The Midwife.

Labour in a Septate Uterus.

The development of the female genital organs is complex, and, to rightly understand it, embryology must be studied; some elementary knowledge is necessary to explain malformations of the uterus. In the early embryo a tube is formed upon either side of the body; these open anteriorly into the body cavity and posteriorly into the uro-genital sinus. Later two canals are formed from these tubes—the Müllerian ducts. By the eighth week, the inner walls of the lower ends fuse to form the uterus and vagina, the upper and divided portions opening into the pleuro-peritoneal cavity ultimately develop into the Fallopian tubes. A depression is at first present at the point of union; by the eight or ninth month this should have disappeared, and all trace of any septum between the two tubes should be

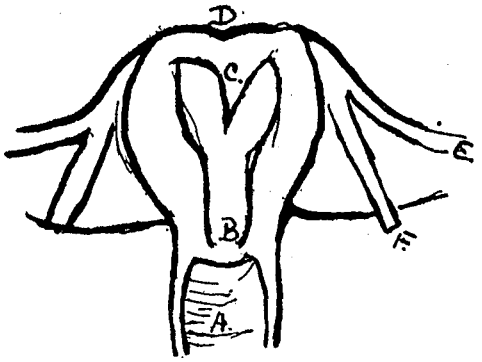

Diagram (*Uteris Septus*).
A. Vagina. B. Cervix. C. Septum.
D. Fundus. E. Fallopian Tubes.
F. Round Ligaments.

lost. If the septum persists in any degree, there results the double uterus, an organ with two sides or compartments—*i.e.*, the two component parts have failed to fuse into one; there is no excessive formation, such as is implied by the term "double uterus." There may be two separate uteri, lying side by side—uterus didelphys—or the uterus may have approximately the same shape exteriorly, and the septum may simply divide the upper portion into two lobes or extend throughout the length of the uterine cavity and down the median line of the vagina (uterus et vagina duplex). Between these two extremes are many varieties to which different names have been given.

In the following case the septum was only present in part of the body of the uterus; fusion of the Müllerian ducts was far more advanced than in the bicornuate uterus proper, but the presence of the septum indicates that the fusion was incomplete. The fundus at term had a well marked depression in the centre, making it heart-shaped in form (uterus cordiformis). The diagnosis of this abnormality is usually made during an intrauterine exploration, such as is necessary in version or removal of the placenta and membranes. In cases in which menstruation occurs every fortnight or persists throughout pregnancy, the presence of a double uterus should be suspected; if the septum extends to the cervix, so that there is a double os, or the vagina is duplicated, the diagnosis of the condition is confirmed.

The following obstetrical history illustrates some interesting points in the clinical phenomena which may accompany labour where the uterus has a partial septum. The patient, Mrs. D., had a normal menstrual history; the onset of the periods occurred at the age of 14, they continued regularly every 28 days; the loss was somewhat profuse, the flow lasted for four days. There was no change after marriage or in the intervals between the pregnancies and suckling. Up to date she has had ten pregnancies; all were full term, with the exception of the second, when labour came on prematurely at the seventh month, and she was delivered of a still-born child. The literature concerning the uterus septus testifies to the frequency of abortion. Ruge divided the septum in a patient who had twice miscarried and she went to term in the next pregnancy.

The course of labour completing the ten pregnancies was as follows:—

1. Natural, vertex presentation, adherent placenta, removed manually; the septum was not discovered by the doctor. It would, therefore, seem improbable that the placenta was attached to the septum, a condition which would certainly cause profuse post-partum hæmorrhage.
2. Premature labour; still-born infant.
3. Arm presentation, version; child still-born. The uterus was then discovered to be septate.
4. Arm presentation; still-born.
7. Arm presentation; still-born. The incomplete septum, it may be easily understood, favours a transverse presentation.

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