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Three Cases of Rupture of the Uterus

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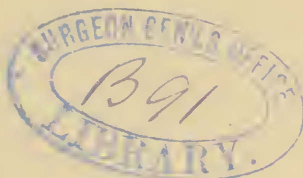

THREE CASES OF RUPTURE OF THE UTERUS.

BY THEOPHILUS PARVIN, M. D.,
Indianapolis, Ind.

The three cases of uterine rupture which I have grouped, occurred in parturition. They illustrate three of the causes of this accident, and they also repeat the common proofs of its terrible mortality.

As to the frequency of rupture of the parturient uterus, statistics and statements have given various results, as one in 940,[1] one in 1,300 or 1,400,[2] one in 1,331,[3] one in 2,433,[4] one in 3,403,[5] and less than one in 4,887.[6] Johnson and Sinclair[7] state that in 13,748 deliveries, the accident occurred seventeen times, or once in a little over 800.

The accident is probably much more frequent than the larger of these proportions would lead us to believe. The number of cases of rupture would, I am persuaded, be greatly increased if, first, known cases were published, and second, if unknown cases were discovered. The first statement is so obvious that it needs neither proof nor comment. As to the second, the testimony of Baudelocque was that he rarely made post-mortem examinations after craniotomies, without finding either ruptures or severe contusions of the uterus.

Case I. *Rupture from mal-presentation.* — The history of the first case, for which I am indebted to my friend Dr. I. C. Walker, illustrates mal-presentation as a cause of uterine rupture, and is briefly this.

When I was called to Mrs. G., a stout, healthy German

[1] Burns. [2] Ingleby. [3] Churchill.
[4] Lehman. [5] Jolly. [6] Ramsbotham.
[7] *Practical Midwifery*, London, 1858.

woman, about forty years of age, the mother of six living children, the physician in attendance stated that she had been in labor forty-eight hours, that the pains had become quite active, but had abruptly ceased six hours previously, and that there was a shoulder presentation which he had vainly endeavored to correct. The pulse was 150, the respiration hurried, and the countenance expressive of great distress and prostration. The rupture was upon the right side of the uterus, and the child had partly escaped into the abdominal cavity. There was no difficulty in turning and delivering. The child of course was dead, and the patient died five hours after delivery.

CASE II. *Rupture from fetal deformity — Hydrocephalus.* — Mrs. C., a healthy woman, thirty-five years of age, who had given birth to seven children and had one miscarriage, was taken in labor on the evening of April 9, 1878. The pains were tormenting but inefficient, and dilatation exceedingly slow, so that it was not until twelve o'clock the next day that a satisfactory digital examination could be made, when the head was found unusually large. By 1 P. M. the pains had become quite severe, but after a terribly intense pain ceased altogether. They did not return, although the patient made frequent voluntary efforts. A thorough examination convinced Dr. McShane[1] that the infant was hydrocephalic. Dr. G. N. Duzan, one of the ablest practitioners of the State, was summoned. Upon his arrival at 5 P. M. he perforated the head, evacuating about a quart of fluid, and delivered. Immediately after removing the placenta he was struck by the woman's remarkable pallor and evidences of prostration.

At once thinking of concealed hemorrhage, he introduced his hand into the uterus until it came in contact with the liver,[2] there being a rent of not less than six inches in the

[1] I am indebted to Dr. J. T. McShane, of Carmel, Ind., who had charge of this patient, and to Dr. G. N. Duzan, the consultant, for this report.

[2] Dr. Duzan's experience reminds one of a passage in Blundell's *Lectures on Midwifery*, where this eminent obstetrician describes his pass-

fundus and right side of the uterus. Nevertheless, the patient lived for thirty-eight hours.

CASE III. *Rupture from improper administration of ergot.* — On Wednesday, July 3, at 1 P. M., my friend, Dr. T. N. Bryan, requested me to visit with him a case of ruptured uterus to which he had been called in the morning. The patient, a robust Irish woman, was thirty-five years of age. She had been taken in labor at 9 on the previous evening. Two former pregnancies had occurred, but the children were still-born. In this third labor a German midwife, at 11 P. M., two hours after the commencement of labor, was sent for. The midwife at 1 A. M. called in a doctor who was associated with her in obstetrical practice.

She represented both then, and subsequently, that the presentation was of the vertex, and that the labor was making favorable progress. Nevertheless two doses, each of a drachm, of the fluid extract of ergot were given at half an hour's interval. The pains were frequent and severe until 3 A. M., and then ceased.

Dr. Bryan found her at 6 A. M. with a feeble, rapid pulse, and complaining of great abdominal distress. She was vomiting every few minutes, and there was some external hemorrhage. The doctor recognized the nature[1] of the accident, and the patient rallying somewhat, and her friends consenting to have efforts made for her delivery, I was summoned.

I found the patient lying upon her left side, her greatest distress being referred to the left iliac region, and its vicinity. The utero-fetal tumor was directed somewhat obliquely from this to the right. Introducing my right hand gently and gradually into the vagina, it first came in contact with a fold of intestine; then passing it on and direct-

ing his hand through a rent in the uterus — for the purpose of reaching the feet to turn — when "he perceived the intestines, felt the beat of the large abdominal arteries, touched the edge of the liver," etc.

[1] When Dr. Bryan suggested to the midwife and her assistant that there was a rupture of the womb, the latter naïvely replied: "It was quite likely He had seen several cases of the kind."

ing it towards the left side of the false basin, I reached the child's right hand, and further up the head. A few minutes' careful examination satisfied me that there was a lateral rupture of the uterus and also of the vagina, that the head and shoulders had escaped through this aperture, but that it was ample for their return without the least violence. Then turning my hand into the uterus, and carrying it upward and to the right, I touched the right knee of the child, and hooking a finger over it, soon succeeded in bringing the foot to the vulva.

Version was then readily completed, and with Dr. Bryan's skillful assistance the delivery of the child, which evidently had been dead some hours, was soon accomplished. Dr. Bryan removed the placenta without difficulty, and but trifling hemorrhage ensued ; no prolapsed intestine could now be discovered, and the uterus seemed fairly contracted. The very night after the accident, the patient's attendants permitted her to get out of bed and sit in a chair for half an hour ! In the treatment of this case, opium and quinia were used, ice-bags to the abdomen, and injections of a solution of carbolic acid. Her temperature only once rose as high as 103°, and most of the time varied between 101° and 102°. The pulse for one day was less than 100, and the bladder and bowels were evacuated spontaneously. Early Friday night she was seized with violent vomiting, and it continued through the night. Most carelessly and unfortunately neither Dr. Bryan nor I was sent for. From that night she commenced to sink, so that all hope of her recovery was lost, and she died a little more than four days after the rupture occurred.

In reviewing the history of the case, my belief is that this patient would probably have recovered had she been properly nursed.

According to Velpeau,[1] Albucasis first mentioned a case of rupture of the uterus ; then Plater[2] one in 1584, and

[1] *Traité Complet de l'Art des Accouchemens.*

[2] Plater's case was the concubine of a priest.

Fabricius de Hildanus cites an analogous case observed in 1593, and adduces two others from Cornarius; "but Guillemeau seems first to have comprehended the nature of the phenomenon which his predecessors had only indicated."

In regard to the etiology of uterine rupture, may we not sum up the intrinsic causes — of course all violent manipulation and all use of instruments are excluded — in this statement: want of correspondence between the uterine force and the resistance it attempts to vanquish. Thus there may be weakened muscular fibre in some part of the uterus; uterine force is exerted, resistance is greater and the weak fibre gives way. Or again, the pelvic entrance is blocked by a hydrocephalic head, or the pelvic cavity packed by a shoulder, and the uterus, roused by this resistance impossible of removal, is ruptured in the vain effort. Or the uterus, equal to the gradual propulsion of the descending head or the slow dilatation of the mouth, is called upon, when goaded to unnatural activity by ergot, to accomplish in a few minutes that which nature designed should occupy hours, and rupture is the result.

Duparcque in his classic work [1] has placed this first among his "conclusions" as to rupture of the body of the uterus in labor: such ruptures have for their determining cause uterine contractions.

And our own eminent countryman and fellow-member, Dr. Trask, who has studied the subject so thoroughly, observes: "Unless caused by direct violence, rupture must, in almost every case, be the result of the contraction of the uterine fibres, whether the uterus be healthy or diseased." [2]

Dr. Tyler Smith [3] remarked, in referring to the causes of rupture of the uterus: "I do not think sufficient prominence has been given to uterine motor action, which, in many cases, is the sole cause of the mischief, and which plays an important part in all." And, again, in the same lecture:

[1] *Histoire Complète des Ruptures et des Déchirures de l'Utérus, du Vagin et du Périnée.* Paris, 1839.

[2] *American Journal of the Medical Sciences*, vol. xv., 1848.

[3] *Lancet*, October 28, 1848.

"Undoubtedly cases of rupture of the uterus do occur which are dependent upon softening of the uterus from inflammatory action, either during or before labor, or upon malignant disease of the uterus; but such cases are rare when compared with rupture from self-contraction of the uterus."

Playfair,[1] by the way, in referring to Tyler Smith's views, attributes to him the assertion "that ruptures are relatively as common in first as subsequent pregnancies." On the contrary, I read Tyler Smith as saying,[2] "It is an interesting and remarkable fact that ruptures of the uterus seldom happen to primiparous women." Be this as it may, and to return, confirmation of Tyler Smith's views as to rupture occurring in certain cases without there being any structural change in the uterine walls to explain the accident, was given by Dr. Robert Barnes when he asserted [3] "that he had carefully examined the tissues in three cases of rupture, and he had found no more degeneration than that normal amount of granular change of the fibre-cells which always existed toward the end of pregnancy as a preparation for solution of the tissues about to become superfluous; certainly, then, although degeneration of tissue might sometimes be present, it was not a constant or necessary condition."

On the other hand, Dr. Angus McDonald makes a statement in almost direct contradiction. He says,[4] "For, as rupture of the cervical portion forms nearly the whole of the cases of uterine rupture, seeing that both experiment and clinical observation agree in leading us to the conviction that spontaneous rupture of the body or fundus is impossible if the uterine tissue is healthy, if we have fully mastered the mechanism by which cervical rupture is brought about, we have been able to explain the great bulk of uterine ruptures."

[1] *System of Midwifery.*

[2] Op. cit.

[3] *Trans. Obst. Soc.*, London, vol. x., p. 45.

[4] *Trans. Edin. Obst. Soc.*, vol. iv., p 431.

Certainly the first part of Dr. McDonald's statement, viz.: "rupture of the cervical canal forms nearly the whole of the cases of uterine rupture," finds no support in the statistics of Dr. Trask. Those statistics show that of 148 cases of rupture occurring (21) in gestation, and (127) in parturition, seventy-six were of the fundus and the body, and only seventy-two of the cervix, involving more or less of the body and of the vagina.

It is not necessary to enlarge upon the special causes — mal-presentation, fetal deformity, and ergot improperly given — that produced rupture in the cases I have reported; for obstetric literature has often had similar testimonies.

In regard to the treatment of this accident, but few words will be said. That treatment has varied from doing nothing to gastrotomy. Each of these two can boast some extraordinary results. Thus, Lambron,[1] of Orleans, in 1775, performed gastrotomy in a case seventeen hours after the rupture; in 1779 he repeated the operation upon the same patient, and in 1781 she gave birth to a living child *per vias naturales.* On the other hand, Dubois[2] narrates a case where rupture occurred, and the escaped infant lodged in the right hypochondrium, the patient recovering. A new pregnancy was followed by rupture, the second child finding a lodgment in the left hypochondrium. One was finally removed by an abscess, the other by incision.

Just now the advocates for gastrotomy in this accident are presenting their views with signal ability. The teaching of Levret and Baudelocque is revived, revived too when the large experience of ovariotomists in abdominal surgery has given priceless wisdom to guide and sustain it.

Nevertheless, while gastrotomy must be admitted to be the best course in case the fetus has entirely escaped into the abdominal cavity, and where it has partially thus es-

[1] Duparcque, op. cit. The first successful gastrotomy, on account of uterine rupture, given by Duparcque, was Thibault's, in October, 1767.

[2] Velpeau, op. cit., ii., 199.

caped and cannot be returned to the uterus without violence; yet if the rent involve merely cervix and vagina and thus present abundant opportunity for drainage, is it not best to deliver by forceps, by craniotomy, or by podalic version? On the other hand, let the rupture be large and high up, may not gastrotomy be advisable to remove effused blood, etc., from the peritoneal cavity because there can be drainage?

The researches of Dr. Robert P. Harris certainly present gastrotomy in a more favorable light than would have been supposed. That seventy-five per cent. of the mothers may be thus saved is indeed a most encouraging statement.

Finally in utterance, though first in practice, the prevention of the terrible accident is chiefly attainable, I believe, holding the creed of Tyler Smith, by the golden rule of moderating excessive reflex motor action; when these turbulent waves of contraction are beating in vain against unnatural barriers — of calming, if need be, with chloroform or other anesthetic, with opium or other anodyne, with bleeding or other sedative — and of removing those barriers.

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