The subject of Periperal Uterine Haemorrhage being one of such frequent occurrence and of such a dangerous nature both to the mother and child, demands our most attentive consideration. The more especially as it sometimes breaks forth without any moment's warning and with such violence as to destroy the mother at the first sight. In the early weeks of pregnancy it is by no means unrequent, and is most intimately connected with abortion, the risk of which it announces. It may be produced by any causes which excite the uterus to contract, or directly may have the power of producing a partial separation of the placenta from the surface of the uterus, and thus permit the effusion of blood into the uterine cavity. It may be the result of constitutional susceptibility, when a very slight shock will be sufficient to cause it to be caused by accident, as blow, fall, or by violent exertion, straining at stool, severe coughing, or the separation of the uterus on its contents may be occasioned by adhesions between its surface and adjoining organ, thus preventing dilatation or the ascent of the child. When threatened with abortion the patient generally experiences a sense of weakness, lassitude.
and pain, in the back, & after these have continued for a time, the pains of labour supervene generally similar to those at the full time, but these symptoms vary remarkably with the period of pregnancy at which the abortion takes place, as in the two first months the ovum is frequently expelled without any remarkable pain or haemorrhage, but more generally there are pains accompanied with edema and in which the ovum may be expelled without being observed. It is rarely dangerous to the Mother at this period, but as pregnancy advances and the size of the fetus increases, the pains and haemorrhage are augmented.

When the haemorrhage is slight even when uterine contractions have come on, the mischief may be some times averted by careful management. The patient be enabled to go to the full time, but when the haemorrhage is considerable our treatment must be directed to moderate the discharge until the expulsion of the ovum. For this purpose we may plug the vagina provided the patient is not too far advanced in pregnancy, cold should be suitably applied to the parts, or effluvia of cold water should be used. The patient should lie on a hard Mattress and be
lightly covered with clothes. The temperature of the
room should be lowered, perfect rest of body. Slight
should be enjoined. Nothing but cold and acetic
drinks should be given.
When the plug is removed we should carefully ex-
amine to ascertain if the orifice is dilated; and if
not, we may replace it and give the weight of
Rye + Borax to excite uterine action; generally
this treatment will succeed in expelling the foetus,
but in some cases it fails and more direct interferences
is necessary, as the use of a delicate pair of forceps
or a wire curettee. But as the use of instruments
in these cases is dangerous, they should not be em-
ployed as we may generally succeed by the use
of the finger alone.
The treatment after abortion varies considerably; in
some cases it is only necessary for the patient to
remain in bed for a few days, but where there
is much debility we will require the use of tonics
with the mineral acids, nourishing but light
diet, wholesome air, gentle exercise; but these will
be more fully entered into when we come to treat
of Haemorrhage after delivery.
Haemorrhage at or about the sixth month of pregnancy is generally owing to the attachment of the Placenta either wholly or partially over the Uterus, but it frequently happens that haemorrhage from this cause does not occur until near the natural period of delivery. It is usually moderate at first, but either may subside spontaneously or yield to treatment but unfortunately in its usual outset it is usually much more profuse and less amenable to treatment. The discharge generally occurs without any obvious cause, but is sometimes hastened by some effort or physical shock and is even occasionally attended by a sensation leading the patient to infer that something had given way in the region of the uterus.

Hippocrates was aware that when the Placenta presented flooding was a necessary consequence but appears not to have suspected that the Placenta was situated primarily over the U, but that it had been attached to the fundus and owing to some violence had been detached and fallen in that position, for he says, "that the after-birth should come forth before the child if it come first the child cannot live for he takes his life from it as a plant does from the earth."
This view of the cause of haemorrhage in these cases was firmly believed on by many physicians of that time, and hence in all cases of profuse flooding coming on before delivery it was a general rule to deliver by turning the child. Mauriceau invariably speaks of the placenta when at the birth as being entirely detached, and that even a short delay will always cause the sudden death of the child if it be not quickly delivered for it cannot remain any time without being suffocated as it is now taught to breathe by its mouth, for its blood is no longer oxygenated by the preparation which it undergoes in the placenta, the function and use of which cease the moment it is detached from the mother's body with which it was connected. The result of this is the profuse flooding which is so dangerous to the mother, for if it be not promptly remedied she will quickly lose her life by the unfortunate accident. He also adds that the placenta is nothing more than a foreign body in the uterus when it is entirely separated from it when it comes into the passage before the child it is then totally divided from the womb.

Paul Portet seems to have been the first who was
experienced with the fact that the placenta was adherent to the os uteri and described a case in which he found the after-birth there placed just before and quite across the whole inner osifice, which had actually been the occasion of the flux of blood for by the opening of the osifice the date after-birth was seen being forced from that spot where it adhered to before, and the vessels containing the blood torn and opened produced this flooding which sometimes is so excessive as proves fatal to the woman, unless it be speedily prevented.

Readers was the first however to point out the cause and describe the symptoms and mode of its attack and dates at the same time published a paper on those in which he says that the placenta is sometimes placed over the os uteri, and that under those circumstances haemorrhage is inevitable and that the safest mode of remedying this accident is by the Accouchement Force; he has also given several arguments in opposition to the suggestion of the placenta being attached primarily to the fimbris, and that it had afterwards accidentally fallen down to the os uteri.

Dr. Nightingale undoubtedly had the secret of first bringing under our notice the cause
of haemorrhage in these cases in this country, and considering the frequency in which this complication exists it is surprising it was not detected sooner. He also divided haemorrhage into accidental and unavoidable, the former being caused by a partial separation of the placenta, which may be attached to and part of the uterus except the 1/3, and the latter where the placenta is attached either partially or entirely over the 1/3 of the uterus.

The causes of this peculiar imputation of the placenta are little if at all known, but the decidua may have some effect on producing it in cases where it may not have attained a proper consistency, and thus allow the down by its own gravitation to fall down to the 1/3. On the other generally however it is suspended by the decidua so that it gets no farther than the orifice of the fallopian tube from which it has emerged. Perhaps this condition of the decidua may be caused by some peculiarly situated state of the atmosphere exciting a fixed action of the uterus through the system, being that this complication appears to be almost epidemic on some seasons.

The first symptom which occurs to direct our
attention to one accident, in the sudden appearance of haemorrhage, which may at first be slight or generally happens when the patient is not very far advanced in pregnancy, and which may generally be arrested by the application of cold, the supine condition, rest, or it may occur in sudden rushes, and in greater or less quantity if the patient be near her full time, for then the ruptured vessels are larger and the separation of the placenta is of greater extent and the uterus itself is more highly developed and consequently there must be a greater determination of blood to the part.

By far the greater number of bleeding consequent upon this unfortunate position of the placenta take place within the last four or six weeks of uterine gestation, for at this time the trophoblast begins to be developed so as to form a grasp of the general cavity of the uterus, it may however take place at a much earlier period as even at the fifth or sixth month, but there is doubt if that depend upon some accidental cause operating in like manner as it would that the placenta was otherwise situated.

The flooding usually comes on without any ap
parent cause, neither occasioned by exertion, accident, nor mental excitement, for it frequently happens whilst the patient is in bed or sitting, or going about performing her accustomed duties.

It has been said that the abdomen is less distended in these cases than usual, owing to the placenta being too low down, but this observation cannot be regarded as established or as one on which we can rely, seeing the difficulty of proving such an assertion.

On examining the old blister in this form of haemorrhage, it is found thicker and softer than usual, and has a more spongy feel on account of its increased vascularity, as well as muscular development, and its orifice is found occupying either partially or entirely by a soft spongy body which must not be mistaken for a coagulum of blood; should the latter exist in this situation, we must not separate it lest the haemorrhage be renewed. We can make sure if it is being the placenta and not a coagulum of blood by the stringy lobular and fibrous feel which is communicated to the finger, by its consistence, and by its not being easily perforated or broken down, whereas a clot may generally be easily removed by the finger.
The Placenta when situated only partially over the 2D may be distinguished by feeling the smooth rounded border with the finger but when placed centrally it may be felt to be attached by its whole circumference excepting perhaps the part from which the haemorrhage is taking place.

It is not always however an easy matter to get the finger to completely introduce as to afford a safe satisfactory means of diagnosis as to whether the Placenta is attached to it or not owing to the position of the 2D Utter in the hollow of the Sacrum.

Dr. Ridley says "the usual method with one finger will not always suffice, but that the hand must be introduced into the Vagina and one finger introdused into the Utter, for in several of the following cases it will appear that though the womb was frequently examined in the usual way the Placenta was not discovered till the hand was introduced for the purpose of turning the Child."

We should most certainly not be satisfied without making an examination Jones Rashman in these cases, in order to ascertain whether the Placenta is partially or entirely attached over the 2D Utter for the treatment differs very materially in the two cases.
In placenta praevia the character of the bleeding itself may lead us to suspect the nature of the case, in as much as it is different from that of common haemorrhage, as it increases during a day and diminishes or entirely ceases on the interval, whereas in haemorrhage under ordinary circumstances it is the reverse. Also in abortive we can generally make out some definite external cause and its occurrence is irregular, the os uteri is also free, closed only by membranes and the cervix is of equal thickness all round, whereas in unavoidable the only exciting cause is the expansion of the cervix, and the time of its first occurrence has a certain degree of regularity, and the os uteri is more or less covered by the placenta or if it only reach the edge of the cervix then later may be felt to be considerably thickened at that point.

When haemorrhage does not occur post partum immediately before labour, it is produced by the gradual dilatation of the os uteri causing the separation of the placenta, and this may happen whether it is only partially or entirely over the os uteri. Professor Maggioli supposed that the period of all of could in great measure depend upon whether the
placenta was centrally or only partially attached to the OS uteri, that in the former case the placenta would be more liable to be separated by the gradual development of the inferior segment of the uterus, and that therefore haemorrhage would come on several weeks before the full time, whereas if only a sparticle of it covered the OS uteri the patient would probably go on to the very end of pregnancy before any flooding appeared on account of the placental presenting that portion of the OS from dilating, until a pretty considerable dilatation of the free border had been effected, but although this would appear a very natural conclusion it is by no means a true one as a great many cases are on record in which the placenta was attached to the whole circumference of the OS and yet the patient went to the full time without any attack of flooding. M. Hugy also considers that when the placenta is attached only partially over the neck of the uterus, or laterally, the dilatation of the neck will occasion only a slight or partial separation of it, and a moderate haemorrhage resulting of being humorously arrested but that when it passed over a great portion of the cervix and OS uteri, the discharge although
Moderate at first will return with greater density of frequency, and will at last continue until the uterus is emptied, or until the mother and child perish.

As pregnancy advances, the danger from Placenta Praevia is greatly increased, and it is at this point that the most alarming attacks of haemorrhage take place when the placenta is partially detached and when the uterus is beginning to be dilated. In this instance, the discharge goes on with occasional slight intermissions, but returns with the same increase as the placenta gets further separated. Such cases, if not interfered with, would almost invariably prove fatal for nature has no means therewith to help permanently the exhausting drain upon the system, but it can however, stop progress for a time, by the state of expunge into which the patient is thrown by applying the horse and thus favoring the formation of coagula in the upper part of the vagina. But this restoring contraction of the uterus, the haemorrhage will be renewed with increased violence, and rapidly prove fatal. In a very few instances however nature has been found equal to the task, as much as the patient have been so strong that
the child has been forced down with the placenta
before it, and thus saved the Mother, although she
is attended generally with a most alarming loss
of blood, or it may happen that the child has
pushed the placental mass - it is then born, but in
the latter case the child almost invariably fre-
ishes, owing to the injury done to as well as the
pressure exercised upon the placental vessel,
the placenta may even be detached and ex-
spelled some time before the birth of the child,
and in this case haemorrhage is sure to go on
with greater or less severity until delivery is effected.
It follows next a case in which the placenta had
been expelled many hours before the birth of the
child. The membranes held upright, and the waters
had discharged a fortnight previous to parturition
from which time until the evening she was brought
to the Hospital, she had none or less haemorrhage.
It was now ascertained that the placenta had been
expelled the evening before her admission, and separat-
ed by the midwife in attendance. She left the
hospital well on the 15th day. Such cases as these
are extremely rare and of course must invariably
prove fatal to the child. Whenever any length of
time intervenes between the separation of the placenta,
and the child's birth.
These cases were at one time considered to be less frequent than what really is the case, and Dr. Simpson has collected fifty-six cases which had been published and seventy-four which had been communicated to him in which the placenta was either expelled or extracted first, and the average mortality in the whole 131 cases to the mother was found to be one in nineteen and of the child one in three died.

Treatment of Placenta Previa
When haemorrhage takes place in the fifth or sixth month of pregnancy, and when the placenta is situated either partially or entirely over the uterine cavity there, we must consider it as a case of accidental rather than of movable haemorrhage as it is generally caused by any circumstance tending the power of producing separation of the placenta, and it has liable to at the fundus or body of the uterus, such as Placenta Previa, which will be explained later, and it is quite independent of the causes of movable haemorrhage, for it cannot scarcely be considered that any change about the 5th or 6th week would have been sufficient to have produced an movable haemorrhage at this time.
It is generally at first but very slight and con
sequently immediately dangerous to the mother, but
should always be taken upon as very dangerous
to the child, as it may cause inflammation or
pulmonary
in its first appearance and when the patient
has the pains, where the CD here has not begun
to dilate, we must try the palliative measures,
and happily these are frequently found to be
successful in arresting the discharge but it
is only for a time as it is rare to return in
the period of uterine retention advances.
The patient ought to be placed in bed on a hard
mattress, and very lightly covered with clothes,
and perfect rest of body and mind should be
strictly enjoined, the temperature of the room
should be reduced very low, and nothing but
cold drinks should be administered, as tea
milk and water being made of cold water have
been found highly beneficial as causing less
effect in the evacuation of the bowels or fluid
saline laxatives with nitrate of Soda may be
given, as there can be no doubt that a loaded
state of the lower bowel must act very injurious
by obstructing the free return of the blood from
the pelvic viscera.
The application of cold cloths over the abdomen, abdomen, or between the thighs, being one of our best
plant remedies should never be overlooked and if
there be any appearance of uterine contractions
an injection of twenty or thirty drops of sedative
mixture of opium will be necessary but care
should be taken lest the bowel be confused for
if such be the case they should be washed out
previously by a large saline enema.
If the circulation be very active and the pulse
strong, with more or less heat of surface, it may
even be desirable to reduce this by the advice
for Dr. Peace says "under any kind of active hemorrhage,
when the pulse is vigorous the taking away
blood from the arm has uniformly been found
successful by producing contractions in the
muscle, diminishing the velocity, and hence especially on
eliminating the vessels, and more especially on
sustaining the velocity within them." But this
may probably have its great and effect by producing
a deviation of blood from the heart, but as a general
rule bleeding and the exhibition of digitalis and
other depressing remedies are inadmissible, unless the
patient is splenetic, and the arterial system acting with
much energy or unless fever be present.
When the haemorrhage is not very profuse, and when the patient has not time to go, the treatment differs but little from that which we would employ in an ordinary case of threatened abortion, our main intent being to stop the discharge of blood and allying any tendency to uterine contractures. Internally, we may give the infusion of Roses, with a large quantity of the Reid Salphoric Dilat ( Epod 3vi) on the dose of one ounce to be taken every three or four hours. In the case of one young to be taken every three or four hours. We may try the portrait of Lead and Opium, and these may either be administered conjointly or be given separately. Of the latter, the Lead may be given in small doses as recommended by Dr. Somnus, but of the Opium is used by itself it may either be given in large doses or in repeated small ones. And if the good effects of the latter there can be no doubt. Dr. Martindale advises us to give to Oostake of Ether in very large doses and speaks very favorably of the result, and as it has on doubt been found useful in other acute haemorrhages it demands a trial. Sometimes with all our remedies we are unable to arrest the disastrous result, either on account of the nature of the discharge, or because the contraction of the uterus are brought on, but on the other hand we are sometimes enabled to arrest the haemorrhage and
carry the patient safely until the full term of their
nurture is completed.

When labour begins and the patient has yet
some time to go, we ought to be the more anxious
on our end to assist the discharge and ward
off the expulsion of the child, for it is of the greatest
consequence that the pregnancy should go on safely
if not to the full time to as late a period as possible,
for the mother will there have attained such a degree
of development as to allow of the bearing of the child
being accomplished with greater facility, to the great
shock, and a greater chance of safety to the mother.

But besides the child will have advanced so much
the more towards maturity as to give it a better
chance of surviving.

Fortunately, we are seldom called upon to perform
artificial delivery of the child by turning or the
clearer month, for it is evident that such an opera-
tion would be impracticable owing to the size of the
uterus, and to this has established the advice on
this point, viz. ‘that when the uterus is too small for
the admission of the hand, the expulsion of the fetus
and placenta will happily be promptly effected by Nature.

It is well known that in the cases where the existence
of fatal termination by flooding have been very
are, as Abbotton shown or later just a step to the discharge. It has been likewise often observed that on flowing at any period of pregnancy women seldom die at least not in the first instance only a considerable quantity of blood has been suddenly lost. But, as the design of a great and sudden loss must obviously depend upon the size of the uterus vessel, and as the enlargement of the vessel is in exact proportion to the increased size of the uterus, it becomes probable that, when the vessels have acquired such a magnitude that when detached from the placenta they would bleed largely and suddenly, the uterus itself must have attained to such a capacity as to admit the hand for artificial delivery, and again the state that as the most matured in order of the uterus does not take place until the end of the sixth month of pregnancy a hemorrhage before that period will seldom require artificial delivery, and after that period should it become necessary, that it is probable the hand may then be admitted for the purpose. When the patient has arrived at or nearly the full term of pregnancy and uterine action commences, and the uterus begins to dilate, the hemorrhage will consequently be greatly increased and then we
Must carefully consider when delivery shall be effected, as it will assuredly be ultimately necessary and the patient be in imminent danger, until this is accomplished. When the os uteri is but slightly dilated, of course it is impossible to introduce the hand for the purpose of terminating delivery, but on the other hand if we wait until the os uteri be widely dilated, the probability is that the patient will be so much weakened, as to have little chance of recovery. Dr. Charnell says, among the following rules: That if you are called to a case and find the woman in a state or nearly approaching to hypnogogia, provided as generally happens, that the bleeding is arrested, let her lie quiet, forbearing to disturb the genitals by manual operation; for, I repeat if you hastily introduce your hand into the uterus at this time, you will but produce a renewal of the discharge, which would most probably destroy the patient; and also that if the woman be not so much reduced in strength by the discharge, as that she does not as it were appear half dead, remember the general rule is, that you should introduce your hand into the uterus as soon as you safely can, and that you should extract the child by the operation of turning.
The hand may generally be introduced without much injury as to warrant the operation, as soon as the Os uteri is dilated to the size of a half inch, as the soft parts are commonly thoroughly relaxed in consequence of the loss of blood, sometimes however, we are not justified in waiting until this amount of dilatation is effected by the action of the uterus for the dilatation is not always to be judged of by the actual dilatation or openness of the parts, for sometimes in amenorrhea the Os uteri will be very capable of being dilated by art, although it hardly seems sufficiently open as to admit of the introduction of a finger but of course we must beware lest by too hastily dilating we produce a laceration of the parts. When the Os uteri is rigid and incapable of being dilated, we should not forcibly introduce the hand, but we should have recourse to the plug for by it we enable the patient to go on with perfect safety until the forcing have produced a sufficient dilatation of the Os uteri as to admit the hand, for this the best substance is a notice of soft sponge moistened with vinegar and introduced into the passage up to the Os uteri. The plug may also be of service when the patient is too much reduced to undergo the act of delivery without running the risk of
sinking during the operation, for it will enable us
to wait until the system had had time to rally
its powers and be recruited by the administration
of proper nourishment, and Ogilby records a case
in which the vagina and uterus were inflated for
two days before delivery could be safely regarded.
In performing the operation of turning, the same
caution is to be observed as that which we follow
under ordinary circumstances, but it is of great
consequence that the membranes should not be sep-
dated until the hand has firmly entered the uterus,
and if possible the hand should be insinuated
between the old cervix and placenta at the place
where the separation which has caused the flooding
has taken place in order to avoid any unnecessary
separation of the placenta and by the pressure on
the long vessels to prevent any great amount of blood
from being lost.
Some authors have advised us to separato the pla-
centa instead of grasping the child between it
and the mother, but this is by no means easily
accomplished, nor is there any advantage gained.
Where there is only a partial separation of
the placenta the flooding is not of such an alarming
nature, and we are not always called upon
to effect artificial delivery by turning, but our treatment must be in accordance with the strength of the pains, and the extent of the dilatation of the exitus.

Not long since, one of treatment had been summarily followed by Dr. West London and Mr. Radford. They advocated the elevation of the placenta before the birth of the child in certain cases with this result, that in nineteen out of twenty cases in which it has happened, the attendant hemorrhage has either been at once arrested or it has become so much diminished as not to be afterwards alarming. But this mode of practice is not intended to increase the influence either the rupture of the membranes or turning the child, and Mr. Simpson gives an account of the cases in which he deems this operation commendable. E "Then the hemorrhage it is great as to show the necessity of interference, and is not restrained or restrained by medical measures (as the evacuation of the Liquor Amnii) but at the same time turning or any other mode of immediate or forcible delivery of the child is especially hazardous or impracticable, in consequence of the undilated or undeveloped state of the exitus, the contraction of the pelvic passages, or to pain the death, prematurity, or any inability of the infant to bear expenses to adopt mode of delivery for it, which are accompanied
(as turning is) with much facility to the Mother provided we have a simpler and safer means, such as the detachments of the placenta, for at once emancipating and retaining the harmonious and guarding the life of the parent against the dangers of its continuation. Hence as I have elsewhere stated, I believe that the supposition of the foetus being the total detachment of the placenta will be found the preferable line of practical in these cases of unavoidable harrowing complicity with an or where so insufficiently dilute and insubstantial as not to allow of assisted being performed with perfect safety to the mother, therefore on most grounds.

In many cases in which placental presentations are (as often the happens) connected with premature labour and imperfect development of the cervix and uterine on labours suffering earlier than the seventh month: when the means is too contrived to allow of turning; when the pelvis or passage of the mother are organically contracted; when the child is dead; when it is premature and not viable and where the mother is in such an extreme state of exhaustion, as to be unable without immediate fear of life to be submitted to the short theatre of turning or forcible delivery of the infant. This enumeration is far from comprehending all the forms of placental presentations that are not with wilfull practice but it certainly includes a considerable portion of the cases of the child's complication, and among them all or almost all of the cases
A dangerous and most difficult variety of unwise labour has. In adopting the practice, one does, which I would strongly protest against, has been committed in some instances. Besides completely detaching and extracting the placenta, the child has been subsequently extracted by direct operative interference. If the membranes cease as it usually does, upon the placenta being completely separated, the expulsion of the child should be subsequently left to Nature unless it presents further material, or the labour show afterwards any kind of complication, which, if it self would require operative interference, under any other circumstances. Both to detach a placenta and extract a child would be regarding it double instead of a single operation.
Accidental Hæmorrhage

In accidental hæmorrhage the placenta may be situated at any part of the cavity of the uterus except the cervix, for then of course it would come under the head of inanition.

When only a very small portion of the placenta is separated the blood may be expelled in small quantity and may be chiefly contused or it may be in very considerable quantity if the placenta is separated to some extent, causing the uterus to expel its contents or if may be the removal of the discharge from which the patient may expire.

The amount of the loss of blood is generally considered to be commensurate with the degree of separation, but this frequently is very illusory rule as fatal hæmorrhage may take place when the situation of the placenta is not more than an inch square. In some rare cases the hæmorrhage takes place between the placenta and uterus and none may escape as the circumference of the former may be adherent, or even if they escape beyond it and shall be retained by the adhesions of the membranes. Banting and Duurmans believe that in some instances the external discharge may be prevented by the head of the foetus pressing upon the back...
of the uterine or by a clot of blood plugging up
the Uterus. In these cases the uterus being
elevated is accompanied with severe internal pain at the
spot where it takes place. This pain is something
like colic or like the pain attending the approach
of the breech. The part of the womb at which the ex-
travasation takes place slowly swells gradually, and in
a short time the uterus falls away. If the quantity
be considerable the size increases, the uterus is left to a
former and forms a mass as well as layer; the
strength diminishes and some fainting's may come on.
In course of time weak throes from uterine felt, but if
the opacity be great these decline as the weakness
increases. They may or may not be attended with the
discharge of corpora from the Uterus.

Sometimes haemorrhage may be caused by separation
of the decidua, and a consequent laceration of the vessel
running to the membrane from the inner coat of
the Uterus. It is however most frequently the result
of a separation of the placenta.

The most frequent causes of Accidental Haemorrhage
are produced by external injuries, as shocks, births,
falls, or strong emotions. Very little is required to
produce it. Dr. Churchill gives a case in which it
was produced by a hearty fit of laughter besides
These causes fatigue on exertion without strain at work, lifting heavy weights, general plication; ovarian, sensibility & dyspeptic action of that part of the uterus to which the placenta is attached; they all be equally effective in producing this mentioned result. Sometimes it is produced without the patient being able to assign any reasonable cause for its appearance.

Dr. Burn observes that sometimes it is produced by "an increased action of the uterine blood vessels, existing as a local disease in this case the patient for some time before the attack felt a weight and uneasy sensation about the hypogastric region with slight starting pains about the belly and back."

The exciting cause may either be instantly followed by the discharge or be preceded by general or local uneasiness, and dull aching pain in the back and of the breech may be retained by supposition and weight in the abdomen and pain after a time. However the discharge terminates either with or without a strain. The quantity of the effusion may vary from a few ounces to as much as would amputate the child. In safety, when the discharge is profuse it seldom at once proceeds to a fatal termination for typhus being induced the discharge is arrested none or death to the foetus follows.
consideration of the blood on the surface as if it had been
its vital powers, but after a while the patient relieves
and the discharge again commences and the dyspepsia
is repeated. Ultimately the surface becomes blanched
and covered by a cold sweat, the countenance sunk
with dark circles round the eye, the pulse becomes
weak and fluttering, and if the hemorrhage be not
arrested there comes on a burning of the ears, a sweats
shaking, nausea and vomiting, anxieties and failing
respiration, a very quick irregular pulses. The power
of respiration is lost, and death generally succeeds
by convulsions.

The diagnosis of accidental hemorrhage is of great
importance as regards treatment. 1st. It is generally
caused by some definite external circumstance, and
its occurrence is irregular. 2nd. If labour pains are
present the discharge takes place freely during the
interval but immediately occurs on the commencement
of one and during its continuance. 3rd. The uterus
on examination will be found to be free, closed by the
branches only, and of an equal thickness all round and
4th. We may by the external parts ascertain the position
of the placenta, and its presence in the fornix or
body of the uterus will decide it to be a case of
accidental hemorrhage.
When it occurs and the patient has yet some time to go before the full term of uterine dilatation is complete, if the discharge be in moderate quantity, if it have not proceeded with much rapidity, if it be clear, if no large clots are formed, or if the vagina or the lower uterus have its normal size, showing that the placenta is not detached, then the child be still alive, if there be no appearance of the accession of labour, and if the discharge become thin and watery, we may conclude that the full term of pregnancy may be expected. In this case we must apply cold suddenly to the parts, the patient should be wrapped up in cloths, emunctore or gentle saline laxatives combined with locomotive pills should be given if the bowels are at all constipated, and if the patient have much heat of surfase and a strong pulse. The limes next to be had recourse to, and the antiphlogistic regimen must be strictly enjoined, or the plug may be used as there is little danger from internal hemorrhage, owing to the uterus being full. She may have internally the acid phlegmatic or any cold drinks, as cold tea, gruel, or with any of the mineral acids, or we may administer the acetate of lead and opium.

In many cases we are enabled to check the flow of blood, and bring the patient to the end of her pregnancy.
On safety, but in those we are entirely baffled on account of the increase of the discharge should it continue long and be justified so that the strength of the patient be much impaired by it, the membrane should be ruptured, for the vessels of the uterus are diminished in size by the contraction of the uterine cavity, the same subject are on a dry plug by the rapture being brought into close and strong contact with that part of the placental mass dissipated from the uterine surface, and the uterine are usually increased in frequency and power by the augmented stimuli impressed upon the os uteri. The uterine should also be crowded to action by the local irritative amniotic with borax, and aided by friction over the outer surfaces and by digestion of the os uteri. When pains are brought on and the hemorrhage is profuse, or when it is profuse from the beginning and the danger is imminent, the membranes should be ruptured for the reasons already mentioned and beside in general soon after the pains increase and the flooding diminished on account of the previous of the placenta against the uterine and consequently when the bleeding vessels, some authors advocate after the puncturing of the Membrane as Hamilton Burn Stewart "for these reasons that these operations i
suspended and that this measure is not always
desirable to bring on labour, or that the 
membrane may not be assisted and consequently the 
operation of turning is rendered so much the more difficult.
In some cases after rupturing the membranes the 
action of the uterine is not excited and then we should 
try the best of life, and friction over the abdomen 
or the rectum might always be given upon rupturing 
the membranes. Should labour pain not be felt and 
if these fail it had then recommends us to try 
herbivora as he had succeeded with it. In case 
where these were no pains and where the cervix was 
found rigid and undilated, perhaps however 
that may fail also and then we must introduce 
the hand and bring down the fetus and thus terminate 
labour and the operation will be more easily ac 
complished owing to the relaxation caused by the 
flooding. Should however the cervix not be dilated 
and the operation otherwise contraindicated, as the 
cervix is generally soft and dilatable to a certain 
extent we may facilitate the head and extract 
with the obstetric.
If flooding occur on the first stage of labour or the 
full time, the membranes should be immediately 
ruptured, but if the discharge should continue and
the frame become weaker and the patient exhausted we must deliver by turning, forceps or embryotomy according to the circumstances of the case. In list for intractable cases we may try the sight of Berce or an injection of one ounce of Spirit of Turpentine which is frequently successful.

If the after-coming of the child remain rigid after the evacuation of the liquor amniæ, the effect should still be employed but we should also exercise to the fluid, assisted by piston and moderate pressure upon the abdomen, in order to increase uterine action. We must however be in our guard lest internal haemorrhage be overlooked and if this take place we must terminate labour by the active measure previously advised.

As after delivery a certain quantity of blood is always lost we must still take that into consideration as constituting a true haemorrhage except so much is lost as to produce a decided impression upon the constitution and on the pulse.

Haemorrhage after the birth of the child and before the expulsion of the placenta, is by no means uncommon and frequently it is sudden and severe. It is often the result of precipitate labour, causing inertia on account of the uterus being suddenly emptied of its contents. In this case strong pressure is
should be used over the Hypogastrium in order to excite uterine action, and a binder ought to be firmly applied over the abdomen, with several folded Yarns under it so that the fundus be compressed.

If in these cases the placenta be entirely absent there is no danger of hemorrhage but if it be partially or wholly separated, immense large vessel will have been exposed and the absence of uterine action permits the uncontrolled flow of blood. Dr. R. Lee advises the introduction of the hand to extract the placenta but this should not be done until the commencement of uterine action, or except the hemorrhage be very slight also if the patient be in a state of syncope and have lost such an amount of blood, so that a very little additional loss might prove fatal we must postpone the extraction until the patient be in a state of consciousness. Taking care however not to wait until the hemorrhage has returned after contraction and expulsion or withdrawal of the placenta, wet cloths with vinegar and cold water may be applied to the external parts,cold drinks should be occasionally given, and the patient should be kept in perfect seclusion for two or three days after. Sometimes the placenta is retained by irregular contraction of the uterus and this may be produced by contraction of the fibers of the cervix uteri by greater assistance than once.
of the fundus or body, or by the permanent contraction of the fibres around the body of the uterus, whilst the reddening portion is only in a state of moderate contraction, or it may be caused by a greater power of the circular fibres. The danger of flooding in these cases is not so great as when the uterus is in a state of atony, but owing to the contracted state of the glands the operation of removal is much more dangerous and difficult. Should there be no haemorrhage we may wait for a considerable time after the birth of the child without interference, but should it supervene we must immediately have recourse to the operation of extracting the placenta, and this must be done in the most gentle possible manner. Retention from sudden atonie may be caused by a frequent kind of inflammation of the lining membrane of the uterus, causing the absorption of a quantity of lymph which approximates the two surfaces of the membranes placenta, or perhaps it may be the result of the extraction of blood, which has become organized. The size of the atonic area remarkably as also the strength, as sometimes it can be removed with great facility at other times it is adherence that is impossible to separate it from its attachment. Should a portion only of the placenta be adherent and expose haemorrhage to supervene, an easy plan must be
to remove the adherent part manually, and the hand should not be withdrawn until the entire separation is effected, and great care must be taken not to leave any small fetuses attached. Sometimes, however, owing to the strength of the attachment we are completely baffled in our attempts at removal, we may then as M'dowson advised "remove as much of it as we possibly can and leave the remainder to be expelled by nature."

Should the patient be in a state of dyspnea, we must be too hasty to introduce the hand to remove the placenta, but must wait until the system has somewhat relaxed so that the effort be not felt in a placid condition and as the restoration of the heart action a fresh and more violent flow of blood should ensue.

Remember that after the birth of the child and expulsion of the placenta it is frequent and exceedingly dangerous.

It is most liable to occur when the placenta has been extracted manually or as consequence of acting on the uterine fishe. This may generally be noticed in women of relaxed habit, and weak muscular fibre, or in those who have born many children, or where the child body has been rapidly extracted after the birth of the head, then leading an excessive owing to the sudden evacuation of the uterus. It may also be caused by the presence of a chloropha which may prevent the contraction of the uterus effectively.
closing the orifice of the vessel. In suppurative degeneration of the placenta I have known hemorrhage occur to an alarming extent probably owing to the like degeneration of the muscular fibers of the uterus.

The blood in these cases may either escape externally or be retained within the cavity of the uterus. In the latter case it is generally prevented by the formation of a coagulum of blood at the site, which has the effect of plugging the uterus, and the danger here is much greater than that of external hemorrhage both on account of its liability of being overlooked, but also as the blood often within the uterus. The orifice of the vessel are gradually more diluted until the thrombus may have attained a size almost as large as it was previously to the commencement of labor. Sometimes the uterus may contract firmly immediately after labor, but in a short time it may again relax, thus go on alternately contracting and relaxing until a great quantity of blood is lost and the patient sinks, or it may be that the uterus is acting powerfully as shown by the afterpains, and yet there is a coagulum hemorrhage which may be caused by the retention of a capillary stream part of the placental membra [sic] or a part of the placenta. Under these circumstances the introduction of the hand if it can safely be accomplished should be tried because in order to clear these away. In some cases it would appear to be caused by
a determination of blood to the uterine vessels.

Our main object in the treatment of hemorrhage after delivery is to produce a firm and permanent contraction of the uterus. For this purpose we should firmly grasp the uterus with our hand and apply cold cloths; or if this be insufficient we may pour cold water from a height over the lower part of the abdomen, or we may insert it into the uterus itself. The application of cold cloths to be repeated several times if the bladder become again relaxed, and we may be fairly sure of its permanent contraction if we can only keep it in a state of tolerable contraction for half an hour. In these cases pressure is of the greatest benefit, but so much in account of producing inflammation as of maintaining it; when once excited cold water师范大学 and cold acridous drinks are of great service in assuring the application of these remedies we may give the local commutations, as it may tend to keep the uterus in a state of contraction afterwards.

Antivsectomy have been much used and have been administered both by the bladder and for vagina and these produce the most rapid effects ought to be employed. Compression of the bladder has been successful in some instances made through the sinuses of the abdomen as recommended by Latour and Hyland, or made by the
hand introduced into the relaxed uterus
Dr. Ford advises a decrystallized lemon to be introduced
with one end cut off & its juice to be squeezed out on
the sides of the uterus until the irritation of its
presence & the effect of its juice have occasional
contraction then it will be expelled with the bag
alum poured round it.

Abandonation has been highly recommended by
Dr. Rushford after these means have failed and
Dr. Good says when all has failed we should introduce
the hand into the uterus for the purpose of exciting it
to action but in the most extreme cases (such
only we should have recourse to transfusion as
the only resource).