A Mirror

OF THE PRACTICE OF

MEDICINE AND SURGERY

IN THE

HOSPITALS OF LONDON.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum allorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Procemium.

GUY'S HOSPITAL.

(OBSTETRIC DEPARTMENT.)

A CASE OF FATAL WOUND OF THE VAGINA CAUSED BY A GLASS SYRINGE.

(Under the care of Dr. OLDHAM.)

THE young woman whose case is here narrated was seen by Dr. Phillips amongst his out-patients at Guy's, and sent by him into the hospital the same day under Dr. Oldham's care.

Harriet B——, aged twenty-two, married, the mother of one child, since her confinement had suffered from leucorrhœa, for which she had been accustomed to use at intervals an astringent injection. That morning she passed a glass syringe, containing a solution of alum, into the vagina, having previously knelt down by the side of her bed. Soon after its introduction the syringe broke, and had to be removed in pieces by her friends, causing great pain as well as severe hæmorrhage, which was controlled by cold. When she was seen by Dr. Phillips at noon, there was no escape of blood externally. The patient, however, was blanched, and felt very faint. Two small incised wounds were found on the inner side of the left labium. After her admission she complained of severe pain in the abdomen; and on the second day her pulse was 140 per minute. The bladder had to be emptied by the catheter. On the third day there was a free discharge, having the odour of retained blood, from the vagina. On examination of the abdomen, a swelling was found, extending half way up to the navel, inclined to the right side, but dipping down into the retro-uterine pouch. This was diagnosed as a blood effusion. By means of the speculum, an aperture, situated in the upper part of the vagina, a little behind the os uteri, was detected, through which the blood was seen to flow, and into which a uterine sound passed readily. The hæmorrhage subsequently ceased; and for some days the patient appeared better. The pain in the abdomen, however, became again more severe, with much tympanites. There was an offensive discharge from the vagina; and a permanganate-of-potash injection brought away much treacly fluid. The pulse remained quick, rarely falling under 130 per minute; and the temperature varied from 102° to 104°. The vomiting was so persistent that nutrient enemata had to be used. The patient was frequently seen by Dr. Oldham and Dr. Hicks, and was carefully watched by the obstetric resident, Mr. Goodhart, but died twelve days after admission.

The autopsy by Dr. Moxon showed that there was limited purulent peritonitis of two dates. The older was in the form of a dark-walled peritoneal abscess in the pelvis, being, indeed, the distended retro-uterine pouch, limited above by a close apposition of the uterus and the sigmoid flexure, together with coils of ileum. This would hold about three quarters of a pint; and it contained a mixture of blood and liquid pus. The older abscess communicated by a small opening with the recent extension of it. This was in the right lumbar region, and reached up to the anterior surface of the liver, which it covered only partially. The remainder of the peritoneum was adherent, moderately, by a small quantity of recent lymph. Behind the os uteri, rather on its left side, there was a clear cut wound, about half an inch long, extending quite through the vaginal wall into the retro-uterine pouch.

The case, Dr. Phillips suggests, is interesting not only on account of its rarity, but also from a forensic point of view; for, had the history been incomplete, it might even have been doubted whether such an injury was likely to be self-inflicted. It is probable that the external hæmorrhage at the time of the accident proceeded chiefly from the labial wounds, involving some branches of the venous plexuses around the orifice of the vagina; while the greater part of the blood from the higher wound gradually collected in the peritoneal cavity behind the uterus. The presence of pure blood in the peritoneum rarely or never leads to severe peritonitis. The blood is slowly absorbed by the serous membrane, as is abundantly proved in the majority of cases of peri-uterine hæmatocele. In the above case, however, there existed a free communication with a mucous surface, permitting the admixture of vaginal mucus with the blood, and probably also the entrance of air from the vagina.