The Midwife.

THE CAUSES OF RUPTURE OF THE UTERUS.

Rupture of the uterus is one of the gravest and rarest accidents which occur during labour. It is much more common in multiparæ than in primagravidæ, partly because the former are more liable to malpresentations of the fœtus, and partly because the uterine wall is weakened by frequent child-bearing. In most cases the cause of this appalling accident is easily discoverable. In the majority of instances it occurs in cases of obstructed labour, in which there is marked over-distension of the lower segment. The administration of ergot in such cases precipitates the grave symptoms which supervene, and is strongly to be condemned. The midwife should recognise the conditions which may lead to obstruction early in labour, or better during pregnancy. If there is evidence that the labour is likely to be difficult or dangerous, the case is one for a skilled obstetrician, and it is safer, where practicable, for the patient to be in hospital. The second most frequent cause of rupture of the uterus is intra-uterine manipulation, such as is necessitated in internal version, forcible dilatation of the cervix, perforation of the head, delivery by forceps with a partially dilated cervix, &c. It has also been known to occur in cases of manual removal of the placenta owing to clumsy and violent manipulations. Even in administering an intra-uterine douche the uterine wall may be perforated by an unskilled operator. Internal version is responsible in a large number of recorded cases. It is therefore most urgent that the diagnosis of transverse lies should be made before the conditions are such as to render the operation of grave risk to the mother and child. External version and bi-polar version have no such grave consequences.

The fear of rupturing the uterus should make the midwife extremely reluctant to attempt intra-uterine manipulations, which may seem to be indicated in grave emergencies. It is usually possible to temporize or carry out some alternative treatment until the arrival of the doctor.

In a few other instances rupture of the uterus is due to misdirection of the uterine axis, such as exists in exaggerated ante-version or marked obliquity. The presenting part is driven against the posterior or lateral wall of the lower segment and a rent may be made in this area. The importance of rectifying these mal-positions of the uterus is obvious. In exaggerated ante-version the patient should be kept in the dorsal position and a tight binder should be applied in such a way as to make the uterine axis correspond to the pelvic axis. In exaggerated obliquity the patient is postured on the opposite side. This cause of delay in labour is often ignored by unobservant accoucheurs. In all cases of delay a careful abdominal examination is as necessary as a vaginal examination.

Degeneration of the uterine muscle, cancer of the cervix, and the breaking down of the cicatrix of a previous caesarian section, or of a uterine operation account for a few isolated cases. There still remain, however, some instances in which the cause is obscure. The labour is normal, and the uterus apparently healthy. The following case is an example of rupture of the uterus, in which the cause is difficult to explain.

The patient was a multipara. Her two previous labours had been normal. There was no pelvic contraction. The presentation was a first vertex. The child was normal in all respects—the labour only lasted four hours. When first seen by the midwife the presenting part was high; the second stage was delayed; the head made no advance, although the pains were strong; the vulva became œdematous; there was no bleeding. A doctor was summoned. Soon after the patient suddenly collapsed. It was decided to remove her to hospital. On admission her condition was grave. The pulse rate was 136, the respirations 26, and the temperature 100.2. The uterus was firmly contracted and tender. An attempt was made to deliver with forceps, but as that failed, and the patient's condition was bad, the head was perforated and delivered with the cephalotribe. The placenta was expressed. On examination a large tear was found to the left of the lower uterine segment. The pelvic cavity was full of blood-clot. Death seemed imminent, the pulse was hardly perceptible, and there were all the symptoms of profound shock. It was decided that any operation would be fatal. So with the exception of raising the foot of the bed, nothing was done. A little later the patient complained of severe pain in the lower part of the abdomen. This was relieved by an injection of morphia. For twenty-four hours her condition was critical.