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(Tubal) Pregnancy.

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Recovery.*

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REPRINTED FROM

The New York Medical Journal
for February 4, 1888.



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A CASE OF
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ON September 22d, ult., I received a letter from Dr. F. E. Hitchcock, of Rockland, Me., the substance of which was as follows:

“ROCKLAND, ME., *September 20, 1887.*

“DEAR DOCTOR: I have a case now under my care which I believe to be one of extra-uterine pregnancy. My reasons for my belief are:

“*First.* She has not menstruated since June last.

“*Secondly.* She has had more or less morning sickness and giddiness, and other reflex symptoms usually accompanying the first months of gestation.

“*Thirdly.* She has had frequent attacks of deep-seated pelvic pain, at times quite severe, and followed by spurts of blood from the vagina.

“*Fourthly.* The breasts have increased in size, the areolæ are darkened, and the papillæ prominent.

“*Lastly.* Within a month there has been a perceptible enlargement in the left side, corresponding to a pregnancy of the

left Fallopian tube. I feel quite sure that the enlargement is not due to any inflammatory process, for there has been no increased temperature to warrant a belief in that theory.

"Within a few days she manifests symptoms which indicate that rupture may soon take place. In case I telegraph you, be sure to come by first train prepared to operate.

"Very truly yours,
"F. E. HITCHCOCK."

About nine o'clock P. M. of September 23d I received the following telegram:

"Refer to my letter of Wednesday. Sac burst this P. M. Profound shock and extreme collapse, but reaction has taken place. Come by boat prepared to make laparotomy.

"F. E. HITCHCOCK."

I arrived at 6 A. M., September 24th, saw the patient, and confirmed the diagnosis. We summoned a consultation consisting of Dr. Banks, of Rockland, and Dr. John Walker, Jr., of Thomaston. The patient was suffering from severe pain, with extreme hyperæsthesia of the abdomen and symptoms of well-marked peritonitis. She could not tolerate the slightest touch of anything anywhere over the abdominal surface. We decided to etherize, in order to afford the members of the council opportunity to examine. This being done, I was able by the bimanual touch to distinctly outline a tumor in the left side, separate from the uterus, which was also enlarged.

The proposition to make abdominal section was unanimously assented to, and I proceeded, assisted by Dr. Hitchcock, Dr. Banks, and Dr. Walker. I found the well-marked indications of peritonitis in adhesions of the tumor to the wall and omentum, also of the peritoneal surfaces to each other at different points. Quite an amount of serum had accumulated, due, probably, both to peritonitis and the extravasated blood which followed the rupture; of this there was about three pints, some of the clots being almost black, while others were bright red.

This difference in color, I am inclined to think, was from the different ages of the clots. Dr. Hitchcock believes that she had a small hæmorrhage a few days before the extreme collapse took place, as she had very severe pain followed by some exhaustion.

The tumor proved to be a gestation sac of the left Fallopian tube, and had undoubtedly existed for about three months, the fœtus being about three inches long. After removing the tumor and blood, and sponging carefully and ligating all bleeding vessels, I poured a quart of very hot carbolized water into the cavity, rinsed the parts, and thoroughly sponged it out; introduced a glass drainage-tube, and closed the abdominal wound with silk, dressing with gauze and absorbent cotton. The operation was closed about nine o'clock, sixteen hours after the rupture. I left the patient at 1 P. M., having given two hypodermatic injections of morphine sulphate, a quarter of a grain each. She was very comfortable, having slept more than half the time for the last hour before I left. From that time forward all signs of peritonitis disappeared, and the recovery was uninterrupted.

The temperature was at no time above 101° , and that only for a single day, most of the notings being 100° or below during the first week. There were some vomiting and nausea for a few days, but a small quantity of morphine controlled all the troublesome symptoms.

I am perhaps needlessly minute in these details, but, as they have a bearing on some conclusions drawn from the case, I am obliged to be thus explicit. The patient is about thirty-three years old, but was married very young, and had one child in her early married life. From the birth of this daughter (now about sixteen years of age) until this summer she had never been pregnant, although no means had been used to prevent conception. This fact was at first somewhat an obstacle to a ready diagnosis of the real condition, although she manifested some of the early signs of

pregnancy. The absolute diagnosis of extra-uterine pregnancy was made by Dr. Hitchcock about a week before rupture, and principally by bimanual examination and being able to clearly separate the tumor from the uterus.

Lawson Tait thinks a diagnosis before rupture very difficult to make, and questions its being made. Certainly in this case Dr. Hitchcock had succeeded in making it, and it would seem as if he had all the essential elements for basing such an opinion upon. The patient had been a woman of very good health in the years intervening between the pregnancies, with no history, so far as I could learn, of any pelvic lesions.

Mr. Tait believes that tubal pregnancy occurs where there has been salpingitis that has destroyed the epithelium of the tube, thus allowing the ovum to adhere to its walls, where it becomes impregnated. In this case I am unable to say whether or not such a condition obtains.

So far as I am able to learn, this is the second successful case of laparotomy for tubal gestation after rupture had taken place, that of Dr. Arthur Johnstone, of Danville, Ky., being the first. The cases differ in this particular: his operation was done thirty days after the first rupture, while mine was done fifteen hours after, and I think before all hæmorrhage had ceased. On this last point I am not quite sure. I removed some very fresh clots and some fluid fresh blood, but whether due to extravasation *immediately* before the operation or to the manipulations made to break up the adhesions I can not say. My anxiety to remove the sac as rapidly as possible prevented me from noticing any minor matters connected with the case.

Dr. Johnstone says he found many very black clots, some even "inspissated"; this he thinks due to former lesser hæmorrhages. In my case there were no inspissated clots, at least none were noted.

Dr. Robert P. Harris, who is certainly authority on abdominal sections, writes me under date of November 7th :

“This operation may be divided into two classes. In one the incision is made while the hæmorrhage is still active, and in the other after it has nearly or entirely ceased and the woman has in a measure recovered from the shock.” The first he would denominate “primary” laparotomy, the latter secondary or “hæmostatic laparotomy.”

I think in my case the patient had a much better chance for life fifteen hours after rupture than if she had been operated upon at the period of collapse and while hæmorrhage was still active.

This is a point that only experience must determine. If we could be at all sure that hæmorrhage would cease before it exhausted the patient, we should all say, wait until reaction takes place. I feel quite certain that peritonitis is no serious bar to operation, but, from my experience in this case and several other cases of peritonitis from different causes where I have performed laparotomy, I am quite confident that from the moment of the operation the peritonitis ceased. In all of these cases I washed out the abdominal cavity with hot water.

I believe the profession have been too much in fear of reopening the wound after abdominal section where peritonitis had supervened. I have no doubt it would be equally favorable were it done in peritonitis from other causes—intestinal obstruction, tubercular deposit, wounds, etc. Hereafter I shall not allow a patient in this condition to die without operating where consent can be had.

Dr. Harris closes his letter by saying, “There is no other successful one on record in the United States but the one occurring in Danville.”

The conclusions I would derive from this case, while

more or less crude and more in the form of suggestions than conclusions, are as follows :

First. If it is true that the diagnosis of extra-uterine, and especially tubal, pregnancy is not so difficult as to prevent us from being certain in a majority of cases, why even attempt fœticide by electricity or any other means, which at the best leave a foreign body in the abdominal cavity, where it may produce septicæmia or other troubles, and keep the patient in a state of invalidism for years? Why not at once remove it by laparotomy, as we would any ovarian tumor? The risk can not be very much greater. Why wait and take the risks of rupture from which the patient may at once die, or a few days later die from peritonitis?

The risk of waiting until competent surgeons can be secured may be too great, even if we permit it to go on to rupture. Lives may be lost even under the most favorable circumstances if we wait for this to take place, and it is liable to occur at almost any period of gestation.

Second. I am satisfied that peritonitis is no bar to operation, but, on the contrary, that the operation is a decided relief to the peritonitis, not only from the cutting and consequent hæmorrhage, but by removing any material which if left might become septic, and this suggests that any plan which tends to relieve the congested vessels and eliminate any fluid exudate must be beneficial in preventing a fatal termination in peritonitis from whatever cause. Acting upon this theory, Mr. Tait has for a long time used the saline cathartics in beginning peritonitis with marked success. My own experience in several cases within the past six months confirms me in the belief that this is a far safer method than the long-continued and universal opium treatment of Alonzo Clark.

Third. That the danger from hæmorrhage is a very grave one. I am quite sure that in this case, had not Dr.

Hitchcock given the patient the most faithful and persistent attention for hours, she would never have rallied from the collapse. The rupture was a large one, occurring just at the junction of the tumor with the remaining, proximal portion of the Fallopian tube. The fat, firm abdominal walls, with a small abdominal cavity, contributed to arrest the hæmorrhage much earlier than would have happened had the condition been the reverse. Therefore I am forced to the conclusion that, if we are sure of our diagnosis, laparotomy at once is the best practice.

