ACUTE INVERSION OF THE UTERUS.

By J. S. QUIN.

WHILE, from a study of the literature on the question, I do not believe that the condition of acute puerperal inversion is as rare as is commonly supposed, still it is fortunately not a complication that is likely to be met with frequently. The relative infrequency of the condition is the justification for this brief account of a case which I was privileged to see through the courtesy of Dr. Gill, of Dundalk.

Case History. The patient, a spare, delicate woman not yet 30 years of age, had previously borne two children without difficulty. On this occasion labour had been rapid, almost precipitate, and was terminated spontaneously before the arrival of the doctor. There was rather a tendency to bleed in the third stage, and some little difficulty was experienced in the delivery of the placenta, but no undue force was used in its expression, and above all there was no traction on the cord, membranes or placenta.

She lost rather more blood than usual during the placental stage. Subsequently the uterus was inclined to be flabby, but the hæmorrhage was controlled by the usual means of fundal massage, expression of clots and pituitrin. I mention all this in detail to make it plain that there was some trouble with the third stage, but nothing unusual in view of her rapid labour and general condition.

During the first three days of the puerperium her temperature and pulse remained normal and her general condition as before, her only complaint being of the presence of what were supposed to be "after pains." These painful contractions occurred at infrequent intervals, and seemed to cause her more distress than it was to be expected they should. However, this was put down to her poor general condition, in which it was only to be considered natural that the sensations of any pain might be magnified. On the evening of the fourth day, complete inversion took place. A large bluish œdematous mass suddenly appeared outside the vulva, preceded by an acute spasm of pain and accompanied by a bearing down feeling. The patient immediately passed into a condition of profound shock, pulse rapid, weak, thready, skin cold and clammy, respirations sighing and shallow. The uterus was immediately swabbed and replaced in the vagina, no attempt at re-inversion being made; the vagina was packed loosely with gauze, and restorative measures immediately started. During the following six days, hot vaginal douches with antiphlogistine packs in the vagina and over the pubes reduced the œdema and swelling to such an extent that when I saw the patient a week after the occurrence of the inversion I can best and most tersely describe the vaginal findings as being those of a uterus upside down and inside out. There was no ring of cervix present as has been described in some cases. Under deep anæsthesia reposition was successfully effected, using the left hand to exert counter-pressure through the abdomen. On account of the thin abdominal wall one was able to dilate the cervix from above and gradually to reinvert the uterus, replacing first the lower segment and finally the fundus. An original attempt to reinvert the fundus first failed. The uterus and vagina were then lightly packed with gauze, and 1 c.c. pituitrin given. Convalescence was uneventful.

In considering the case in light of a recent study of the literature, several points present themselves. Even in cases occurring immediately at delivery hæmorrhage is not always present, being present to an alarming degree in only a few cases. Severe shock, however, is often present, usually out of all proportion to the

amount of blood lost. This shock is variously described as being due to sudden decrease in abdominal tension, compression of the ovaries in the cul de sac formed by the inverted uterus, and to traction and stretching of peritoneal structures. Some cases (quite an unexpectedly large number) show no immediate symptoms; in others the clinical picture is later that of sepsis with or without gangrene of the uterus from strangulation.

The mortality appears to be about 25%. In considering the management of a case of acute inversion it must be remembered that a successful correction of the inversion at the expense of a life is not an obstetric triumph. In going over the records of reported cases one finds a great number of deaths following immediate reposition. To touch a patient in severe shock is to court disaster. The lines of treatment recommended are either simple manual reposition, or operative measures by the vaginal or abdominal route. In a recent paper read to the American Gynæcological Society, Findley advocates immediate vaginal amputation of the uterus if reposition fails, and records three cases with one death from shock. He makes a plea for sacrificing the uterus to save the patient, stating that all danger of subsequent gangrene or sepsis is thus avoided.

It appears to me, and I have not seen this observation previously recorded, that there can be no danger of strangulation if the inversion is absolutely complete as in the case I have reported. Gangrene and interference with the uterine circulation can occur only when there is a constricting ring of cervix through which the inversion has occurred. This ring is frequently mentioned in the literature as being the cause of trouble in replacement, and it is this constriction that is divided by those who advocate operative procedures either by the abdominal or vaginal route. Furthermore, in the cases in which gangrene and sepsis do not occur, it is more than likely that this ring still causes sufficient interference with the circulation to cause a certain amount of tissue swelling, rendering a subsequent reposition more difficult, if not impossible, while if the condition is left for any length of time there will be a definite tissue change in the uterus.

I would therefore suggest that in any case in which manual replacement at the time of occurrence is either inadvisable on account of the patient's condition or immediately unsuccessful, that this ring should be sought for and, if present, obliterated by entirely completing the inversion by gentle traction. There will be less danger of sepsis in a uterus with a good blood supply.

The patient's condition at the time of the inversion is the best guide to treatment. Shock must be dealt with immediately. Blood transfusion, or saline, warmth and morphia are essential. Reposition is of only secondary importance. Early or immediate reposition is naturally best, but if this fails after a short trial under anæsthesia, or is inadvisable on account of the patient's condition, we should make sure that the inversion is absolutely

complete before leaving her alone. Hæmorrhage may be controlled by hot packs and hot douches, and in some cases may be due to obstruction to the venous return by the cervical ring already referred to. The successful result here reported shows that reposition may be done comparatively easily under more favourable conditions after a week has elapsed.

IN MEMORIAM.

FRANCIS KENNEDY CAHILL

(1876-1930).

It is with deep regret that we record the untimely death of Dr. F. K. Cahill, which took place with dramatic suddenness at his residence, 80 Merrion Square, Dublin, during the night of January 27th, 1930. On the day of his death he had seen his patients as usual, and that evening he had dined with friends at Malahide, from whose company he returned to his home in his customary good spirits. The following morning, on being called, it was discovered that he had passed away quietly in his sleep. A further element of tragedy in the sad occurrence was the fact that at the time of his unexpected demise Mrs. Kennedy Cahill was in London for the obsequies of her son-in-law.

Cahill was one of the best-known figures in the social and medical life of Dublin. The son of the late Dr. Mark Cahill, also a well-known Dublin medical man, he was educated at the Catholic University School, Dublin, and Clongowes Wood College. His clinical studies were pursued at St. Vincent's Hospital, whence he proceeded to his qualifying diploma in the Conjoint Colleges. During his earlier professional practice as a dispensary doctor in Dundrum, Co. Dublin, he obtained the D.P.H. and Fellowship of the Royal College of Surgeons. After a few years of general practice, he decided to specialise in diseases of the stomach, and for this purpose went to Boston, U.S.A., where he studied under Professor Hemmeter, one of the leading American authorities on gastro-enterology. On his return to Dublin, he speedily built up an extensive practice as a consulting physician. Although an infrequent contributor, he was one of the most constant attendants at the various Sectional meetings of the Academy of Medicine, of which he had been a Fellow for many years. He was Consulting Physician to the National Hospital for Consumption, a Fellow of the Royal Institute of Public Health, and was for long an active member of the Committee of Management of the Dublin Sanitary Association.

In private life, Cahill was one of the most sociable and popular of men. He was a prominent member of the United Arts Club, and was one of the most assiduous " first-nighters " at the Abbey Theatre, many of whose gifted artistes were his private patients. His generosity was of the widest and most unostentatious nature; to many of his clients he was in handsome fact the " friend in need " of the proverb. A capital *raconteur* and conversationalist, and one who dearly loved the company of his fellow-men, Cahill's passing will leave a large gap in many Dublin circles.