THE RECENT GASTROTOMY CASE AT SYDNEY.

By W. V. Jakins, L.R.C.P., L.M. Edin., Fell. Obst. Soc. Lond.

Some of the difficulties met with in the diagnosis of uterine pregnancy are well set forth in this case, and one of the Sydney journals has not hesitated to impugn the skilfulness of the medical men concerned therein. I purpose making a few comments thereupon, and also give a short account of a case in which I was deceived.

About eighteen years ago, to my personal knowledge, the best and most renowned physician in his special department which the last fifty years has produced was carefully explaining to a numerous class the diagnosis between ovarian tumour and pregnancy, as illustrated by the young woman then under treatment for that ovarian complaint; the next morning she was delivered of a child at full term. As it is human to err, it is well to err in such good company, and also to look back upon the points wherein we have been misled. Of the London case just referred to I shall say nothing, as I was not practically acquainted with its details. A case of probably bifid uterus which gave rise to peculiar signs, and two cases of retroflexion with pregnancy at the fifth and fourth months, may together help to elucidate some of the difficulties in the case under review.

About six years ago I was called in consultation upon the case of a respectable-looking young girl, 20 years of age, unmarried. She had been suffering from severe bilious vomiting, very copious, dark green in colour, with obstinate constipation; no food would remain on the stomach. Her medical attendant had used the ordinary remedies without success. The catamenia had always been irregular and scanty from the time of their commencement, five and a half years before; they had ceased for the past twelve months, and then began obstinate constipation, so bad that she had never had an action of the bowels save through enemata, and during this time she was troubled with bilious attacks, although never so severe as the present.

On carefully examining the abdomen, it was seen to be well-shaped and perfectly natural in appearance, save slight fulness towards the left ilium; deliberate examination of all the viscera was made by palpation and percussion. Everything was found normal, except at the sigmoid flexure, which felt large and cylindrical and hard, with its inner margin well-defined; the

swelling was gradually lost in its descent into the pelvis. Fæcal obstruction was diagnosed, and copious enemata with effervescing salines suggested for treatment. For the two days following she experienced great relief, but on the third day colicky pains set in, and I was asked to see her again. The swelling was decidedly less; stimulating antispasmodics were agreed upon. A few hours afterwards I was sent for hurriedly, and found her in strong labour; I delivered her in a few minutes of a well-developed eight months' child. This was probably a case of left lateri-version of the uterus, masked by fæcal obstruction in the rectum.

The following case of bifid uterus occurred to me about eight years since. A tall fair multipara, of lax fibre, sent for me because of a tumour in the right side; she was about seven and a half months pregnant. Careful examination of the entire abdomen disclosed the head of a child under the right lobe of the liver, well under the ribs; the limbs of the child were easily made out. The fœtus was readily moved to the left side, and, in fact, rolled over when the mother changed her position; the os was soft and open, and a sound passed in four and a half inches. Tubal pregnancy was diagnosed, and I determined on gastrotomy whenever labour set in. She went however to her full time, and when I was called to her I found a well-developed living child had been born ten minutes before; but the mother was in a state of collapse—cold, pale, with slight lividity of extremities, upturned eyeballs, clammy skin, insensible, and almost pulseless. The placenta was just inside the vulva, so I removed it, put on a light binder, applied warmth to different parts of the body, and gave teaspoonful doses of hot strong brandy and water containing a little laudanum. I suggested that Dr. Hudson should see the case with me, and he agreed that the uterus was ruptured and that it would be better to avoid all examinations. On the following day I left the case in his hands, as I was going out of town, and she recovered without a bad symptom.

The next case was pregnancy in a uterus in strong retroflexion with placenta prævia. Her first pregnancy terminated at the seventh month with a living child; her second at the third month; and this, her third, she thought was about the third month. She was a delicate woman, small, and about twenty-one years of age, with slight phthisis. I was called in the country to her last year; twelve days before she suffered from slight hæmorrhage; two days before I saw her this increased somewhat; an experienced

practitioner examined her, declared she was not pregnant, and prescribed for the hæmorrhage. When I arrived, severe flooding had occurred, leaving her blanched, almost pulseless, cold, and insensible. Ligatures were placed above the elbows and knees; laudanum in a drachm dose, in hot brandy and water, was administered, and a drachm of liquid extract of ergot was injected into the cellular tissue of the abdomen. On examining, I found the os open to the size of half-a-crown, with the placenta over it, strongly adherent posteriorly; on removing it I felt the fœtal head through the flexion, which just admitted two fingers; by manipulating with two fingers of the left hand in the rectum, I was enabled to bring a foot near enough to the two fingers of the right hand so as to be seized by them and brought down through the flexion, and so turned the child. It took some time to get the head through the flexion; the child seemed about a fourth months' fœtus, born dead. Had this been a case of retroversion, the uterus would generally have risen as pregnancy advanced. The patient made a good recovery.

The second case of retroflexion occurred to me ten years ago, in a tall woman, a middle aged multipara. Pains began at 2 p.m.; I saw her a quarter before 8. Two fingers passed through the os came to the flexion; by adopting the same means as in the above-mentioned case she was delivered of a dead child in three-quarters of an hour, after much difficulty; eight days afterwards, while quiet in bed in the afternoon, severe hæmorrhage occurred, for which I plugged and gave hæmostatics; two days afterwards I removed the plug, and on the day following she flooded again; with the same treatment, but the plug left in for four days, she made a rapid recovery. In this case there were probably adhesions, which prevented proper contraction of the uterus, and therefore twice caused flooding.

My three cases thus give fæcal obstruction with uterine lateriversion masking pregnancy, and uterine retroflexion removing the abdominal appearances of pregnancy. And now for their bearing on the Sydney case, as reported in the *Morning Herald* and *Evening News*. The first medical man "found a tumour in the right side of the abdomen, at its lower part, about the size of a child's head at the full term;" he diagnosed "ovarian cyst and doubtful pregnancy." Three months afterwards a second medical man brought her back, and after examination, "without passing a sound," "extra-uterine fœtation"

was agreed upon. The third medical man made a separate examination and found an "internal enlargement, very movable, moving from side to side;" he heard the child's heart beating; the neck of the womb was not shortened in any way, ballottement gave a negative result. On the following day, he examined her again; with the speculum he found the os more open than usual, some creamy discharge issuing from it, the cervix not at all shortened; by digital vaginal examination he discovered an enlargement anterior to the uterus, between it and the bladder, towards the *left* side—(the two previous examiners make no mention of this, W.V.J.)—the uterine sound passed very easily three and a half inches into the uterus; after passing it this distance, he tried turning it round, trying to pass it further at different points, without success; he diagnosed "extra uterine pregnancy, probably ovario-tubal," "7½ to 8 months advanced." On the following day he performed Porro's operation, in the presence of the second medical man and six others; the uterus was removed "with the idea that it was the cyst covering the child;" before so doing, he said "he could feel the uterus deep in the pelvis behind the cyst;" another medical man tried, but could not feel it, and the operator replied, "Yes, I am sure it is there, I can feel it." Bichloride of methylene and æther were used, and the operation was performed antiseptically with care and skill. The patient died two days afterwards, as the jury found, "from peritonitis, supervening on gastrotomy, under mistaken diagnosis."

Now, what led to the mistakes, to which the best men are liable? 1. An abdominal tumour (the uterus) on the right side, very movable. 2. Cervix not shortened. 3. No ballottement. 4. Sound entering three and a half inches.

Right lateri-flexion of the uterus of some duration would account for all four of these peculiarities; if the flexion were tight, the plug of mucus would form above it and only the body of the uterus above it would much increase in size as pregnancy advanced; below it, there would be only a small amount of growth, to be accounted for by the usual increase of vascularity of the parts during pregnancy. In her first examination, the patient said "she had a lump in her side, which she had felt for two or three months, and before she felt it she experienced great pain in the same part;" this "before" would mean the time when the uterus began to enlarge after conception and also to rise from

its bed and disturb all the parts with which it came in contact, and therefore cause pain. I have frequently removed a pain of many years' duration the very moment I restored a displaced uterus. As the uterus rose, still on the right side, unless there were adhesions it ought anatomically to be very movable, as in my case of bifid uterus. Shortening of the cervix sometimes does not occur even in multiparæ, as in the case mentioned in last month's *Journal*, and ballottement is frequently absent. Had the first and second medical men used the sound, probably it would have been with the same result obtained by the third, its passing $3\frac{1}{2}$ inches. The cervix open, enlarged, soft and spongy, the flexion still existing, an ordinary sound would fail most certainly to pass round the bend. In my cases of retroflexion the uterus could not rise; therefore, after a certain stage of development, according to the roominess of the back pelvis, pressure came upon the canal of the flexion and it dilated, abortion quickly following; from the os to bend, in the first case, was at least 2 inches, in the second case nearly 3 inches, so that at first they felt like very long cervices; on entering them, there was great difficulty in getting round the bends, and their want of development at the flexions was shown by it taking in each case a good half-hour to get the heads through. The enlargement found by the third medical man only the day before the operation, during his second examination, "between the uterus and bladder, towards the left side," was probably fæcal, as it did not exist at the first examination on the day before.

To conclude, the error in diagnosis was caused probably in the same way as my own, by lateral displacement of the uterus; the same kind of error also that occurred to the medical man who examined my first case of retroflexion. Fæcal accumulation, had I any reason to suspect pregnancy, would have proved no hindrance to correct diagnosis in the employment of Sims' bimanual method of examination, and minute details could have been ascertained by exploration with the hand in the rectum.

Ballarat, 8th June, 1881.

Medical Society of Victoria.

ORDINARY MONTHLY MEETING.

Wednesday, July 6, 1881.

(Hall of the Society, 8 p.m.)

Present: Mr. E. M. James, Dr. J. Robertson, Dr. Williams, Mr. Tudor Hora, Dr. J. D. Thomas, Dr. LeFevre, Dr. Moloney, Dr. Meyer, Mr. Girdlestone, Mr. Malcolmson, Dr. Balls-Headley, Dr. Allen, Dr. Morrison, Mr. W. Barker, and Dr. Burke.

The Vice-President, Mr. E. M. James, occupied the chair.

Dr. Walsh was present as a visitor.

The minutes of previous meetings were read and confirmed.

The Hon. Secretary announced that Baron von Mueller had kindly presented to the Library the following works:—"The Medical and Surgical History of the War of the Rebellion: Medical Volume, Part II." and "The 16th Annual Report of the Sanitary Commissioner with the Government of India, 1879."

New Members.

The following gentlemen were elected members of the Society:—Dr. Dickinson, Dr. J. de Burgh Griffiths, Dr. Harricks, Dr. Hillas, Dr. H. Lindsay Miller, Dr. J. Lindsay Miller, Dr. Sparrow, and Dr. Wilmott. Dr. Astles, of Adelaide, S.A., was elected a corresponding member. Dr. Williams and Dr. LeFevre acted as scrutineers.

The following paper was then read:—

NOTES ON TWO CASES OF HEMIPLEGIA.

By James Robertson, M.A., M.D.

Physician, Melbourne Hospital.

Understanding that there might be a lack of matter for discussion at *this monthly meeting of the Society, I have been induced to bring under your notice brief excerpts of two cases of hemiplegia. The patients were admitted into the Melbourne Hospital on the same day, 17th May; and as their cases present a remarkable contrast, and afford matter for reflection and room for a difference of opinion, I have thought that a brief commentary on them would be neither uninteresting nor uninstructive. Diseases of the brain are often difficult to diagnose, the symptoms being obscure

* This paper was written for the June meeting of the Society, which was occupied entirely by a discussion on numerous pathological exhibits, other business being unavoidably postponed.