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From the Author

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CASE OF SPONTANEOUS INVERSION OF THE UTERUS OCCURRING IMMEDIATELY AFTER DELIVERY.

WITH REMARKS.

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POST-PARTUM inversion of the womb is justly regarded by most obstetric authorities as one of the most distressing and dangerous complications to be met with in midwifery practice. It is an accident which claims and demands the most prompt and serious attention of the accoucheur. This form of uterine displacement is fortunately, however, one of very uncommon occurrence. Indeed, it has often been to me a matter of wonder and surprise that inversion of the womb should be so seldom met with, considering the disturbing influences to which this organ is oftentimes subjected and the rough usage to which it is frequently exposed. In proof of the rarity of inversio uteri I may mention the fact, that in 71,000 cases of delivery which occurred in the Dublin Lying-in Hospital, there was not a single instance of inversion of the womb.* The following case I consider a good example or illustration of uterine inversion.

Case.—January 7, 1864. I attended Mrs. W. in her second confinement at the full period. The presentation was natural. There was no peculiarity in the labour, either as regards severity or duration. The child was not suddenly or rapidly expelled, and when born was strong and vigorous. A few minutes after the birth of the infant, and before the expulsion of the placenta, the patient suddenly complained of severe pains of a bearing-

* Hardy and M'Clintock's Practical Observations, p. 223.

down description, which were soon followed by alarming symptoms of sinking and exhaustion, bordering on syncope or collapse. The countenance became pale and anxious, the skin cold, and the pulse hardly perceptible; there was also considerable nausea and retching. There was no hæmorrhage of any consequence, not more than usual in natural labour. On placing my hand over the supra-pubic region in order to ascertain the condition of the womb, I was surprised to find no uterine tumour, but in the situation it ought to have occupied there was an impression conveyed to the hand of a most unusual void or want. On proceeding to make a vaginal examination there was found a large globular tumour protruding several inches beyond the vulva, which proved to be the uterus in an inverted state. The inversion of the uterus appeared to be quite complete and was accompanied, as it usually is, with inversion of the vagina. The placenta was found to be firmly adherent to the inverted fundus. After the administration of brandy, ammonia, &c., so as to revive the patient a little from the shock communicated to the system in consequence of the accident, I proceeded without further delay to attempt reduction of the inverted organ. I endeavoured to replace the uterus before removing the placenta, but soon found that the bulk of the tumour was such as to preclude the possibility of this being done. I accordingly very cautiously peeled off the placenta from the inverted fundus, and thus considerably reduced the size of the tumour. The removal of the placenta only occupied a few seconds, and was not accompanied or followed by any hæmorrhage of consequence. I now firmly grasped the protruded uterus with the hand (so as to empty the vessels of the organ by compression) and pressed it gently through the vaginal orifice. As soon as the vagina was put upon the stretch, gentle and steady pressure was applied by the hand principally upon the fundus. This pressure had not been long continued when it became obvious that some progress towards reduction was being made. The uterus was found gradually to recede, and by still maintaining the pressure in the axis of the inlet of the pelvis, the uterus was found to start or bound suddenly from the hand, "like a bottle of india rubber when turned inside out." The restoration of the organ was now found to be complete. The hand was introduced into the cavity of the uterus, and retained there for several minutes; this was done not only for the purpose of guarding against any recurrence of the inversion, but also of exciting more active contractions by its presence. On now placing the hand over the hypogastric region, the uterus was found firmly and well contracted just as after normal delivery. From this time all the symptoms of collapse

began gradually to disappear. The patient made an excellent recovery.

Remarks.—There can I think be no doubt that this was a case of spontaneous inversion of the uterus. The cause of the inversion was most probably due to violent and irregular action of the uterus immediately after the birth of the child. One part of the uterus was in all likelihood in a state of active contraction, while another portion at the same time was flaccid and relaxed, or in other words, in a state of atony or inertia. While the uterus was in this condition, the fundus by the violent after pains already noticed, must have been forced down into the cavity, and then through the os, and hence the inversion. It must be observed that no traction had been made upon the cord, nor the least effort made to extract the placenta. Ergot of rye was not administered in the course of the labour. The cord was about the usual length, and was not coiled or convoluted around any part of the infant's body. The patient cannot be said to be an individual of lax fibre, nor to possess a pelvis more capacious than usual.

Whenever inversion of the uterus occurs it is of the utmost importance that such an accident should be promptly recognized, in order that immediate steps may be taken to reduce the displaced organ. Promptitude in action in such cases is certainly one of the great elements of success. The difficulty of re-inversion as a general rule, becomes increased in proportion to the delay. This is occasioned by the rapidly increasing contraction of the os uteri, which, by impeding or preventing the return of blood, causes the tumour to increase in size Delay not only increases the difficulty, but augments the danger. Every minute that elapses after the occurrence of this accident, before reposition of the uterus is effected, may be said to increase both the difficulty and danger. A very important practical point in connection with the treatment or management of such cases as this, is—Should the placenta be removed before attempting reduction? or should reduction be first attempted, and the placenta removed afterwards? Considerable discrepancy of opinion exists among obstetric authorities as to the proper course to be pursued in regard to this point. Several authors recommend that the placenta should first be separated from its attachments before any attempt is made to replace the inverted uterus. Other writers again advocate the propriety of leaving the placenta undisturbed until the uterus is replaced. Davis, Burns, Velpeau, Dewees, Newnham, and others, recommend the uterus to be restored before detaching the placenta. Denman, Blundell, and others, advise separation of the placenta first, provided it be detached to a considerable extent; but if it be completely adherent, it should

be returned with the uterus and removed afterwards. It appears to me that no rule applicable to all cases of this kind can be laid down. We must, I think, regulate our practice according to the circumstances of each individual case. In the foregoing case, I think the practice that was adopted was the proper and correct one. It certainly, in this case, seemed to me impracticable to restore the uterus to its normal condition in consequence of the great addition to its volume which the adhesion of the placenta occasioned. The removal of the placenta certainly very much facilitated the reduction of the inversion by lessening its bulk. As has been already stated, the separation of the placenta was unattended with difficulty, and was completely effected without hæmorrhage. I am inclined to think that the danger of hæmorrhage which is said to result from the removal of the placenta first, in cases of this kind, is somewhat exaggerated.