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ON

Uterine Hemorrhage

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BY

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To

John W. Watson, M. D.

Professor of Obstetrics and the

Diseases of Women and Children

In The

University of Nashville,

These pages are respectfully in-

-scribed in grateful remembrance

of his talents as a teacher, and

his Kindness as a Student Friend.

By the Author

Uterine Hemorrhage

I have Selected the Subject of Uterine Hemorrhage upon which to write my Thesis. It is perhaps my duty to precede what I shall have to say on this Form of Hemorrhage by a brief description of the Anatomy of the Uterus.

The Uterus is Situated in the Cavity of the Pelvis, at the upper extremity of the Vagina, with the Bladder before and the rectum behind. It is Muscular in its Structure, and the Cavity is triangular, and Lined by a fine Membrane. The Uterus is generally from 2½ to 3 inches in Length, rather inclined to be pear Shaped, Somewhat flattened, with its Small extremity hanging in the Vagina. It is divided into Fundus body and neck, has three openings two leading from about that portion where a Line would divide the Fundus

from the body into the Fallopian tubes;
The other is at its neck.

The Fallopian tubes are connected with the Uterus on either side. They are small hollow tubes four or five inches long. with the Uterine Extremity small, and terminating at the other extremity in an opening of some capacity, which is surrounded by an uneven fringe called fimbriae.

The Ovaries are situated in the folds of the lateral or broad ligaments near to the abdominal Extremities of the fallopian tubes, one on each side, They are two small roundish bodies about the size of an Almond or Nutmeg, and are the seat of Conception.

The Ligaments of the Uterus are the posterior or Utero-Sacral, the broad and the anterior or round.

The Anterior or round ligaments, arise from the superior and lateral parts of the Uterus, Down in the doubling of the broad Ligaments,

Cross over the brim of the Pelvis, through the abdominal Ring and Canal and loose themselves in the groins,

The broad Ligaments are duplicatures of the Peritoneum, as it passes from the Uterus to the Lateral portions of the pelvis, one on each Side,

The posterior or Utero-Sacral Ligaments take their origin from the posterior part of the neck of the Uterus, near its middle, diverge and rise towards the middle of the Lateral Edges of the Sacrum, and are lost in the Cellular membrane Covering that bone.

The Uterus is supplied with Blood by the Spermatic and Uterine Arteries, and with nerves from the Aortic plexus, and from the hypogastric nerves and plexus, being a mixture of Sacral Sympathetic nerves,

But

of all the Foetal appendages which are highly Essential, it is perhaps of the most importance to understand

the Medium of Communication between the Mother and her Child (The Placenta); the organ through whose means nourishment is supplied, growth perfected, and life sustained. The placenta consists of a somewhat flat irregularly circular, soft or spongy mass entirely made up of arteries and veins with the exception of a mixture of a pulpy or cellular substance. Of the vessels, there are two orders, strongly interwoven with each other. The first is a continuation of those from the funis, which ramify on the internal surface of the placenta; the arteries running over the veins, which is a condition peculiar to the placenta, and then, sinking into its substance, communicate with each other, and divide into innumerable small branches. The second order proceeds from the Uterus, and divides or ramifies in a similar manner, with those of the funis. The veins of course in their divisions accompany

the arteries as in other parts,

The Placenta, is attached to the Uterus by the interventions of the Connecting membrane. It may be attached to any portion of the internal surface of the Uterus, but is most usually placed against the upper surface of the body occasionally at the very fundus, more rarely towards the neck, and still more seldom over the mouths of the Womb itself. In which latter Condition, its situation, must necessarily give rise to a great loss of blood, when its orifice opens in Labour.

This brings me to the direct consideration of my subject

Uterine Hemorrhage

Hemorrhage is when properly considered a source of frequent and alarming danger to the parturient woman. When we recollect it is so common an occurrence, is so terrifying in its character, and so destructive in its operation, this unforseen occurrence

claims our Special attention, Hence the importance of being thoroughly acquainted with the nature of such an alarming accident, as the one we are about to consider, as well as the most efficient means of relief (to the fainting and unfortunate Female) that Nature and Science have placed at our Control.

There is no period at which hemorrhage may not happen after the first Month of Uterogestation. But what I shall have to say, upon this subject will be directed to hemorrhage occuring during and after delivery. This may be accidental or unavoidable,

I will first enter upon the consideration of accidental, or when the placenta is in its usual situation, but from some unknown cause, is partially detached from the Uterus, either before or after Labour has commenced,

In proportion to the Separation will be the danger present from hemorrhage.

The Causes that may be enumerated, as producing so much alarm and terror from Flooding, may be either Exciting or remote, instances such as falls, blows, violent shocks, &c &c, may have the effect of a partial seperation of the placenta from the Uterus, thereby exposing the blood vessels, and giving exit to the vital fluid. Other causes than those already enumerated, might be mentioned, such as lifting heavy weights, excessive Exercise, fatigue, straining at stool. Indeed excessive Utero placental contractions, plethora and spasmodic action of that portion of the Uterus, to which the placenta is attached

Symptoms

The Exciting Causes may be followed immediately by a gush of blood, or it may be preceded by dull pains in the back and abdomen or by general as well as local uneasiness. If the blood should be retained, by rigor tension, weight in the lower part of the abdomen, faintness, &c. The discharge will

(at length) show itself, either with or without pain; the quantity thus discharged, will vary from a few ounces to a sum sufficient to produce syncope. On the occurrence of syncope the discharge ceases, but to be renewed, as soon as the patient recovers from the state of faintness into which she has fallen.

These fainting spells may be repeated from one to two or three times, if the bleeding be not arrested. The skin becomes covered with a cold and clammy perspiration, sunken countenance, pulse quick and fluttering, and most generally a dark circle around the eyes. &c

And if the flooding is not arrested - all of the above named symptoms will increase; with slight dimness ringing in the ears, sighing or groaning, jactitation and death.

Death may be preceded by fainting or convulsions.

In this form of hemorrhage, the accession

of labour pains, will check the flow, which is again renewed when the pains become very weak or cease. a great deal depends, upon the period of gestation at which the hemorrhage occurs, &c. If before the commencement of labour, we institute a vigiual examination, the Mouth of the Uterus, will seldom be found open or even dilatable unless the hemorrhage be excessive, or it has been flowing for a considerable time, then it is that it may be dilatable.

Diagnosis

It is not very difficult to settle in our minds the difference between this and unavoidable hemorrhage, as we are generally able to trace the accidental to some probable, if not known cause. The importance of being able to distinguish this from unavoidable is very great as the treatment differs materially. But as before stated we can usually trace this to some External and exciting cause, and another means of great utility to us in forming our

Conclusions in this form is: That there is an arrest of hemorrhage during Uterine Contractions, or Labour pains, while in the other there is an increase of hemorrhage during the same, With this light upon the subject there certainly cannot be much danger of an Error in diagnosis,

Treatment

This will depend upon the period of gestation at which the flooding occurs, The state of the Os-Uteri, and the Amount of discharge. It is therefore certainly necessary, if there be much hemorrhage, to ascertain as soon possible the State of the Mouth of the womb.

If the patient has not gone her full time, and she experiences no pain, the Mouth of the womb not dilated nor dilatable, we should direct, that she be placed in the horizontal posture, upon a firm, hard and unyielding matress. that she keep perfectly quiet, thinly covered, the room well Ventilated, and allowed

as much ice water to drink as she desires. we may then give some acid mixture, as that, one laid down in Churchills Midivifery- to wit, Sulphuric Acid and infusion of Roses- or we may give large doses of Acetate of Lead, or Opium in large doses, or small ones frequently repeated,

And as before stated let the patient have as much cold drink, as she desires, to which may be added Nitrate of Pottash, and if the bowels be costipated, it is best to relieve them by injections, as the relief will be more prompt, and at the same time saving the exertion for their Evacuation.

If this does not put a stop to the flow, we may resort to the tampon as a certain and sure means of arresting the hemorrhage. This we cannot do with safety or without considerable risk, after the Uterus is Emptied of its Contents, that is after the birth of the Child, as there would be ~~considerable~~ danger

From internal hemorrhage, before delivery there is no danger From internal hemorrhage as the Cavity of the Uterus is full.

In this Forms of hemorrhage the flow is arrested during pains - or Uterine Contractions, as the Contents of the Uterus prep against the placenta; thereby Compressing the bleeding Vessels, and putting a stop to the flow for the time being. as by Contractions the Vessels are made Smaller, diminished in Size, and in proportion to the diminution must be the degree of arrest. But when the flow is Excessive and the Contractions weak, the patient is in imminent danger, in which Case, it becomes necessary to rupture the membranes, as this will most likely produce or increase the Contractions, and thereby terminate the labour more speedily. That the rupturing of the membranes are successful, we have the best Authority. as Dr. Ramsbotham Dr. Baudelogue and others, while some

authors object to it.

In cases where we are call-ed, after alarming (Excessive) hemorrhage, we may succeed in delivering the patient, but she may die from the loss sustained before our arrival. It is in such cases as these that transfusion, is recommended. I have however such little confidence in transfusion, that I think I could hardly be persuaded in my mind, that any good would likely result, from such a course of proceeding; and therefore believe that I should not resort to it, under any circumstances. In these cases if the placenta is not expelled very soon, it is best to Extract it, and secure a firm contraction of the Uterus at once. As the hemorrhage will continue until it is done, some recommend Opium in these cases, (small doses) but I would certainly prefer the Ergot first, in order to produce the contractions more

Effectually after which I think the Opium might be given for its stimulant effect &c, Frictions over the abdomen or grasping the Uterus through the abdominal parietes, are good remidies. Cold water suddenly applied to the abdomen is without doubt, a remedy of great utility, One in which I have decided confidence, The frictions and grasping are however generally sufficient to excite the contractile powers of the Uterus; Enough to effect the desired End, after which the patient should be attentively watched and every care taken to prevent a recurrence of hemorrhage.

Unavoidable hemorrhage,

This is when the placenta, is the presenting part or placed over the mouth of the Uterus, It is in such cases as these that the contractions of the Uterus produces bleeding, and in proportion to the contractions will be the amount, or severity of the hemorrhage.

And it is in these cases that the hemorrhage is increased on the accession of Labour. This form of hemorrhage may occur at intervals, with or without pain, from one to six weeks before the term of Utero-gestation Expires, or Labour Commences, It generally comes on very suddenly, and without any apparent cause, - may do so while the patient is Engaged in her usual business, or when she is perfectly at ease, or at rest, while sitting. Standing or lying in bed, indeed it may occur, while in the enjoyment of Society. The first indication is very often, and I may say generally a sudden gush of blood, and without the patient being able to assign a cause. These gushes are however generally arrested, by the time the patient becomes Sensible, of the accident. It is liable to return at intervals of from 5 to 8 days from the first attack, until Labour commences upon the accession of which, as before stated the flow is

Sensibly increased at each succeeding pain. The cause of hemorrhage in these cases, is evidently the seperation, between the placenta and the Uterus, and in proportion to the seperation will be the danger present.

These cases almost always terminate fatally, unless manual aid be resorted to at once. As the Contractions, recur in frequency the flow increases Exposing or rupturing a greater No of bleeding Vessels, And so this it seems that the very act that nature calls into use to relieve herself in common cases, is an aggravation in these and adds to the danger. It is therefore highly necessary to resort to other means for relief.

The Symptoms in these cases are very much Like those already noticed only much more rapid in their progress and termination,

Diagnosis.

The Sudden and apparently causeless occurrence of the hemorrhage increased

discharge during pain- and finding the placenta over the mouth of the Uterus, are said to be the Characteristics of this Form of hemorrhage.

In Accidental hemorrhage (as before stated) there an arrest of the flow during pain; in this Form there is an increase. It may may be thought difficult to determine, whether there be a clot, or portions of the placenta presenting. To distinguish, between these; the former is yielding and can be easily broken down and withdrawn, while the latter is more firm and seems to be attached to the Uterus, which is in reality the case, And cannot be removed without considerable Violence.

Treatment.

If called upon to treat a case of this Nature, or when the discharge has taken place before Labour Commences, and where there is no pain.- The Uterus not dilated, the discharge not great,

or alarmingly so, we may try the palliative treatment, as recommended in accidental hemorrhage. As perfect rest in the horizontal posture, or @ firm bed thin clothing, cool room, Cold drinks, Small doses of Opium, and if necessary, Empty the bowels, by the administration of some gentle Cathartic.

But should the discharge be Excessive, so as to threaten the life of the patient immediately - other and more prompt measures must be resorted to at Once.

And if this is not the case at first, It will most certainly be at the Commencement of Labour;

And from the Very nature of the case, little hope can be indulged of a Natural termination, unless the Contractions, be strong Enough to Expel the placenta, before or with the Foetus, which according to the testimony of the most Experienced, is seldom Ever the case.

We have then but One and the only resort,

and that is to terminate the Labour or deliver as soon as possible. This should be done before the Constitution is Seriously effected, if it be possible to do so. Still I donot by any means think it desirable to have to introduce the hand into the Mouth of a rigid Osteri- but from the best information, I have in possession upon this subject, there is but little danger of being so unfortunate as to meet with such cases, As the Mouth of the Uterus, is generally softened, by the hemorrhage- before or by the time we may be called.

If it is not already dilated, it is dilatable and we may proceed at once, to introduce the hand into the Vagina; in the axis of the outlet changing it as soon as it gains admittance into that of the brim where it comes in direct contact with the Mouth of the Uterus- into which it is to be firmly but gently insinuated.

Then pass between the placenta, and

Cervix on the side most convenient.
Some say where the placenta is thinest
until we come in contact with the
membranes - which must be pierced.
The feet of the child searched for, found,
and brought down. When the body
of the Child gets into the pelvis,
the hemorrhage will be partially
arrested, as it acts as a plug
or compress; thereby stopping the
blood for the time being, &c
But notwithstanding, we should
not delay the delivery long - as there
might be internal Hemorrhage,
If the Uterus should not act
vigorously and promptly I should
think it advisable, to administer
Ergot. in decided doses, which
I think would be an invaluable
remedy. And I would in such
cases, give the Ergot. at or before
the time of introducing the hand
That is when the powers of the Uterus,
would appear to be very feeble, and

ineffectual. If the placenta be not Expelled with or soon after the Child, it should be brought away by gentle traction at the Cord. at the same time we should make steady but gentle friction over the abdomen or grasp the Uterus through the abdom-inal parietes, in order to promote a more speedy Contraction.

If these meas-ures should fail to Expel the placenta, Ergot Constitutes the palladium of our hopes. The after treatment will be very near the same as in accidental hemorrhage; perfect rest both of body and mind The patient should be carefully watched in order to prevent a recurrence of hemorrhage if popible. After delivery there is al-ways more or less hemorrhage, but to constitute a flooding, the discharge must be Excessive or at least considerable, such as to

produce a decided impression upon the system, This is generally caused by a want of a Contraction of the Uterus.

In the treatment of this accident, the first indication is to cause Uterine Contractions, this may be done by frictions, The application of a Napkin well saturated in ice water, is a very handy and often Effectual, means of Exciting the Uterus to Contraction. It should be applied suddenly thereby giving the system a shock. Ergot May be given in these cases with a happy benefit, also Sugar of Lead, Opium. Etc,

Some recommend the introduction of the hand, if the hemorrhage does not yield to the treatment men tioned, thereby making friction in and Externally as a last means of Exciting

the Uterus to Contract.
I have great Confi-
-dence in this plan of treat-
-ment, but think it shou-
-ld probably be the last
resort, as it will hardly
(if Ever) be necessary.
I have
thus briefly gone through the
subject. I conceive that
I have noted all the leading
facts. in relation to acciden
-tal and unavoidable
hemorrhage, that will serve
to make it properly attended
to, the Medical man, of
Service, in such states of dis
-tress and danger, as in Uterine
Hemorrhage. I do not
however present the Forego
-ing as Containing any
original ideas, but as a
Summary of the same,

Collected, from various
Sources - all of which are
respectfully submitted
By William H. Pilcher