On the methods of arresting haemorrhage per vaginam / by Edward Blake.

Reprinted from the 'Annals of the British Homœopathic Society.']

ON THE METHODS OF ARRESTING HÆMORRHAGE PER VAGINAM.

By Edward Blake, M.D.

(Read June 22nd, 1881.)

Mr. President and Gentlemen,—

The methods of controlling vaginal hæmorrhages are chiefly of two kinds—medicinal and mechanical.

With the names and properties of those substances which are credited by the different schools of medicine with the power to influence vaginal hæmatic discharges, you are all so well acquainted that it would be a mere formality for me to enumerate them here. With regard to the others, the more mechanical measures, in which I will include the employment of the correlated physical forces, there is still so much divergence of view, and such infinite variety of practice, that I feel we can scarcely spend our time to better effect than by rapidly passing in review the most approved and the most reasonable methods of procedure. Indeed, such an enormous number of women die annually, often when life and strength are just the most urgently needed, of either the immediate, or the remote effects of hæmorrhage from some part of the genital tract, that no apology is needed for bringing before your notice a monograph on so vital a point.

However much one may privately object to recognised methods and appliances for promptly dealing with this formidable foe to human life, however conservative ones views, however historic ones practice, it is indefensible *not*, at the least, to be well acquainted with those methods

and appliances. But it might be reasonably retorted that, given one is catholic in wishing to learn from all sources, honest and conscientious in the desire to keep abreast of recent advance, even then the information is nearly inaccessible, and, when acquired, the authorities appear hopelessly to disagree.

We certainly do seem to derive from admitted authorities such diametrically opposed directions that any inquiring general practitioner might well plead embarrassment.

For example, one of the leading obstetricians of this country says, "Inject the cavity of the uterus in cases of violent flooding with some powerful styptic." I have myself seen him use a concentrated solution of *Perchloride of Iron.* Many gynæcologists, and, I think, you will agree with them, can only view this proceeding as fraught with peril. Again, another says, "Plug the cervical canal;" and with regard to this mode of treatment, yet another authority warns us to keep the cervix patulous, lest we convert a comparatively controllable vaginal flooding into an inaccessible intra-peritoneal hæmorrhage, a far more grave affair.

Can we not call this an instance of the trumpet making an uncertain sound? Yet this apparent discordance is really only on the surface; it chiefly comes of the attempt to generalise where generalisations are inadmissible, to reduce irreconcilables to one unyielding rule. To attempt to give invariable directions for the management of specific hæmorrhages is an impossible feat. The treatment which would prove beneficial to one form of flooding may be highly detrimental to another. To make this clear, we have only to call to mind that *Ergot* will arrest the bleeding from a flabby, empty uterus, and, perhaps, more surely than any known agent, will augment the flooding of placenta prævia. The rules of treatment for puerperal hæmorrhage differ so widely from those of the non-puerperal form that it is impossible to consider them together.

The main subdivision of our subject would then be into puerperal and non-puerperal hæmorrhage.

1. Puerperal Hæmorrhage.

a. *Preventable Hæmorrhage.*

Under this heading we will consider all the forms of hæmorrhage connected with pregnancy, and first we naturally turn to miscarriage and abortion, which can be conveniently treated of together. We are called to a case of threatened abortion at the third month. There has been no preceding hæmorrhage since pregnancy commenced. Florid blood is passing freely, and we ascertain that no fœtus has escaped. Now what shall we do? Many men content themselves with enjoining perfect rest and giving an appropriate remedy, and many women die who need not die. Wishing to avoid this catastrophe we decide to plug, but how shall we plug? The ordinary tampons are worse than useless, for they delude us into a false security. The vagina soon contracts on them, then, slowly dilating, forms a large pouch for the retention of clots. This objection applies less to small pledgets of styptic wool packed neatly and tightly first around the cervix to compress it, then on its patulous orifice, as figured and practised by Gaillard Thomas in the best recent work on *Diseases of Women.* But nothing is equal to the vaginal air-bag. It is easily and quickly introduced and removed. There is no exposure needed, no accompanying fœtor, and, above all, the longer it remains the larger it grows, owing to the expansion of the contained air by the warmth of the pelvis. In many cases this is enough, and a few warm medicated douches complete the case. But should the bleeding persist in spite of all our efforts to control it, we should, after tenting, introduce inside the cervix a Molesworth's dilator, into which hot water is gently propelled. This instrument is invaluable. It absolutely prevents external hæmorrhage, thus enabling us to quit the case with perfect safety, till the time be ripe for evacuating the uterine contents. This can readily be done by means of a Marion Sims' scraper. The greatest care should be taken that no portion of the chorion or placenta remain

behind. Hæmorrhage will persist as long as the smallest piece is left adherent to the uterine wall. The patient is in peril as long as it remains, and after the lapse of weeks, or even of months, may fall a victim to her doctor's culpable ignorance or indolence. When the cavity of the womb has been completely voided, the injection of a little warm calendulated water removes clots and *débris,* at the same time controlling the oozing of blood.

B. *Non-preventable Hæmorrhage or Placenta Prævia.*

Here we cannot do better than follow the main outlines of Sir James Simpson's method. Dilate thoroughly by means of Molesworth, aided if needful by anæsthetics. Then sweep the internal aspect of the cervix with the index finger, and ascertain at what point the placenta is the thinnest, pass the hand gently through, turn and deliver, peel off the placenta, and give a full dose of *Ergot.* A hot intra-uterine calendulated douche will materially add to the safety and comfort of the patient.

C. *Post-partum Hæmorrhage.*

As this is not a paper on obstetrics, I will not speak of the importance of following down the contracting uterus during delivery, leaving the nurse to tie the cord, so as, if possible, to get away the afterbirth with the first contractions before inertia set in. Then, if the fingers gently knead the fundus for half an hour, formidable hæmorrhage rarely takes place. But in certain cases it will do, especially where there has been pre-existing cervical disease and the so-called "papery" os, showing old effused semi-organised lymph, which destroys the normal elasticity of that region. Should flooding now threaten, the clots should be quickly turned out by a well-oiled and disinfected hand, and a method adopted for which we are indebted to the bold and original sagacity of a San Francisco doctor. A double canula, the egress tube being much larger than the ingress, is introduced into the uterus, and hot water is freely injected, beginning at a temperature of 100° Fahr., and rising as high as the

patient can tolerate. *Calendula* or *Hamamelis* may with advantage be added to the water.

The use of powerful styptics I have entirely abandoned under these circumstances.

The employment of hot instead of cold water to arrest hæmorrhage has so revolutionised modern practice, and the question of its originator has given rise to so much controversy, that the following letter, which I recently received from Dr. Lombe Atthill, of the Rotunda, may not be without interest:

"ROTUNDA HOSPITAL, DUBLIN;
"*Dec. 8th*, 1880.

"The use of hot water in post-partum hæmorrhage was first practised by Dr. Whitwell, of S. Francisco, and was introduced here by me two years ago. You will find my paper in the *Dublin Journal of Medical Science* for, I think, January, 1878, under the heading "Obstetrical Transactions," or in the sixth volume of the *Obstetrical Journal*, p. 126. There is also a paper of mine in the *Lancet*. I forget the date; it was early in 1878.

"I am, yours,
"LOMBE ATTHILL."

A great deal of nonsense has been written about injected fluids passing along the Fallopian tubes into the peritoneal cavity. If it be difficult to pass even a *surgical probe* into the Fallopians when the tissues are relaxed by death, how much more difficult for *liquids* to pass during the tonic condition of life! It may be said that liquids might be drawn into these tubes by capillary action. Such objectors seem to forget that the very same capillary attraction which would tend to draw a liquid into a tube would also tend to keep it there when drawn. I do not deny the possibility of blood being forced along the Fallopians by a powerfully contracting uterus, especially when acute flexion or atresia cervicis exists, but I do deny that such a thing frequently takes place. Hæmatocele might possibly occur, but against it is the fact that most hæmatoceles are subperitoneal, at least in early stage.

The fact is, a moderate quantity of blood in the peritoneal cavity is not inimical to life. I believe that intra-peritoneal effusion occurs normally in the cow during menstruation.

I have made a series of experiments with an artificial uterus of glass provided with a pliable neck. Here I could see the behaviour of injected fluids. These experiments have led me to the following conclusions :

1st. That there is no danger, under ordinary circumstances, of liquids passing along the Fallopians into the cavity of the peritoneum.

2nd. When liquids are propelled into the uterus they fail at times to return, not so much through want of space at the neck, as is sometimes supposed, but from absence of atmospheric pressure.

I do not think that sufficient attention has been paid to the reaction of intra-uterine applications. Tripier's well-known experiments show conclusively that the tolerance of the endometrium for alkalies is very marked. This may explain why the acid salts of iron are so ill borne.

If an alkaline or neutral solution, not colder than 100° Fahr., be injected gently by means of a double canula, the egress tube being decidedly larger than the ingress, and the former not being pushed far beyond the ostium internum, no evil effects need be dreaded. The most appropriate posture for the patient will of course vary with the position of the uterus. Under ordinary circumstances the supine posture will evidently be the best.

Besides the condition of which we have spoken, we may have, as causes of hæmorrhage complicating pregnancy—

1. Extra-uterine gestation.
2. Hydatidiform chorion or placenta.
3. Varix of vulva or vagina.
4. Bleeding from an abraded and hypertrophied cervix.

These, of course, will be treated each on its own individual merits.

The other main subdivision of our subject is non-pregnant hæmorrhage.

2. Non-Puerperal Hæmorrhage.

Hæmorrhage in connection with the non-impregnated uterus is divided by Dr. Barnes into three classes:

A. Hæmorrhages without structural uterine change.
B. Hæmorrhages with structural uterine change.
C. Internal hæmorrhages.

A. *Under the first no marked change in pelvic tissues being present, we find—*

1. Heart, liver, lung disease.
2. Menorrhagia.
3. Hepatic or general abdominal stasis, sometimes hereditary.
4. Reflex pain, fæcal impaction, piles, fissured anus.
5. Complementary of hæmorrhage suppressed elsewhere.
6. Emotion or physical shock.
7. Suppressed skin action.
8. Ovarian or mammary excitation. Excessive and ill-timed *coitus*.
9. Climacteric and senile hæmorrhage.
10. Blood disease:
    - Variola.
    - Scarlatina.
    - Typhoid.
    - Acute hepatic atrophy.
    - Leucocythæmia.
    - Hæmophilia.
    - Scurvy.

B. *When structural change is present.*

1. Metritis proper.
2. Cervical metritis.

Hyperplasia from congestion caused by—

- *a.* Stenosis.
- *b.* Displacement.
- *c.* Distortion.

4. Endometritis (especially gonorrhœal).

5. Hypertrophy of cervix or corpus, especially of the mucosa; syphilitic, &c.
6. Granular os (especially if syphilised).
7. Fungating tumour of os.
8. Ovarian disease.
9. Fibroids.
10. Polypi.
11. Cancer, sarcoma.
12. Wounds of uterus, vagina or vulva:
    - *a.* Accident.
    - *b.* Operation.
    - *c.* Leech-bite.
    - *d.* Abrasion.
    - *e.* Pessaries.
13. Thrombi; hæmatocele.
14. Labial varicosis.
15. Subinvolution with perimetric effusions.

Hæmaturia, piles, and diseases of the meatus are mistaken for uterine flux.

c. *Internal Hæmorrhage.*

1. Retro-uterine hæmatocele, from menstrual veins:
    - *a.* From ovary.
    - *b.* From ovarian plexuses.
    - *c.* From Fallopians.
2. Perimetric hæmatocele, thrombus:
    - *a.* In broad ligament.
    - *b.* Between bladder and cervix.
3. Reflex pain, ovarian congestion.
4. Rupture of ovarian tumours or of vessels in the wall.
5. Atresia or sharp flexions.
6. Uterine rupture.

Though I have abstained from alluding in any specific way to the internal remedies for these pelvic hæmorrhages, I think it would be both interesting and helpful to know which are those drugs that secure the suffrages of our body generally. I would, therefore, with your sanction, Mr. President, like to invite an expression of experience on the part of the members, with regard to our exceedingly valuable remedies for pelvic hæmorrhage.