Thesis for M. D., (Edin. Univ.)
On
Some Morbid Conditions of Pregnancy, considered Clinically and Pathologically.
by
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Some Morbid Conditions of Pregnancy.

In the course of the last ten years of General Medical practice, I have attended about three hundred cases of labour—including abortions and premature labours—and out of this number, I have been fortunate in having had three cases of Rare Morbid Conditions of Pregnancy.

I have decided to take these cases as the subject of my Thesis for the M.D. Degree (Edin. Univ.).

The first case was one of Incomplete Abortion. The second case was that of Triplet: One live fetus; two dead fetuses retained in utero; in conjunction with Hydramnios.

The third case was one of Hydrothorax Gravidarum. I propose taking these cases in the order just mentioned, giving the clinical notes of each patient, and afterwards making a few general observations on their Pathology and Diagnosis, and in the first and last cases discuss the treatment pursued.

1st Case—Incomplete Abortion

Mrs. R., 33, married, consulted me on the 29th of March 1895, complaining of haemorrhage and leukorrhoeal discharge from the vagina, which had lasted since the beginning of January of the same year. The discharge
began in the first week of January, and was accompanied by a good deal of pain of a bearing-down character which was situated in the lower part of the abdomen. She "miscarried" on the 4th January, and describes the mass that came away to be of the size of an egg and of firm consistency. She further informed me that she was at this time about three months pregnant, and was attended by an untrained woman, who told her that all had come away right. But in about a week's time afterwards the haemorrhage commenced to flow again, and this flow continued for about three months. At times the discharge was of a red colour and very profuse, especially when standing or walking about, and was never absent above three or four days; at other times the discharge was of a yellow colour, but she distinctly says that at no time during its flow was it of an offensive odour. Her usual medical attendant was consulted on account of this discharge, as she considered that the renewal of the haemorrhage was a sign of "something gone wrong." The Doctor, however, assured her that her complaint was not of a serious or dangerous nature, and that the cause of the discharge was due to a "slight alteration"
of the womb,” the result of the miscarriage; but that in a few weeks’ time, and under proper treatment, she would soon be well again. This medical gentleman had examined the patient per vaginam on the first occasion she consulted him. He continued to visit her daily, and gave instructions for her to keep absolutely quiet in bed, and live on a low diet consisting of milk food, beef tea. He also regularly sent her a bottle of medicine every third day; this medicine he said was “to dry up the discharge.” However, in spite of his treatment and regular attendance, the discharge still continued to flow, and the patient said she was daily getting weaker. At this time, another medical practitioner was called in for consultation. He, however, corroborated the other doctor’s diagnosis and prognosis.

On March 29, and acting upon the advice of a lady friend, she consulted me.

Obstetric History. I found on questioning my patient, that she was a sailor’s wife, had been married twelve years, and was the mother of three healthy children, aged 11, 9, and 7 years respectively. All the children had been carried to the full time, and all the labours and puerperium were normal.
She had never miscarried previously to this time. Menstruation began at the age of 15 years, and she had been quite regular as regards her menstrual periods except when pregnant, and suffered no pain during these times.

Present condition. Patient is of the average height and of fair complexion, but is thin and anemic looking. She says that she has lost much flesh during the last three months. Temperature 98. Pulse 84.

She had enjoyed good health previous to her present illness, and her family history was satisfactory; but I found on questioning her husband, that he had contracted syphilis two years back, and my patient admitted having had sore throat and swelling of the cervical glands, and had noticed a red rash on the front part of her chest, together with "falling off of the hair" about eighteen months ago, and was treated for these symptoms by her Doctor, which symptoms disappeared in a month or two under medical treatment. At present there is no trace of the eruption of on the chest or of the enlargement of the cervical glands.

Abdomen. There is no tenderness on palpation and no swelling of the abdomen.

Vaginal Examination. The vaginal walls
were relaxed and very moist due to the distaste. The os uteri was high up and slightly patent; the index finger could be passed a short distance up the cervical canal, but not as far as the internal os. By the bimanual examination the uterus was found enlarged.

My diagnosis was that of Incomplete Abortion, and I told the patient my opinion of her case, but in order to make certain of the diagnosis, I informed her that it would be necessary to insert an instrument to open the mouth of the womb, leaving this in for about twelve hours, and at the end of this time she would be just under the influence of Chloroform and the womb would be explored, and if my diagnosis proved correct, I would proceed to evacuate the womb of the remains of the miscarriage, and by these means hoping to cure her and bring her back to her previous good health. The patient consented to my proposals. Accordingly, the next day (March 30th) I called at her home and found my patient in bed. I douched out the vagina with warm carbolicated lotion (1 to 40), and then introduced into the cervix a fairly large sponge-tent. The following day at 10 a.m., and about 12 hours after the time of the insertion of the sponge-tent, I called there accom-
promised by a medical colleague—who was to give the anaesthetic—and also by a trained nurse.

I found the patient looking anxious and excited, her face was flushed. Pulse 120.

Pep. 28. Temp. 102.6. The discharge was now—and for the first time since the abortion—of a very offensive odour. I was not alarmed on seeing such a marked change in my patient's condition, as I had seen and treated another case of incomplete abortion in 1894, where these signs of septic poisoning had supervened after the introduction of the sponge-tent into the cervix uteri. I examined the patient per vaginam and found the sponge-tent loose in the vaginal cavity. The cervix was by now found sufficiently dilated to allow of my introducing two fingers into the cervical canal. The uterus and vagina were washed out with a quart of warm carbolic lotion (1:40) by means of a douche and Bogerma's double channel uterine tube. The patient was then placed on the bed in the supine position, and was put under the influence of chloroform. Having previously got my hands thoroughly washed and rendered surgically clean, I now introduced two fingers of the right hand into the vagina, but found the os very high up, and also by using the Binomial method,
I could depress the uterus slightly, still it could not be brought sufficiently low into the pelvis, so as to allow of my fingers passing beyond the internal os uteri. Fortunately, however, I had included a curved volsella amongst the instruments brought with me, and by means of these I grasped the anterior lip of the cervix as high up as possible, and the uterus was brought down to the bottom of the pelvic cavity, and retained in this position by the nurse keeping a firm and steady hold of the volsella. The uterus was by now sufficiently low to allow of my fingers to explore its whole cavity.

At the fundus uteri and extending downwards on its posterior wall, a mass could be felt, which by its position and feel I took to be a retained placenta.

The whole mass was adherent to the uterine wall. I endeavoured to feel it off "en masse" by commencing to detach it with my fingers from below, but owing to its being most friable in some points, though tough and very adherent in other points, I was obliged to separate its connections from the uterine wall in "piece-meal" fashion. I succeeded, however, in this
get out of bed on the 7th April, and on the 8th April came downstairs. The discharge by now had entirely ceased. She gained in strength daily and put on flesh in an astonishingly short space of time. I called for the last time at the end of April, and found her at her ordinary household duties, looking well; and she said she was feeling better and stronger than she had been for the past four months.

**February 1900** - Mrs A. was confined of two healthy children - both females - one born in May 1896, and the other in December 1897. I attended her in these confinements. The labours and puerperium were quite normal.

In August of last year, and whilst on a visit to some relatives in Liverpool, she - without any apparent cause - aborted about about three months previous. She very wisely called in a medical man and a trained nurse to assist on her. She appeared to have got over the abortion in quite a natural manner. There was no hemorrhage or leucorrhoeal discharge or any symptoms pointing to the abortion being incomplete. She came back home on the 14th day after the abortion had taken place, and at once sent for me. I examined her then her vagina, but found the uterus firm and contracted. There was no hemorrhage or leucorrhoea. She continued
to improve and last week (Feb 27th) I called again and found her quite well.

Comments.

This case is of interest and importance from several points of view:—

1st. Because of its Rarity
2nd. On account of its difficulty of Diagnosis
3rd. The absence of septic infection to the patient
4th. Its Pathology
5th. Its Treatment

1st. Rarity of Incomplete Abortion.

Statistics as to the frequency of abortion are incomplete and consequently not satisfactory. Many abortions occur, especially during the first three months of pregnancy, that do not come to our knowledge, and undoubtedly a great number of abortions take place prior to the third month, which are not even suspected as such even by the patients themselves. Therefore, the actual number of abortions must be largely in excess of the statistics of observed cases. Prof. A. R. Simpson says "that Hegar estimated that about one abortion occurs to every 8 or 10 normal births, and that Whitehead calculated that at least 90 per cent of married women, who lived to the

Lectures on Midwifery, Session 1889-1890.
change of life had occurred." All authorities agree that the majority of abortions take place within the first three or four months of gestation.

But as regards the frequency of incomplete abortions, most writers have not expressed a definite opinion. Dr. J. Mathew Duncan in his admirable work on the subject merely states that "cases of retention and absorption of the placenta or of portions of it have been recorded," and further on he gives a full account of five cases of incomplete abortions that had happened in his large obstetric practice. Also Prof. A.R. Simpson records a case in his "Contributions to Obstetrics and Gynaecology." But the literature on imperfect or incomplete abortion is very sparse.

2.5 Difficulty of Diagnosis.

The cardinal symptoms of abortion are: hemorrhage, which is usually profuse; pain; and expulsion of the ovum.

In W.R.'s case, all these symptoms had been present to a greater or lesser degree. The importance of correct diagnosis in the case was of the most vital importance to the patient. The fact that two elderly and experienced obstetricians and general practitioners, had inaccurately diagnosed the condition, was perhaps due to its rarity, and also to the
exceptional and misleading symptoms the case presented. The absence of putrid smell or
fetor in the discharge, and the absence of
septic inflammation up to March 29—date of
the introduction of the sponge-tent—were sym-
ptoms that are not found wanting in the
majority of recorded cases, and the absence
of these probably led my conferees astray
in diagnosing the case.

Fetor of the vaginal discharge is not path-
ognomonic of Incomplete Abortion, neverthe-
less, in the great majority of cases it is
present, and in some to a very noticeable extent.
Dr. Matthews Duncan, writes in treating on this
part of the subject—"Every Obstetrician is
well aware that the discharges from the genital
passage of women are excessively fetid in a
number of different circumstances. All
discharges from these passages have a disagreeable,
strong animal odour. Among the causes
of fetor in the vaginal discharges of
women may be mentioned, — the retention
in utero or in the vagina of menstrual
fluid, an occurrence not infrequent in some
women; the retention of lochia; the retention
of decidual membranes; cancer of the vagina
or uterus; extrauterine pregnancy; disintegra-
ting fibrous tumour; abscess of the

loco cit., p. 274
Genital organs, or in the pelvis; and thrombus or hematocoele in the same parts. These causes do not invariably, or under all circumstances produce feter, but they all frequently do so; and it may be added that tents and pessaries often rapidly induce fetor of the discharges, as well as anything introduced from without that will decompose or lead to retention of matters that readily undergo this change. Consequently, we see that putrid smell of the vaginal discharges is common to many and varied pathological conditions. Further on St. Duncan says—"The absence of feter in some examples of imperfectly completed abortion is very remarkable, and almost unaccountable; and this absence of feter renders such cases less likely to be correctly diagnosed and treated, and makes them in this respect, of much importance. The presence of feter, indeed, ought soon to attract attention, and lead to careful investigation of the case in which it occurs; but, in its absence, there may be no special symptom to lead the practitioner to suspect that the case under his care, is one having any character to distinguish it from the more ordinary uterine ailments."

The fact that the hemorrage and leucorrhoeal discharge could in the case of my patient be
distinctly traced to date from, and follow the abortion, and also the continuous character of the discharge, and the bearing-down nature of the pains— which varied often in intensity—all these symptoms together, I say, should have at least raised a suspicion in the minds of the Medical Gentlemen who first saw the case, that the abortion was not a complete one, and having got thus far, a vaginal and bimanual examination would have told them that the uterus was enlarged and the os prematurely open. These signs, I believe, and even with the absence of fetus in the discharge, ought to have led them to a correct diagnosis of the case.

3dly. The absence of septic infection to the patient, from the retention of the placenta in the uterus, for the long period of three months after the expulsion of the ovum, is also a very interesting feature in my case. Writing on the subject of Abortion in his work on Midwifery, Sir Burns' says: 'While part of the ovum is left, or the whole of the secundines are retained for a considerable time, we have another danger besides haemorrhage; for within a few days suppuraction comes on and much irritation is given to the system, until the putrid substance is expelled. Sometimes, if gestation have not been far advanced, or a piece which is left be

Principles, 1st edit., p. 334.
not very large, it continues to come away in small bits for many months, during the whole of which time the woman is languid, hysterical, and subject to irregular sanguineous discharges or often to obstruction. But more frequently the symptoms are very acute; we have loss of appetite; frustration of strength; tumid or tender belly; frequent, small and sharp pulse; hot and parched state of the hands, skin of the hands or feet; nocturnal sweats, and various hysterical symptoms. The discharge from the vagina is abominably fetid, and hemorrhage sometimes occurs to a violent degree."

Also Dr. Ramsbottom believes "that retained parts of the placenta begin to decompose and to be putrid very early, and at farthest within a period of some days." The absence of putrefaction of the placenta and of septic absorption in my case, is to be attributed and explained, I think, to the complete adherence of the placenta to the uterine wall, and as dust says the placenta continues then to derive nutrient supplies from the uterine blood vessels whilst its connections with the uterus were intact. Decomposition started the day of the insertion of the sponge-tent, and probably septic material was introduced into the uterus through the medium of the tent.

'*Obstetric Medicine and Surgery, 2nd ed. p. 666

"Science and Art of Midwifery, 6th ed. p. 240"
4. **Its Pathology.**

The cause of the retention of the placenta and of its close organic connections with the uterine wall, is to be attributed, I believe, to a syphilitic cause. The husband had an admission of having contracted syphilis two years prior to the date of the incomplete abortion, and the unmistakable secondary signs of syphilis which showed themselves in my patient, and which disappeared under treatment, are proof positive of the woman having been inoculated through her husband. Furthermore, the appearance and structure of the portions of the placenta removed from the uterus, coincided with the description of a syphilitic placenta usually given by obstetricians. Norris says that "a syphilitic placenta is flaker than usual, its colour being pale red, but in its diseased parts it is yellowish-white. Here and there the tissue is firmer, more resistant, compact and friable than normal placental tissue."

5. **Its Treatment.**

The chief indications for treatment in my case were: To check the hemorrhage and leukorrhea, and to relieve pain. These indications could be accomplished only by a complete evacuation of the uterus. Prof. A. R. Simpson in his valuable work on Obstetrics and "Textbook of Obstetrics, Vol. 1, p. 237" and "Contributions to Obstetrics and Gynecology"
Gynaecology, and when treating of the subject under consideration says: "The evil effects of an incomplete abortion are either immediate or more remote. The great immediate risk is the occurrence of excessive hemorrhage, which, though but rarely fatal, is sometimes very alarming, and always leaves the patient in a state of deteriorated health. Then apart from the chances of decomposition of the retained fragments or of the discharges that attend it, and the possibility of septic absorption from the surface where separation may be taking place, the uterus which contains a foreign body remains decidedly hypertrophied, so that when it finally becomes evacuated, the walls may remain permanently thickened and the cavity enlarged. In a patient with the uterus in such a condition, dislocation of the organ easily occurs. Such imperfect involution may easily be the starting point of other morbid changes, and thus it comes about that many of the women who come under observation suffering from utrine affections can trace back the commencement of their distress to an abortion in the early months of gestation." Hence, we see that not only is the patient in immediate danger of life while the discharges continue, but also a woman may become a life long
suffered through other and remote Pathological conditions supervening, which would not have happened had the proper treatment of the abortion been carried out. My patient would most certainly not have stood the effects of the severe drain on her system very much longer, had not the correct diagnosis been made and the proper treatment carried out. The marked and most rapid improvement in the patient's general condition, as shown by the Temperature and pulse rate, after the complete removal of the placenta, struck me at the time as most astounding. The continuance of the low temperature and the low normal pulse rate for days after the operation, are to be attributed, I believe, to the complete evacuation of the uterine contents, and also to the thorough cleansing and disinfecting of the operator's hands and instruments, and to the flushing of the uterus and vagina before and after the operation. The contrast between the old and new methods of treatment in cases of imperfect abortion is well illustrated in a case recorded by Cazeaux, in his work on Obstetrics: "A lady 35 years of age, whom I suspected to be pregnant, although she would not believe it, felt a discharge from the parts after a suspension of the menses for 2½ months, which she at first mistook for
a return of her course, but which after riding out in
a carriage was suddenly converted into a profuse flooding.
Having been summoned immediately, I found the os-
uteri slightly dilated and I forthwith employed various
measures adapted to the arrest of the discharge; and
among others the ergot. The haemorrhage gradually
diminished, and at 10 o'clock p.m. (six hours sub-
sequent to the invasion of the symptoms) it had
entirely ceased. During the first five days the
patient did well, but on the 6th I thought I
detected a slight odour in the lochia, and at three
o'clock in the afternoon a violent chill came on,
which lasted an hour. From this moment all the
phenomena of absorption were manifested. I
immediately administered 40 grains of the ergot,
but without effect; for nothing came away; and
notwithstanding the enlightened efforts of Messrs
Chesnel and Morcan, who were several times
called in consultation, this unfortunate lady
died on the 10th day following the appearance of
the first symptoms. At the post-mortem examin-
ation, we found the uterine tissue softened, and
its cavity filled by the putrefied and still adherent
placenta, which we could not separate without
harming. Had the modern treatment been carried
out in this case, the probabilities are that Mr.
Cogerwa would have had the pleasure of seeing
his patient get over her abortion. I must
express my entire agreement with Prof. A.R. Simpson's method of complete evacuation of the uterus in cases of abortion, viz. by using the volsella to pull down the uterus from above, and I cannot do better than put it down in his own words: "We seize one or other of the lips of the cervix uteri — usually the anterior — with a volsella, double or triple pronged, and slightly curved. One of the blades grasp the vaginal aspect of the front wall of the cervix as high up as the roof of the vagina, the other at a corresponding level within the cervical canal. The uterus is capable of being dragged far down without any injury to its ligaments or laceration in the site of the volsella. It may be pulled down with the right hand, and kept fixed with it, whilst the fingers of the left pass into the cavity and explore and evacuate it. Or the volsella may be held in the left hand, or given to an assistant, to keep the uterus depressed, whilst the more familiar right hand fingers do the intra-uterine work. The cavity of the uterus is thus brought within full reach of the fingers, and we can — and in all those cases of imperfect delivery in the early months we ought to control the emptying of the cavity from the fundus to us. Whilst the method of gaining access to the interior of the uterus by pressing it down from above is that
Which has hitherto been ordinarily followed, my own experience leads me to expect that this second method, which I have just described, will largely supplant it. For, first, it is applicable in all cases where the other can be employed, and in some where the rival method is not available. Second, it is less painful, and may be carried out occasionally when there is not time for the administration of an anaesthetic. Third, it saves the expenditure of muscular power demanded of the practitioner, who presses and keeps the uterine pressed down from above only by overcoming the resistance of the abdominal walls. The one circumstance that will enable the bimanual method to hold its ground is that we may find ourselves called upon to clear out the uterus at a time when we have no volutella at command, whilst our hands are always carry with us. I feel quite arrived that had I not employed Prof. Simpson's method in my patient's case, the work of separating and extracting the placenta from its close connections with the uterine wall, would have been a very tedious and protracted proceeding, and the results probably not so satisfactory. For, by adopting this method, I could with the greatest ease explore with my fingers the entire uterine cavity, and consequently I felt satisfied with the end of the
operation, that not a single portion of the placenta was left behind in the uterus. I must also express my agreement with Prof. Simpson when he states that the finger,—or as Prof. John Chiene used to call it—"the educated finger,"—is far superior to any instrument yet invented, for the efficient detachment of the placenta from its uterine connections.

**24th Case. Triplets; One live fetus born at full term; two dead fetuses; Hydramnios.**

On Sunday morning January 15th 1899 at 1.30, I was hastily summoned to go and see Mrs. E., whom I was told was in labour. I arrived at the patient's house by 2 o'clock, and found her looking very pale and collapsed. She was also shivering and felt very cold; her pulse at the wrist was scarcely perceptible. I soon got an explanation for their state of affairs. For, the nurse who had been with the patient since 4 o'clock the previous night, informed me that about a quarter of an hour before my arrival there, Mrs. E. had given birth to triplets, and that one child was living, but the remaining two were dead, and that the latter stages of labour had been most precipitate, for as soon as the membranes ruptured, a great volume of water rushed out, which was
so great as to deluge the bed and floor. The live child presented by the breach, and was delivered without any trouble or delay; then the two dead foetuses came away and simultaneously with them the placenta was ejected. The patient as soon as this was over then a severe shivering fit came over her, and she felt cold all over the body. The nurse now got alarmed and hurriedly sent a messenger for me to come to her assistance. I applied my hand on the lower part of the patient's abdomen, and found the uterus firm and fairly contracted, and as I could not find sufficient evidence of an unusual amount of hemorrhage having occurred, I gave the patient a hot drink of brandy and water, and applied hot-water bottles to her feet, thighs and loins, and placed three or four blankets over her. The patient soon rallied, and in about 10 or 15 minutes afterwards, the shivering fit had disappeared and was now replaced by a profuse sweating stage; this, however, soon passed off, and in a very short time she was feeling warm and comfortable, and the pulse had again become fairly strong and regular.

I have questioned Mrs. C. as to the history of this most remarkable state of affairs. She informed me that her "courses" had stopped Easter week (second week of April) of the previous year, but that rather a partial "flow"
lasting two or three days and accompanied by pain, had occurred on the 3 ½ week of the following July—without apparent cause. Since this last date and up to the time of her confinement, there had been no loss of blood or any other vaginal discharge, and that nothing unusual had taken place to attract her attention until the beginning of October, when she noticed that the enlargement of her abdomen was altogether beyond that which she thought ought to exist at that period of her pregnancy; in fact, she said that the distension at this time was more than it was at full term in her previous pregnancies. Her most intimate lady friends had remarked to her at this period of her pregnancy, that undoubtedly she was going in for twins; and another person who probably was more mercifully disposed than the others, assured my patient that the Queen's Bounty would certainly fall to her lot this time—a prophecy which proved true. From this time onwards, the abdomen went on enlarging, but during the last two months of her pregnancy, the increase was not so great as it was during the 6th and 7th months. Her patient's power of locomotion was by now sadly impeded, and at times caused her actual pain in the lower part of the abdomen, and which she describes as being
of a dragging down character. She was uneasy in every attitude or position, but most so when lying down. She also suffered from dyspnea and palpitation. Her general health, however, was not impaired during the whole period of pregnancy; but she had passed several restless and sleepless nights. She ridet urine often but sparingly.

On the 26th, continued on in this manner up to Friday morning January 13th, when on getting up from her breakfast table, she felt giddy and dropped back on her chair into a dead faint. She, however, soon recovered and after vomiting back the greater part of her breakfast, she felt well enough to attend to her usual household duties. But she says that throughout that day she felt very queer, having slight intermittent pains at the lower part of her back, but believing that these pains were not true labour pains, she took a good dose of castor oil at 9 p.m. The aperient soon had the desired effect, for the bowels were well moved and then the pains became less severe, so that she passed a fairly good night. Throughout the next day (Saturday), she complained of pains both at the bottom of the back and in front at the lower part of her abdomen, which had by now assumed more of a bearing down character; and at 10 o'clock that night her husband was sent off for the horse. The horse
came as soon as she was summoned. On examining
the patient, she found the os only slightly
dilated and the pains were not frequent and strong,
so that she considered it too soon to send for me.
However, about one o'clock on Sunday morning
the pains got suddenly much stronger and more
frequent, and as previously stated the 'waters' broke
suddenly and everything was over in a very short
time. The patient made a most satisfactory
recovery.

Obstetric History - Mrs. E., aged 44, wife of a
Railway Inspector. Had been married 20 years,
and has had 7 children. One child (a female) died
at 4 years of age of 'Brain Fever.' The remaining
six children are now alive and healthy; the
oldest being 18 years old and the youngest 2 years of age.
All the children were carried to the full time.
The labours and parturition were normal, with the
exception of the first labour, which was protracted,
and the forceps had to be applied to effect the
delivery of the child. Insemination began at
the age of sixteen. Patient has never suffered
from neurosis or dysmenorrhoea; has never
miscarried and there is no history of syphilis.
There is no history of multiple births in her case,
and as far as she knows not in her family.

The placenta was examined and found to
be a double placenta. It was enlarged and
covering a much larger surface than usual. It was composed of two portions, but both were in close apposition and connected together by a thin membranous ridge. The larger portion covered at least twice the extent of the smaller portion, it was of a paler color than natural, edematous and swollen, and had a soft, spongy feel; it was about an inch thick at its thickest part and tapered off at its circumference. Its greatest diameter measured 5 inches. The cord of the live child was attached at its centre. The smaller portion of the placenta was dry and atrophied, of a wash-leather color and of tough consistence, and attached to it at different points were the cords of the dead fetuses.

The bag of membranes was abnormally large, and when inflated assumed an oval shape. It measured in length 14 inches, and 12 inches at its widest part. Judging by its size, I should say it would certainly have contained 2½ quarts of fluid.

The living child lived for 22 hours after its birth. Sex - male. It was poorly nourished and considerably smaller than the average full term fetus. It was not dysmural. It measured in length 15 inches. Weight - 3 lbs. The body was covered with vernix caseosa. The head was covered with long dark hair. The nails of fingers,
and toes were well developed. In fact, although smaller and thinner than a nine months fetus, still it had all the characteristic points of a full term child.

**Dead Fetuses.** I have had these photographed of the natural size. (See photo).

Both were of the female sex. It will be noticed that the fetus to the left in the photo, graph is larger and thicker than its fellow. They are of a dark brown colour—(same colour as the smaller portion of the placenta to which they were connected). They are both much shrivelled and flattened from before backwards. This flattening being due probably to the pressure exerted upon them by the living child and the uterine wall. The skin of the face and body is much wrinkled, and the face in both has a sour aspect. There were no hairs on the scalp or on any other part of the body. The length of the larger fetus is 6 1/2 inches. Weight 28 lbs. Smaller 6 1/4 lbs 80 1/2 lbs.

The epidermis is detached in some parts and may be easily separated all over the body.

The front of the chest is much flattened and the form of the ribs is to be seen. The abdomen is also flattened. The eyeball is to be seen though the ribs and the lobes of the ears are just appearing. The fontanelles and sutures are very large and
and the bones of the head are freely held together, and are easily movable on each other. There is no spine bipida in either fates. The forehead and nose and mouth are clearly seen, and the lips and tongue are well marked. The fingers and toes are distinct, and the nails appear as their membranes. The umbilical cords are thin and cord-like, the spiral turns being very evident; but there is no torsion, knotting or strangulation to be noticed in either cord. In short, the two fates have all the characters of a 2½ month fates.

(I should be very pleased to present these specimens of dead fates to the Gynecological Museum of the Univ of Edinburgh, should Prof. Simpson care to have them for exhibition.)

**Comments.**

**Frequency of Triples.** The frequency of triples varies remarkably in different countries, as the following table of Ciech will show:—

<table>
<thead>
<tr>
<th>Countries</th>
<th>Proportion of Triples to Single Birth</th>
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<tbody>
<tr>
<td>England</td>
<td>1 : 6,720</td>
</tr>
<tr>
<td>Grand Duchy of Baden</td>
<td>1 : 6,375</td>
</tr>
<tr>
<td>France</td>
<td>1 : 8,256</td>
</tr>
<tr>
<td>Ireland</td>
<td>1 : 4,995</td>
</tr>
<tr>
<td>Norway</td>
<td>1 : 5,442</td>
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<tr>
<td>Prussia</td>
<td>1 : 7,820</td>
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<tr>
<td>Russia</td>
<td>1 : 4,054</td>
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<tr>
<td>Saxony</td>
<td>1 : 1,000</td>
</tr>
<tr>
<td>Wurtemburg</td>
<td>1 : 6,464</td>
</tr>
<tr>
<td>Mecklenburg-Schwin</td>
<td>1 : 6,436</td>
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1. *Ciech, Des Naissances Multiples.*
It will be seen by this table that the largest proportion of triplets occurs in Saxony (1:1,000), Russia comes next (1:4,054), and the smallest proportion (1:7,820) occurs in Prussia. Taking the average of cases occurring in various countries, it will be found that triplets occur about once in 7,679 labours.

Several cases of triplets are on record, but I have only been able to come across one instance which resembled my case. This was recorded by Caygans, where one fetus was born at the full time and healthy; the remaining two fetuses were dead-apparently for a long time. Dr. McIlwraith showed to the Edinburgh Obstetrical Society on Dec. 11th, 1867, a large piece of membrane containing two placentas—one apparently a six-month one, and the other a four-month one, which had been expelled after the birth of an ordinary full-sized child and placenta. But as my case differs from those of Caygans and McIlwraith in having also hydramnios associated with triplets—one live and two dead fetuses—it becomes not only interesting and rare but in my opinion quite unique.

Cases of twin pregnancies followed by the death of one fetus are quite numerous. My case shows the possibility of one or more fetuses being dead and retained within the uterus for several months, and conjointly with them—a living.
fetus which continued to live and grow, without interfering with the normal term of gestation.

The fact that in the last week of July 1898, a rather profuse hemorrhage from the vagina occurred and lasted for a few days, would indicate the probable date of the death of the two fetuses, for by this date they would be about 14 months old, and their size and other characteristics tally with a fetus of about 14 months development.

Mr. Cruveilhier explains the atrophy and death of the fetuses, as being due to a gradual separation of the placenta, and his opinion is founded on a case which occurred in his own practice, in which the hemorrhage was great enough to account for the early death of one of the twins. It is quite likely that his explanation of Cruveilhier's is also applicable to my case.

The mother did not feel any sign or symptom which sometimes occurs, when a fetus dies and is retained in utero. Ceylans* thinks, "that the occurrence of the death of one of the twins can only be known after delivery, but that in single conceptions the symptoms are generally well marked."

In the first place an absence of physical signs—especially if previously verified—a decrease in size or stationary condition of the abdomen, the breasts become flabby and shrink; a sensation of weight is often experienced in the uterus, and sometimes

an impression of coldness is imparted; in some cases a watery discharge is present, and when this is observed, it will prove a valuable diagnostic point."

I questioned my patient carefully respecting these symptoms of Isegan, but she denied the occurrence of any of them at or soon after the loss of blood, when about 4 months pregnant. Cohnstein showed that in doubtful cases the thermometer may be used. His propositions may be laid down as follows:

The temperature of the child is higher than that of the mother; the temperature in the uterus is consequently higher than that in the vagina, because in the former the thermometer registers the heat of the mother plus that generated by the child. If the child dies, the latter factor fails, and the temperature of the uterus and vagina become equalised. He gives 5 cases in which a correct diagnosis was made of the life or death of the child by this means. Other Obstetricians have confirmed Cohnstein's observations. Unfortunately, I did not see Isegan at any period of her pregnancy, the first time I became acquainted with her being on the morning of her confinement; consequently, no confirmation by me of the diagnosis of the death of the fetus was possible.

My case is also important, in that it shows the possibility of the retention in utero of a dead fetus or fetuses, for a period of...
several months, and this fact has long been recognized by
many observers; but my case also shows that the
contents of the uterus were not retained beyond
the normal term of pregnancy. Dr. Fox of
Frankfort, reports a remarkable case where the
fetus was retained in the uterus more than 5 years.
And as though time was of small account, Hottger\textsuperscript{2}
reports a case of a woman who thought herself
to be pregnant for 51 years, and whose autopsy being
made, a completely dessicated fetus was found in
the uterus. Still, these cases must be regarded
as very rare exceptions, the general rule being,
that if a fetus dies in utero, it is cast off, if
not at the time of its death, at the expiration
of 9 months.

The case is also important as showing that
the retention of the dead fetus, did not cause
any injurious effects to the mother's health. For
her general health had been very good during
the whole period of her pregnancy, and I failed
to elicit from her, that any symptoms of septic
absorption had taken place subsequently to the
death and retention in utero of the dead fetus.
I find that standard authorities are divided
upon this subject. One side state emphatically
that no bad effects are experienced by the mother,
by reason of a dead fetus being retained
within the uterus. The other side claims that
such a condition will lead to beneficial results. I propose giving here some of the evidence adduced by each side:—

104. Evidence offered to septic infection.

Layeace writes thus: "As a general rule, the prolonged retention of a dead infant does not produce any distinct result to the mother, and I suspect that writers have greatly exaggerated on this point; they say, indeed, that the woman becomes depressed, uneasy, and of a fretful temper; she experiences a sense of alteration of heat and cold, depression at the epigastrium, headache, syncope. Palpitations of the heart; her face is pale, the eyes dull and surrounded by a blood circle; the breath fast, pulse frequent and irregular; in a word, all these general phenomena of a slow fever have been considered by them as so many rational signs of the child's death. But these symptoms are certainly absent in the majority of cases; for most women, after we have succeeded in calming their fears, experience nothing of the kind, and I have known many of them to carry a dead child for several months without even suspecting it, and some even to congratulate themselves upon the amelioration of the sudden disappearance of the sympathetic disorders of pregnancy."

Playfair says: "Certain changes in the mother's health have been noted in connection with the death of a fetus, such as depression and lowness..."
of spirits, a feeling of coldness and weight about the lower part of the abdomen, paleness of the face, a livid circle round the eyes, irregular shiverings, and feverishness, shrinking of the breasts, and diminution in the size of the abdominal tumour. All these, however, are too indefinite to justify a positive diagnosis, and they are not infrequently altogether absent. At most they can do no more than cause a suspicion as to what has happened.

In a report made to the Philadelphia Obstetrical Society, upon a case of "blighted ovum" by Dr. Jenkins, chairman of the committee, the following conclusions were arrived at: "In closing, your committee would call attention to the fact that neither the health of the mother nor that of the remaining child seem to be at all affected by the retention of the blighted ovum, as long as the membranes remain unruptured. In most of the cases, as in the one under consideration, there are no unusual phenomena during gestation, though in few cases the occurrence of hemorrhage, after powerful mental emotion, or produced by some mechanical cause, with commencing labor pains, would lead us to suspect that in these cases more or less placenta apoplexy had taken place; but in the majority of instances, there is nothing in the history of the pregnancy to warrant the supposition of a blighted ovum."

Dusk writes thus: "If the air be excluded from the uterus in cases of retention (dead fetus) indefinitely prolonged, the fetus either becomes mummified, and forming intimate connections with the uterus through the medium of inflammatory products, remain in utero without giving rise to any symptoms, so that the retention of a dead fetus is comparatively devoid of danger."

Evidence in favour of septic infection.

That the lymphatics of the uterus are capable of absorption, no one can doubt. In recently delivered women, septic infection from absorption of putrefying clots and portions of the placenta left in the uterus is no uncommon occurrence. The following condensed report of a case of Dewsay shows that he was acquainted with pernicious effects of the retained fetus: "Mrs. H., at 29, became pregnant about the 1st April 1822. Quickening took place about the 4½ month. About two weeks before the expected time of labour, she was attacked with the usual symptoms of this process. These continued for 10 hours and then subsided; from this time no motion of the child was felt."

The woman, forelaced for several months, and the following record shows the termination of the case. "April 10th 1824 - She was attacked with pain, vomiting, cough, etc., and continued in this way until May 26th, when she died." The post mortem examination agreed. "Obstetrics. 2nd Med. 3rd edit., p. 141"
revealed a full grown fetus. Commenting upon this case he speaks of her as "dying from inflammation and general irritation of the system."

Dr. Fordyce Barker says: "And here I shall remark that I feel quite confident that Schneider and several other writers are in error, when they assent, in substance, that the mother cannot be infected by a dead fetus, if the access of air have been prevented, that is, if the membranes have not been ruptured and the waters discharged."

Dr. Melintock writes: "On a few rare occasions I have seen symptoms present that might, perhaps, have been set down to septicemia, and two cases have fallen under my notice of phlegmasia dolens of one and of both legs, induced apparently by the presence of the dead ovum in utero."

I think we can sum up and draw the following conclusion from our present knowledge upon this subject: In many cases where a dead fetus remains in utero for some time—perhaps several months—the mother's health is not seriously affected by its presence.

The appearances of the dead fetuses in Mr. C.'s case show that as a result of their death and retention in utero, a peculiar pathological change called "mummification" had taken place. The fetuses, when born, were quite free from any putrefactive change, as is proved by their having no bad odour, and

probably this is the explanation why no injurious effects were experienced by the mother during their sojourn within the uterus for about 5 months. The mummification change in the fetuses is to be attributed too, I believe, to the fact that the bag of membranes remained unruptured up to the time of labour, and consequently the fetuses were in this way protected from the external air. If the membranes became ruptured some time before the full term of pregnancy had been reached, air would then have had access to the fetuses and uterine cavity, and putrefaction change, together with symptoms of septic infection would probably have ensued, and the mother’s health would thereby have suffered. The liquor amnii is also supposed—owing to the large amount of salts it contains in solution—to be an element in preventing decomposition taking place.

Pathology of Hydramnios.

The literature on this subject is very extensive, but little seems to be definitely known of its precise cause. All authorities agree that “Hydramnios occurs more frequently in multipara than in primipara—23 to 5. It is more frequent with female than with the male sex, in the proportion of 25 of the former to 8 of the latter, and more frequent in multiple than in single
frequencies." The amniotic fluid varies considerably within normal limits, still most writers agree that when the amount of fluid exceeds 2 or 3 pints, it produces pressure symptoms upon the abdominal organs, which consequently causes inconveniences to the patient, so that Hydramnios may then be said to be present. Cases have been recorded where more than 20 quarts existed. Hydramnios appears to be very unfavourable to the well being of the fetus, as 9 of the children were dead born, 5 of which were in a_header condition, and 10 of the live children died within a few hours after birth. Some writers state that the cause of Hydramnios is of fatal origin; others say it is of maternal origin. Prof. A.D. Simpson has recorded two cases where the cause of the Hydramnios was due to malformations of the foetus - (dispariety affection of the cerebro-spinal system).

McClintock says that out of 33 of his cases of Hydramnios, 1 in 6 of the children presented some unnatural or morbid condition, such as hydrocephalus, atrophy &c. Merriman, Lee, and others attribute Hydramnios to a morbid state of the mother, and particularly to the effects of syphilis. There is no marked relation between this morbid condition and a general disproxiiris affliction of the mother. The theory that the disease is of a purely local origin, is favoured by the fact that it frequently occurs with twins, and one-fatio

1McClintock, Diseases of Women, p. 393. 2Loc. cit. p. 386.
6Theory of Dispersing the Blood.
only then being affected. Charpentier mentions a case of Hymarmos where the placenta was found to be diseased to a third of its extent. My case resembles this one of Charpentier's, inasmuch that as far as I could find out, the cause of the Hymarmos was due to the morbid condition of the larger portion of the placenta, and to which the live fetus was connected. This part of the placenta was large, thickened and edematous and had a soft spongy feel. On the other hand, the appearance of the dead fetuses and of this portion of the placenta, showed them to be dry, shrivelled and of a very pale colour; characters which do not coincide with the cause of the Hymarmos being of fatal origin. The appearance and stage of development of the dead fetuses, show them to be about 4 months, frequently old when they finished in utero. At this period of pregnancy (6th month), the mother did not feel or notice any symptoms pointing to Hymarmos; in fact, at this time she did not observe that the size of her abdomen was larger than it should be at this period of her pregnancy, and it was not until about the 6th month of uterine gestation that she and her friends noticed the abnormal size of the abdomen. This fact is suggestive that the Hymarmos was not the cause of death of the fetus, and also that the Hymarmos owed its origin to the morbid condition of the dead fetus or to their portion of

Traité pratique des accouchements, par Dr. Charpentier, p. 586.
the placenta. The history of a rather profuse hemorrhage having occurred when the patient was about 14 months pregnant, is probably the true cause of the death of the fetus. The dead fetus were not cast off, because the development of the uterus is kept up by the stimulus of the living fetus (theory).

I wish, in concluding, to mention the severe shivering fit which came over the patient directly after the 3rd stage of labour was over. I have not seen this symptom stated by any writers in connection with this subject except by Prof. A.R. Simpson. Had the supervision of this alarming symptom not taken place, I doubt not peradventure have been called to the case, with the result that the history and description of this most remarkable and rare case would not have been written. For the nurse had no difficulty with severe in dealing with the 2nd and 3rd stages of labour, these stages being so very precipitate. I should therefore offer my gratitude for the welcome appearance of the 'shivering fit' as being the means of giving me the opportunity of describing the case.

3d Case - Hydrocolpos Gravidarum.

Miss W., at 29, married, consulted me on the 16th January 1899, complaining of a thin, watery discharge from the vagina, which was intermittent and had lasted for two months.

History of Present Illness. The discharge commenced the second week of November, and when the patient was four months pregnant. At first, the condition did not alarm the patient. At its commencement, the discharge was thin, watery, and had a peculiar sickening odour. For some days, she would be free from the discharge, but when it did occur, it came on suddenly and without any warning, and lasted for one or two days only, and the quantity lost at each interval of its appearance amounted to only a few ounces. The flow was not preceded, accompanied, or followed by pain, and her general health was not impaired.

Towards the end of December, the discharge became more profuse, and lasted three or four days, and by this time, it was slightly yellowish in colour, and at times tinged with blood leaving stains on the patient's linens. At this time, the patient was not free at a time from the discharge for more than two or three days. During the last week or two, the patient had noticed that the discharge was greater at night during sleep, and now becoming alarmed at its persistent nature and its more frequent appearance, she consulted me as above stated.
Patient's Previous health has been satisfactory, except that for 4 or 5 months previous to the date of her marriage, she was troubled very much with a leucorrhoeal discharge, and suffered much pain for the first day or two of her "unwell times." But she does not think that the leucorrhoea had produced any marked effect on her bodily health and strength.

Obstetric History. Patient was married the first week of August 1893. Menstruation commenced when she was 15 years of age, and her menstrual periods had always been quite regular previous to her marriage. She was last "unwell" the last week of July 1898. She first felt the "quickening" in the middle of the following December.

Present condition. Patient is short in stature and of a light build. She is extreme-looking and slightly emaciated. The abdominal enlargement—due to her frequent condition—is very set evident. Pulse 70, regular and fairly strong, not intermittent. Temp. 98.6.

Family Health. Her father died of Pneumonia pulmonalis at the age of 42. Her mother died of carcinoma of the stomach in August 1897. Patient is the only child of the marriage. Her husband looks and feels strong and healthy, and has always enjoyed excellent health.

Physical Examination. I examined the patient on the day she consulted me. The breasts
were enlarged and firm, and milk could be easily expressed from both nipples.

On examining the patient (nox vagina), I found the os uteri softened but not very patent, the point of the index finger could not be pressed within the external os. By the bimanual method, I could distinctly feel the uterine to be enlarged, and the fundus uteri was slightly below the level of the umbilicus. The fetal heart sounds could be faintly heard at a point midway between the umbilicus and the anterior superior iliac spine on the right side, but the rate of the pulsations could not be counted.

Diagnosis. There was no doubt about the presence of pregnancy in this case. The hydromatous was the most interesting feature of the case. When the patient mentioned about the thin and watery discharge, the first thought that crossed my mind was, that the discharge was the amniotic fluid; but when she said that the fluid had been coming on intermittingly for the past two months, and was not accompanied by pain, and the vaginal examination showed that the os uteri was not patent, and since the pregnancy was continuous, I altered my opinion and diagnosed the discharge as hydromatous gravidarum. I informed my patient of the diagnosis that I had arrived at, and advised her to take complete rest, esp.
icularly during the appearance of the flow, to avoid all kinds of physical and mental excitement; to live on plain, unstimulating food; to see that the bowels were relieved gently and naturally every day. I also prescribed for her some Heim in the form of a pill—go 4 each, one to be taken every 4 hours whilst the discharge lasted. The patient promised to carry out my instructions. I told her that in three days' time I would call and see her. However, on the evening of the 18th January, a lady friend of I mounted to see her, and on this friend being informed of the intermittent and watery discharge, she told her that she had been the same when pregnant with her second child, and advised my patient to adopt the treatment which she maintained had cured her, viz.: to have the vagina washed out once daily with an astringent solution, containing alum, one teaspoonful to a pint of warm water. Mrs. W. being young and very easily impressed, and thinking that since the pills which I had prescribed and which she had taken regularly the last two days had not cured her of the discharge, she yielded to her friend's request, and on the following morning the services of an untrained woman were requisitioned to carry out the washing treatment. The nurse appeared to have not only thoroughly
cleansed the vagina by means of the syringe and lotion, but also had excited strong uterine contractions, so that in a few hours afterwards the watery flow came out of the vagina in gushes, saturating the patient's clothes, and the patient now noticed that the discharge was of a much redder colour than previously, and that it was followed by sharp pains situated in the lower part of the back - the patient was naturally become alarmed and I was hurriedly sent for at 3 p.m, and upon my arrival at the patient's house, found that the "much thought of nurse" had disappeared, and the patient was left with only a young servant girl to comfort and attend to her. 

I...gave me the above described account of the old woman's treatment and its consequences. I told my patient that in all probability a miscarriage was pending. I got her to bed, and on making a per vaginam examination found that the os was sufficiently dilated to allow of my index finger being inserted within the cervical canal, and the bag of membranes could be felt at the point of the examining finger. The child was present, by the head - I administered a hypodermic injection of morphia to the patient and sent the husband (who had just arrived home) for a trained nurse. The nurse soon arriv...
and I gave instructions to have the patient kept very quiet in bed, and should the pains become stronger and more frequent, to send for me at once. I was not called there again until 8 p.m. of the same day, and on my arrival found that the child had been born a few minutes before I arrived, but that the placenta had not come away. The nurse informed me that the pains had become much stronger about half an hour before I was sent for, and as soon as the pains got stronger, the 'fantes' burst, and the child was born in a few minutes afterwards.

I had no difficulty in getting the placenta away, by compressing the fundus uteri through the tubo-mesial walls (Credé's method). The child (a female) lived for four hours after its birth. She was light and very emaciated, its size and stage of development corresponding to a fetus of six months' growth.

The placenta presented a very normal appearance. It was normal in shape and size for a placenta of a six months' pregnancy, but very pale in color, soft and friable. It was a very good specimen of fatty degeneration of the placenta; for, almost throughout its entire extent, large and small yellowish masses of fat were to be seen embedded in connective healthy placental tissue. I examined the bag of membranes carefully, but failed to find traces of an old rupture in it.
The patient made a quick and satisfactory recovery. The lochia during the first 3 days of the puerperium were very profuse and had a very fetid odour. The uterus was washed out daily with a strong solution of corrosive sublimate (1:6 000). On the 4th day the discharge became less in quantity and the odour less pronounced, and by the 8th day of the puerperium the discharge had almost entirely ceased and no disagreeable odour could be perceived. The most interesting features during the puerperium—(in addition to the presence of the fatal lochia)—were the absence of symptoms of septic infection to the patient, as was shown by the temp. and pulse rate, which were normal throughout.

**Comments.**

*Frequency of Hydronema Gravidarum.*

Cases of this momentous condition associated with pregnancy have been recorded by several obstetricians. Priestley says: "Hydronema is a somewhat rare condition, only 70 cases having been collected in the most recent essay on the subject." All writers agree that Hydronema is most commonly met with in multipara, and is also more common during the latter months of pregnancy, although it may happen in the early months of utero-separation— but this is rare. They also state that Puerperal Severe accompanied by Hydronema generally progresses...

"Pathology of Infant Mortality, p. 90."
favorably to the full period. Hence, the case is of interest, inasmuch as it differs from the majority of cases of Hydrotheca recorded:

1st. Because it occurred in a Primipara, and
2nd. Because it made its appearance during the early months of pregnancy.

I am not prepared to go so far as to state that the pregnancy would probably have gone on to the full time, had not the untrained nurse interfered and excited uterine contractions by doucheing out the vagina in the manner described; but I am inclined to believe that under the most favorable conditions and precautions, the pregnancy would not have proceeded beyond the 7 and a half month, and for the reason that the appearance of the placenta showed signs of very far advanced fatty degeneration almost throughout its entire extent. In all probability by the 7 and a half month of pregnancy, the placenta would have become so completely diseased, and so seriously interfere with the nutrition of the fetus, as to cause its death and premature expulsion from the uterus. The fetus when delivered bore distinct evidence of extreme emaciation—its being puny and very emaciated—and doubtless this deficient development in the fetus is to be attributed...
to the morbid condition which the placenta presented.

**Pathology.** The Pathology of Hydrothorax has given rise to much discussion, and very much has been written on the subject. A great diversity of opinion has been expressed with regard to the source of the fluid. According to Hegar, the fluid comes from the cavity of the decidua, which he states is a secreting membrane even during pregnancy, and that Hydrothorax is only a hyper-secretion of this membrane depending on chronic inflammation of the decidual glands. Playfair writes thus: "By some it is attributed to the rupture of a cyst placed between the ovum and the uterine walls; Baudeloque referred it to a transudation of the liquor amnii through the membranes; while Burgess and Dutrois believed it to depend on a laceration of the membranes at a distance from the os uteri. More recently, more recently, he attributed it to the existence of a sac between the chorion and the amnion." But I think that the theory which best explains the source and seat of the Hydrothorax in my case, is the one advocated by Anville, who states: "That the fluid which escapes in the course of gestation had accumulated between the inner uterine surface and some portions of the membranes that were detached, and that the fluid secreted by

The internal surface of the organ gradually detaches the membranes, thereby forming a pouch for itself until its constantly increasing quantity succeeds in separating them as far as the neck, when an interruption of the liquid takes place. In my case there can be no doubt that the mucous membrane of the uterus was in an unhealthy condition before conception took place, as shown by the leucorrhea discharge from which the patient suffered for several months during the early part of the year 1848, and a short period prior to her marriage. Also during the first 3 days of the menstruation, the lochia were so intensely thick, that frequent douching of the uterus and vagina was necessary in order to diminish the foul discharge, and this fact, I believe, confirms the view of the diseased condition of the uterine mucous, and indirectly gives a clue to the seat and source of the Hydrohceal gravidarium in my case.