

## Part First.

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### ORIGINAL COMMUNICATIONS.

ARTICLE I.—*On Intrauterine Puerperal Coagula.* By  
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(Read before the Obstetrical Society of Edinburgh, 14th January 1880.)

PUERPERAL coagula differ from menstrual coagula essentially in the time of their occurrence. Menstrual coagula may occur at any time during the child-bearing period of life remote from childbirth or abortion. Puerperal coagula occur only in the period called that of the puerperal state, which is easily limited on one side by the childbirth or abortion, uncertainly limited on the other side. This other limit is the period of the return of the uterus to its healthy unimpregnated condition, and into a nice discussion of it I do not enter, satisfying myself by allowing an interval of six weeks from childbirth or abortion to elapse before the puerperal state is probably quite passed.

The peculiarities of puerperal coagula which I propose to illustrate are their size, the liability of the uterus to increase in capacity as if with a view to contain them, the liability to haemorrhage while they remain in utero, and the liability of the clot to form and maintain connexion with the uterus and become a polypus.

It is evident from even a superficial study or a small experience, that the liability to dilatation of the uterus increases with the nearness of the bleeding or formation of the clot to the childbirth or abortion; and that the danger is greater in a like proportion.

On the soft and often adherent clots and the rapid dilatations of post-partum haemorrhage this is not the place to enter. That serious and too familiar accident is limited to a period comprised by, at most, the few hours immediately following delivery or abortion. When bleeding occurs later, it is generally called secondary haemorrhage. Although this distinction is more or less formally and precisely made, it is justified almost exclusively by the rarity

and less danger of the secondary hæmorrhage as contrasted with the frequency and greater peril of ordinary post-partum flooding. There is no essential distinction between primary and secondary hæmorrhage, so far as I know. There is no time in the puerperal state when a woman is safe from perilous hæmorrhage. There is no time in the puerperal state when a woman is safe from expansion or dilatation of the uterus and its attendant dangers. The subjects of puerperal clots and hæmorrhage in the puerperal state, although different, are so german to one another as to justify the introduction of these remarks on what is called secondary hæmorrhage.

Primary intrauterine clots of childbirth or abortion are frequently retained for a few days, become firm from draining off of serum, and are then expelled with slight or severe after pains. Such clots are generally so soft and broken as to retain little of the shape of the uterus. All this requires no proof; it is an occurrence familiar to the practitioner, and were proof required it could be easily produced. In passing, reference may be made to John Ramsbotham's<sup>1</sup> chapter on relaxation of the uterus after delivery, and its subsequent enlargement.

In describing puerperal coagula, I shall divide them into two kinds,—first, those discharged from uteri which have not been dilated to an extraordinary size in order to accommodate them; second, those in which the uteri have become dilated just as they become dilated after contraction in post-partum hæmorrhage.

The puerperal coagula which form and are retained in the puerperal uterus not specially dilated vary in size according to the time at which they are formed, being larger, of course, the nearer in time to the childbirth or abortion. Hæmorrhage may occur while they are retained, without displacing them.<sup>2</sup> They may be discharged entire, or they may break down and pass as brownish débris in lochial fluid.

"A not uncommon cause of secondary uterine hæmorrhage," says M'Clintock,<sup>3</sup> "is the retention of a coagulum, or of a portion of the placenta or membranes. A coagulum of any size is not apt to be found in the womb beyond the first few hours after delivery, as a very moderate degree of uterine action would be sufficient to expel it or to prevent its formation. Should it occur, however,—and experience abundantly proves that it may,—there will be a constant risk of hæmorrhage so long as the clot remains in utero. No doubt, the hæmorrhage in these cases is apt to go on continuously after the expulsion of the placenta, even with a tolerably firm contraction of the uterus, as Dr Ramsbotham has well shown. But on other occasions there is an intermission in the hæmorrhage, and it may not come on for hours or days after delivery. Thus, a woman had frequently recurring attacks of hæmorrhage during the ten days

<sup>1</sup> *Practical Observations in Midwifery*, 2d edition, 1842.

<sup>2</sup> *Ibid.*

<sup>3</sup> *Clinical Memoirs on Diseases of Women*, p. 334.

following delivery, until at length, the loss becoming dangerous and her strength much reduced, 'the hand was passed into the vagina, and the fingers introduced into the uterus, by which means some coagula were removed and the discharge ceased' (Collins)."

Of the formation and long retention of a large clot the following case is an example:—

Mrs Y. H., a young recently married lady, was confined of twins at the end of the seventh month of pregnancy. Both children soon died. There was considerable and rather long-continued haemorrhage post-partum, and the uterus was not brought, even at last, to firm, cricket-ball-like hardness of contraction. Her recovery was on the whole satisfactory, but the lochial discharge persisted of red tint. On the 19th, 20th, and 21st days of lying-in there was considerable secondary haemorrhage, treated by ergot. On the 21st the discharge was chiefly red serum. During these days the uterus was felt to be bulky, but its size was not specially noted. The cervix uteri was patulous, but not open or dilated. On the 22d day after delivery a large clot came away. It had the shape of the uterine cavity, being rounded in all its outlines, and it measured 3 inches in greatest breadth, and  $3\frac{1}{2}$  in length from the part corresponding to the fundus uteri to the part corresponding to the internal os uteri. Below this part the clot was soft and broken. It had points indicating the position of the opening of the Fallopian tubes. Over the whole surface of its lower parts it was partially decolorized in the fretted style well depicted by M'Clintock; and on its upper part corresponding to the fundus the decolorized layer was dense and covering the whole surface. In the fundus of the clot a lacerated aperture was observed which easily admitted the finger, and which was presently accounted for. The bleeding was nearly, but not completely, arrested on the discharge of the clot. Five days afterwards, on re-examination, I discovered a fibrinous polypus and removed it. It had firm adhesion high up in the uterus. Its structure was of the ordinary kind, decolorized on the surface. It was of the size of a chestnut, and had chorionic structures in its pedicle. There could now be no doubt that the haemorrhage flowed around the old clot, which was probably nearly as old as the polypus. It was not so old, for it had been formed around the polypus, and its displacement from the polypus which it surrounded left the lacerated opening in the clot which was observed at the time of the discharge of the latter, but was then thought to be accidental.

In his memoir<sup>1</sup> on polypus of the uterus, Dr M'Clintock relates a case. "In proof," says he, "that a coagulum may be formed in the uterine cavity soon after parturition, and be retained there for a considerable time before being discharged, I may mention the following case which fell under my notice last spring, when temporarily in charge of the Lying-in Hospital for Dr Denham

<sup>1</sup> *Clinical Memoirs on Diseases of Women*, p. 191.

Dr J. R. Kirkpatrick was good enough to furnish me with the particulars, of which the following outline will suffice:—A young woman was delivered naturally of her first child the 19th February. Twenty-four days afterwards there passed from the vagina, without pain or any considerable bloody discharge, a very dense, firm coagulum representing an exact mould or cast, even to the Fallopian orifices, of the uterine cavity. The annexed woodcut shows its size and shape. Externally it had a mottled, dark-red and black colour, and towards the centre it was of a lighter shade of red, and not quite so compact in structure. It presented no sign of decomposition. She had not shown any uterine symptoms from the time of delivery."

In the two cases just given, the intrauterine puerperal clots were old and partially decolorized, not putrid. A case is referred to by M'Clintock<sup>1</sup> as narrated by Lachapelle<sup>2</sup> which, although not quite satisfactory in its details, seems to show that such clots may, instead of growing hard and decolorized, become putrid. "Another interesting remark," says Lachapelle, "which this observation may furnish us, is the return of the haemorrhage at so late a period, without our being able to attribute it to any other cause than the presence of two somewhat voluminous clots, whose fetidity proved their age." The patient had been delivered, at the full time, of twins. The labour was tedious. The membranes were ruptured after about twenty hours of pains, and the first child was soon born. The second soon followed, and then a bilobed placenta. Severe haemorrhage followed and continued for five hours, uterine inertia being at last dispelled by injections of cold water. The woman did well till the eighth day, when she got up, and then a little blood flowed. Haemorrhage continued, although the woman was put to bed, till two fetid clots were discharged. The woman was taken with shiverings, vomiting, fever, etc., and died the following day.

In cases of ordinary secondary haemorrhage it is not rare to find the uterus relaxed and full of soft clots; and it is often recommended and practised to remove these clots, in order to facilitate or secure uterine contraction and retraction. Examples of this are not rare in practice. Sometimes such cases are fatal, and then the clots, often adherent, may be observed in autopsy. Cases are related by Collins, Ingleby, Ashwell, M'Clintock, and several references may be found in my paper on the introduction of the carbolized hand into the uterus at long periods after delivery.<sup>3</sup> All such cases are regarded justly as rather cases of haemorrhage than of clots, just as in the analogous post-partum haemorrhage.

There is another class of cases of great importance, mention of which cannot be omitted, where, in consequence of the retention in

<sup>1</sup> *Clinical Memoirs on Diseases of Women*, p. 334.

<sup>2</sup> *Pratique des Accouchemens*, tom. ii. p. 474.

<sup>3</sup> *British Medical Journal*, Oct. 27, 1877, p. 583.

uterus of some adherent ovuline structure, the involution of the uterus is retarded in a remarkable degree, or completely arrested, till the adherent mass is removed, and then involution again makes progress. Of such occurrences I have recently seen several striking examples, where the still retained mass was very small, not bigger than a small hazel-nut, yet where involution was arrested for weeks or months, and when haemorrhage had proved almost fatal. In such I have removed firm old but not decolorized clots. Such clots do not interfere with the haemorrhage, seeming, indeed, to encourage it; and they are often discharged with more or less pain, new ones being formed in the place of the former. I shall not relate the particulars of any such case, but only refer to one which I published<sup>1</sup> lately.

I cannot advance to the subject of fibrinous polypus without making special remarks on a case of M'Clintock's<sup>2</sup> which he, indeed, calls a fibrinous polypus, but which cannot be regarded as truly such. For he describes the tumour as "not seeming to have any attachment to the uterus, but simply retained by the constriction of the os." The case, then, is very rare, if not unique, and deserves quotation at length, being an unattached decolorized puerperal clot resembling a fibrinous polypus, except that it was unattached and contained no ovuline structure. It is right to note M'Clintock's tone of caution, which justifies the remark that the case is not quite conclusive as it stands. "A married woman, aged 35 years, applied at the Lying-in Hospital dispensary, in the month of September 1861, on account of frequently recurring bloody discharges from the vagina. These had been going on for three months, but were at no time very profuse in quantity. On making an internal examination I found the os uteri open, and a soft fleshy substance, which had all the feel of an ovum, protruding from it. With the aid of a volsellum I drew it away. This was effected without the use of force, the tumour not seeming to have any attachment to the uterus, but simply retained by the constriction of the os. The body so removed was totally devoid of foetor, and was about the size of a large hen egg, but more elongated, and pointed at the ends. It was tolerably firm, but could be cut with a blunt instrument such as a spatula. Its exterior was of a reddish-yellow colour, and within it was apparently composed of coagulated blood. It contained no vestige of a distinct membrane, nor any structure properly belonging to the ovum. This woman had had an abortion or a premature labour (I forgot which) about four months previously."

Into the whole subject of true fibrinous polypus I do not propose to enter. Many such cases have come under my observation. They all occurred in connexion with recent pregnancy, and were the cause of continued loss of blood, sometimes copious, sometimes inconsiderable. They were all easily cured by removal of the polypus.

<sup>1</sup> *Clinical Lectures delivered in St Bartholomew's Hospital*, 1879, p. 3.

<sup>2</sup> *Clinical Memoirs on Diseases of Women*, p. 190.

In all there were ovuline structures in the pedicle or near the attachment of the mass. In most the shape was polypus-like, and the body of the polypus lay in the dilated cervix uteri. In one, already related in this paper, the polypus was within the body of the uterus. In one case the polypus had not the shape of a pear, but was largest at its broad insertion, smallest at its intra-cervical portion; it followed an abortion, and was recent, being scarcely decolorized on its external surface.

In his original writing<sup>1</sup> on fibrinous polypus, Kiwisch, as is well known, thought it probable that the uterus was relaxed, and enlarged or dilated, in order to contain it. His view has been generally rejected, and it is to be remembered that he was writing the first lines penned on the subject, and in ignorance that such polypi were observed only in women who had recently been pregnant. Dilatation of the uterus will be admitted to be easier, and therefore more probable, in a uterus which has recently been pregnant than in one not in the puerperal or lately emptied condition; and I know no good reason for positively denying that such dilatation of the cavity of the body of the uterus ever takes place.

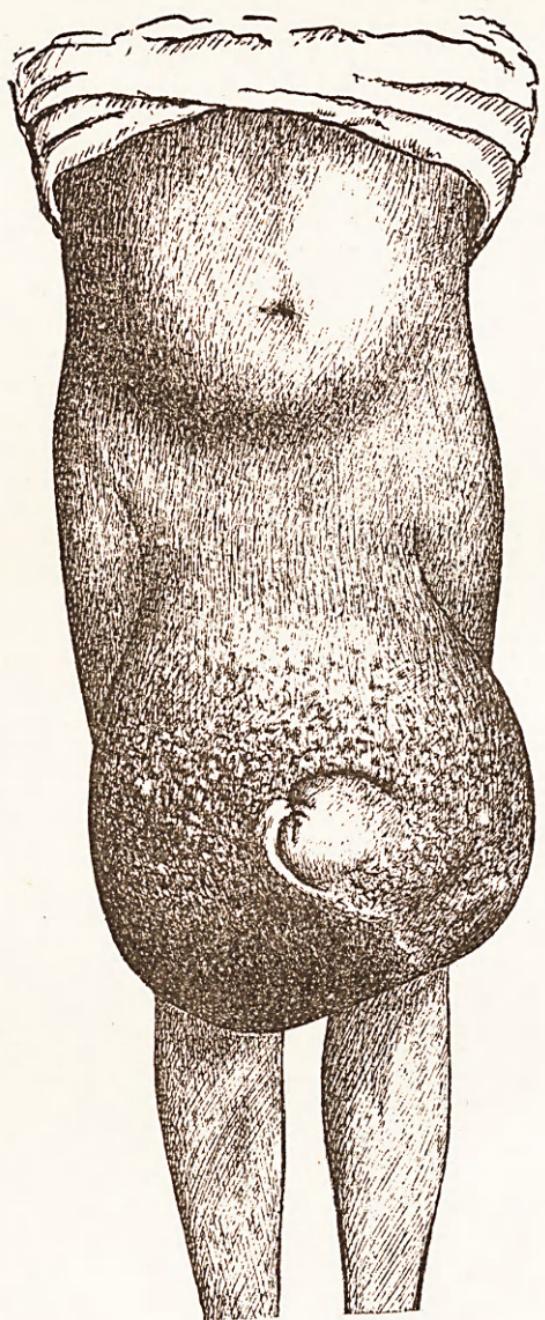
But it is important to remark that we have no clinical evidence that, in order to contain a fibrinous polypus, the cavity of the body of the uterus undergoes special dilatation. It is, indeed, in consequence of its recent repletion in pregnancy, already in a dilated condition. The structure of such polypi and their history show that they are generally, if not invariably, formed of one attached clot, which shrinks and hardens as it undergoes decolorization, and is generally expelled from the cavity of the uterus proper and lodged in that of the cervix, so far as its body is concerned, while its stalk in the proper uterine cavity maintains the connexion of the body of the polypus with its attachment.

I come now to consider the second class of cases, in which the proper uterine cavity is enlarged or dilated, and that probably very rapidly, in order to contain and retain the puerperal clots.

Rapid enlargement of the uterine cavity is well known as a not rare occurrence soon after parturition. This enlargement is too rapid for growth of tissue to have any part in its production. Growth of tissue goes on in regulated concurrence with the expansion of pregnancy; and even in morbidly rapid or extreme expansions there is at least time for growth of tissue to aid in the expansion. Of extreme expansion, often with thinness of wall, examples are found in the hydramnios of advanced pregnancy, and in some cases of uterine hydatids, where it may occur to a marvellous degree either in early or late periods of the gravid condition. But of such expansion as we here consider better illustrations are found in the (too few) post-mortem experiments of Glenard, and in the cases of introduction of the hand into the uterus at long periods after delivery.<sup>2</sup>

<sup>1</sup> *Klinische Vorträge*, 1851. I. Abtheilung, S. 472.

<sup>2</sup> See *British Medical Journal*, Oct. 27, 1877, p. 583.



Ingleby<sup>1</sup> mentions that a case "in which so late as the nineteenth day after delivery the uterus was emptied of a large quantity of putrid blood, shows its capability of distension at this remote period." In my own practice a well-observed case occurred, in which the sudden dilatation with formation of intrauterine clots occurred on the ninth day after delivery. Mrs S., a healthy young woman, was attended by me in 1862 in her first confinement. It was easy and natural. Eight days after her confinement, while she was making a satisfactory recovery, she was seized with faintness and a free discharge of blood. When I reached her, I found the uterus enlarged to about the size of a four months' pregnancy, its fundus rising above the pubes to fully half-way towards the navel. It was by kneading made to contract and expel large firm clots. Ergot and pressure maintained the contraction. When reduced in size, the uterus did not feel more bulky than it would be expected to be on the ninth day. It is a curious fact that this woman, delivered on December 3d, was again delivered on September 29th of a mature, well-developed child, which came into the world a fortnight earlier than the day calculated for by the doctor in attendance. She had had within four weeks after delivery what she described as a scanty anticipatory menstrual flow.

The cases of relaxation and dilatation of the uterus in the puerperal state, when there has been no retention of ovuline structures, which have come within my observation or reading, have been cases of haemorrhage rather than of puerperal clots. In Ingleby's case, where the clots were fetid, there is evidence of retention of clot for a considerable time; but I know no case where the decolorization of the clot indicated length of retention in utero. But there is no apparent reason why such an occurrence may not take place; and M'Clintock's case of so-called fibrinous polypus is the nearest approach to its realization. It would, indeed, be a case in point were there any evidence that the uterus had been expanded to contain the decolorized clot which he removed.

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ARTICLE II.—*Elephantiasis Arabum.* By EDWARD HENDERSON,  
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(Continued from page 596.)

I HAVE already referred to the scrotum as a common seat of elephantiasis in the male; and most surgeons are familiar with the appearance of the remarkable growths resulting from the disease in this situation,—if not practically, at least through the medium of the illustrations given in standard works on surgery. The figure in the diagram is a sketch-tracing from a photograph of one of these tumours, which, with the assistance of my partner, Dr Neil

<sup>1</sup> *On Uterine Haemorrhage*, p. 248.