The Midwife.

INTERESTING CASES.

Cases of interest are reported in the *Lancet* in papers read before the Obstetrical and Gynæcological Section of the Royal Society of Medicine.

The first, read by Dr. J. D. Barris, was an account of a case of retroflexion of the gravid uterus, complicated by hæmaturia. The patient, a multipara three months pregnant, had severe abdominal pain and difficulty in passing urine. This condition continued for a week, and then for a fortnight she passed urine every hour, the abdomen meanwhile becoming greatly distended. On admission to hospital an abdominal tumour was found, which extended to within one inch of the costal margin. The catheter was passed, and seven pints of urine drawn off; later on, another three and a half pints. The tumour then disappeared. On vaginal examination the cervix was found to be directed far forward, almost out of reach; the sacral hollow was occupied by the retroverted gravid uterus. The bladder was again emptied, and this time 28 oz. of bloody urine were withdrawn. The retroversion was then corrected, a rubber catheter was left in position for twelve hours, and for the next twelve hours the urine was drawn off four-hourly. There was no further hæmorrhage, and the patient made a good recovery. There was no cystitis.

It was thought that the hæmaturia, being in this case unaccompanied by cystitis, might have been due to the tearing of a vessel in the wall of the bladder, either from over-distension or from sudden relaxation on emptying the bladder. It has been demonstrated with the cystoscope that varicose veins of the bladder do occur during pregnancy, as well as varicose veins of the vulva, and hæmorrhoids.

Cases of this kind may occasionally come under the midwife's observation, though they occur so early in pregnancy that usually the patient has not yet engaged a midwife. When there is no pain and only partial retention of urine, or retention with incontinence, the patient frequently ignores or does not recognise the condition. If, however, any discomfort is felt, or complete retention is experienced, the patient will be very likely to consult a midwife who is known to her rather than a doctor. The duty of the midwife is, of course, to recommend the advice of a medical practitioner, though in the meanwhile she would be acting rightly in relieving any immediate discomfort by passing a catheter.

This backward displacement, or retroflexion of the gravid uterus, is often corrected spontaneously during the first two months, and before the bladder has become distended or any distressing symptoms are felt. Later on, too, it may reduce itself spontaneously if the bladder is emptied, but it is then more often necessary to replace it artificially. Neglect of the condition may lead to abortion, ruptured bladder, cystitis, uræmia, or surgical kidney, all of which are grave complications.

The other paper was an account, read by Dr. H. W. Williamson, of a case in which the child died during labour from rupture of the umbilical vessels.

The mother had a generally contracted pelvis, but, as the head was small and entered easily, labour was allowed to proceed naturally for a time. Later on, as there was some hæmorrhage, which did not cease on the rupture of the membranes, forceps were applied, and the child was delivered without difficulty. It was pale, bloodless, and the heart was not beating. On delivery of the placenta, which was of the velamentous type, it was found that an umbilical artery was ruptured two inches from the cord, and the corresponding umbilical vein was greatly thrombosed.

Dr. Williamson points out that in cases of this kind the placenta is usually velamentous, and if the wandering vessels run in that portion of the membranes in front of the presenting part, they may endanger the life of the child in two ways: (1) by being pressed between the presenting part and the lower uterine segment, and causing asphyxia; (2) by being torn across on the rupture of the membranes, and causing hæmorrhage.

In the case quoted it is evident that both these mischances occurred, the rupture of the membrances and of the artery near the upper pole of the uterus being probably due to increased strain when, at full dilatation, the membranes failed to rupture at the cervix.

Dr. Williamson considers that the condition might be diagnosed during labour if the pulsating vessels were felt running across the presenting part of the bag of membranes. After bleeding has taken place, however, the case is usually mistaken for placenta prævia, or accidental hæmorrhage. If diagnosed before rupture, the best chance for the child's life lies in Cæsarian section. M. F.

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