Rupture of the Uterus—Gastrotomy successfully performed.

By John H. Bayne, M. D., of Prince Geo. County, Maryland.

On the 25th day of June, 1856, I was requested to visit Christina, a servant woman, 25 years of age, robust constitution, who had been in labour two days with her fourth child. Midwife present during this time. Immediately after my arrival, I proceeded to make examination per vaginam. The os uteri was fully dilated, and the vertex of the head could be distinctly felt presenting very high up. Patient complained of having experienced some hours previously an excruciating pain in the epigastrium, accompanied with a peculiar tearing sensation. There was then an entire cessation of pain, and of all expulsive uterine efforts. Pulse 130 per minute. Difficulty of respiration, and prostration. She soon became comatose, with great tendency to collapse. The head of the fœtus seemed to be rapidly receding, and in a very short time the entire contents of the uterus escaped into the peritoneal cavity. Child could now be very distinctly felt externally through the parietes of the abdomen, and appeared to be very high up, mechanically pressing against the diaphragm, which rendered the respiration still more laborious. Diagnosis was now easy. On again introducing my hand into the womb, I found an extensive laceration had taken place in the anterior portion of the

fundus. As it seemed impracticable in this case, on account of the complete disappearance of the fœtus, to introduce the hand through the rent and deliver per vaginam, I communicated the nature of the case, and suggested gastrotomy as the dernier resort. The operation was soon determined upon, and as the woman's life was in the most imminent danger, only time was allowed to obtain the assistance of those medical gentlemen who resided very near the residence of the patient. Drs. Heiskell, Wood, and Hill were promptly upon the spot, and with their aid, and without any anæsthetic agent, I proceeded to perform the operation in the following way. After adjusting the bedstead on which she was lying, I made an incision with the convex bistoury, beginning at the umbilicus in the medial line, and terminating near the pubis, dividing the parietes of the abdomen down to the peritoneum. It was then cautiously opened, and the finger used as a director to avoid injury, until the peritoneum was divided. As soon as the abdominal cavity was opened, there was a sudden gush and escape of at least one quart of serosanguineous fluid. There was no hemorrhage. A very large fœtus was now exposed to view, which was removed with as much celerity as possible.

The abdominal cavity was then cleansed. The intestine at this time *in situ*. Womb at the rupture thin, and the laceration jagged and irregular. The lips of the wound were now approximated and kept in contact by interrupted sutures and adhesive straps, observing to leave the depending part of the wound free to allow the escape of matter.

The incision was next covered with lint spread with simple cerate, over which was placed a large compress, and a body bandage completed the dressing. The operation subsequent to the incision and extraction of the fœtus was completed by Drs. Wood and Heiskell in the neatest and most skilful manner.

The patient was then removed to bed, and a stimulant administered. In a short time the heart reacted, respiration improved, coma subsided, and her condition was rendered so comfortable as to inspire her with strong hopes of recovery. For two days after the operation no untoward symptom occurred. On the third day fever set in with a tumid abdomen and pain on pressure, and considerable peritoneal inflammation. But under the influence of the antiphlogistic regimen, antimonials, calomel and opium, purgatives, enemas, &c., all inflammatory action subsided, and the patient soon seemed to be convalescent. Complete cicatrization took place in twelve days, and the case continued to progress favourably. A dark grumous, purulent, and offensive discharge continued per vaginam for several weeks unaccompanied with irritative fever.

About three months before the patient's last confinement she was attacked with anasarca of the feet and ankles, which gradually extended up the legs and thighs, encroaching upon the abdominal and thoracic parietes; at last involving the upper extremities, apparently invading the whole exterior structure. The œdema excited no great uneasiness, as it was attributed to

the mechanical obstruction produced by the gravid uterus pressing upon the iliac veins, and preventing a free return of blood.

Remarks.—There was in this case some deviation from a normal condition of the pelvis. The antero-posterior diameter was less than the standard, and the capacity of the pelvis was evidently less than ordinary, and from this circumstance, her labours had always been protracted, continuing from two to three days; then there seemed also to be some softening of the substance of the womb which predisposed to this accident.

The selection of gastrotomy was made in this case on account of the rapid contraction of the uterus occurring after the escape of the fœtus, and rendering it impossible to reach the child; deliver through the laceration and per vias naturales. It appears to me the extraction of a full grown fœtus through the rupture would always prove very difficult, and even more dangerous than the operation which was adopted.

Would not a prompt performance of gastrotomy in cases where this formidable accident has occurred diminish the mortality?

P. S. It is now two months since the operation, and the patient is perfectly well and able to resume her duties as cook.