion, which is but one step to death.

From the head symptoms of approaching syncope she recovered considerably, so much so as to make some observations upon other matters than her own condition. Her pulse rose slightly, but again sank progressively.

From fatigue and uneasiness of posture, and the discomfort of her bed, she was anxious to turn, which she did ultimately from her back to her left side, with her face from me towards the wall. She soon moaned and complained of pains from sacrum to pubis, alternating so as to denote after-pains. We gave her ten drops of black drop; she became quiet, and apparently asleep, her breathing full, slow, and expansive, as that of a healthy individual. The noise of respiration soon ceased, and, being unable in the dim light of the room to see any movement of the bedclothes, I laid my hand under them upon her chest, and found that her respiration was at an end. I had given her brandy as freely as she could take it. Her pulse was extinct, and, although seated on the bed close behind her, I was not aware of the exact moment of her departure.

Upon examining the secundines, the membranes had been ruptured close to that edge of the placenta which had crossed the os uteri. The placenta was longer in one diameter than the other. It had been located on the left side of the cervix, and extended in its greatest length from the centre of the os along the longitudinal direction of the womb. The cord was implanted about an inch and a quarter from its lower edge.

For more than two centuries it has been an established practice to evacuate the womb in cases of unavoidable hemorrhage. Accordingly, in a standard work on obstetrics, the *London Practice of Midwifery*, we find the following aphorism: "He that determines to deliver early, has determined that his patient shall not die." This, without certain implied conditions on the one hand, is peremptory, and does not guard the hasty practitioner against delivering too early; and, on the other, instils a confidence of safety which experience will be often found to contradict.

Dr. Lee says: "At the best, it is a dangerous operation, and you can never tell with certainty whether or not the patient will recover after its performance, however easily it may have been effected."

Professor Simpson has been at pains to construct a table of cases in which turning has been resorted to, by various practitioners of eminence, and gives us the statistical average mortality of one in three. Dr. Lee pounces somewhat ferociously upon the table, and proceeds to prove that it cannot be relied on. The cases in it assigned to Ramsbotham, junior, are stated by Simpson at fifty, and the deaths at thirty-three. Ramsbotham says that Simpson has been entirely mistaken, as he gave *thirty-two children* as stillborn; that he finds he had omitted to state the maternal mortality, but, in an after note to Lee, puts this down as fifteen. Now, however this may modify his own proportion of deaths, the whole table of Simpson, if otherwise correct, presents a maternal mortality of three in ten.

Collins delivered by turning in four cases of placenta prævia out of eleven, and two of the women died, one from laceration and the other from hemorrhage. Rejecting the case of laceration, we have a mortality of one in three. For the most part, it is said that in these cases the os uteri is dilated or dilatable very early, and this condition is ascribed to the relaxing effects of the hemorrhage. Now, the rigid condition of the uterine orifice arises from its cohesion of tissue. Normal dilatation results from the physical impress of the ovum upon the lower segment of the womb, determined on it by the parturient throes, from the concurrent contractions of the longitudinal fibres of the organ, and from some interstitial change in the tissue of the cervix and os uteri. Loss of blood may impair muscular contractility, but cannot be supposed much to promote relaxation of physical cohesion. Admitting the fact as stated, it must be explained that the hemorrhage proceeds from disruption of the placental attachment. The disruption from physical expansion induced by the throes, and therefore one of the efficient causes of dilatation, is present; but the implantation of the placenta upon the lower segment of the womb causes undue vascularity, and this may contribute to that interstitial change by which the os uteri is rendered more easily dilatable.

But the hemorrhage is often anticipatory. It may become merged in the commencement of labour. It is known often to induce this prematurely, and, accordingly, we may not only find a serious hemorrhage along with a rigid os uteri, but even with a cervix not yet obliterated, as the term of gestation is

not yet complete. This state of the passage will not allow the introduction of the hand with safety. Laceration would almost inevitably ensue. It is not here my intention to enumerate the means to be resorted to in order to stay the hemorrhage while we await with anxiety the dilatability of the os uteri, because in the case (IV.) to which these comments are chiefly directed, I have no idea that I entered my hand a moment too early. 1. I found more resistance and inflicted more pain in insinuating my hand into the vagina than in passing my fingers cone-shaped through the uterine orifice. 2. My attention was persistently bestowed upon the resistance I met with. 3. In bringing down the arms in succession, and in placing a finger in the mouth of the fœtus, to depress the chin upon the sternum, and, after the birth of the fœtus, in dislodging the placenta jammed into the expanded os uteri, I had a full examination of its circle, and could scarcely have overlooked any rent, had such been inflicted. Moreover, there occurred no sudden symptoms annunciatory of serious laceration, although, in ascribing the fatal event to hemorrhage, it is fair to say that the patient had no jactitation or convulsive movements, common in fatal losses of blood, but passed from life to death with all the quiescence of the closing stage of Asiatic cholera. But there are cases on record where the woman has died at once from the first gush of blood at the commencement of labour. Here, it may be conceived, the transition is almost instantaneous from a rigid os uteri to the moribund state. Such cases are confessedly rare. It is more common that a period of delay, avoidable or unavoidable, may allow flooding to such extent, after the dilatation of the os uteri, as may sink the patient to a state of exhaustion. Burns considers such a case to be one of extreme danger. He would reason thus: let her alone, and she must die from hemorrhage; turn, and you inflict such a shock upon her dilapidated condition that she may die while your hand is in the uterus, or soon after delivery. He would give her the latter alternative, with all its risks. Moreau thinks "the fears of writers on the subject of *forced delivery*, in cases of insertion of the placenta over the os uteri, appear to be exaggerated," and gives a case of this kind of his own. He found the woman pale, exhausted, and apparently dying. The operation of version was easily performed. When he drew on the body, after bringing down the feet, the woman had a sort of convulsion, which threw her backward, and he thought she had breathed her last. He hastened to terminate the labour. The mother died, but the child was saved; "whilst, if we had been less *energetic* (?), it likewise would have perished." Dr. Murphy says the time for turning is at the commencement of exhaustion. In my patient this presented itself ultimately, but was not manifested when I began my manipulation. Case IV. contrasts unfavourably with the first two cases sketched. In neither of these had there been any anticipatory waste; in both the os uteri was fully dilated; in both the placenta was centrally implanted; in both the amniotic fluid had been discharged, lessening the bulk of the ovum, and rendering it more solid in its resistance to the surface of the uterus. In the first case the hemorrhage

occurred as I approached the bed for examination. In less than five minutes after the flooding was announced, my hand brought down the feet. I passed my hand between the detached placenta and the denuded womb. The fœtus came down reversely in that interspace. Its body became applied to the bleeding surface, whether uterine or placental, forming a perfect internal tampon. The uterus immediately responded by contraction, which gave assurance that no further hemorrhage could occur internally, as that which was external was instantly stayed.

The second case was still more favourable. I was present early after the commencement of the flow. I brought down the feet in the same relation as in the first case, to the disrupted space. Uterine action had not been suspended. These two cases were triumphantly managed, mainly from the favourable circumstances which they evinced.

My fourth patient had anticipatory hemorrhage. There was much flooding at the onset of the labour, which had just placed the os and cervix uteri in a state for the safe introduction of the hand. Although no general exhaustion was manifested, the womb had suspended its throes. For greater facility and less violence, I entered my hand through the unoccupied area of the uterine orifice, and came upon the abdominal aspect of the fœtus, more readily gaining command of the foot. In being turned, the fœtus came down, not interposed in, and compressed upon, the disrupted interspace, but upon its own side of the placenta. I was foiled in attempting to lessen the bulk of the ovum by rupturing the membranes. Now the womb evinced great atony, and failed to respond by contractions to the stimulation of version. This fact made me uneasy. I proceeded, on the one hand, to endeavour to arouse its action by ergot, and, on the other, as speedily as gentle efforts would permit, to advance the delivery. Up to the descent of the body and limbs through the os uteri, the delivery was purely artificial. The ergot at last acted with power, inducing the permanent diminution of volume and firm contraction of the uterine walls; but this event was postponed, through a protracted period of atony, allowing internal hemorrhage to proceed, as was evinced by the fluid discharged with the expulsion of the head of the fœtus, consisting no doubt of lost blood added to the liquor amnii. This waste, in addition to what had previously been sustained, sunk the patient too low for reaction to take place, and over this atonic state the means resorted to had failed.

On the one hand, then, I did not interfere with hasty violence, inflicting a physical lesion on the walls of the uterus, nor, on the other, did I postpone a "determination to deliver early," which determination, "that the patient should not die," was not verified, from causes which I could not control.

In contemplating the danger of the case beforehand, I felt assured that I could not be seduced into any hurried effort to dilate the passage prematurely; I had the fear, however, that I might find the patient ready for the physical manœuvre, but too much exhausted to bear the shock of turning. Had this been her condition, I had made up my mind to practise a minor operation

within a few years recommended by Dr. Radford and Professor Simpson, which, although not called for by the circumstances presented on examination, it seems not out of place to speak of here, because, before the delivery was accomplished, a state of exhaustion was really progressive, and was anxiously apprehended, by considering the uncertainty of uterine efforts; suggesting to my mind the minor operation of detaching the placenta, with the reasons why this last was not adopted. My third case was one of delivery without interference, in which nature proved herself competent to rectify the apprehended evils of her own mistake. This woman's pains kept on efficiently, and emptied the womb of its contents.

The organ then was placed in the exact condition it presents after normal parturition. The steps of the process were, successively, detachment of the secundines, their expulsion, and, lastly, the delivery of the fœtus, with permanent shrinking of uterine muscle. Simple and plainly appreciable as were these steps, my own ignorance of what had been observed by others, made me deem this an anomalous case. I find some apology for this want of knowledge in the notice of a case in *Braithwaite's Retrospect*, part ii. p. 203, published by Mr. Gower, of London, as having occurred in the practice of a practitioner of my own name, the details of which are essentially similar. Mr. Gower thereupon remarks: "Perhaps there is no other such case upon record."

But the researches of Prof. Simpson prove that such occurrences are by no means uncommon. Dr. Clark, of the Dublin Lying-in Hospital, had one such case, but the woman died. Collins had another, in which the preceding hemorrhage had ceased when the woman came to the hospital. The fœtus was brought down, in a semiputrid state, by the feet, and no placenta could be found in the womb. It was afterwards ascertained that it had been removed by a midwife the evening before; that is to say, it had probably been entirely detached by nature, and the midwife had nothing to do but take it from the upper part of the vagina. This woman recovered.

Similar cases were well known to Kinder Wood, of Manchester, Eng., more than thirty years ago, and that gentleman had remarked, that as soon as complete separation of the placenta took place, the hemorrhage ceased. In one fortnight, he met with three cases of placenta prævia; turned in all, and all the women perished. He avows, candidly, that under improved information, two of these women could probably have been saved. A fourth case occurring, he says of it: "I durst not deliver, the woman was so low." He imitated nature, entirely detached the placental connections, and the woman was afterwards delivered by her own pains. This, his practice, was well known in Manchester, but, for many years, not beyond it. Dr. Radford, of that city, pursued his example, and, about the same time, the subject suggested a similar practice to Dr. Simpson, of Edinburgh, and these two authors have simultaneously recommended dislodgment of the placenta, to arrest unavoidable hemorrhage in cases where it might be unsafe or impracticable, to turn and deliver. Admitting the propriety of the more serious manipulation of

entering the hand into the womb, and performing version in certain cases, Simpson proposes to detach the placenta in such as come under the following heads: Where the os uteri is undilated and undilatable; in premature labours; in all occurring before the seventh month; where the uterus is too contracted; where the passage is too contracted; in most primiparæ; in cases of exhaustion, and where the child is dead. With perhaps too much enthusiasm in his views, he goes on to give the rationale of the benefits of the operation.

The placenta is connected with the uterus by arteries and veins. They form part of the channel of the maternal uterine current of blood. But being nowhere continuous with the circulation of the fœtus, the maternal circle is completed by the interposition, between these arteries and veins, of placental cells, into which the arteries pour their blood, and from which that blood is delivered into the veins in the homeward circulation of the mother. A partial detachment of the placenta breaks open the maternal channels by rupturing both arteries and veins, but not such as correspond with each other. The capillary size, vermicular course, and essential contractility of arterial tissue, causes direct hemorrhage from them soon to cease. Other arteries not disrupted, continue to pour their blood into cells, which, detached from the uterus at their venous connections, effuse the blood so received on the surface of the placenta, and therefore into the cavity of the womb, and thence externally.

Detach the placenta to its extreme edge, and you cut off the arterial supply, and if it be a universal fact that this operation arrests hemorrhage, ergo, in such cases, the flooding is hemorrhage per placentam. But as in cases of post-placental hemorrhage, terminating fatally, the uterus is found flaccid and atonic, its interior surface studded with pits, large enough to receive the tip of the little finger, leading to venous channels spoken of as uterine sinuses, running straightwise, forming free plexuses, without valves, and consisting only of the inner coat of venous tissue, endowed with no contractility, the veins of the womb are entirely dependent upon the contraction and permanent shrinking of uterine tissue, to arrest a retrograde loss of blood from the vena cava itself, and when this loss does occur, it is because of the utter atony of uterine muscle.

If the fact, however, be partially true, that artificial complete separation of the placenta does so arrest a hemorrhage proceeding from its partial detachment, it must be because the operation stimulates the womb, brings on and arouses its contraction, and the shrinking of its tissue, enough to effect the closure of the orifices and channels of the veins of the organ. Sufficient testimony exists that the fact is as stated in many cases, and as this operation can be performed with more ease and far less shock, in cases of exhaustion, it may save many females who would perish notwithstanding turning and delivery.

At the moment of my disappointment by the manifestation of uterine atony when I had performed the version, the idea occurred to me to detach the placenta, in addition to what I had done. But, in the first place, the

stimulation of version had not aroused the womb to contraction—it might therefore fail if I detached the placenta. To have entered my hand on the left side of the uterine cavity, it would have been doubtful whether, with such force as I dare exert, I should have been able to effect entire separation. To have increased the partial disruption, according to Simpson's own views, would have increased the hemorrhage. To have succeeded in reaching the far periphery of the placenta, would have inflicted a far more violent shock on the increasing dilapidation of the patient than the more easy version performed in the case.

On the 17th of August, 1855, after the foregoing cases and comments were prepared for publication, I was called in consultation to the following:—

Case V.—Mrs. W., aged 43 years, has calculated the term of her tenth pregnancy to be due on the 1st of October next—her last confinement took place in August, 1853, with a good getting up. In February, 1854, she was attacked with hæmoptysis, which recurred in August and December of that year, and in March, June, and July respectively in the present.

In May last she shed blood from the uterus, again in June, twice in July, and on the night preceding my call. She is pale and feeble, and has been considered much impaired by preceding phthisis. I made no auscultation, as it was important she should avoid the effort to undergo it. The flooding of last night was protracted, accompanied with pain, apparently derived from a distension of the upper part of the vagina by large coagula, which from time to time were expelled. Her medical attendant had made a cautious examination, and found the os uteri undilated, but sufficiently open to allow the introduction of a finger. He recognized the placenta over the orifice, detached on one side, and beyond it a presentation of the head of the fœtus. I repeated the examination, and verified his diagnosis. There was now no discharge of blood. I visited the patient morning and evening to the night of the 21st, inclusive, during which there were occasional anticipatory hemorrhages, ceasing spontaneously. But her dilapidation progressed so that on that visit she seemed likely to sink before midnight, and that probably without delivery.

I was surprised early on the next morning to learn that she was still alive by a message to visit her immediately.

Her accoucheur reported that labour set in about 1 o'clock A. M., accompanied for an hour and a half by free losses of blood, when the flow ceased, to return no more. The labour proceeded with increased force and diminished intervals in the throes, and at half-past five o'clock a still-born premature infant was delivered. I found no flow from the vagina, the cord detached from the placenta, this separated and lying loose in the cervix uteri, while the womb, as felt above the pubes, was shrunken and constricted upon its contents. The secundines were easily removed and without giving any pain, when the uterus assumed the character of firmness and permanent contraction which the experienced obstetrician knows so well how to appreciate in cases of threatened or actual hemorrhage. Her aspect, respiration, and pulse indicated extreme exhaustion, and although brandy was assiduously administered, she sunk in less than an hour after delivery.

On examination, the placenta presented a strip of about 4 inches by 1¼ or 2, upon one of its edges, blackened by coagula, marking the site of its detachment from the uterus, which gave rise to the anticipatory hemorrhages which from time to time had occurred.

There appear to be some points of interest in the above case, which, if they add but little to the mass of information collected on the subject, at least seem to confirm the propriety of the negative course pursued. The patient was considerably advanced in phthisis. Now, whether or not it be true that pregnancy suspends the progress of that disease, although masking its manifestations, labour resulting in premature delivery often occurs, and the patient is unable to establish a good getting up.

Our patient had her dilapidation aggravated by frequent and free anticipatory hemorrhages. In general, these are innocuous, 1st, because the pregnant female bears losses of blood better than she bears repletion; 2d, the loss at each occurrence being moderate, her bloodvessels, by a process of shrinking in calibre, easily accommodate themselves to it; and 3d, because in the intervals the powers of assimilation more or less repair the waste.

Upon the ascertainment of the presentation of the placenta, we had a right to expect unavoidable hemorrhage whenever labour came on. This might induce, and that rapidly, a state of exhaustion, which would forbid the attempt to evacuate the womb by turning, as the shock of the manœuvre might at once prove fatal.

The only alternative then would be, to separate the placenta from its entire connection with the womb, in order to save the woman from flooding to death. If so far successful, the question would afterward come up, whether to leave the uterus to empty itself without aid, or to turn and deliver. At 1 o'clock A. M. (22*d*), labour comes on with much hemorrhage. In an hour and a half this ceases, to return no more. Whatever might have been the influence on the system at large, the flooding did not paralyze the womb itself; but it was still competent to evacuate itself of the fœtus by its own powers. This event superseded the introduction of the hand into its cavity. But in performing its rhythmical efforts to expel the fœtus, it also detached the placenta, so that this was not required to be done artificially.

Now, the woman did not die directly from flooding, but from the shock of spontaneous delivery upon the exhaustion produced by the combined causes of phthisis and previous or anticipatory hemorrhagic waste; and if, in some cases, the accoucheur in his efforts to be prompt to save his patient from flooding to death, is obliged afterward to feel that his very efforts, designed for benefit and put forth with judgment, have added to the danger and fatality of his case, in this instance he can reflect that meddlesomeness had no share in the fatal event.