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ORIGINAL COMMUNICATIONS.

THE HISTORY OF EIGHT CASES OF PLACENTA PRÆVIA.

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No variety of abnormal labor requires at the hands of the obstetrician more careful consideration, mature judgment, and prompt action, than that which is complicated by unavoidable hæmorrhage. The placenta being attached so near the os internum that the dilatation of this part necessarily involves its detachment, the very process by which the mother gives birth to her child, tends to destroy not only its, but her own, life. Fortunately placenta prævia is not of common occurrence. Many a practitioner will pursue his vocation for years without meeting with a case. Yet

so serious are its results that although it occurs not oftener than once in five hundred cases, which is the proportion computed as correct by some authors, it exerts a marked influence upon the statistics of obstetrics. According to the calculation of Sir James Simpson, based upon the analysis of 399 cases, one third of the mothers and over one half of the children are supposed to have been lost. The reasons for this great mortality are probably the following:

1st. The dilatation of the cervix for the passage of the child unavoidably exposes both mother and infant to great danger from placental detachment and hæmorrhage.

2d. Repeated hæmorrhages occurring during the ninth month, as the os internum dilates under the influence of painless uterine contractions, which then occur, the woman at the time of labor is usually exsanguinated, exhausted, and depressed both physically and mentally.

3d. Profuse flooding generally occurring with the commencement of labor, the medical attendant is often not at hand, and reaches his patient only after a serious loss of blood has occurred.

The dangers attendant upon the condition develop themselves most markedly in the first stage of labor, and death not infrequently occurs before the os externum is dilated to a size not greater than a Spanish dollar. At this time surgical interference, if resorted to to accomplish delivery, often destroys the lives which it is intended to save. The hand forced too soon through a rigid os will often rupture

its walls, while a delay without the adoption of the means capable of controlling hæmorrhage will necessarily favor the occurrence of a fatal result.

On the other hand, should full dilatation of the os have taken place, and the patient be exhausted from sanguineous loss, the practice of rapid artificial delivery will not rarely be followed by fatal prostration.

There is no question, in my mind, of the fact, that when it becomes the recognized practice to resort to premature delivery as a prophylactic measure in these cases, the statistics which have been quoted will be very much improved upon. By resorting to this measure we should be dealing with a woman who is not exhausted by repeated hæmorrhages; the obstetrician would be in attendance at the commencement of the labor; and he would be able by hydrostatic pressure to control flooding, while the same pressure accomplished rapidly and certainly the first stage of labor.

When this step has not been deemed advisable or from any cause labor has absolutely set in complicated by unavoidable hæmorrhage, there are two plans by which we may endeavor to save the lives of mother and child.

1st. We may alter the state of affairs at the cervix so that dilatation may occur without hæmorrhage.

2d. We may hasten the delivery of the child so as to render a *gradual dilatation* of the cervix unnecessary.

The means at our command for accomplishing these indications may thus be tabulated and presented at a glance:

MEANS FOR PREVENTING HÆMORRHAGE WHILE THE OS DILATES.

1. Distension of cervix by bags of water.
2. Evacuation of liquor amnii.
3. Partial detachment of placenta.
4. Complete " " "
5. The tampon or colpeurynter.

MEANS FOR HASTENING DELIVERY OF CHILD.

1. Ergot.
2. Version.
3. Forceps.
4. Craniotomy.

The following cases will illustrate these remarks.

CASE 1.—Mrs. W—, aged 26, primipara, in good health, was suddenly taken with hæmorrhage three weeks before full term. She sent for me in great haste, but being occupied, I was unable to go to her, and she was seen for me by my friend, Dr. Reynolds. He discovered that she had lost a few ounces of blood, but that the flow had ceased. Three days afterwards she was again affected in the same way, the flow ceasing spontaneously. About a week after this she was taken during the night with a flow, which was so profuse as to result in partial syncope when she endeavored to walk across the room. I saw her early the next morning, found her flowing slightly, and upon vaginal examination succeeded in touching the edge of the placenta through the os, which was dilated to the size of a ten cent piece. Later in the day, Drs. Metcalfe and Reynolds saw her and agreed in the propriety of premature delivery. In accordance with this consultation, at 7 p. m. I introduced into the cervix, with considerable difficulty and by the employment of some force, the smallest of Barnes's

dilators. This in twenty minutes was followed by the next larger dilator, and in an hour by the largest. Dilatation was rapidly accomplished, but instead of removing the largest bag, I left it in the cervix until ten o'clock that night. Expulsive pains coming on at that time, I removed it, when the head rapidly engaged, and before morning Mrs. W. was safely delivered of a living girl. The placenta followed rapidly, and both mother and child did well.

Remarks.—In this case, although hæmorrhage continued slightly throughout the labor, it never amounted to a sufficient quantity to endanger the lives of either mother or child. The implantation of the placenta being lateral, cessation of the flow occurred as the head advanced and made firm pressure against the bleeding surface.

As to the fact of the case being one of placenta prævia there could be no doubt. The placenta was distinctly touched by Drs. Metcalfe, Reynolds, and myself; one lip of the cervix was disproportionately developed, and the placental murmur was much more distinct over the symphysis than near the fundus.

Case 2.—Mrs. D., a lady over forty years of age, whose last pregnancy had been completed fourteen years previously, was placed under my care by Dr. Metcalfe. She was an excessively nervous and hysterical woman, but in good health. About three weeks before full term she was taken with hæmorrhages, which lasted for very short periods, recurred at intervals of four or five days, came on

without assignable cause, and ceased without remedies. The cervix was not dilated, and no physical signs of placenta prævia could be detected either by vaginal touch or auscultation. Dr. Metcalfe saw her in consultation, and as all the rational signs of placenta prævia were present, and our patient was suffering from the repeated losses, and was becoming extremely nervous and apprehensive, we concluded to bring on premature delivery. Accordingly at 11 a. m. I introduced a large sponge tent into the cervix, and at 3 or 4 p. m. removed it, and succeeded in inserting Barnes's smallest dilator. At 9 that night the cervix was fully dilated at the expense of very slight hæmorrhage, and Dr. Metcalfe then being present, I removed the bag, intending to leave the case to nature, provided no flow occurred. Previously during the evening, upon changing the bags, I had distinctly touched the head as the presenting part, but now to my surprise, I found that the bag impinging on this part had caused the child to revolve in the liquor amnii, and that the breech was now within the os.

We decided under these circumstances to deliver at once. The patient being put under the influence of ether, I drew down the legs and delivered a living female child. The placenta followed in fifteen minutes, and both patients did well, the child rapidly recovering from an injury to one of its legs received during delivery.

Remarks.—In this case the placenta was very nearly centrally attached. At one side of the os internum a

space of only two fingers breadth was free. Through this digital examinations were made and the hand pushed to seize the feet. The first stage being accomplished by means of the hydrostatic dilators, no hæmorrhage attended it; but without this means having been employed it is highly probable that profuse and dangerous flooding would have occurred.

Case 3.—Bridget B—, an Irishwoman in the lowest walks of life, was under the care of two of my students. Whether any premonitory hæmorrhages had occurred I could not ascertain. When I saw her the os was nearly fully dilated, and although considerable blood had flowed, the woman, who was quite robust, did not appear to be suffering from the loss. The placenta could be distinctly felt, laterally attached, but not very near the cervix. Feeling confident that evacuation of the liquor amnii would result in compression of the placenta by the head to such an extent as to check hæmorrhage, I resorted to this plan, predicting with some confidence that the child whose heart-beats could be heard would be delivered alive.

These anticipations were only in part fulfilled. The hæmorrhage was so much diminished that no further interference was necessary, but the child, which was delivered some hours afterward by the gentlemen in attendance, was still-born.

Remarks.—It appears to me that a better plan in this case would have been to have practised version. The os was dilated, the liquor amnii present, and the

woman strong. All things were favorable so far as she was concerned, and I do not doubt that by this operation we would have delivered a living child. This opinion I do not base upon my experience as to the fœtal mortality after version, but upon the fact that the pelvis was so capacious and the soft parts so relaxed as to have warranted the belief that such a result would have occurred.

The woman, I believe, recovered without accident.

Case 4.—Mrs. L—, a multipara, aged thirty-five years, was placed under my care by Dr. W. H. Van Buren. Although not yet advanced much beyond the seventh month of pregnancy, she had often-recurring attacks of hæmorrhage which behaved precisely like those of placenta prævia. The patient was intractable, fretful, and unreasonable to such a degree that I found much difficulty in examining very completely, and to this circumstance I in part attribute the fact that no physical signs of the condition could be detected. After attending her for a week I was suddenly called to her and found that she had lost so much blood as to be alarmingly prostrated. I at once introduced a Sims's speculum and applied a firm tampon of wet cotton. This was removed in twelve hours and replaced by another. Upon the removal of this, or rather some time before it, full doses of ergot were administered, and in a few hours a still-born child, with placenta and membranes, was cast off. The mother slowly recovered.

Case 5.—I was sent for in great haste by Dr. J. B.

Reynolds to see with him Mrs. B—, a very thin, delicate, primiparous woman, who without premonitory hæmorrhage had been taken at the commencement of labor with alarming flooding. In his note Dr. Reynolds stated that he feared that the death of the patient would occur before my arrival unless I made great haste.

Upon my arrival I found the patient very pale, and almost pulseless. The os was dilated to about the size of a Spanish dollar, but was completely dilatable, and hæmorrhage was going on actively. Upon consultation we agreed that forcible delivery in her prostrate condition would result in exhaustion and death, while the rigid and contracted state of the soft parts would offer little hope for saving the child. In preference to immediate delivery we anæsthetised the patient with ether, and I, introducing my whole hand into the vagina, slowly but completely dilated the cervical canal, ripping off a portion of the placenta at its lowest point of attachment. Stimulants were then freely given, with opiates. The head fortunately soon descended, and the patient was delivered by Dr. Reynolds in about three hours. We had told the patient's friends that the child would be still-born, but to his surprise Dr. Reynolds found in it traces of life. He tells me that he resorted to active means of resuscitation for half an hour before a distinct respiratory effort could be detected. At last, however, he succeeded in restoring it.

The mother made a very slow and tedious recovery.

Remarks.—In this case version could have been

readily accomplished when I saw the patient. I feel satisfied, however, that it would have destroyed the life of the mother, and I doubt whether the child would have been saved by the operation. The exhaustion which would have attended gradual dilatation by the water bags or tampon would have been highly prejudicial, and I am impressed with the conviction that the plan which was followed was the best which could have been chosen.

Case 6.—Dr. Metcalfe requested me to see with him Mrs. D. R—, of whom he gave me the following history. She was a multipara, in good health and in the eighth month of pregnancy. Without assignable cause she was affected by recurring hæmorrhages of considerable violence, for which he had been forced to use the tampon. Upon my seeing her, we agreed to employ the colpeurynter, Barnes's dilators not being then in use, and it was faithfully tried. For a time it would control the flow, but it excited violent efforts of the abdominal muscles without bringing on labor.

In four or five days the patient became so much exhausted that we were apprehensive as to the result. The os was half dilated, fœtal heart inaudible, and hæmorrhage recurring at intervals. The patient was anæsthetized with ether, and Dr. Metcalfe passed his hand slowly into the cervix and removed the entire placenta.

After this all flow ceased; the child was delivered in twenty-four hours, and the patient recovered without a bad symptom.

Case 7.—I was called on by Dr. Charles F. Heywood to see Mrs. C—, a multipara, who during the first stage of labor was taken with a most alarming hæmorrhage. Upon examination I found the os three quarters dilated and quite dilatable, fœtal heart audible, and woman not much prostrated but beginning to show the effects of the rapid flow. With the sanction of Dr. Heywood I at once proceeded to turn, an easy operation, as everything was favorable, and delivered a living child. Both patients did well.

Case 8.—I was sent for by Dr. R. to see in consultation with him, Mrs. B—, multipara, 37 years of age, who was in labor with her fourth child. Her husband, who came to seek me, told me as we went to his house that he had been in search of me two hours and a half, and that upon his starting out his wife was bleeding profusely. He likewise stated, that with her two previous labors she had lost a great deal of blood, so that in the last her life had been considered in great danger.

Upon arriving at the bedside I found the patient excessively pallid, her surface cool and covered with perspiration, and the pulse weak but not very much accelerated. She complained of dizziness upon lifting the head from the mattress, and expressed herself as much exhausted. The uterus was not contracting with any force. Upon making a vaginal exploration I found the vagina distended by a large clot, upon the removal of which there was a free flow of blood. The os was fully, or nearly fully, dilated, bag of water ruptured,

and a large piece of placenta could be felt in the cervical canal.

Version could have been performed very easily, and as immediate relief was absolutely demanded, it of course suggested itself as the most promising resource. But so completely exhausted was the patient that I felt very sure that the operation would destroy her life. For the child we had no hope in view of the great loss which had occurred. Rather than risk the draught upon her vital forces, which was necessary for such a procedure, I proposed the entire removal of the placenta, which would control the flow and give time for stimulation and nourishment before the delivery of the child. This being agreed to I introduced my left hand into the vagina, and carrying the thumb and two fingers into the uterus easily detached and removed the placenta. The hæmorrhage ceased at once with the exception of a slight oozing, and in four hours the uterus expelled the child. At this time the patient was taken with a profuse flow, which her physician informs me he found it impossible to control by any means, and in an hour and a quarter she died.

Remarks.—I have reflected a great deal over this unfortunate case, the result of which filled me with disappointment, as I was most sanguine for the mother's recovery upon my leaving her after the operation. I feel that were I called to a similar case now I should reason and act as I did then. Of version under the existing circumstances I have already fully expressed my opinion; all means calcu-

lated to act as mechanical hæmostatics, would have been too tardy and incomplete in their effects and too exhausting in their application, and the head was too high to be easily or surely reached by the forceps. The only other procedure which suggested itself to my mind was perforation and very cautious extraction of the child, and this would have exposed the patient so much to exhaustion that I preferred the operation to which I so vainly resorted.